MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Andrea Sutcliffe
Date: 20/03/2024

I, Andrea Sutcliffe, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made on behalf of the Nursing and Midwifery Council (NMC) in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be “Exhibit 1”.

Qualifications and positions

1. I have held the following national positions. From 2000 to 2007, I was Planning and Resources Director, and from 2004, Deputy Chief Executive of the National Institute for Health and Clinical Excellence. From 2007 to 2012, I was Chief Executive of the Appointments Commission. From 2012 to 2013 I was Chief Executive of the Social Care Institute for Excellence. From 2013 to 2019 I was the Chief Inspector, Adult Social Care at the Care Quality Commission. I am the Chief Executive and Registrar of the NMC. I have held this role since 14 January 2019.

Module

2. I have been asked to provide a statement for the purpose of M3: Professional Regulation.

3. My evidence relates to paragraphs 10 to 13 of the Inquiry’s Terms of Reference.

4. I have been asked to address a number of questions for the purpose of my statement and I will address each of those in turn. I will start with an outline of the role of the NMC, before moving on to explain our role in education and quality assurance and answering the specific questions relating to that area of our work. I

then explain our fitness to practise process before answering the specific questions raised by the Inquiry around that process.

The role of the Nursing and Midwifery Council (NMC)

5. The NMC is the regulatory body for nursing and midwifery professionals in the UK. We are a statutory body, established and governed by the Nursing and Midwifery Order 2001 ('the Order'), in accordance with s60 and s62(4) Health Act 1999. We hold a register of 808,488 nurses and midwives in the UK and nursing associates in England.[1]

6. Our statutory obligations and powers are set out within the Order, which sets out that our principal functions are to establish standards of education, training, conduct and performance for nurses, midwives and nursing associates, and to ensure the maintenance of those standards.[2] Rules made under the Order regulate the performance of these statutory functions.[3]

7. We do not regulate the conduct of students but we are required to assure ourselves of the quality of their education and training. More detail is provided from paragraph 13.

8. Our over-arching objective is the protection of the public.[4] Our Order provides for us to pursue this objective in three ways:[5]

    a. Protect, promote and maintain the health, safety and wellbeing of the public.

    b. Promote and maintain public confidence in the nursing and midwifery professions.

    c. Promote and maintain proper professional standards and conduct for members of the nursing and midwifery professions.

[1] Data correct on 30 September 2023, published on 30 November 2023
[2] Article 3(2) of the Order
[3] The Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004 (the Registration Rules) provide the powers to develop education standards.
[4] Article 3(4) of the Order
[5] Article 3(4A) of the Order

9. These objectives are central to everything that we do, and we want to make sure every nurse, midwife and nursing associate can provide good and safe care.

10. Our core role is to regulate. We set, monitor and promote high education and professional standards for nurses and midwives across the United Kingdom (UK), and nursing associates in England. We maintain the register of professionals eligible to practise, ensure that professionals continue to meet our standards throughout their careers, and investigate concerns about nurses, midwives and nursing associates.

11. To regulate well, we support both the public and the nursing and midwifery professions. We create resources and guidance that are useful throughout the career of the professionals on our register, helping them to apply our standards in their day-to-day practice and to use their professional judgement and decision making when addressing new challenges. We support both the public and individual professionals when they are involved in our fitness to practise investigations.

12. Regulating well and supporting people who use health and care services and the professionals on our register allow us to influence health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice and evidence base to speak up for issues affecting our professions and public safety.

Q1. Please provide an explanation of the competencies which are expected of Registered Learning Disability Nurses.

Our role in regulating education for Registered Learning Disability (LD) Nurses

13. We set the standards of proficiency necessary to join the register for each of the professions we regulate.[6] These standards represent the skills, knowledge and attributes all registered nursing and midwifery professionals must demonstrate.

14. We set the standards of education and training necessary to achieve the standards of proficiency.[7] Together, these are used by the Approved Education Institutions

[6] Article 5(2)(a) of the Order
[7] Article 15 (1)(a) of the Order

(AEIs) and their practice learning partners to shape the content and design of both the theory and practice programme curricula delivered by AEIs.

15. Through our quality assurance (QA) process we approve education institutions and programmes that meet our standards of education and training, and we seek assurance that the quality of practice learning placements for students is managed through effective partnerships between AEIs and their practice learning partners. Once programmes are approved, we undertake monitoring of institutions and their programmes to ensure our standards continue to be met. This includes activities such as exceptional reporting, annual self-reporting, new programme monitoring, enhanced scrutiny, listening events (including with students), monitoring visits and extraordinary reviews. This ensures that nurses, midwives and nursing associates are consistently educated to a high standard and can deliver safe and effective care at the point of entry to the register. It also provides similar assurance if they expand their practice through our post-registration qualifications. Where we have concerns that our standards of education and training are not, or will not, be met, we can refuse to approve, commission an extraordinary review of, or withdraw approval from, a programme or AEI.

16. Our QA framework (**Exhibit 1**) explains our approach to QA and how it is delivered. This version came into effect on 17 August 2020. We also publish a quality assurance handbook (**Exhibit 2**) which sets out the detail of our processes and the evidence that AEIs (and their practice learning partners) will need to provide to demonstrate that they meet our standards.

17. To support our QA function, we contract a provider for QA operational delivery which is currently Mott MacDonald. They appoint lay and registrant visitors who undertake documentary reviews and attend AEIs to assess whether our standards are being, or will be, met. The QA visitors review and scrutinise how AEIs propose to meet our standards for student supervision and assessment (SSSAs); (**Exhibit 3**), curriculum, programme specification and module specifications alongside the university approval panel members, which include external examiners appointed by the university. We expect students and members of the public to be involved in the development and delivery of curricula, and they can also inform the approval process, including attending in-person approval events.

18. The QA visitors then provide a report with their recommendations to inform our decision whether to approve a programme or AEI or consider whether action needs to be taken in respect of existing programmes. These decisions are ratified at our QA Board.

19. Our Standards framework for nursing and midwifery education (**Exhibit 4**) states that AEIs, together with practice learning partners, must have robust, effective, fair, impartial and lawful fitness to practise procedures to swiftly address concerns about the conduct of students that might compromise public safety and protection.

20. Our Standards for pre-registration nursing programmes (**Exhibit 5**) state that AEIs, together with practice learning partners, must ensure students' health and character are sufficient to enable safe and effective practice both on entering and throughout the programme. The same applies when submitting the supporting declaration of health and character in line with the NMC's health and character decision-making guidance (**Exhibit 6**). This declaration includes satisfactory occupational health assessment and criminal record checks.

21. They must also ensure students are informed of the requirement to declare immediately any police charges, cautions, convictions or conditional discharges, or determinations that their fitness to practise is impaired made by other regulators, professional bodies and educational establishments. They need to ensure that any declarations are dealt with promptly, fairly and lawfully.

22. Our health and character decision-making guidance sets out how students (and apprentices where they exist) and AEIs must approach health and character.

23. When students apply to study to be a nurse, midwife or nursing associate they must tell their AEI about any health conditions and/or disability which could affect their ability to practise safely and effectively. They must also declare any police charges, cautions, convictions or conditional discharges.

24. If a student is charged with a criminal offence or receives a caution, conviction or conditional discharge while they are studying, they must tell their AEI. The AEI will then investigate and decide if it calls their good character into question and whether they should remain on their course. If the student remains on the course, they must

declare the charge, caution, conviction or conditional discharge to us when applying to join the register.

25. This will be included in the supporting declaration that the AEI provides when students apply to join the NMC's register. When we assess health and character at during the registration process, we check whether students have disclosed these to their AEI. We also consider whether a failure to disclose a police charge, caution, conviction or conditional discharge affects their character and ability to provide safe and effective practice. When we decide whether an applicant is capable of safe and effective practice, we may make a different decision to an AEI.

26. Our Standards for education and training programmes set out the requirements that AEIs and their practice learning partners must have in place in order to be able to provide a supporting declaration for nurses, midwives and nursing associates who are seeking to join the register. We provide guidance on the process on our AEI portal guidance[8].

27. All programme providers must have a local fitness to practise panel to consider health or character issues and to protect the public. For health these should only be used if a student's health or disability is likely to compromise or has compromised their ability to meet the required competencies and practise safely. If a student is charged with a criminal offence or receives a caution, conviction or conditional discharge while they are studying, a local fitness to practise panel will meet to make a decision about their suitability to remain on the programme if their attitude or behaviour is such that it calls into question their good character.

Fields in nursing education

28. To qualify as a nurse or midwife in the UK, or a nursing associate in England, individuals must complete an approved qualification provided by an AEI. The recruitment and admission of students and the design and delivery of curricula and assessment strategy are undertaken by the AEIs and practice partners in line with our standards.

29. In accordance with the Nurses & Midwives (Part and Entries in the Register) Order of Council 2004 (SI 2004/1765), which states that entries in the register are to

[8] https://nmc.mottmac.com/Training-resources/portalguidance

include a registrant's field of practice, UK students that qualify in a specific field of practice as a level 1 nurse may apply to enter the NMC register as a nurse in one or more of the four fields of nursing practice: adult, children, learning disabilities (LD) and mental health.

30. AEIs and their practice learning partners develop, deliver and manage pre-registration nursing programme curricula. However, AEIs must include routes specific to the relevant fields of nursing practice within any programme leading to registration for which they seek NMC approval.

31. On successful completion of a programme students are registered by the NMC as qualifying in one or more field of nursing practice.

Education and training requirements for Registered Learning Disability Nurses

32. In 2004 we published our Standards of proficiency for pre-registration nursing education (**Exhibit 7**). These were then updated in 2010 (**Exhibit 8**) when we introduced graduate only entry to nursing for the first time.

33. These documents combined both the proficiencies (the knowledge and skills directed at individuals) with the education standards (the programme content for education providers should be doing). This led to some repetition of content and inconsistencies so in 2016 we embarked on a significant education change programme.

34. In 2018, following our commitment to undertake a strategic programme of change for education we reviewed and updated new education and training standards, including:

    a. Standards framework for nursing and midwifery education (**Exhibit 4**)

    b. Standards for student supervision and assessment (SSSAs) (**Exhibit 3**)

    c. Standards for pre-registration nursing programmes (**Exhibit 5**)

    d. Standards of proficiency for registered nurses (**Exhibit 9**).

35. When we consulted on updating our standards we published an easy read version of the consultation document (**Exhibit 10**) to help people with learning disabilities to understand and respond to our proposals.

36. The standards for pre-registration nursing programmes were updated in March 2023 now the UK is no longer in the European Union. This included changes to general education requirements and the use of up to 600 hours of simulation for practice learning.

37. The nursing fields are referenced throughout the standards, which are designed to ensure that all students are both exposed to the breadth of all four fields and have the in-depth knowledge, skills and experience to be suitable to join the register in one or more of the fields. The sections relevant to preparation for the specifics of LD nursing are outlined below.

Standards of proficiency

38. Our standards of proficiency reflect what we expect a newly registered nurse to know and be capable of doing safely and proficiently at the start of their career. The proficiencies are grouped under seven platforms:

    a. Being an accountable professional
    b. Promoting health and preventing ill health
    c. Assessing needs and planning care
    d. Providing and evaluating care
    e. Leading and managing nursing care and working in teams
    f. Improving safety and quality of care
    g. Coordinating care.

39. The outcome statements for each platform have been designed to apply across all four fields of nursing practice. Registered LD nurses must also be able to demonstrate a greater depth of knowledge and the additional more advanced skills required to meet the specific care needs of people in their chosen field of LD nursing practice.

40. The two annexes to these standards of proficiency describe what registered nurses should be able to demonstrate they can do at the point of registration in order to provide safe nursing care. Annexe A specifies the communication and relationship management skills required, and Annexe B specifies the nursing procedures that registered nurses must demonstrate that they are able to perform safely. They also

identify where more advanced skills are required by registered LD nurses working in the LD field of nursing practice.

Programme standards

41. In order to run a programme leading to Registered Nurse (Learning Disabilities) the AEI, together with their practice placement partners, must meet the standards framework for nursing and midwifery education, SSSAs and standards for pre-registration nursing programmes.

42. The legislation setting out our role in regulating education refers to establishing standards, not designing curricula. Our standards therefore give AEIs, in partnership with practice partners, the flexibility to design their own curriculum and the autonomy to decide on the proportion of core and field specific hours provided. We expect them to use evidence and engagement from people who have experienced care by LD nurses to inform programme design and delivery for all fields of nursing practice.

43. AEIs, together with practice learning partners, must state routes within their pre-registration nursing programme that allow students to enter the register in one or more of the specific fields of nursing practice.

44. They must:

    a. Confirm on entry to the programme that LD students are suitable for the LD field of nursing practice.

    b. Set out the content necessary to meet the programme outcomes for LD nursing practice, including field-specific content in relation to the law, safeguarding, consent, pharmacology and medicines administration and optimisation.

    c. Provide practice learning opportunities that allow LD students to meet the communication and relationship management skills, and nursing procedures, within the LD field of nursing.

45. Our SSSAs state that AEIs, together with practice learning partners, must ensure that LD nursing students are assigned to practice and academic assessors who are NMC registered nurses with appropriate equivalent experience for the LD field

of practice. Practice supervisors must be registered health and social care professionals. However, they can be non-NMC registered members of the multi-disciplinary team provided they are registered with another professional regulator[9].

46. Throughout the programme they must ensure that LD students meet the standards of proficiency for registered nurses and programme outcomes for LD nursing, including all communication and relationship management skills, and nursing procedures, within the field of LD nursing.

47. To help support implementation of the standards we have published a series of practice learning experience case studies setting out how nursing students can demonstrate their proficiency in a range of practice learning environments. One of these was written by a second-year learning disabilities student nurse, following her practice learning experience with the learning disabilities Liaison Service at an acute hospital.

Internationally educated LD nurses and LD nurses returning to practice

48. Internationally educated LD nurses who wish to join our register must have undergone training in nursing and passed a Test of Competence (ToC) to demonstrate that they have met the standards of proficiency for admission to the nurse part of the register.[10]

49. Our ToC therefore reflects our standards of proficiency for registered nurses, and LD nursing applicants need to take a test that is specific to LD nursing.

50. The ToC is split into two parts: a multiple-choice computer-based test (CBT) and a practical test known as the OSCE (objective structured clinical examination). The CBT has one part for numeracy and one for clinical questions related to nursing. The OSCE has ten stations to assess evidence-based practice as well as the candidate's values and behaviours.

51. To support internationally educated LD nurse applicants we publish a test blueprint (**Exhibit 11**) showing how the LD standards of proficiency and associated skills and procedures may be tested in either the CBT, OSCE or both parts. We also

[9] Such as the General Medical Council, General Pharmaceutical Council, Health and Care Professions Council or Social Work England, or with a professional health and social care organisation accredited by the Professional Standards Authority.
[10] Article 13(1)(d) of the Order

publish an LD nursing reading list (**Exhibit 12**), marking criteria (**Exhibit 13**) and mock OSCE (**Exhibit 14**).

52. Former LD nurses must undertake a minimum number of practice hours to rejoin our register.[11] Our return to practice (RtP) standards (**Exhibit 15**) state that former LD nurses applying for readmission who have not undertaken enough practice hours can either take the LD ToC as above or a tailored LD Return to Nursing course.

53. The length of the RtP course and the amount of practice learning former LD nurses do depends on their individual needs. AEIs and their practice learning partners design RtP programmes to include practice learning so that returners gain appropriate knowledge, skills and confidence to deliver safe and effective care for a diverse range of people with learning disabilities, their families and carers.

54. AEIs and their practice learning partners must state routes within the RtP programme that allow former LD nurses to be readmitted to the register in the field of LD nursing practice, and they must set out the content necessary to meet the programme outcomes for the field of LD nursing practice.

Q2. How does the NMC ensure that Registered Learning Disability Nurses have the specific competencies to care for people with complex needs admitted to specialist learning disability inpatient settings?

55. Our role in regulating LD nursing education is to establish standards, and it is for AEIs and their practice learning partners to design curricula that allow LD nursing students to enter the register in the LD field of nursing practice.

56. Our Standards for pre-registration nursing programmes set out how students need to be able to practise across settings and sectors.

57. They state that AEIs, together with practice learning partners, must ensure that students experience the variety of practice expected of registered nurses to meet the holistic needs of people of all ages.

[11] Article 19(3) of the Order

58. They must provide practice learning opportunities that allow LD nursing students to meet the communication and relationship management skills and nursing procedures, as set out in Standards of proficiency for registered nurses, within their selected fields of LD nursing practice.

59. Throughout the programme they must ensure that LD students meet the standards of proficiency for registered nurses and programme outcomes for LD nursing, including all communication and relationship management skills, and nursing procedures, within the field of LD nursing.

60. As set out above, through our QA process we approve education institutions and programmes that meet our standards of education and training. Once programmes are approved, we undertake monitoring of institutions and their programmes to ensure our standards continue to be met. Where we have concerns that our standards of education and training are not, or will not, be met, we can refuse to approve, commission an extraordinary review of, or withdraw approval from, a programme or AEI.

61. Quality assurance (QA) of education gives us the confidence that education institutions are meeting our standards for education and training, ensuring that students meet the standards of proficiency necessary to join the register and provide safe and effective care. AEIs, together with their practice placement partners, are required to confirm that students have met the standards of proficiency when they are submitted to join the register.

Q3. How does the NMC seek to apply the professional standards of practice and behaviour to Registered Nurses on different parts of the register?

62. In addition to our education and training standards, the Order also requires us to set the standards of conduct, performance and ethics expected of registrants and prospective registrants.[12] We do this through our publication of 'the Code', which sets out the professional standards that nurses, midwives and nursing associates must uphold as registered professionals.

[12] Article 3(2) and Article 21(1)(a) of the Order

63. All professionals on our register, regardless of the part or parts of the register that they are on, must abide by our professional standards of practice as set out in the Code.

64. The Code was last updated in January 2015 (**Exhibit 16**), with a minor update in 2018 in response to the inclusion of nursing associates in England on the register. Since 2015 the Code is structured around four themes:

    a. prioritise people

    b. practise effectively

    c. preserve safety

    d. promote professionalism and trust.

65. The Code contains a series of statements that signify what good practice looks like, it puts patients and service users first, ensures safe and effective practice and promotes trust through professionalism.

66. We do not set specific training on the Code but we have developed supporting information and animations to support the use of the Code in day-to-day professional practice. All students learn about the Code in line with our standards and how this is achieved is the responsibility of individuals AEIs and their practice learning partners.

67. We monitor how the AEIs provide education and training on the Code through our QA process as outlined above. One of the outcomes specified in our Standards of proficiency for nurses is that at the point of registration, registered nurses will be able to understand and act in accordance with the Code.

68. Professionals must demonstrate their continued ability to practise in line with our Code and standards through revalidation. We can also take action through our fitness to practise process where we receive concerns that professionals may have failed to meet our Code and standards.

Revalidation

69. All those on our register are required to renew their registration every three years. Since April 2016 this has been done through our revalidation process. Revalidation

strengthens practice by ensuring that in addition to undertaking continuing professional development and practice hours, professionals also need to take part in reflective practice. Revalidation ensures that those on our register continually reflect and develop their practice in line with our Code and standards of proficiency. Our revalidation requirements are set out in our revalidation guidance (**Exhibit 17**). To meet our revalidation requirements, every three years those on our register must declare that they have completed:

a. 450 practice hours, or 900 hours if renewing two registrations (for example as both a nurse and a midwife). Specialist Community Public Health Nurses (SCPHN) registration can be renewed alongside registration as a nurse of midwife without the additional 450 hours.
b. 35 hours of continuing professional development (CPD) including 20 hours of participatory learning
c. Five pieces of practice-related feedback
d. Five written reflective accounts
e. Reflective discussion

70. When a professional revalidates, they also must sign a health and character declaration, confirm their professional indemnity arrangements and have a confirmer validate their submission.

71. Revalidation is about promoting good practice and strengthening confidence in the nursing and midwifery professions; it is not an assessment of fitness to practise.

72. We encourage registrants to use our Code and standards to plan their CPD around where they might need to improve their knowledge and skills. We also proactively encourage registrants to consider the standards as part of the emails we send reminding them to revalidate. In our new Spotlight report (**Exhibit 18**) we encouraged professionals to revalidate against our standards, and employers, system regulators and leaders to support professionals to develop their practice in line with our standards.

Fitness to practise

73. When a concern is raised about a professional on our register's conduct, health, or competence we investigate through our fitness to practise (FtP) process. Our fitness to practise process is one of the ways in which we fulfil one of our principal statutory functions of ensuring the maintenance of the standards[13]. We take regulatory action where needed to protect people who use health and social care services and to ensure public trust and confidence in the professions is maintained.

74. For further details of our FtP approach please see paragraph 101.

Q4. Does the NMC set and assess post-registration standards for registered nurses? If so, how are post-registration standards for registered nurses set and assessed?

75. We set standards and approve programmes for certain post registration and specialist practice qualifications. These are:

    a. Prescribing standards[14] (**Exhibit 19**)

    b. Standards of proficiency for Specialist Community Public Health Nurses (SCPHNs)[15] (**Exhibit 20**)

    c. Standards of proficiency for community nursing specialist practice qualifications (SPQs)[16] (**Exhibit 21**)

    d. Associated post-registration programme standards (**Exhibit 22**).[17]

76. The SCPHN part of the register is for registered nurses or midwives with an additional qualification as a health visitor (HV), school nurse (SN), occupational health nurse (OHN) and public health nurse (PHN).[18]

[13] Article 3(2) of the Order
[14] Article 19(6) of the Order
[15] Article 5(2) of the Order
[16] Article 19(6) of the Order
[17] Article 15(1) of the Order
[18] Article 7 of the Nurses and Midwives (Parts of and Entries in the Register) Order of Council 2004

77. Specialist Practice Qualifications (SPQs) are recordable qualifications that meet our standards and are visible on public register entries but do not lead to admission to a part of the register.[19]

78. We routinely review our standards to make sure that nurses, midwives and nursing associates are equipped with the knowledge, skills and behaviours they need to deliver safe care now and in the future.

79. When developing standards, we work collaboratively with nursing and midwifery professionals, representatives from the wider health and social care community, advocacy groups and members of the public.

80. All these people have a valuable contribution to make and help us to develop standards that reflect best evidence which support our professionals in delivering safe, effective and kind care.

SCPHN and SPQ post-registration standards review

81. We began a major review of all our education standards and our quality assurance processes in 2016. As part of this in July 2022 we launched new SCPHN and community nursing SPQ post-registration standards which will make sure our professionals have the additional knowledge and skills they need to deliver high quality care.

82. The review started in 2018 with an independent evaluation of our existing SCPHN and SPQ post-registration standards (**Exhibit 23**) to help inform our approach to developing new standards.

83. In Autumn 2019 we set up a steering group to oversee the project, review and ratify the outputs and make recommendations to our Council, chaired by Dr David Foster OBE. The group included a range of key stakeholders from across the four countries of the UK.

84. The steering group made the following recommendations which our Council agreed at its January 2020 meeting:

[19] Ibid.

a. To do an initial phase of work to scope standards of proficiency content of a proposed new SPQ for community nursing practice and associated programme standards.

b. The development of new standards of proficiency for the health visitor, occupational health nurse and school nurse and fields of SCPHN practice, and associated programme standards.

85. Our Council met in May 2020 and reaffirmed the importance of this work and our need to continue to work with others to co-produce the new standards.

86. To make sure that our draft standards were shaped by a diverse range of voices and perspectives, we undertook a range of engagement activities in the summer and autumn of 2020. Because of the coronavirus pandemic and restrictions on travel and meeting in person, this engagement took place online. We were pleased that 2,200 people attended 12 webinars between June and October. We also held 16 virtual roundtable meetings with specific audiences, such as frontline practitioners, educators, employers and advocacy groups, to hear their views and understand what they think should be considered for the new standards.

87. Following this engagement we published a pre-consultation engagement activity report (**Exhibit 24**) and a report by Pye Tait, an independent research organisation, on themes from the pre-consultation engagement (**Exhibit 25**).

88. We held an extended 16-week public consultation, which included publishing an easy read version of the consultation document (**Exhibit 26**) to help people with learning disabilities to understand and respond to our proposals. This was followed by assimilation of the independent findings of the consultation with stakeholders, and user testing. The assimilation included engagement with representation from the four UK nations including Chief Nursing Officer representatives, advocacy groups, the Council of Deans of Health and a significant number of professional bodies and trade unions.

The current SCPHN and SPQ post-registration standards

89. In May 2022 Council approved the new SCPHN and community nursing SPQ post-registration standards, which came into effect in September 2022.

90. Our new outcome focused standards of proficiency for SCPHNs will ensure that future SCPHN professionals are ideally placed to lead and influence public health services, are culturally competent, address health inequalities and make a difference to the health and the wellbeing of people of all ages, and across communities and populations. Core standards of proficiency apply to all fields of SCPHN and field specific standards of proficiency apply to the HV, SN and OHN fields of SCPHN practice.

91. Equally our new outcome focused standards of proficiency for community nursing SPQs reflect the specialist knowledge, skills and attributes required by nurses working in the community in any roles which involve more autonomous decision making for those registered nurses managing greater clinical complexity and risk, both in terms of the people they care for and the services they work within, which in turn may be integrated with other agencies, professionals and disciplines.

92. Our new post-registration programme standards highlight the need for these programmes to adopt an inclusive approach to recruitment, selection and progression, ensuring admissions and all other academic processes on the student journey are open, fair, and transparent, and demonstrate an understanding of and take measures to address underrepresentation.

93. Curricula for specialist community public health nurses and community nursing specialist practice qualifications may be flexible to accommodate opportunities for shared learning but must be clearly tailored and relevant to individual post registration students' intended field of SCPHN or community nursing SPQ practice.

94. All post-registration education providers must have new programmes approved against the new standards by 1 September 2024. No students will be able to commence a programme approved against the former SCPHN or SPQ standards from 1 September 2024.

Prescribing standards

95. In order to prescribe medicinal products, nurses and midwives must have recorded their prescriber qualification on our register.[20] There are two types of nurse or

[20] Human Medicines Regulations SI 2012/1916, regulations 214(3)(c), 214(3)(d) and 214(4)

midwife prescribers: community nurse or midwife prescribers and independent and supplementary nurse or midwife prescribers.[21]

96. We have adopted the Royal Pharmaceutical Society's Prescribing Competency Framework (**Exhibit 27**) as our standards of proficiency for prescribing practice. All prescribing programmes approved under our new standards for prescribing programmes must deliver outcomes which meet the requirements of the framework.

97. This competency framework sets out what the professionals on our register need to know and be able to do by the time they register their prescribing qualification with us. The requirements of the competency framework will be the standards we consider safe and effective prescribing practice for all prescribers on our register.

98. As with all our programmes, AEIs, together with their practice placement partners, must meet the standards framework for nursing and midwifery education, SSSAs and standards for prescribing programmes to be able to offer programmes that lead to a prescribing annotation on our register.

99. We first adopted the RPS competency framework in 2018. The RPS published a refreshed framework in September 2021, which we then adopted in November 2021.

100. All Approved Educational Institutions (AEIs) had to confirm their approved prescribing programmes meet the refreshed framework no later than 1 September 2022. We are also asking our existing prescribers to familiarise themselves with the refreshed standards.

Our fitness to practise process

101. When a concern is raised about the conduct, health, or competence of a professional on our register, we investigate through our fitness to practise process. We take regulatory action where needed to protect people who use health and social care services and to ensure public trust and confidence in the professions is maintained.

[21] Article 7(2) of the Nurses and Midwives (Parts of and Entries in the Register) Order of Council 2004

102. Our fitness to practise process is set out in the Order and the Nursing and Midwifery Council (Fitness to practise) Rules 2004 (SI2004/1761). The Order sets out that we can take action where a nurse, midwife or nursing associate's fitness to practise is impaired by reason of misconduct, lack of competence, criminal conviction or caution, physical or mental health or not having the necessary knowledge of English.

103. Decisions at each stage of our fitness to practise process are made in accordance with our guidance which is publicly available on our website.

Screening stage

104. Screening is the first stage in our fitness to practise process.[22] If we receive a concern about a nurse, midwife or nursing associate's conduct or practice our screening team completes an initial assessment of the referral, including an assessment of risk based on the information referred. We assess whether a case requires, or may require, an application for an interim order. If we decide that an application for an interim order is necessary, we aim to list the application for a hearing to take place within 28 days of receipt of the referral.

105. We consider three questions at this stage:

a. **Step one** – whether we have a written concern about a nurse, midwife or nursing associate on our register.

b. **Step two** – whether there is evidence of a serious concern that could need us to take regulatory action to protect the public.

c. **Step three** – whether there is clear evidence to show that the nurse, midwife or nursing associate is currently fit to practise.

106. Our screening team can:

a. Make enquiries to enable them to make a decision.

b. Decide to refer the matter for investigation.

c. Decide not to investigate at that stage.[23]

[22] Rule 2a(4) of the Fitness to Practise Rules.

[23] We also have a process where we can reconsider these decisions.

Investigation

107. Following a decision at the Screening stage to refer a matter for investigation, the investigation team investigates the concerns, including gathering key information, documentation and witness statements. At both Screening and Investigation, we ask the professional to respond to the concerns made against them. This provides them with an opportunity to reflect on the concerns raised and provide context to the case.

108. Once the investigation team have concluded their investigations, the case is passed to case examiners to review and decide the next steps.[24]

Case Examiners

109. Case examiners review the evidence from our investigation and decide[25] if the concerns relating to the nurse, midwife or nursing associate's practice or conduct should be closed or referred to the fitness to practise committee. Case examiners decide whether there is a case to answer in pairs, with one being a registrant and one a lay person.

110. Case examiners must assess on the papers whether there is a realistic prospect that a panel would find the professional's fitness to practise to be currently impaired. This involves considering the possibility that the Fitness to Practise Committee (FTPC) would decide, using the evidence we have gathered so far, that:

a. there is a case to answer on the facts

b. the nurse, midwife or nursing associate's fitness to practise is currently impaired.

111. Case examiners do not decide whether the case against the nurse, midwife or nursing associate is proved, whether or not the incidents in the case happened, or whether or not the nurse, midwife or nursing associate's fitness to practise is actually impaired.

[24] The process for referring an allegation falls within Article 22(1)(a) of the Order and (b) is further expanded in Rule 2A of the FtP Rules

[25] Rule 6C of the FtP Rules

112. The outcomes at this stage are:

a. **No case to answer** – if case examiners decide there is no case to answer (either on the facts or on the question of impairment), there will be no further action, and the case will be closed. Case examiners may choose to give the registrant advice which will be private and will not be published on the register. They can also choose to give a professional a warning which is published on our register for 12 months.

b. **A case to answer** – if case examiners decide there is a case to answer, they can either refer the matter to the FTPC for final determination or recommend undertakings. Undertakings are steps a nurse, midwife or nursing associate agrees to take, for example, extra training. Undertakings are reviewed by case examiners to make sure the nurse, midwife or nursing associate has done what they said they would.

Investigating Committee

116. Before the introduction of case examiners in March 2015, these case to answer decisions were made by the Investigating Committee. That Committee still exists and meets to consider:

a. The making and reviewing of interim orders.

b. Cases relating to fraudulent or incorrect entry to the registers.

c. Cases where the case examiners disagree on what the case to answer decision should be.

Fitness to Practise Committee

113. This is the final stage of our fitness to practise process. If the case is referred to the FTPC,[26] a panel of the FTPC will consider the case at a meeting or hearing. The panel is independent and must make its own decision about a nurse, midwife or nursing associate's fitness to practise. In both meetings and hearings, there will be an independent legal assessor to give legal advice.

[26] Part 4 of the FtP Rules

114. At a meeting, the panel makes its decision in private based only on the documents that have been submitted. The nurse, midwife or nursing associate does not attend the meeting, nor do any witnesses although their written statements will be considered by the panel. Hearings are held in public and live evidence is presented to the panel. Anyone who gives evidence can be asked questions about their evidence by the other party and the panel. Nurses, midwives and nursing associates will always be able to have a hearing if they wish to.

115. The panel must decide on the balance of probabilities whether it finds the facts proved and whether those facts prove the charges in relation to the professional's misconduct or competence. The panel must then decide whether or not the professional's fitness to practise is currently impaired and if so, what sanction if any it is appropriate to impose.

116. At a meeting or hearing, a panel will make a decision about the case. Possible outcomes include:

a. **No sanction** – this is where either the panel has decided there is no current impairment or the person on our register is impaired but no sanction is needed.

b. **Caution** – a caution is like a warning. Cautions can last between one to five years and are published on our register.

c. **Conditions** – if a registrant receives conditions of practice, they are still allowed to work, but there are restrictions to what they can do. For example, they may be supervised during work or be instructed to go on specific training and provide reflections. Conditions last between one and three years.

d. **Suspension** – A registrant is not allowed to work during this period. Suspensions can last anywhere between one and 12 months. After this time, it might expire or be looked at again at the end of the suspension period and be extended.

e. **Strike off** – if the panel decide to strike a registrant off the register, they will be taken off the register altogether. During this time, they cannot work or call themselves a registered nurse, midwife or nursing associate but can

make an application to re-join our register after five years, which will be considered by the FTPC to determine whether they should be permitted to re-join the register.

Interim orders

117. Article 31 of the Order gives us the power to seek and impose an interim order. Interim orders temporarily suspend or restrict a nurse, midwife or nursing associate's practice while their case is being investigated and may include cases of lack of competence, misconduct, poor clinical practice and serious convictions or imprisonment. They can be made at any time of the process as information indicating risk becomes available. Our Fitness to Practise Rules 2004 provide additional procedural provisions relating to interim orders. We have published guidance for interim orders (**Exhibit 28**). Our guidance is reviewed and updated to ensure it reflects current case law and a revised version of our interim orders guidance will be published on 25 March 2024.

118. There are two types of interim orders available under Article 31(2):

a. **Interim suspension order** – the panel suspends the nurse, midwife or nursing associate's registration for up to 18 months.

b. **Interim conditions of practice order** – the panel imposes conditions on the nurse, midwife or nursing associate for up to 18 months.

119. We can seek an interim order at any stage of our fitness to practise process[27] before a final decision has been made on the substantive case. Where a final decision is made by our FTPC, an interim order can be made at the same time as a condition of practice, suspension or striking off order.[28] Substantive orders do not come into effect until after the expiry of the appeal period[29] so this provides an important safeguard for this period.

120. The grounds for imposing an interim order are set out under Article 31(2). The Practice Committee must be satisfied:

[27] Article 31(1)(a) of the Order
[28] Article 29(5) (a-c) of the Order
[29] Article 29(10) of the Order

'that it is necessary for the protection of members of the public or is otherwise in the public interest, or is in the interests of the person concerned, for the registration of that person to be suspended or to be made subject to conditions'.

121. When an interim order is imposed the maximum length of time it can be imposed for is 18 months. If an interim order has been put in place before a final decision has been made there needs to be a review of that interim order every six months.[30] We also must hold an early review of the order at any time '*where new evidence relevant to the order has become available after the making of the order'*[31].

122. The Committee conducting the review has no power to vary the original length of the interim order but they can:[32]

a. Revoke the order or any condition imposed by the order.

b. Confirm the order.

c. Vary any condition imposed by the order.

d. Change the type of interim order in place.

123. If it becomes necessary to extend an interim order timeframe, we must apply to the High Court in England and Wales, the Court of Session in Scotland, or the High Court of Justice in Northern Ireland, where appropriate, for an extension. There is no limit placed in the Order on the number of times an interim order can be extended by the Court. The Court also has powers to change the type of order in place.[33]

124. Our Order also outlines the circumstances where an interim order would cease to have effect.[34]

125. Once a case has been considered by an Interim Order (IO) panel, whether they impose an order or not, it automatically progresses to investigation from screening.

[30] Article 31(6) of the Order
[31] Article 31(6) of the Order
[32] Article 31 (7) of the Order
[33] Article 31(9) of the Order
[34] Article 31(5) of the Order

Third party investigations

126. Our fitness to practise cases can sometimes also be subject to investigations by third parties such as the police, Health and Social Care Northern Ireland Counter Fraud and Probity Services and other regulators. When this happens, we can decide to place a case on hold if there are clear and compelling reasons to do that and it is in the public interest.

127. We issue operational guidance for our colleagues on how to deal with cases that are also subject to a third-party investigation. The aim of the guidance is to help inform decisions about whether our fitness to practise investigation should be put on hold while the third party investigation takes place.

128. We emphasise that we will do as much as we can to progress our own case, and that we will be proactive in seeking updates and assessing risk when our case is delayed (**Exhibit 29**).

129. We have established a working protocol with the police and our cases relating to Muckamore Abbey are currently on hold pending the outcome of the criminal proceedings. We are having ongoing discussions with the Belfast Health and Social Care Trust and Police Service of Northern Ireland (PSNI) to progress cases in a way that respects the criminal investigation but also protects the public.

Q5. How many referrals did the NMC receive in respect of registrants working at MAH across the time period covered by the Inquiry's Terms of Reference, that is between 02 December 1999 and 14 June 2021.

130. The NMC was established on 1 April 2002 and replaced the UK Central Council for Nursing, Midwifery and Health Visitors (UKCC). Since our establishment we have logged all fitness to practise concerns on a case management system. That system and the information we record has changed over time.

131. Since 2017 we have logged allegation type and employer information for each case. Between 2014 and 2017 our data was structured in a different way and the data we have on employers was backfilled into the system so the data is less

reliable. As with all data, the reliability in the reporting is dependent on consistent user input.

132. With those caveats, we conducted a search using relevant search terms, including employer coding and we were able to identify 51 referrals relating to 51 nurses received between 2 December 1999 to 14 June 2021. However, as our data recording has changed over time, there may be other cases received between 2 December 1999 and 2014 which we have not been able to identify.

Q6. Regarding the outcomes of NMC investigations in relation to those referrals:

i. How many of those referrals led to an interim suspension?

133. For these 51 referrals:

a. 21 of the nurses have had an interim suspension order applied to their registration.

b. Five nurses had an interim suspension order applied that was then changed to an interim conditions of practice order at a subsequent review hearing.

c. Eight nurses had an interim conditions of practice order.

134. That means that the total number of interim suspension orders applied on these referrals is 26.

135. Seven of the nurses who had initial interim suspension orders appealed to the High Court of Northern Ireland against the imposition of these orders on 11 September 2018. That appeal was upheld and all seven of the interim suspension orders were revoked.

136. Those seven nurses have then had either subsequent interim suspension orders (three) or interim conditions of practice orders (four) imposed between May and July 2019 when we had gathered additional evidence to support an application.

ii. How many interim suspensions were there after the allegations of abuse by staff at MAH came to light?

137. One of those interim suspension orders was imposed in 2013. The others were all imposed after November 2017 which we consider is the period when the allegations came to light[35].

iii. How many of those referrals proceeded to Fitness to Practise investigations?

138. All referrals that progress past our Screening stage become fitness to practise investigations. When we apply for an interim order, the referral will then also be sent for investigation. Of the 51 referrals received between 2 December 1999 to 14 June 2021, 40 of those have progressed for an investigation, 11 are still at our screening stage awaiting a decision.

iv. How many referrals resulted in:

a. Condition of practice orders

b. Suspension orders

c. Caution orders

d. Striking off orders

e. No sanction

139. Three cases of the 40 we can identify in the cohort that were received between 2 December 1999 and 14 June 2021**,** have been progressed to the final stage of our fitness to practise process and have been considered at a substantive hearing or meeting. Of those:

a. Once case received a caution order in February 2013.

b. One case resulted in a finding of fitness to practise not impaired in October 2018.

c. One case resulted in a suspension order in November 2022.

140. A further five cases within this cohort have been closed for the following reasons:

[35] Muckamore Abbey Hospital: Four staff members suspended - BBC News

a. One closed by the Investigation Committee with no case to answer.

b. Three have been closed by the Case Examiners with no case to answer.

c. One was an administrative closure as the registered professional died.

141. The remaining 32 cases at the investigation stage are on hold.

Q7. Does the NMC monitor fitness to practise trends within practice units, for example, at MAH, or within parts of the register, for example Registered Nurses for Learning Disability?

142. We have two internal oversight groups where colleagues from across our organisation come together to share and consider emerging issues or concerns. These groups focus on concerns relating to patient safety which are identified from a variety of sources including our regulatory intelligence work, education assurance activity and concerns identified through external inquiries, reviews and media reports.

143. We do not routinely monitor trends either by employer, practice units or for specific parts of the register as the data set is small but these groups can commission thematic such as employer or field specific analysis across our fitness to practise referrals to identify trends. We only started formally recording employer and case allegation information for referrals received from January 2017 and although a professional may be a registered learning disability nurse, we would not be able to confirm from our data whether they are working in a mental health or learning disability service setting.

144. Where we have conducted analysis in the past, we have seen that professionals do not necessarily work in their specific nursing fields. We have also seen that an increased number of fitness to practise referrals can be a lag indicator of a systemic problem already being identified rather than being a lead indicator of an emerging area of risk.

145. Regulation Advisors in Employer Link Service (ELS) have responsibility for specific regional areas and they engage regularly with local Health Boards to discuss areas of risk. They provide and advice and support to employers who are

considering making referrals to us and are able to escalate to our internal oversight groups any areas of emerging risk.

Q8. If the answer to question 7 is yes, what were the trends as MAH across the time period covered by the Inquiry's Terms of Reference, that is between 02 December 1999 and 14 June 2021?

146. As outlined above, we do not routinely monitor trends within practice units or for specific parts of the register so we are unable to answer this question.

Q9. Can nurses make whistleblowing reports to the NMC?

Raising concerns

147. Anyone, including professionals, people using health and social care services, families and members of the public can raise concerns about a nurse, midwife or nursing associates' fitness to practise with us. We are required to consider whether those concerns mean that a professional's fitness to practise may be impaired.

148. We provide information on our website on how people can raise concerns with us. Concerns must be made in writing and anyone looking to make a referral is directed to the online referral form on our website and we can provide support with this.

149. Once an individual has decided that they want to make a referral to us, they complete our online referral form. The form asks for:

a. Details of the person they are raising a concern about.

b. A description of what happened.

c. Details of what they have already done to raise their concern.

d. Details of any other people who saw what happened.

150. Our Public Support Service (PSS) was launched in October 2018 and provides support to people who have made or are involved in a fitness to practise referral. This includes people using health and social care services, carers, families,

colleagues and others. The service plays a key role in ensuring that raising a concern with us is accessible for all. The PSS helps to ensure that as an organisation we fully understand the concerns being raised with us and support people's needs to enable them to engage with the fitness to practise process. Colleagues in PSS can help individuals understand who we are and how our investigative process works. We help others to understand our regulatory decisions and the reasons for decisions. We also support people to deal with the impact the process can have on them. The service is available to support those involved in the fitness to practise process as well as those who send an email to our whistleblowing email address.

151. Our ELS supports employers with raising concerns. It operates an advice line which employers can call to seek advice on the appropriateness of making fitness to practise referrals. We advise employers to make referrals where an individual poses a risk which the employer cannot manage effectively and which means that their right to practise needs to be withdrawn or restricted immediately.

152. All those on our register are expected to act in accordance with our Code. This document set outs the professional standards that nurses, midwives and nursing associates must uphold as registered professionals. Our Code is clear that our professions must:

a. Raise and, if necessary, escalate any concerns they may have about patient or public safety, of the level of care people are receiving in their workplace or any other health and care setting and use the channels available to them in line with our guidance and their own working practices (16.1).

b. Take reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse (17.1)

c. Share information if they believe someone may be at risk of harm, in line with the laws relating to the disclosure of information (17.2).

d. Have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people (17.3).

Whistleblowing

153. Nurses are also able to raise whistleblowing concerns with us. We are a 'prescribed person' in law[36] meaning that nurses (and others who meet the legal definition of 'worker') who raise concerns directly with us have legal protection from detriment under the Employment Rights (Northern Ireland) Order 1996. We have a dedicated email address for workers wanting to raise a whistleblowing concern with us. As set out above, concerns can also be raised using our fitness to practise referral form.

154. When considering whistleblowing concerns, we act according to our legal obligations which includes giving careful consideration to a whistleblower's request that their identity should not be disclosed. Whistleblowers are afforded certain legal protections such as protection from being dismissed from their employment due to whistleblowing. However, we need to respond to the concerns raised in line with our public protection obligations and fitness to practice processes, where relevant. This means that if an issue is serious and requires a fitness to practise investigation, the information we receive and use to assess the allegations could expose the identities of referrers.

155. We provide whistleblowing guidance for nurses, midwives, students or other members of staff (**Exhibit 30**). That guidance outlines:

a. What whistleblowing is.

b. The criteria set out in law to protect whistleblowers.

c. What whistleblowing concerns should be raised with us.

d. How to raise a whistleblowing concern.

e. What happens when a concern is raised.

f. Sources of advice and support.

156. In the Screening section of our fitness to practise guidance library, we include guidance on referrers that wish to remain anonymous. We make clear that we may need to disclose the referrer's identity to refer a case to the case examiners or

[36] Schedule to the Public Interest Disclosure (Prescribed Persons) Order (Northern Ireland) 1993 as amended by The Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2022

FTPC. If the referral meets our screening requirements, then we have the power to investigate and refer a case ourselves[37] without an external referrer. We offer the same support to whistleblowers that we do to others raising concerns.

157. Since April 2017 we have had a legal duty[38] to publish an annual report on the whistleblowing disclosures made to us. We publish a joint report with other health and care professional regulators to show the action that we have taken and how we work together to handle serious concerns raised with us.

i. If the answer to this question is yes, were any whistleblowing reports received by the NMC in relation to MAH across the time period covered by the Inquiry's Terms of Reference, that is between 02 December 1999 and 14 June 2021?

ii. If so, how many such reports were received?

iii. If such reports were received, please provide details of those reports and how they were dealt with.

158. We have reviewed concerns raised through our whistleblowing mailbox and there is no record of any whistleblowing concerns received about Muckamore Abbey. When a fitness to practise concern is raised with us, we conduct a whistleblowing assessment. We have reviewed all the cases relating to Muckamore Abbey that we can identify in our case management system and none of these were categorised as whistleblowing reports.

Q10. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of paragraphs 10-13 of the Terms of Reference?

Additional background to our interim order applications

159. As outlined in paragraphs 133-136 above, seven of the nurses referred to us had initial interim suspension orders imposed in August and September 2018.

[37] Article 22(6) of the Order and Rule 2(A)(4) of the Fitness to Practise Rules

[38] The Prescribed Persons (Reports on Disclosures of Information) Regulations 2017 (SI2017/507). These Regulations apply to Great Britain only. However, we include whistleblowing data concerning Northern Ireland in its annual reporting.

These seven nurses lodged appeals against the interim suspension orders in the High Court in Northern Ireland and the judge revoked these orders due to criticisms of our approach to the underlying evidence of the registrants' wrongdoing.

160. Between May and July 2019 all of these cases subsequently had interim suspension or condition orders imposed once we had gathered additional evidence.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 20 March 2024

List of Exhibits (Andrea Sutcliffe)

Exhibit	Description
1	Quality assurance framework for nursing and midwifery education
2	Quality assurance handbook
3	Standards for student supervision and assessment
4	Standards framework for nursing and midwifery education
5	Standards for pre-registration nursing programmes
6	Health and character decision making guidance
7	Standards of proficiency for pre-registration nursing education 2004
8	Standards for pre-registration nursing education 2010
9	Standards of proficiency for registered nurses
10	Easy read version of future nurse consultation
11	Test of competence learning disabilities nursing blueprint
12	RN5 learning disability reading list 2021
13	RN5 learning disability nursing marking criteria 2021
14	RN5 learning disability mock OSCE 2021
15	Return to practice standards
16	NMC Code
17	How to revalidate booklet
18	Spotlight on nursing and midwifery report 2023
19	Standards for prescribing programmes
20	Standards of proficiency for specialist community public health nurses
21	Standards of proficiency for community nursing
22	Standards for post registration education programmes
23	Evaluation post registration SCPHN and SPQ standards
24	Post registration review pre-consultation engagement report
25	Post registration review Pye Tait pre-consultation engagement themes November 2020
26	Easy read consultation questions post -registration
27	Prescribing competency framework
28	Interim order guidance
29	Investigating at the same time as other organisations

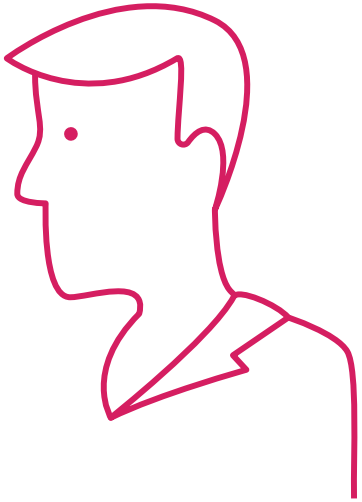
30	Whistleblowing guidance

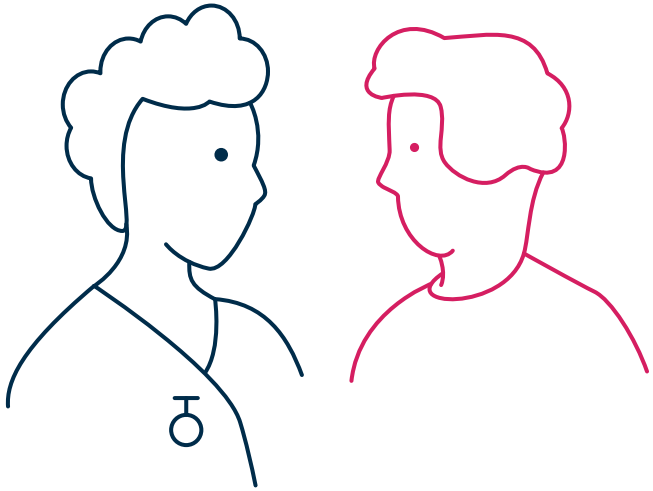
Nursing & Midwifery Council

Quality assurance framework for nursing, midwifery and nursing associate education

Revised in August 2020

Contents





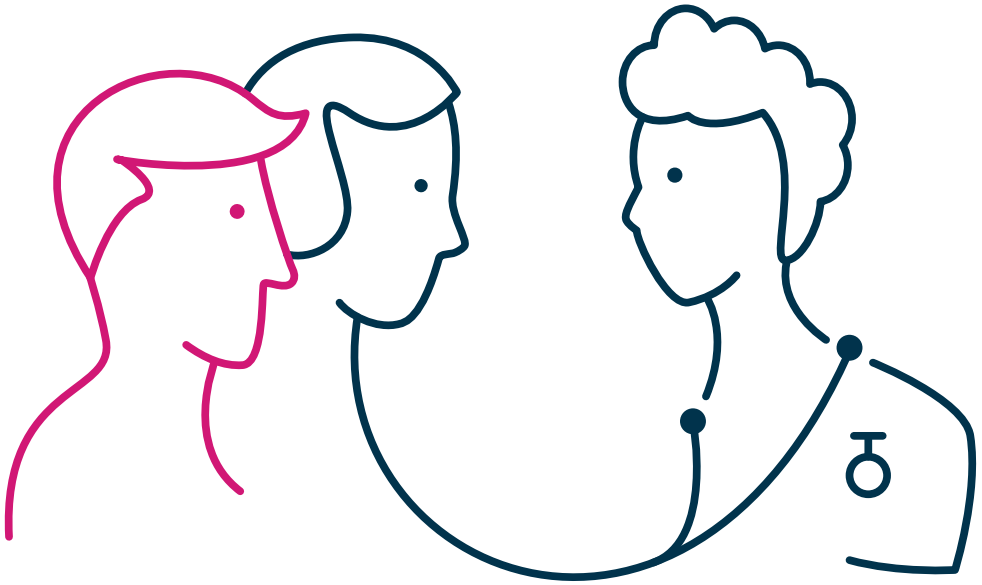
Introduction

To make sure that people have confidence in the care they receive we must make sure that nursing, midwifery and nursing associate education and training is high quality and meets our standards.

Quality assurance (QA) of education gives us the confidence that education institutions are meeting our standards for education and training. This helps us to know that students who have successfully completed an approved programme are meeting the standards of proficiency that we require before they join our register. It's one of the ways we fulfil our duty to protect the public.

If our QA identifies that an education institution isn't meeting our standards we take action so that the education institution returns to compliance. This ensures that there is public confidence in our role in nursing, midwifery and nursing associate education and encourages the education institution to remain responsible for meeting our standards.

Our QA framework shows how we do this, who we engage with and what we expect of our approved education institutions (AEIs) and practice learning partners that manage and deliver professional education and training.



Our education standards

As part of our ambitious five year programme of change for education we're reviewing all our education standards.

Standards reviewed to date:

- Standards framework for nursing and midwifery education
- Standards for student supervision and assessment
- Standards for pre-registration nursing programmes
- Future nurse: Standards of proficiency for registered nurses
- Standards for pre-registration midwifery programmes
- Future Midwife: Standards of proficiency for midwives
- Standards for prescribing programmes
- Standards of proficiency for nurse and midwife prescriber
- Standards for pre-registration nursing associate programmes
- Standards of proficiency for nursing associates
- Standards for return to practice programmes

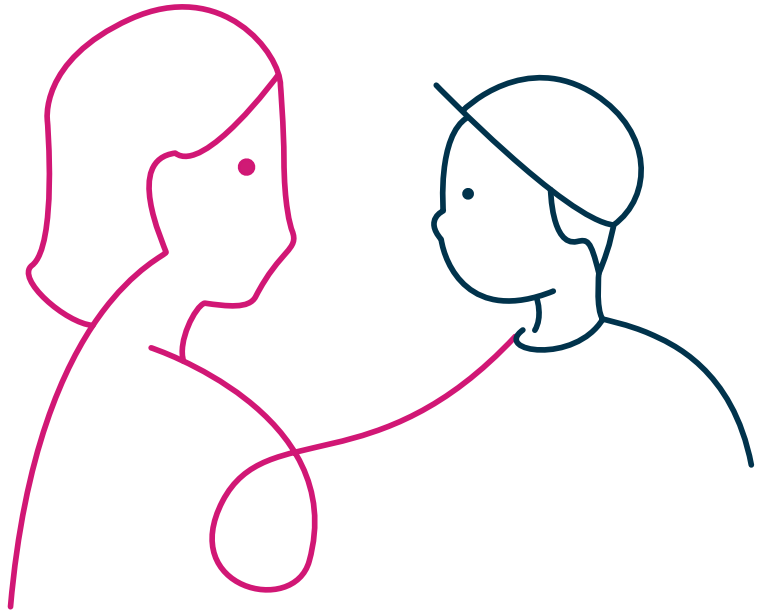
Standards to be reviewed:

- Standards for specialist community public health nursing
- Standards for specialist education and practice

About the framework

We've produced the QA framework for people who are interested in our work in quality assurance. In particular, it's for people who are involved in managing and delivering nursing, midwifery and nursing associate education. Like our new standards, our QA framework is informed by the ways in which health, care and professional education are changing. It reflects our outcome-focussed approach to setting new standards.

Our approach to QA gives us the flexibility to assure new and flexible models of educational programme delivery, which may involve local partnerships, blended learning and work based approaches. The QA framework enhances our ability to recognise issues early, making use of data from different sources to make sure we can be proactive in focussing on areas where we know there are risks, or where data suggests that we should be focussing our attention.



People at the heart of QA

As with all aspects of our work at the NMC, we involve people to ensure that the person-centred approach to our standards follows through to QA of education.

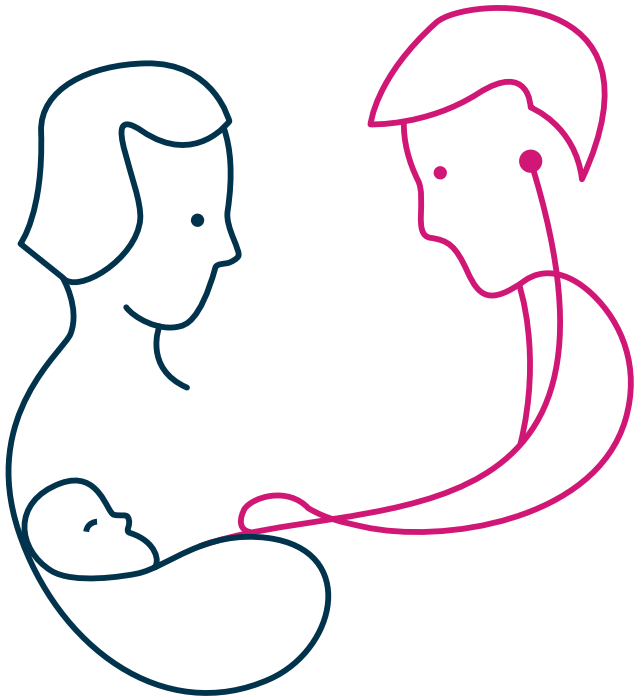
We are committed to make sure that people are at the centre of our work in education and training, that their voices are heard, and that people know how they can take part in QA of education.

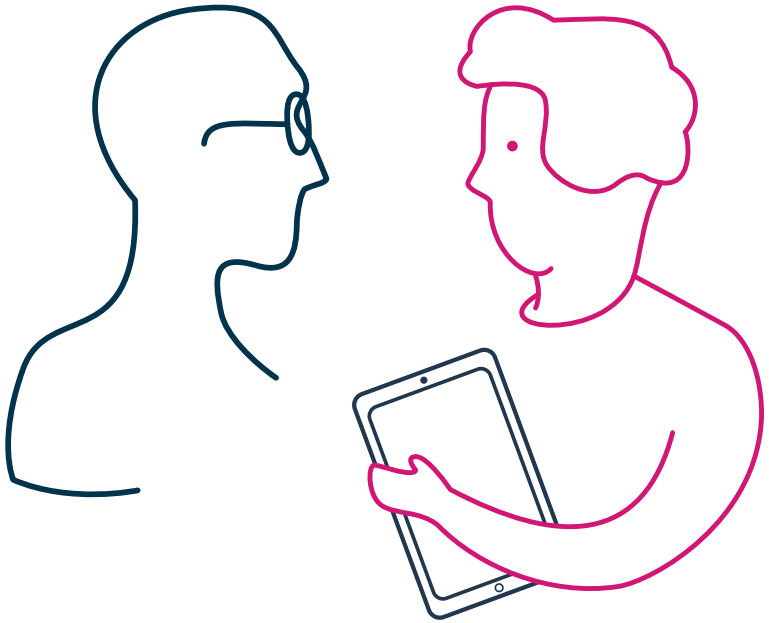
We'll actively listen and we'll act appropriately when we get feedback. We believe this will continue to instil confidence in the way in which nurses, midwives and nursing associates are prepared for professional practice and will demonstrate our commitment to being a person-centred professional regulator.

Our delivery partner

Mott MacDonald are our appointed QA service delivery partner, carrying out approval activity on our behalf.

Mott MacDonald will visit organisations to give us the information we need to make approval decisions about programmes and institutions.





How we quality assure

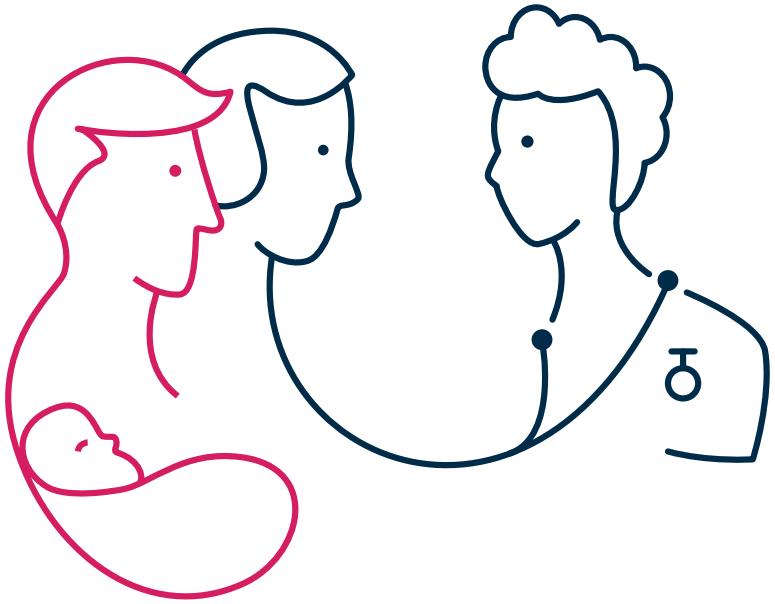
Part of our role[1] is to set standards for education and training that enable students to achieve our standards of proficiency before joining the register[2]. We also have to satisfy ourselves that AEIs and practice learning partners are meeting the standards and requirements we set[3].

This QA framework and our QA handbook set out the evidence education institutions need to demonstrate to satisfy us that they meet our standards when we decide to give approval.[4]

Our regulator, the Professional Standards Authority (PSA), defines right touch regulation as being proportionate, consistent, targeted, transparent, accountable and agile. We've aligned our QA framework to these principles.

We believe that it's best to realise the professionalism of those joining our register through education and training that's underpinned by effective partnerships between education institutions and their placement learning partners at all levels. Our QA approach focuses on how effective those partnerships are.

We've set the standards for nursing and midwifery education as degree level entry professions and nursing associate education as a foundation degree level entry profession. So education institutions seeking approval of programmes and AEIs delivering programmes must have the relevant degree awarding powers (or have formally agreed access to those powers through another degree-awarding institution).



[1] Article 15(1) of the Nursing and Midwifery Order 2001 (the 'Order')
[2] Article 5(2) of the Order
[3] Article 15(2)(b) of the Order
[4] Article 15(8) of the Order

Our standards for education and training apply to all AEIs and their practice learning partners that are running NMC approved programmes.

They aim to provide AEIs and practice learning partners with the flexibility to develop innovative approaches to professional education while being accountable for local delivery and management in line with our standards.

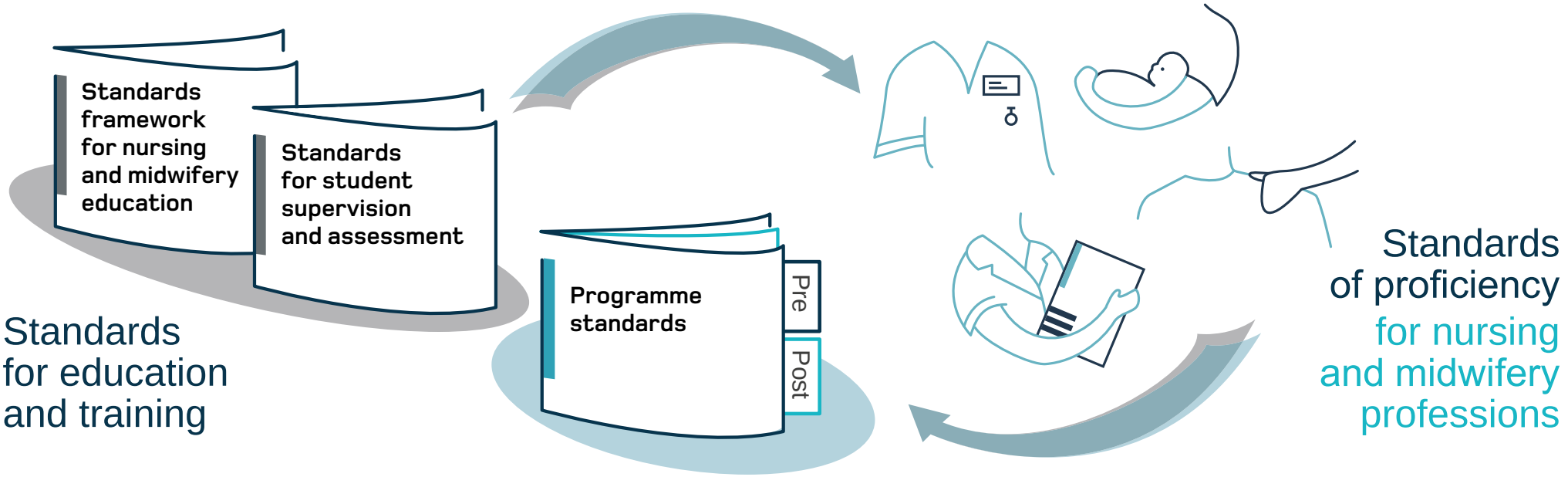
The standards for education and training are in three parts:

Part 1: *Standards framework for nursing*[5] *and midwifery education*

Part 2: *Standards for student supervision and assessment*

Part 3: Programme standards

These standards help students achieve proficiencies and programme outcomes.



[5] We've used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.

A gateway approach to approval

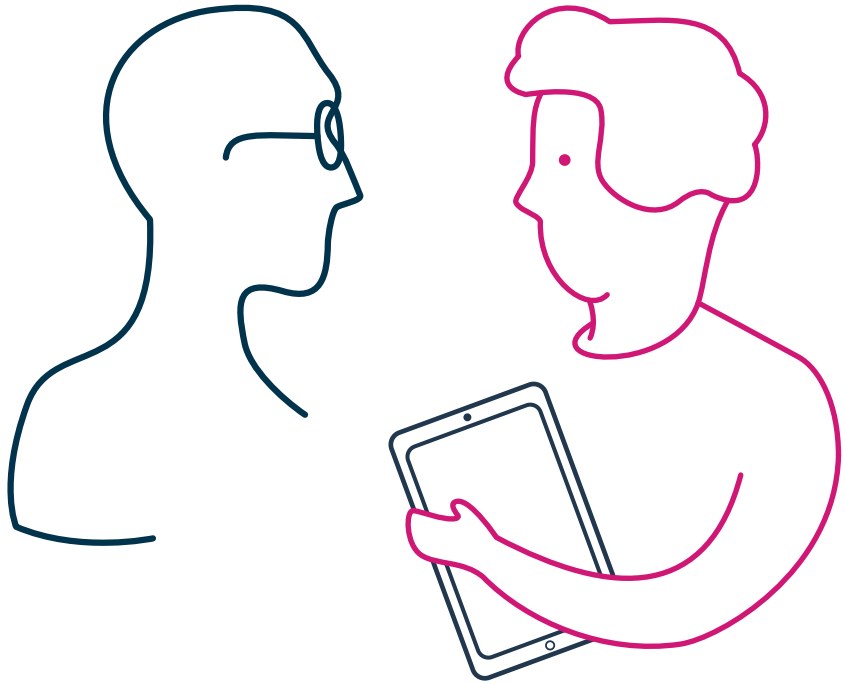
Our QA framework aligns the structure of our standards to how we approve education institutions and new programmes.

Using a gateway model enables us to take a proportionate yet robust approach to QA for organisations that want to implement our standards. Through this model, we can differentiate the approval process between education institutions depending on whether or not the institution is already running approved programmes.

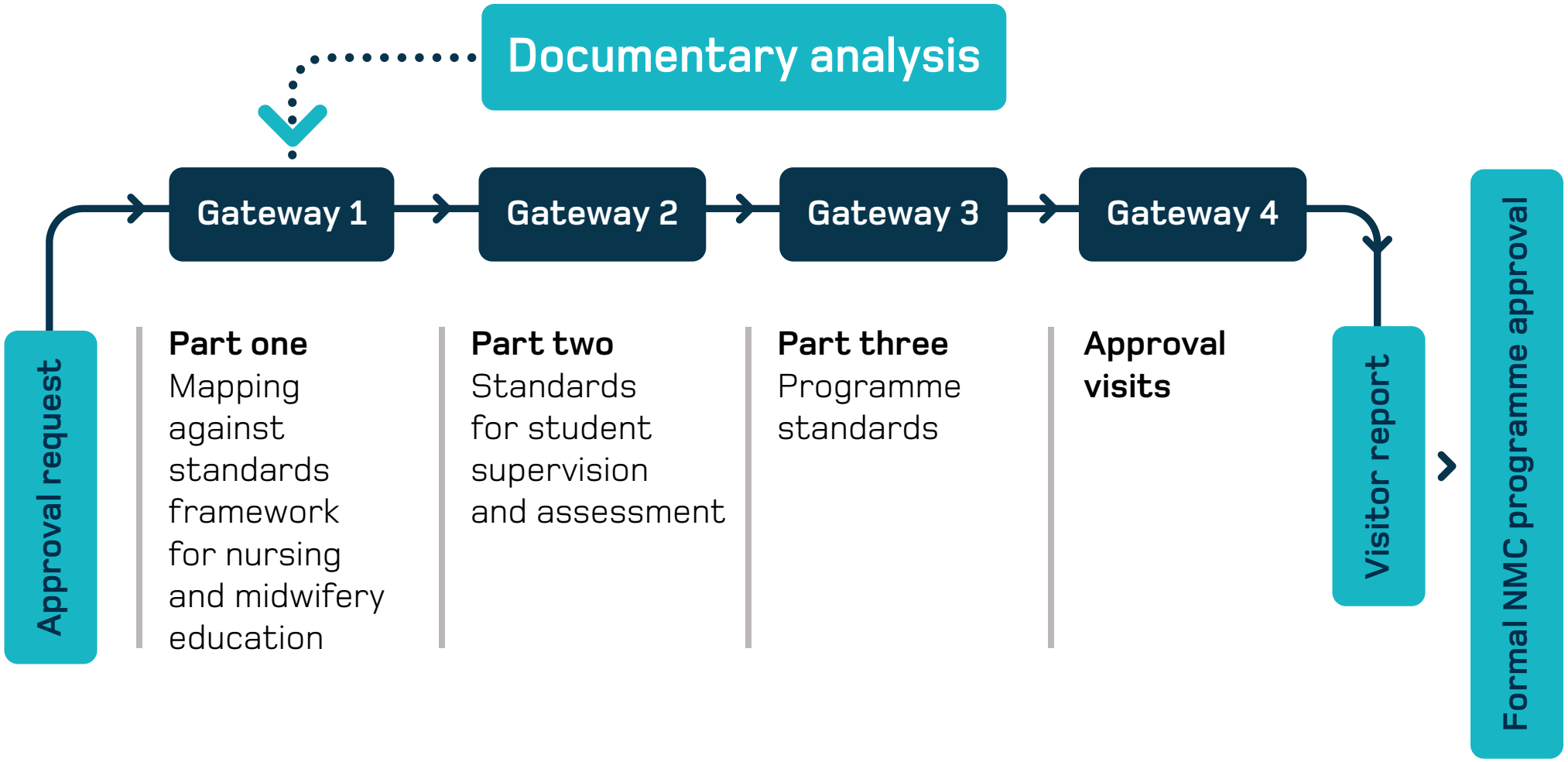
An education institution that's either new to nursing and midwifery education (or is wishing to return to nursing and midwifery education) and is seeking approval must submit their initial proposal via the QA Link. Once we've had assurances about the education institution's proposal we'll begin our preliminary checks. We'll share this information with our QA delivery partner, Mott MacDonald, which will conduct the QA through the gateways on our behalf.

Under our QA framework we'll approve programmes indefinitely, so programmes will not need to seek re-approval. However, we will proactively monitor institutions to ensure that our standards continue to be met.

Find out more about our QA processes in the QA handbook.



Process of programme approval



Process of programme approval

	Part one Standards framework for nursing and midwifery education	**Part two** Standards for student supervision and assessment	**Part three** Programme standards	**Approval visits**
1st programme approval **New education institution**	✓	✓	✓	✓
1st programme approval **Existing AEIs**	Right touch	✓	✓	✓
Subsequent approvals	N/A	Right touch	✓	✓

Gateway 1: *Standards framework for nursing and midwifery education*

After we've screened their initial proposal, **new education institutions** must give us the necessary evidence for seeking approval of a programme for the first time. QA visitors will review the evidence to ensure compliance.

Gateway 2: *Standards for student supervision and assessment*

All **existing AEIs, new education institutions** and their practice learning partners will give us the evidence to tell us how they will meet our standards. QA visitors will analyse the documents.

Gateway 3: Programme standards

All **existing AEIs**, **new education institutions** and their practice learning partners will submit evidence to show how they will meet our standards.

Gateway 4: Approval visit

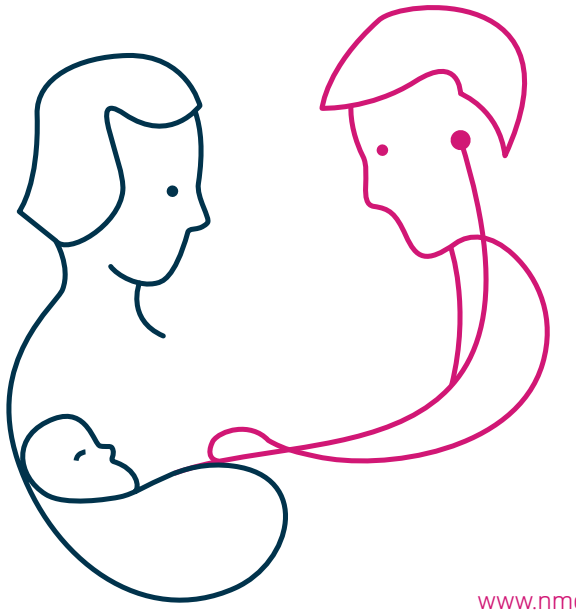
Representatives from **existing AEIs** and **new education institutions** and their practice learning partners will come together for the approval visit. We also expect people and existing students (where applicable) to attend.

We aim to minimise the burden on AEIs and their partners by taking part in conjoint approval visits with AEIs and/or other regulators where possible, but we do so with clarity about our respective roles. QA visitors will engage with the presenting panel and representatives from the AEI and its practice learning partners. They'll make recommendations to us in a report about whether our standards are met. We'll then decide whether to approve the programme.

How we'll QA pre-registration nursing programmes

As we have updated Standards of proficiency for registered nurses and Standards for pre-registration nursing programmes, all existing AEIs that are approved to deliver a pre-registration nursing programme are required to seek approval to deliver the programme against the new standards by September 2021. This means the gateway approach to pre-registration nursing programme approval applies to all AEIs. AEIs and practice learning partners will identify the routes within their pre-registration nursing programme they're seeking to approve. This may include undergraduate, postgraduate, work based or apprenticeship routes.

Existing AEIs and their practice learning partners may want to transfer current student nurses onto the new programme. If so, they'll need to give us the evidence to support this proposed transfer at Gateway 3. QA visitors will look at the evidence to make sure it confirms how all standards will be met through the transfer. We also expect transferring students to engage with QA visitors during Gateway 4: Approval visit.



How we'll QA pre-registration midwifery programmes

Since January 2020, we have been able to approve programmes against the new 'Future Midwife' standards. Existing AEIs and practice learning partners were able to adopt the Standards for student supervision and assessment before 2020.

As we have updated Standards of proficiency for midwives and Standards for pre-registration midwifery programmes, all existing AEIs that are approved to deliver a pre-registration midwifery programme are required to seek approval to deliver the programme against the new standards by September 2022. This means the gateway approach to pre-registration midwifery programme approval applies to all AEIs. AEIs and practice learning partners will identify the routes within their pre-registration midwifery programme they're seeking to approve. This may include undergraduate, postgraduate, work based or apprenticeship routes.

Existing AEIs and their practice learning partners may want to transfer current student midwives onto the new programme. If so, they'll need to give us the evidence to support this proposed transfer at Gateway 3. QA visitors will look at the evidence to make sure it confirms how all standards will be met through the transfer. We also expect transferring students to engage with QA visitors during Gateway 4: Approval visit.

How we'll QA post registration programmes

Prescribing programmes

As we have new standards of proficiency for nurse and midwife prescribers and new programme standards, all existing AEIs and practice learning partners that are approved to deliver prescribing programmes are required to seek programme approval against the new standards before September 2021.

This means that the new gateway approach to prescribing programme approval (V100, V150 and V300) will apply to all AEIs.

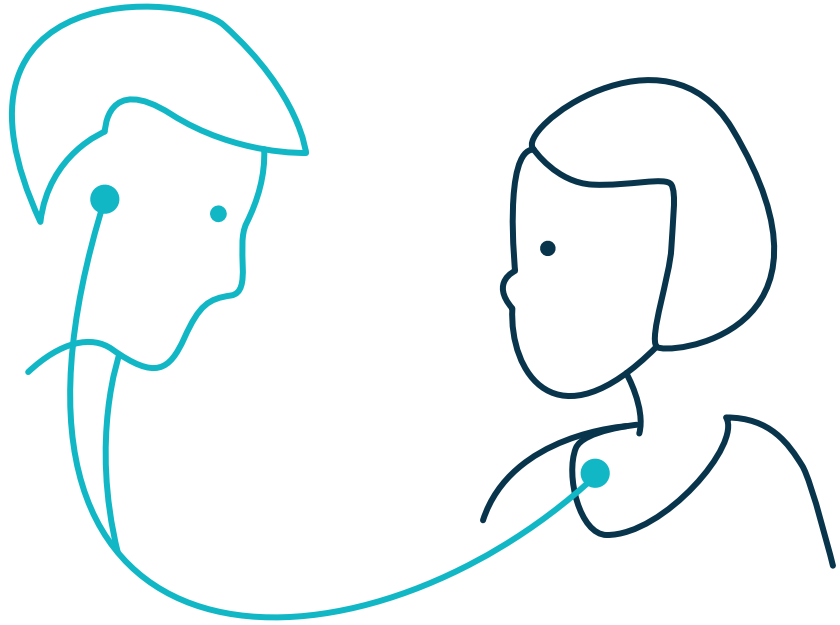
Specialist practice qualification programmes and specialist community public health nursing programmes

An independent organisation evaluated all our other post registration standards. The evaluation findings have led us to create an expert steering group who will review how post-registration education and development continues to evolve. However existing AEIs and practice learning partners can choose to move to the Standards for student supervision and assessment for these programmes with full adoption by September 2021.

Return to practice programmes

We published our latest Return to practice standards in May 2019. Our Registration and revalidation standards set out the minimum number of practice hours that a nurse, midwife or nursing associate must undertake to remain on, or re-join, our register. People unable to meet these practice hours requirements who wish to remain on, or re-join, our register must successfully complete an NMC approved return to practice programme, or, pass the NMC test of competence.

AEIs that are delivering Return to Practice programmes will need to transfer by September 2021.



How we'll QA pre-registration nursing associate programmes

We became the regulator for nursing associates in England on 12 July 2018. Northern Ireland, Scotland and Wales don't plan to use the new role at this time so our legislation reflects that we're regulating nursing associates only in England. One consequence is that we have powers in respect of nursing associate education in England only – we can't approve nursing associate programmes in other parts of the UK.

We have published our Standards of proficiency for nursing associates and Standards for pre-registration nursing associate programmes. The Standards framework for nursing and midwifery education and the Standards for student supervision and assessment also apply for nursing associate programmes.

Nursing associate programmes have been piloted through partnerships involving several stakeholders. We're happy to receive applications for the approval of programmes delivered through such partnerships, as long as the AEI awarding the qualification is prepared to be accountable for delivery.

Since 26 July 2019, students in England must join an NMC approved programmes to be eligible to join the nursing associate part of our register.

Programme modification

AEIs may submit requests for major modification to approved programmes. How we manage these depends on the extent of change as detailed in the QA handbook.

AEIs will manage and record minor modifications in case we need to review their decisions and their impact on our approval of the programme. We expect AEIs to report every year on their minor modification decisions as part of the annual self-reporting process.

Programme endorsement

AEIs may choose to deliver parts of approved programmes outside the UK which we call endorsement[6]. The UK-based AEI is accountable for this local delivery as part of their overall assurance to us.

We need robust evidence of how the programme meets our standards in all non-UK settings. This must include, but is not limited to, evidence of strategic and operational partnerships with practice learning partners, resources, risks and controls. The requirements for endorsement are in the QA handbook.

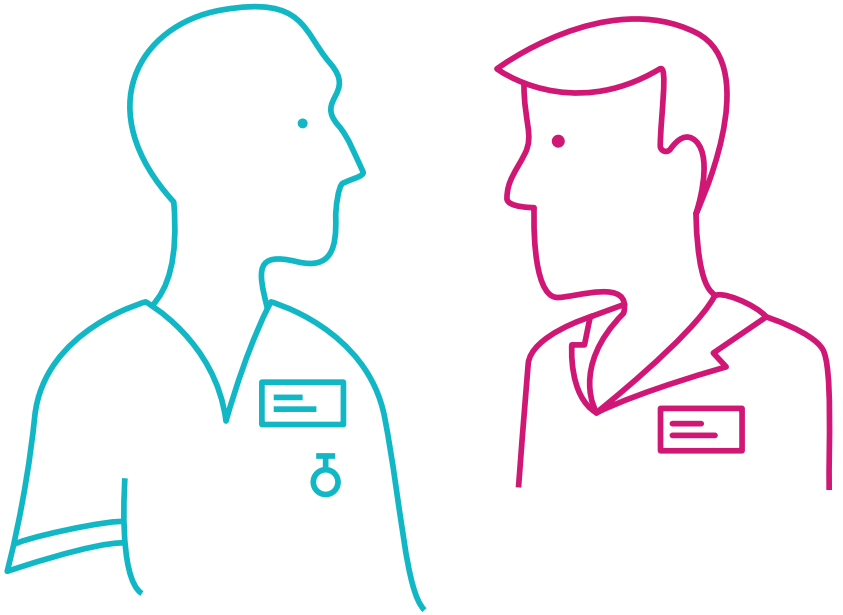
Refusal of approval

Education institutions and AEIs seeking approval of programmes must give us (and those who work on our behalf) the information and assistance that we may reasonably need[7]. If an education institution or AEI seeking approval refuses a reasonable request for information we may refuse approval[8]. Institutions and programmes must meet all of our standards for us to grant approval. We'll assess this at each of the gateways. If our standards are not being met then we may refuse approval.

[6] Article 15(7) of the Order
[7] Article 17(4) of the Order
[8] Article 18 of the Order

Withdrawing approval

If an AEI or its practice learning partners aren't meeting (or won't meet) our standards or requirements, we may seek to withdraw the programme approval or AEI status[9]. We may also seek to withdraw approval after we get a QA visitor's report.



Process

If we find that an AEI or its practice learning partners aren't meeting (or won't meet) our standards or requirements, we'll initially look for the AEI to put steps in place to address the concern. However, if a concern remains, we'll tell the AEI that we plan to withdraw their approval, specifying the extent of the withdrawal. We'll explain the reasons for withdrawing approval in writing. We'll give the AEI a month from the day we tell them of our plans to make any observations and objections[10].

We'll take no further action until the deadline, or until the AEI submits any observations or objections. We'll acknowledge any correspondence we get within five working days.

If the AEI can't assure us that it's mitigating and managing the risks, we'll write to the AEI, specifying the date that we're withdrawing approval.

[9] Article 18 of the Order
[10] Article 18(4) of the Order

Programme monitoring

Monitoring review visits

At present, we are focusing on programme approval so we won't do any routine monitoring visits. We think this is proportionate as we know that organisations and teams have been gearing up for new approvals and making plans to introduce our ambitious standards. We will, however, continue to respond to known or emerging risks to patient safety or compliance against our standards.

Annual self reporting

We expect all AEIs and practice learning partners to continue to submit an annual self-assessment report and confirm that they continue to meet our standards across all approved programmes.

Thematic review reporting

Over the next few academic years, we plan to continue to build on our current approach to thematic reviews. This will add to our assurance about the implementation of our standards. Thematic reviews will focus on particular aspects of nursing and midwifery education and training. They enable us to gain a deeper understanding of issues and areas of good practice that we can disseminate when we engage and report on our QA activity.

New programme monitoring

This applies to new AEIs and AEIs delivering new pre-registration programmes that have not been run by that institution before.

We'll apply new programme monitoring from approval of the programme until the first group of students register with us. This is because new providers who are unknown to us present a degree of additional risk. As part of new programme monitoring, we'll ask for regular updates that tell us how the new programmes are progressing. We'll follow up on these updates. This information will inform our future approach to risk based monitoring. If concerns arise we'll take action in line with our published processes and might proceed to an extraordinary review.

Enhanced scrutiny

When we have a concern regarding an AEI or a programme we may apply enhanced scrutiny. As part of this enhanced scrutiny, we'll ask for regular updates that tell us how the AEI is addressing the issues we have raised with them. We'll follow up on these updates. This information will inform our future approach to risk based monitoring. If further concerns or complaints arise we'll take action in line with our published processes and might proceed to an extraordinary review.

Extraordinary review

We carry out additional quality assurance work when we believe nursing and midwifery education providers are not meeting our standards. It might be necessary for us to carry out an extraordinary review of an education provider which may also include their practice placements in certain circumstances.

For example, when there is an adverse incident that presents a risk to public protection, or if an approved education institution (AEI) is seen to be either unaware of the incident or not to have effectively managed the risks. We would organise an unplanned monitoring review visit, usually at short notice. The focus of the extraordinary review is stated to the AEI. The review team will have a specific plan for their quality assurance activity for both AEIs and practice learning partners.

Delivery of QA of education

Our role includes:

- setting the strategic direction and policy for QA of education, ensuring that people are at the centre of QA, and developing the QA handbook and QA link
- commissioning and overseeing effective and proportionate QA operational delivery
- approving, monitoring and withdrawing approval of programmes
- effectively using data and intelligence from wide ranging sources to inform QA that protects the public
- sharing intelligence from QA activity appropriately with others both within and outside the NMC
- using our evidence from QA activity to influence the strategic context for education to enhance public protection and strengthen stakeholder relations.

Our operational delivery partner's role includes:

- recruiting, training and managing the performance of our QA visitors
- scheduling and organising QA processes and visits
- sharing and updating the information and documentation that govern QA processes, including the QA handbook inclusions and their website
- seeking the views of people – including the public, patients, service users, carers, families and students
- supplying and maintaining data relating to AEIs and practice learning partners and reporting to us.

[10] Article 18 of the Order

How we use data

We may collect information about individuals if they work for an AEI or practice learning partner, or take part in our education QA processes. We'll collect the individual's name and contact information. If they're taking part in one of our QA visits we'll also collect details of their professional experience.

During QA reviews, education institutions and practice learning partners may give the visitors a significant amount of supporting documentation. This documentation sometimes contains personal information like the CVs of academic staff or minutes of meetings. The only people who'll read this personal information are those who need to see it as part of our QA activity. We occasionally share personal information with third parties.

Normally, we process personal information because we have a legal obligation to do so or because it is necessary for the exercise of our statutory functions or any other functions in the public interest.

- Read our privacy notice
- Read the education and standards information handling guidance.

How we report on QA

We publish a list of approved programmes. We also publish monitoring reports, and we share an annual report on QA with our Council. We'll publish our QA approval outcome summaries as part of our commitment to transparency and information sharing.

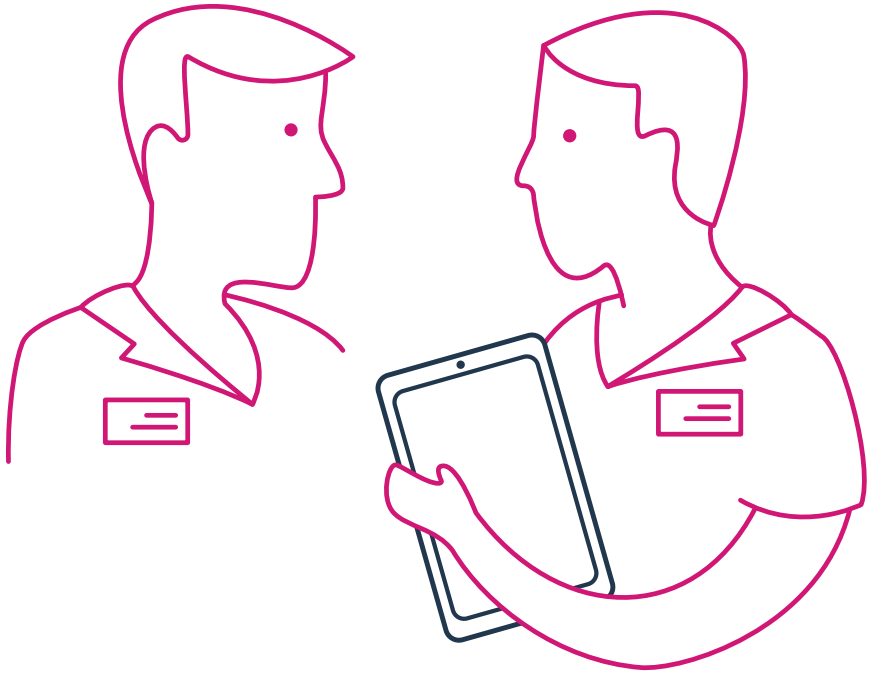
Responding to concerns in nursing and midwifery education

One aim for the QA of education is to make sure that people are protected when students care for them as part of their education and training. To protect the public, we act on concerns when someone raises them to us.

In this context a concern could be:

- an incident that may affect patient safety
- a notification that an AEI or practice learning partner that delivers approved nursing and midwifery programmes is not meeting our standards
- whistleblowing, or
- a complaint.

The need to protect the public guides how we respond to concerns. We assess the nature of possible risks, and combine that with the assurance we receive from AEIs and practice learning partners about how they manage risks when they arise. Our response to concerns ensures that there are measures in place to protect the public when issues affect nursing or midwifery education.



How we respond to concerns

Exceptional reporting by AEIs and practice learning partners

When risks emerge AEIs and their practice learning partners must respond swiftly to manage and control risks appropriately.

AEIs should email exceptional reports to us. We'll take action when these risks are not being effectively managed and controlled locally. We expect approved education institutions (AEIs) to tell us any concerns about an approved programme, in particular an issue which might affect the student learning environment or where there may be a patient safety concern. If there's the potential that our standards are not being met then this should be raised with us via our exceptional reporting form.

Whistleblowing

If a third party raises a concern about the safe and effective delivery of an approved programme, we'll tell the AEI concerned within five working days so it can manage the risk locally where possible. We'll also contact the third party to make sure we understand the risk and information correctly. Where appropriate, we'll redirect any concerns about systems or practice to system regulators, our fitness to practise teams, or other professional regulators. Our duties around managing and acting on information provided through whistleblowing are set out in the Public Interest Disclosure Act 1998.

Responding to concerns and handling complaints about AEIs

We'll investigate and, if necessary, act on concerns raised about AEIs. We deal with concerns and complaints fairly and consistently.

Responding to concerns and handling complaints about our QA delivery partner, Mott MacDonald

We'll investigate and, where appropriate, act upon concerns raised about our QA delivery partner. We'll make sure that we deal with concerns and complaints fairly and consistently. We won't consider complaints regarding the judgment of QA visitors delivering QA activity.

Glossary

Approved education institutions (AEIs): the status awarded to an institution, part of an institution, or a combination of institutions that work in partnership with practice learning providers after we've approved a programme. AEIs will have assured us that they're accountable and capable of delivering approved education programmes.

Education institutions: institutions seeking our approval of a programme.

Educators: in the context of our standards for education and training, educators are those who deliver, support, supervise and assess theory or practice learning.

Employer link service (ELS): Our ELS liaises with employers, listens to feedback, takes part in local health sector forums, advises on making referrals, and offers inductions for directors of nursing on fitness to practise and other core functions.

Enhanced scrutiny: A process to allow the AEI to demonstrate how they have addressed issues raised with them or their programme and how they continue to meet the standards and requirements.

Endorsement: This is the process of approving the delivery of part of an already approved programme outside the UK.

Extraordinary reviews: Reviews conducted to identify if the AEI and practice placements continue to meet our standards, if concerns or intelligence suggest that an AEI or a programme is no longer meeting our standards and requirements.

Learning environments: Includes any physical location where learning takes place as well as the system of shared values, beliefs and behaviours in these places.

New programme monitoring: A process to allow the AEI to demonstrate how they and their programmes meet the standards and requirements. New institutions and new preregistration programmes will undergo new programme monitoring from approval through to the first group of students completing the programme.

Nurse and midwife prescribing programmes: The programme that a registered nurse or midwife in the UK completes to acquire the proficiencies needed to meet our criteria for an annotation on our register.

Nursing associate: A nursing associate is a new member of the nursing team who will care for, and support people. This role is being used and regulated in England and it's intended to address a skills gap between health and care assistants and registered nurses.

Nursing associate is a standalone role in its own right and will provide a progression route into graduate level nursing

Nursing degree apprenticeship: The nursing degree apprenticeship will enable people to train to become a graduate registered nurse through an apprentice route. Apprentices will be released by their employer to study part-time in an AEI and will train in a range of practice learning settings. They will be expected to achieve the same standards as other student nurses.

People: individuals or groups who receive services from nurses, midwives, or nursing associates, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and other within and outside the learning environment.

Pre-registration nursing programme: The programme that a midwifery student in the UK completes to acquire the proficiencies needed to meet our criteria for registration.

Pre-registration nursing associate programme: The programme that a nursing associate student in the UK completes to acquire the proficiencies needed to meet our criteria for registration.

Pre-registration midwifery programme: The programme that a midwifery student in the UK completes to acquire the proficiencies needed to meet our criteria for registration.

Programme standards: The standards we set for all nursing, midwifery and nursing associate programmes

Professional Standards Authority (PSA): The independent body that helps to protect the public through their work with organisations that register and regulate people working in health and social care. They regulate the NMC along with other health and social care regulators.

Quality assurance (QA): Our processes for making sure all AEIs and their practice learning partners comply with our standards.

QA Link: The online portal that AEIs will access to submit documentation i.e. during the approval gateway process.

Regulatory intelligence unit (RIU): Our RIU is responsible for identifying and assessing regulatory risk. It makes decisions on escalating this within the NMC and to external stakeholders where required.

Stakeholders: Any person, group or organisation that has an interest or concern in the situation in question, and may affect or is affected by its actions, objectives or policies. In the context of our standards for education and training this includes students, educators, partner organisations, patients, families, carers, employers, other professionals, other regulators and education commissioners.

Students: Anyone enrolled onto an approved education programme.

The Nursing and Midwifery Order 2001 (the Order): Legislation that establishes us and sets out our primary purpose of protecting the public, our structure, and our functions and activities.

The role of the Nursing and Midwifery Council

Nursing & Midwifery Council

What we do

Our vision is safe, effective and kind nursing and midwifery that improves everyone's health and wellbeing. As the professional regulator of more than 700,000 nursing and midwifery professionals, we have an important role to play in making this a reality.

Our core role is to regulate. First, we promote high professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate when nursing or midwifery care goes wrong – something that affects less than one percent of professionals each year.

To regulate well, we support our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to influence health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

These standards were approved by Council at their meeting on 2 July 2020.
This document was revised in August 2020.

Nursing & Midwifery Council

Quality assurance handbook

Published May 2023

Contents

Section 1: Introduction

1. Quality Assurance (QA) is the process the NMC follows to ensure that education and training of nursing, midwifery and nursing associate students enable them to develop the proficiencies to join our register.

2. The QA Framework explains our approach to quality assurance and the roles stakeholders play in its delivery. The QA Handbook provides the detail of our processes and the evidence that approved education institutions (AEIs) and education institutions and their practice learning and/or employer partners (in the case of apprenticeships) must provide in order to meet our standards.

3. The Nursing and Midwifery Order 2001 (the Order) establishes us and sets out our primary purpose of protecting the public, our functions, and activities. The Order sets out our powers in relation to QA. This ensures that nurses, midwives, and nursing associates are educated to consistently deliver high quality care.

4. We update this handbook when we introduce new standards or make changes to our QA framework which impact on QA operational processes.

5. The handbook is intended mainly for those directly involved in nursing, midwifery, and nursing associate education, in particular education institutions seeking our approval of a programme for the first time, and existing approved education institutions (AEIs) and their practice learning/employer partners. Practice learning/employer partners are organisations that provide practice placements for students, for example Trusts, Health Boards, GP surgeries, care homes etc.

   Note: new education institutions seeking programme approval and AEI status will be referred to as 'education institutions' throughout this handbook.

6. The handbook sets out the detail of our QA processes and details the evidence that AEIs, education institutions and their practice learning/employer partners must demonstrate to meet our standards, and the timelines to do so.

7. QA visitors are appointed by our QA delivery partner, Mott MacDonald, to carry out QA activities on our behalf. QA visitors are appointed either as registrant visitors with experience in the relevant field of practice, or as lay visitors to obtain assurance as a member of the public.

8. This handbook also provides information for QA visitors about the QA of education and supporting processes to make sure that AEIs and education institutions provide the relevant education and training to meet our standards.

9. This handbook must be read in conjunction with the NMC QA framework.

1.1 Our role in education

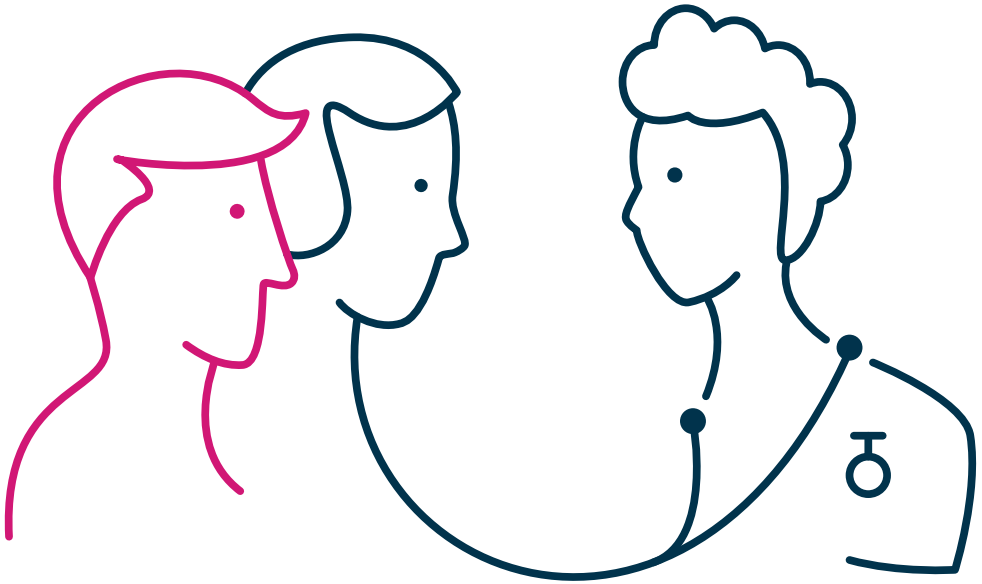
10. We want to make sure that nurses, midwives and nursing associates are consistently educated to a high standard, so that they are able to deliver safe and effective care at the point of entry to the register and throughout their careers. We also want to make sure that patients, people who use services and carers and the public have a clear understanding of what nurses, midwives and nursing associates know and are competent to do.

11. What we do

- We set education standards, which shape the content and design of programmes and the standards of proficiency for nurses, midwives and nursing associates seeking to join the register.
- We approve education institutions and programmes and maintain a database of approved programmes (courses).
- We carry out approvals against our standards.
- We deliver quality assurance of our approved programmes.
- We register nurses, midwives and nursing associates when they have successfully completed their courses.
- We assess and ensure the quality of practice placements for students.
- We carry out monitoring activities and investigate concerns about education programmes.
- We take regulatory interventions, when necessary.

12. What we don't do

- We don't educate or select students. This is done by the AEIs and practice/employer partners in line with our standards.
- We don't set curricula. This is done by the AEIs and practice/employer partners in line with our standards.
- We don't regulate students. If there are concerns about a student, this is dealt with by the AEI.
- We don't assess the quality of care in hospitals or the community. This is the responsibility of other regulators: the Care Quality Commission in England, Healthcare Improvement Scotland, Healthcare Inspectorate Wales and Northern Ireland's Regulation and Quality Improvement Authority.



1.2 How the QA of education will be arranged and conducted

13. To ensure that the activities listed above can be carried out, we work closely with our QA delivery partner, Mott MacDonald. Further to this, Mott MacDonald's appointed QA visitors will also be called upon to ensure that conjoint approval events can be undertaken, and that appropriate discussions are taking place to ensure assurance against our standards.

14. QA visitors will review documentation submitted through gateways, conduct visits and make recommendations to us as to whether programmes meet our standards. QA visitors are independent of the NMC and are not allowed to be employees from the NMC. From time to time NMC employees and/or members of the professional team at Mott MacDonald may attend visits as observers. Whilst the visits are managed by Mott MacDonald and recommendations made for approval by QA visitors, the NMC remains responsible for determining whether to approve a programme or not.

15. Activities that will be undertaken by us include new programme monitoring, enhanced scrutiny of programmes, where necessary, managing concerns around education and training, and maintaining data sources to feed into our data driven approach.

16. Our standards for education and training apply to all AEIs, education institutions and their practice learning/employer partners that are running NMC approved programmes. The standards for education and training are in three parts:

- Part one: Standards framework for nursing and midwifery education
- Part two: Standards for student supervision and assessment
- Part three: Programme standards:
  - Standards for pre-registration nursing programmes
  - Future nurse: Standards of proficiency for registered nurses
  - Standards for pre-registration midwifery programmes
  - Future Midwife: Standards of proficiency for midwives
  - Standards for prescribing programmes
  - Standards of proficiency for nurse and midwife prescriber
  - Standards for pre-registration nursing associate programmes
  - Standards of proficiency for nursing associates
  - Standards for return to practice programmes

17. Newly published NMC standards:

- Standards of proficiency for specialist community public health nurses
- Standards of proficiency for community nursing specialist practice qualifications
- Standards for post-registration standards.

Section 2: Information for new AEIs and EIs seeking approval

2.1 Information requests

18. AEIs and education institutions seeking approval of programmes must give us, Mott MacDonald and QA visitors the information and assistance that they may reasonably need[1]. If an AEI or education institution seeking approval refuses a reasonable request for information, then we may refuse approval[2].

2.2 A Gateway approach to approval

19. The QA approach to approval of AEIs and education institutions programmes is achieved through a gateway process. Using a gateway model enables us to take a proportionate and robust approach to QA for organisations that want to implement our standards. To gain programme approval, an AEI or education institution must meet the requirements set out in the standards for education and training and the relevant programme standards.
This handbook details the process, and the evidence required to meet the standards for each of the gateways:

- Gateway 1 – Part one: Standards framework for nursing and midwifery education
- Gateway 2 – Part two: Standards for student supervision and assessment
- Gateway 3 – Part three: Programme standards
- Gateway 4 – Approval visit

[1] Article 17(4) of the Order
[2] Article 17(5) of the Order

20. The diagram below provides an overview of the approval of a programme through the gateways.

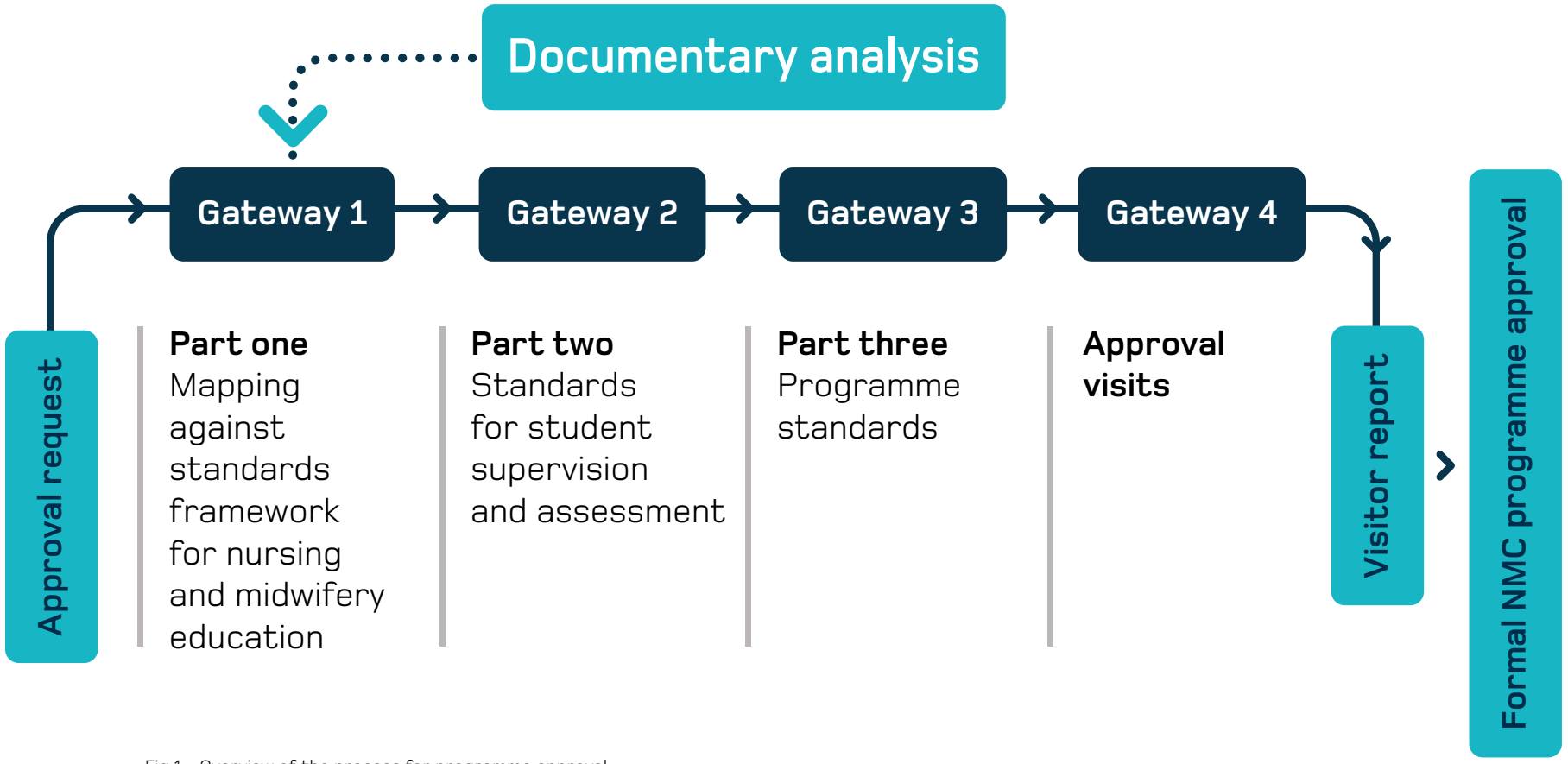
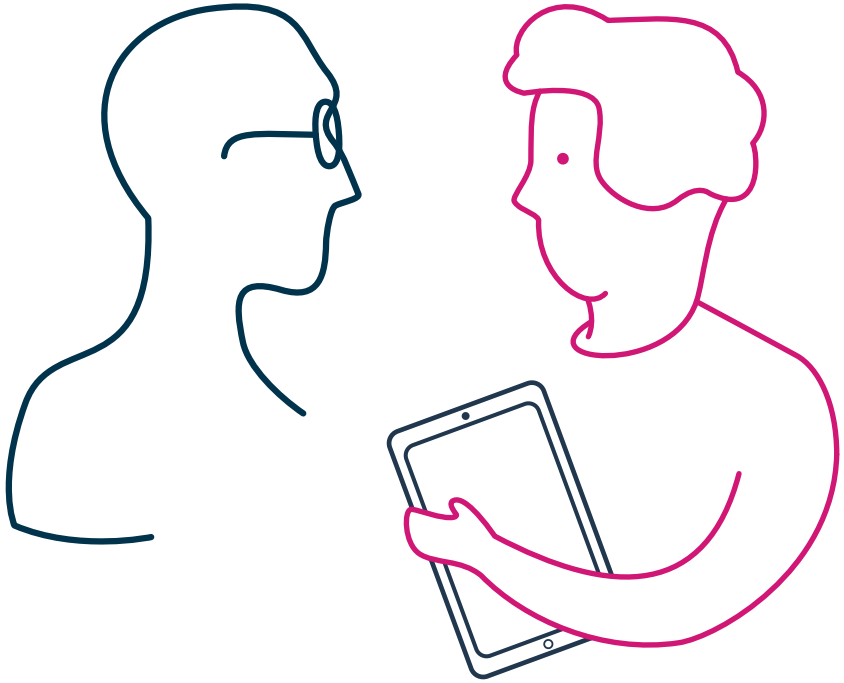


Fig 1 – Overview of the process for programme approval

2.3 Conjoint approval

21. We undertake conjoint approval with education institutions for education programmes. The approval of both academic and professional aspects of programmes is closely linked and in order to meet our standards and requirements, AEIs and education institutions will have to approve their qualification award at the prerequisite level. Having a conjoint approval event will allow for the consideration of qualification of the award to take place at the same time as NMC approval. AEIs cannot present a programme that has previously been approved by the university. Conjoint approval will require the EI/AEI to appoint a Chair and key information can be found in Annexe 7.5. A programme will not be recommended for approval by a QA visitor if it has been previously approved by the AEI or education institution **only**.



22. This will also reduce additional burden or duplication of processes for AEIs and education institutions.
Please note: even if the approval request was raised by an already established AEI, we still require a conjoint approval event to take place.

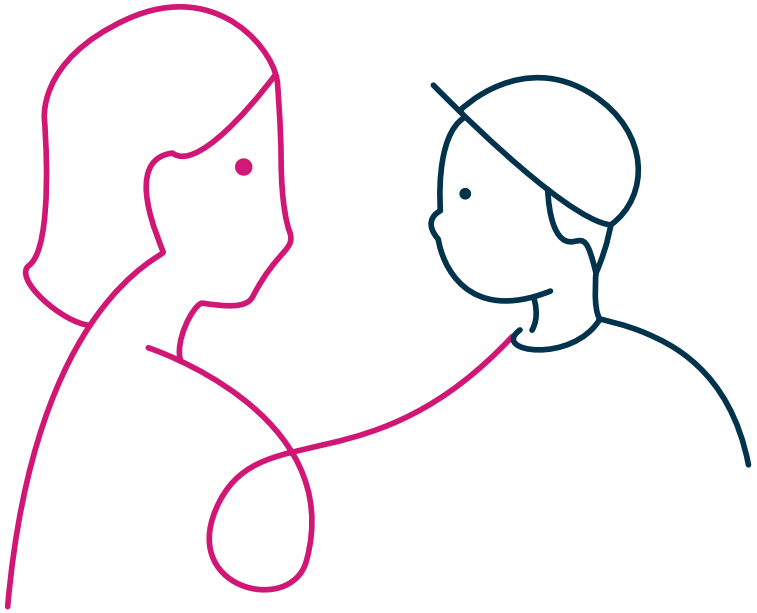
2.4 Gateway 1 – Standards framework for nursing and midwifery education

Gateway approach for an education institution seeking to have programme approval and AEI status

23. An education institution that's either new to nursing, midwifery or nursing associate education (or is wishing to return to providing nursing, midwifery or nursing associate education) and is seeking approval must inform us of their proposal via the QA Link. The proposal should include the following information:

- the rationale for the proposal and intended programme delivery;
- confirmation of the appropriate qualification awarding power;
- evidence of resources in place to support the proposal;
- details of wider support (for example, partnerships with employer organisations, practice learning providers, education commissioners, employer led initiatives and senior level support such as chief nursing officer[s]);
- proposed numbers of student intakes, start dates, fields of nursing (where appropriate) and a breakdown of student numbers for each programme; and
- a timeline for all aspects of the proposal including intended future delivery of programmes.

24. You should request approval to run a programme at least 12 months before you expect your first cohort of students.



25. ***What we will do***

26. We will follow the published process.

Once we've received your proposal, we'll carry out some preliminary checks and then share the information with Mott MacDonald. This can take **up to 20 working days**, but we'll let you know when we've done this. Mott MacDonald will then commence the QA of the approval, via the gateways process.

27. We will provide you with access and the necessary guidance and training on the use of the QA Link. You will be required to complete an event request form through the QA Link which will commence the gateway approval process. When the completed event request has been submitted in the QA Link, a mapping tool will be released which is a guide to ensure the Standards framework for nursing and midwifery education are met.

28. ***What an education institution and their practice learning/ employer partners must do***

29. When an education institution requests an approval, they will be asked to provide some preferred dates on which the gateway 4 approval visit could take place. When an AEI submits an event request, they are declaring that they will be prepared for the visit to go ahead on those dates. These dates will only be able to be changed in exceptional circumstances.

30. Following receipt of the AEI/education institution's event request, the Mott MacDonald team will contact registrant visitors with due regard to the relevant profession with which they are to report on. If appropriate, lay visitors will also be contacted to request their availability on the AEI/education institution's preferred visit dates, and to seek their opinion on any apparent conflict of interest.

31. In order to meet the approval deadline, the mapping tool for gateway 1 will be open for **four weeks**. During these four weeks, the education institution, in partnership with their practice learning/employer partners, will be required to provide evidence to demonstrate how they will meet our standards for nursing and midwifery education. The mapping tool must clearly signpost the QA visitor(s) to where the evidence is located in the uploaded documentation in the QA Link. The education institution must meet the gateway deadlines as outlined in the QA process and by Mott McDonald. Where deadlines aren't met this may result in the visit date being postponed.

32. The evidence must include:

- An evaluative summary against each standard and requirement to demonstrate how they will be met.
- Confirmation and evidence that all suitable systems, processes, resources, and individuals are in place, including evidence of collaborative partnerships that support safe and effective practice;
- Appropriate policies and processes focusing on equality and diversity, admissions, and fitness to practise;
- Evidence of appropriate mechanisms for members of the public, patients, people who use services and carers to be involved in the development and review of programmes;
- Information and supporting evidence that students will be made aware of the support and opportunities available to them within all learning environments;
- Documentation which demonstrates that students will be supported to take responsibility for their learning in a way that is reasonable for the student and doesn't compromise public safety;
- Appropriate mechanisms are in place for concerns to be escalated about student performance and public protection;
- Details of a range of relevant people who participate in the education of students and how they will be prepared and trained for the role. The way in which this is organised will depend on the requirements of the programme and the needs of the student.

33. The education institution will upload relevant copies of supporting documentation including policies and procedures, ensuring up to date documents are uploaded including the date for the next internal QA review of each document.
Please note: URLs are not accepted in the QA Link.

34. In addition, the education institution must provide details of all practice learning/employer partners used for student placements for all NMC approved programmes being delivered (or proposed to be used) by the education institution.
To assist in this process, information will be pre-populated and can be selected via a drop-down list. However, the education institution will be able to input data manually if the information required isn't available within the drop-down list provided.

35. Information provided should relate to any practice learning environment which is used for a student placement, or employment of apprentices, for a minimum of **four weeks** duration and forms part of the programme. Please note, elective placements are not required to be uploaded but assurances around the implementation of the Standards for student supervision and assessment in relation to elective placements may be sought at the point of approval/major modification.

36. Information provided can be selected using a drop-down list but must include:

- Correct name of Trust/Health Board/Group/Service: e.g. Cambridgeshire County Council
  - **Please note:** The name should mirror what is shown on the CQC (England), Healthcare Inspectorate (Wales), Care Inspectorate (Scotland) Regulation and Quality Improvement Authority (Northern Ireland) databases.
- First line of address.
- Postcode: e.g. CB3 0AP

37. When this practice learning environment information has been populated the education institution will be able to link to the relevant practice learning/employer partners and environments required for programme approval in gateway 3.

38. ***What the QA visitor will do***

39. The QA visitor(s) will have access to the gateway 1 mapping tool which will signpost them to where the evidence provided by the education institution and their practice learning/ employer partners is located in the QA Link.

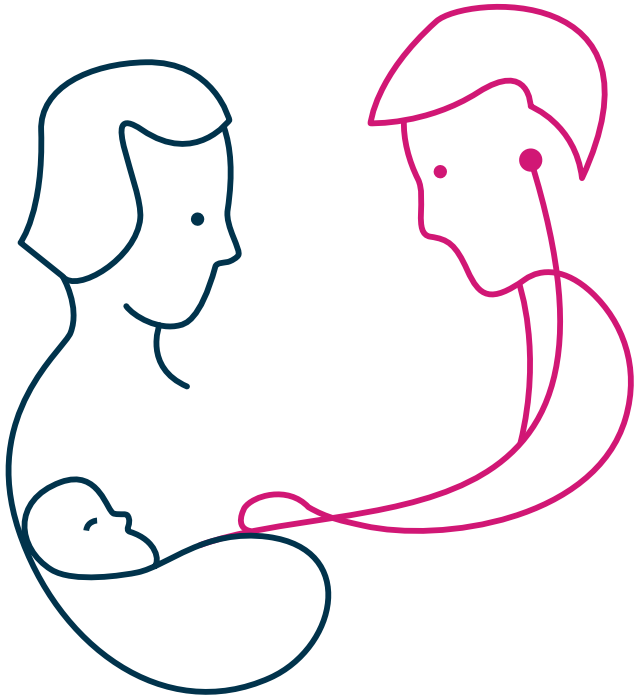
40. The QA visitor has **two weeks** to review and record their findings. If they find the evidence provided is insufficient to meet the Standards framework for nursing and midwifery education this will be escalated to the quality assurance director (QAD) or a quality assurance deputy director (QADD) at Mott MacDonald and the education institution informed of the additional information required. The evidence provided will be discussed and a resolution will be agreed, which will normally result in the resubmission of evidence and the timeline to programme approval will be amended accordingly. We will be informed about this situation.

41. If the QA visitor confirms the evidence provided ensures compliance with the Standards framework for nursing and midwifery education, the education institution will move to gateway 2.

2.5 Future use of the evidence submitted by existing AEIs and new education institutions to meet the Standards framework for nursing and midwifery education

42. The evidence provided in gateway 1 will provide a benchmark for future QA activities and will be used by QA visitors to support the approval of subsequent gateways and standards.

43. The evidence provided will be available to QA visitors who are involved in our QA activities, to us, to the Mott MacDonald QA team, and to the AEI or education institution for the purposes of updating any changes. As part of their annual self-report, AEIs will also need to confirm that gateway 1 requirements are still met and report by exception on any changes to their ability to meet the standards.



2.6 QA visitors

44. Programme scrutiny will be undertaken by QA visitors, both registrant and lay. Lay visitors may attend any approval/ modification or monitoring event.

45. Registrant visitors include those who are currently, or have been, practising in nursing, midwifery, nursing associate and/or education in the past three years. They must not be current employees of the NMC. They will be assigned to undertake QA activities for parts of our register in which they hold registration and have a recorded qualification. Mott MacDonald requires QA visitors to declare the currency of their registration on an annual basis.

46. Lay visitors include those that do not hold registration with the NMC and are seeking assurance as a member of the public, patient, people who use services and/or carer. Lay visitors will actively participate in the approval of pre-registration nursing, midwifery, nursing associate, specialist community public health and specialist practice, alongside a QA registrant visitor. They are prepared to ensure that people are at the centre of our work in education and training, and their role is to represent the interest of the public.

47. The QA framework emphasises the importance of education and training that's underpinned by effective partnerships between AEIs, education institutions and their practice learning/employer partners at all levels. One of the areas of focus for all QA visitors will be the effectiveness of these partnerships.

48. When a date for a programme approval visit has been agreed with Mott MacDonald, potential QA lay and registrant visitors will be selected with due regard to the profession with which the education and training they are to report on is concerned, and at least one of the visitors will be registered on the part of the register which relates to that profession[3]. At least one of the QA visitors who are to report on the education and training of nursing associates shall be registered on the nurses' or the nursing associates' parts of the register.

49. Potential QA visitors will be required to indicate their availability, agree to complete the work within the given time frames and confirm that there's no conflict of interest. Ensuring that there's no conflict of interest is a statutory safeguard for us and the visitor's role in the QA of education[4].

50. Conflict of interest means any connection which might give cause to question a QA visitor's credibility or the objectivity of their judgement. This includes a QA visitor working in the education or practice learning/employer partner, for example this could include as an external examiner, or where the QA visitors' employers provide or share practice learning environments with the AEI or education institution to be approved. The AEI or education institution will be informed of the details of potential QA visitors and they will also confirm that there's no conflict of interest, or otherwise.

51. QA visitors are prepared thoroughly for the review of information presented for each relevant gateway in line with the QA Framework and our standards and requirements. They will analyse and interpret documentary evidence provided by the AEI, education institution and their practice learning/employer partners, and facilitate discussions with all stakeholder groups, as appropriate.

[3] Article 17(4) of the Order
[4] Article 17(5) of the Order

52. QA visitors will make judgements and recommendations based on reliable and substantiated evidence to provide assurance our programme standards are met and the programme can be recommended for approval to us.

53. QA visitors will behave with integrity and courtesy when conducting QA activities, and in accordance with the Mott MacDonald Code of Conduct for QA visitors (annexe 7.2 and 7.3). In turn, QA visitors will expect that AEIs and education institutions work in collaboration with the QA activities. Two of our values are 'fair' and 'kind', and we expect QA visitors to both abide by our values but also be treated the same way.

2.7 Support and QA of approval activities by Mott MacDonald

54. Mott MacDonald will employ a range of measures to assure a high standard of QA activities are undertaken on behalf of us, including:

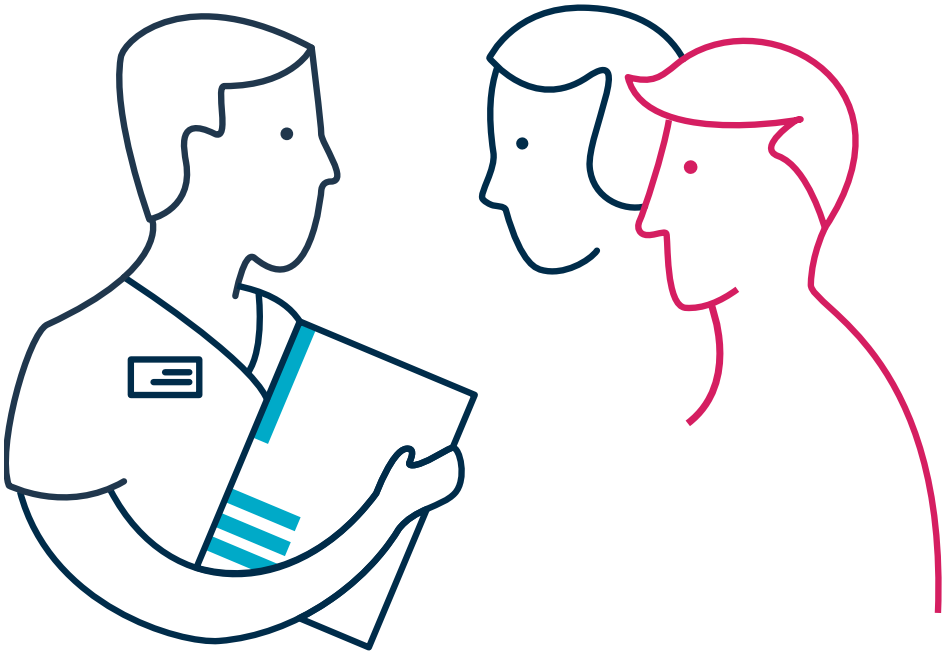
- clear guidance about the QA processes for QA visitors, education institutions seeking programme approval and AEI status, existing AEIs, and their practice learning/employer partners;
- training, development, and feedback for all QA visitors;
- allocation of QA registrant visitors with due regard to the part of the register the programme under review relates;
- Appropriate support for both the QA registrant and lay visitors in their conduct of visits;
- observation of the performance of QA visitors at a proportion of approval visits to ensure QA processes are adhered to;
- QA of programme approval reports;
- evaluation of the work of QA visitors;
- receiving, analysing, and responding to all evaluations completed by AEIs and education institutions to check they are satisfied that the QA activity has followed the procedures in this handbook, and in support of our commitment to continuous improvements;
- set out and follow a clear complaints procedure (annexe 7.8);
- the QA process is supported by the NMC QA Link which is the centre for all QA processes, electronic documents, gateways and reports. The QA Link offers password protected support to AEIs and education institutions and provides access to relevant QA activities, the gateways, and the function to upload documentation to support the approval processes. The QA Link is made available to QA visitors to complete their work only by arranged permissions set up by NMC QA officers, ensuring information security.

55. The introduction of indefinite programme approval requires robust scrutiny by QA visitors during the approval process to ensure risks are identified, mitigated, and/or escalated. It is particularly important to ensure effective decisions are made about the AEIs and education institutions readiness to proceed through the gateways, and to provide advice and guidance to QA visitors on standards and QA processes when making judgements and recommendations about the proposed models to meet our standards as appropriate.

Section 3: Information for new and existing AEIs

3.1 Gateway 2 – Standards for student supervision and assessment

56. When Gateway 1 has been completed by AEIs and their practice learning/employer partners they will be provided with a mapping tool in the QA Link to demonstrate how they must meet the Standards for student supervision and assessment.



3.2 Guidance for an AEI to complete Gateway 2

57. ***What the AEI and their practice learning/employer partners must do***

58. Following the release of the mapping tool the AEI or education institution and their practice learning/employer partners have **four weeks** to provide evidence to demonstrate how they intend to meet the Standards for student supervision and assessment.

59. The AEI must also identify which programme standards the Standards for student supervision and assessment will apply to.

60. The mapping tool will be used to ensure that all the standards and requirements for student supervision and assessment have been addressed. It will also signpost QA visitors to where the evidence is located in the uploaded programme documentation.

61. The evidence provided must include:

- a summary against each standard and requirement to demonstrate how they will be met. The QA criteria identified against each requirement in the mapping tool should help with this process. In addition, supporting information available on our website will assist in this process;
- confirmation that practice learning is compliant with those standards within the Standards framework for nursing and midwifery education which relate to supervision and assessment;
- confirmation that practice learning is compliant with those standards within the specific programme requirements which relate to supervision and assessment;
- confirmation that practice learning is designed and delivered in such a way that enables the student to meet their programme proficiencies and outcomes (for each programme) which will use the Standards for student supervision and assessment;
- suitable systems, processes, resources, and individuals are in place, including evidence of collaborative partnerships that support safe and effective practice;
- information that students will be made aware of the support and opportunities available to them within all learning environments;
- documentation which demonstrates that students will be supported to take responsibility for their learning in a way that is reasonable for the student and does not compromise public safety;
- details of a range of relevant people who participate in the education of students and how they will be prepared and trained for their roles. The way in which this is organised will depend on the requirements of the programme and the needs of the student; and
- a rationale which demonstrates why a particular approach to student supervision and assessment is proportionate.

62. Examples of the type of documentation that we would expect to meet the above requirements are:

- programme plan detailing student supervision and support arrangements;
- student focused information in a practice learning handbook for example on their role and responsibilities for engaging in learning, reflection, assessment, feedback, and evaluation;
- practice supervisor focused information in a practice learning handbook for example on their role and responsibilities for facilitating learning, reflection, contributing to assessment, feedback, and evaluation;
- academic assessor and practice assessor focused information in a handbook for example on their role and responsibilities for facilitating learning, reflection, assessment, feedback, and evaluation;
- supervisor and assessor preparation and training focused information detailing the content of the preparation, training, support and updating of practice supervisors, practice assessors and academic assessors; and,
- details of any programme standards specific variations to any of the above.

63. AEIs and their practice learning/employer partners can submit evidence as part of Gateway 2 submission which details the organisation wide approach they will take to student supervision and assessment across all approved programmes.

64. If an AEI and their practice learning/employer partners decide to take an organisation wide approach to student supervision and assessment across all NMC approved programmes the following must be taken into consideration and assurance provided against the following:

- Will the approach to student supervision and assessment be the same for all our programmes across all practice learning/employer partners?
- How will the AEI and their practice learning/employer partners ensure consistency in the approach taken?
- Does the chosen approach(s) to student supervision and assessment demonstrate a proportionate approach and meet the relevant programme standards?
- How will partnership working ensure responsibility for the management and QA of the approach(s) used?
- Who will take responsibility to co-ordinate the management and QA of the approach(s) used?
- How will partnership working ensure responsibility for the preparation of individuals for their roles?
- Will there be shared responsibility between the AEI and their practice learning/employer partners for the development of systems and processes used to support the organisation wide approach?
- How will an organisation wide approach support consistency in the assessment of practice and theory and moderation processes at programme level?

65. ***What the QA visitor will do***

66. The QA visitor has **two weeks** to review submitted documentation and evidence provided against each standard and requirement using the QA criteria and record if the evidence provided:

- demonstrates partnership working between the AEI or education institution and their practice learning/employer partners which relate to supervision and assessment in the Standards framework for nursing and midwifery education and Standards for student supervision and assessment; and
- shows practice learning is compliant with those standards within the Standards framework for nursing and midwifery education which relate to supervision and assessment and demonstrates that the Standards for student supervision and assessment are met;

OR

- there is insufficient and/or incomplete documentation to evidence the Standards for student supervision and assessment are met.

67. If the QA visitor reports the evidence is insufficient and/or incomplete they will inform Mott MacDonald's QAD or QADD of the shortfalls and escalate their findings to the AEI or education institution. The evidence required will be discussed and a resolution will be agreed which will result in the resubmission of evidence.

68. We will be informed about this situation. Also, the evidence will provide a benchmark for future QA activities and will be used by QA visitors to support the approval of subsequent gateways and standards.

3.3 Gateway 3 – Programme standards

69. Following successful completion of Gateway 1 and 2 the AEI or education institution and their practice learning/employer partners will proceed to Gateway 3.

70. A mapping tool for the Gateway 3 programme standards for approval will be released in the QA Link for the AEI or education institution to complete.

3.4 Guidance for an AEI and education institution to complete Gateway 3 for pre-registration nursing, pre-registration midwifery, return to practice, prescribing, pre-registration nursing associate, SCPHN and SPQ programmes

71. The AEI or education institution and their practice learning/employer partners have a maximum of **four weeks** to complete the gateway. This will include providing narrative and uploading documentary evidence in the QA Link to support achievement of the relevant programme standards and requirements. The AEI or education institution must clearly signpost the QA visitor(s) to the uploaded documentation which supports achievement of the programme standards.

72. Effective partnership between the AEI or education institution and key stakeholders is a key principle underpinning our QA Framework, including the commitment to actively engage people such as patients, people who use services and carers and the public in programme development and the proposed programme delivery. This should be reflected in the programme documentation and approval process.

73. In addition, the programme should be designed to ensure:

- our programme standards are explicit in the intended programme and relevant standards of proficiency
- compliance with the Standards framework for nursing and midwifery education
- arrangements are explicit at programme level to meet the Standards framework for nursing and midwifery education
- compliance with the Standards for student supervision and assessment;
- arrangements are explicit at programme level to meet the Standards for student supervision and assessment
- contemporary knowledge and practice is addressed
- AEI and education institution policies and procedures are compatible with our standards and requirements
- pre-registration nursing and midwifery programmes are presented with explicit information around fields of practice and routes, if approval is requested
- nursing associate programmes are presented with explicit information around the routes available i.e. direct entry or apprenticeship route.

74. Documentation that is provided to QA visitors and the approval panel must be same. We expect that all documentation provided at gateway 3 is provided to the approval panel so that the information being analysed is consistent and a conjoint approval can be ensured. The type of documentation/evidence we would expect includes:

- Programme document, including proposal, rationale, and consultation;
- Programme specifications;
- Module descriptors;
- Definitive information given to students about the programme e.g. student handbook;
- Curricula vitae for academic and practice learning staff who contribute significantly to each programme, including the registered nurse responsible for directing the education programme;
- Practice learning documentation which details the range, and QA of practice learning environments;
- Documentation detailing the preparation and provision of practice supervisors and assessors and other persons supporting practice learning (for programmes that have not yet adopted the Standards for student supervision and assessment);
- Proposed student numbers and frequency of intakes for which programme approval is requested;
- Practice assessment documentation for all years of the programme;
- Ongoing record of achievement (ORA);
- Mapping document providing evidence of how the programme standards are met within the programme(s);
- Strategic plan for practice partnerships and use of practice learning environments;
- Strategy for people who use services and carer involvement in programme design and delivery;
- Written confirmation by the AEI, education institution and associated practice learning partners that resources are in place to support the programme intentions, including a sample of signed supernumerary agreements from practice learning partners and protected learning time for nursing associate programmes;
- Signed statements of commitment from all employer partners demonstrating their commitment to our standards; and
- Strategic plan/business plan, if a new education institution.

75. For approval of apprenticeship routes, the AEI must also clearly identify the employer partners they are working with, and those they intend to work with in future in the delivery of their programme. This information must be submitted along with the other Gateway 3 information for the QA visitors to review. Those employer partners must be prepared and available to attend the Gateway 4 visit, and the QA visitor will select which ones will be expected to attend closer to the date, but with sufficient notice to allow the employer partners to make suitable arrangements.

76. As part of the collaborative nature of programmes, the commitment and collaboration between AEIs and their practice learning/employer partners is fundamental. In the instance of apprenticeships the employer partner must demonstrate their commitment to our standards in order to approve the apprenticeship route. In order to be approved, written evidence of a commitment statement signed by the intended apprentice employer partner needs to be provided

at Gateway 3. In the instance whereby an AEI is involved in a procurement exercise and engagement with an apprentice employer partner therefore isn't possible to understand their commitment, a condition will be set to gain written evidence of their commitment to working with the AEI and complying with the NMC standards once the procurement process is complete.

77. If any of the above documentation has previously been submitted as part of the evidence against the requirements of Gateway 1 or 2, explicit reference to it should be made in the Gateway 3 mapping tool. This documentation does not need to be submitted again. The QA visitors will have access to this information via the QA Link.

3.5 Pre-2018 standards and arrangements to transfer current students on existing approved programmes onto new programmes

78. ***Programme standards for pre-registration nursing, midwifery, prescribing and return to practice programmes***

79. AEIs and their practice learning/employer partners may wish to transfer current students onto the new programme to meet the Standards for pre-registration nursing programmes (NMC, 2018), Standards for pre-registration midwifery programmes (NMC, 2020), Standards for prescribing programmes (NMC, 2018) and Return to practice standards (NMC, 2019) respectively. If so, evidence must be provided to support this proposed transfer as part of the mapping process at Gateway 3 and students who would potentially transfer must also be available to engage with QA visitors during the approval visit within Gateway 4.

80. ***What the QA visitors will do***

81. The QA visitors will be given password-controlled access to the programme information uploaded by the AEI or education institution in the QA Link. In addition, QA visitors will receive a briefing pack from Mott MacDonald containing:

- The AEI's latest annual self-assessment report, if applicable.
- Relevant external system regulator monitoring reports e.g. Care Quality Commission (CQC), Health Improvement Scotland (HIS), Healthcare Inspectorate Wales (HIW), Regulation and Quality Improvement Authority (RQIA in Northern Ireland).
- Details of apprentice employer partners, if applicable.
- Transfer to the Standards for student supervision and assessment major modification reports, if applicable.
- Approval letter from the NMC (major modification pack only – see section four).
- Previous programme approval report and subsequent reports (major modification pack only – see section four).

82. The above documentation provides an overview of an AEI's management of risk affecting existing NMC approved programmes, as well as issues which may impact on the practice learning environments.

83. The QA visitor(s) have **four weeks** to independently analyse the programme documentation, supporting evidence and briefing pack information. The evidence provided will be assessed against each standard and requirement to make sure the evidence confirms how our programme standards will be met.

84. The AEI or education institution **cannot** proceed to Gateway 4 if the QA visitors are not satisfied from their analysis of the documentation submitted that the AEI or education institution and their practice learning/employer partners will meet the programme standards.

85. The QA visitors will complete an initial draft programme approval report to record their findings and identify areas which they want to discuss at the approval visit and inform the AEI or education institution if further evidence is required against the standards.

86. During **week four**, the QA visitors (registrant and lay, as applicable) will have a telephone conversation and/or email communication to confer on their findings before releasing the initial draft programme approval report to the AEI or education institution's nominated representative in the QA Link, at the end of week four (**two weeks**) before the approval visit. This initial draft programme approval report informs the AEI or education institution of any issues or further requested documentation. The AEI or education institution should respond to the questions/issues raised in the QA visitors' initial draft programme approval report through the QA Link **one week prior** to the approval visit. This information should be available to the chair of the approval panel and will inform the agenda for the approval panel visit, which, when finalised, must be deposited in the Ad-hoc Evidence Request area in the QA Link.

87. AEIs and education institutions cannot expect QA visitor(s) to review documentation provided immediately prior to, or tabled at, the approval visit.

88. AEIs and education institutions can proceed to Gateway 4 if the QA visitor(s) are satisfied that there is sufficient information available to proceed to meet stakeholders, and their representatives as part of the final triangulation of the documentary analysis of the programme standards, at the approval visit.

3.6 Deferral of an approval visit

89. During the scrutiny of programme documentation, a QA visitor(s) may identify that there is insufficient and/or incomplete documentation to evidence how our standards are met and to enable the AEI and education institution to proceed to the next gateway.

90. The QA visitor(s) will complete the initial draft programme approval report, no later than **two weeks** before the approval visit date identifying where standards are not met.

91. The QA visitor(s) will escalate their findings to the QAD or QADD at Mott MacDonald within **two working days** of identifying the issues. The extent of the evidence required will be discussed and a resolution will be agreed which will normally result in the resubmission of evidence and the timeline to programme approval will recommence from Gateway 3.

92. The QAD or QADD will contact the AEI or education institution's nominated representative to inform them the AEI or education institution is deemed not to be in a state of readiness to proceed and the approval visit will be deferred.

93. The initial draft programme approval report will then be released to the AEI or education institution via the QA Link.

94. The QAD or QADD will inform us of this decision within **two working days**.

95. In exceptional circumstances, an approval visit may be deferred on the day of the visit for example if further development is necessary, or due to other regulatory input being required. In these circumstances, it may not be possible to indicate the outcome of the visit on the day.

3.7 Withdrawal of a programme route

96. An AEI will not be able to withdraw programme routes once the panel meeting has started. If an AEI wishes to withdraw a route this must be done prior to the visit commencing.

3.8 Gateway 4 – Approval visit

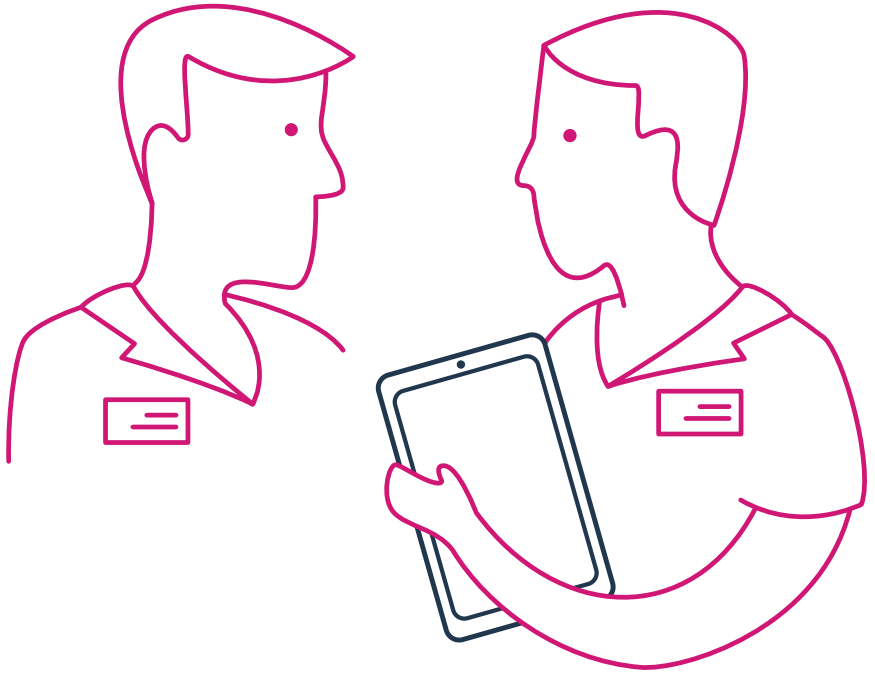
97. The timeline from the submission of the event request by an existing AEI and their practice learning/employer partners to the approval visit is normally **20 weeks**. This is provided the Standards framework for nursing and midwifery education and the Standards for student supervision and assessment are met and there is sufficient evidence to proceed through Gateways 1, 2, and 3.

98. The timeline from the submission of the event request by an education institution seeking programme approval and AEI status, to the approval visit is normally a minimum of **24 weeks**. This is provided the Standards framework for nursing and midwifery education and the Standards for student supervision and assessment are met to proceed through Gateways 1 and 2, and there is sufficient information available to proceed through Gateway 3 to meet stakeholders as part of the final triangulation of the documentary analysis of the programme standards at the approval visit.

99. We aim to minimise the burden on all AEIs, education institutions and their practice learning /employer partners by taking part in joint approval visits with the AEI or education institution and/or other regulators, where possible, but we do so with clarity about respective roles. QA visitors will engage with the presenting panel and representatives from the AEI, education institution, and their practice learning/employer partners and other regulators.

100. We undertake conjoint approval with education institutions for education programmes. The approval of both academic and professional aspects of programmes is closely linked and in order to meet our standards and requirements, AEIs and education institutions will have to approve their qualification award at the prerequisite level. Having a conjoint approval event will allow for the consideration of qualification of the award to take place at the same time as NMC approval.
A programme will not be recommended for approval by a QA visitor if it has been previously approved by the AEI or education institution **only**.

101. This will also reduce additional burden or duplication of processes for AEIs and education institutions.
Please note: even if the approval request was raised by an already established AEI, we still require conjoint approval event to take place.



3.9 Structure of the approval visit

102. Approval visits will be undertaken by Mott MacDonald according to our hybrid approach. This approach provides flexibility where some visits may be undertaken remotely.

103. Visits which must be undertaken face to face are:

- Education institutions seeking approval for the first time to become an AEI
- The approval of a new programme at an existing AEI (or combined with education institution to AEI approval)
- Endorsement of a programme or the addition of a satellite site

104. All Visits which require a visit to educational facilities or a practice learning/employer partner must be undertaken face to face.

105. Where there may be exceptions, AEIs must discuss these with Mott MacDonald at the earliest opportunity.

106. The QA visitor(s) will agree with the AEI or education institution the agenda and structure of the approval visit, the membership of the approval panel, the attendees required at meetings and any arrangements for visits to departments/facilities on the teaching campus or other sites where required. A copy of the details and e-mails confirming agreement should be forwarded by the QA visitor to Mott MacDonald (nmc@mottmac.com) for completion of the audit trail purposes. In addition, the AEI or education institution must upload the final agenda for the approval visit into the Ad-hoc Evidence request area in the QA Link for audit trail purposes. A sample agenda for the conjoint approval visit is provided in annexe 7.4. **Please note:** it is important that the agreed agenda is followed at the visit, withstanding any unforeseen delays where possible.

107. If there is any commercially sensitive information that the AEI or education institution or their practice learning/employer partners do not wish to have discussed openly during the day of the approval visit, this must be brought to the attention of the QA visitor(s) in advance of the visit. A decision must be made about an appropriate time that this will be discussed with the visitor(s) at the approval visit.

108. The minimum approval event conjoint panel membership should normally include:

- A senior academic representative for the AEI/education institution who has no direct involvement in the programme (Chair);
- Administrator for teaching and quality at the AEI/education institution;
- Academic member(s) at the AEI/education institution (not directly involved in the programme);
- QA visitors appointed by Mott MacDonald on behalf of us;
- External subject specialist(s) Please note: this person(s) should not be from a partner AEI;
- People who use services and carer representative(s); and
- Student representative(s).

109. The AEI or education institution should confirm in advance with the QA visitor(s) through e-mail and the QA Link whether people who use services, carers and student representatives will form part of the panel membership. In line with best practice, we would encourage that representation from people who use services, carer and student groups are present within panel membership. However, we wouldn't stop an approval event from going ahead if this could not be achieved.

110. An NMC observer may be present at approval visits. The observer role will be maintained unless there are issues arising from the approval visit that relate to risks to public protection, in which case our staff member's role as representative of the regulator will override their status as an observer. The QAD or QADD from Mott Macdonald may be in attendance to observe and support QA visitor(s) and to ensure QA processes are followed.

111. The approval panel members will follow the agreed agenda for the visit which normally commences with a short presentation from the programme team outlining the development and key areas in the student journey through the programme. This presentation must also address issues submitted to the AEI or education institution by the QA visitor(s) prior to the visit.

112. The programme development team will normally be expected to comprise both academic staff and representatives from practice learning/employer partners, and other stakeholders, for example this could include students, people who use services and carers who have been involved in the co-production.

113. It is essential that there is an effective balance between practice and AEI/education institution based learning to demonstrate the shared partnership development.

114. QA visitors will explore arrangements for both practice and AEI/education institution based learning and student supervision and assessment. In addition, any other issues identified for exploration by panel members will be explored with the programme team and in separate meetings with key stakeholders including, but not limited to: students; educators; practice leads, strategic level PLP colleagues, practice supervisors/assessors; and people who use services and carers. If students, practice learning/employer partners and people who use services and carers were present at the presentation with the programme development team, then it is expected that a different group is met during these meetings.

115. AEIs/education institutions must provide access to relevant stakeholders groups at the visit, otherwise the programme cannot be recommended for approval.

116. Speaking to stakeholders at the approval visit enables the final triangulation of the documentary analysis of the programme standards. It is also necessary to pursue these issues in discussion with students, educators, employers, assessors and people who use services and carers; and, if a practice learning environment visit is required as part of the programme approval, with practice learning/employer partners. This must inform and assist the approval panel in making an evidence-based decision regarding the outcome of the visit and gateway approval process.

117. Annexe 7.7 provides guidance for meetings with AEI or education institution senior staff, educators, students, practice leads, practice supervisors/assessors, employers and people who use services and carers.

118. The QA visitor(s) will summarise responses to the issues they have previously raised on the initial draft programme approval report, to determine whether regulatory requirements have been met, or not met.

3.10 Visits to practice learning environments

119. QA visitors are not normally expected to undertake visits to practice learning environments. This may happen if the education institution is seeking AEI approval status or has not previously provided a pre-registration nursing (or new field of practice), midwifery or nursing associate programme. Also, this may happen in instances where previous QA reviews have indicated continuing problems in practice learning environments. QA visitors are also not normally expected to undertake visits for new post-registration programmes.

120. If visits to practice learning environments are planned they will need to be arranged on dates prior to the approval visit. Guidance for visits to practice learning environments is provided in annexe 7.6.

3.11 Attendees at the approval visit

121. Partnership is central to programme development and proposed delivery, and this should be reflected in the approval process. The QA visitors and relevant members of the approval panel may meet with representatives from the AEI or education institution and their stakeholders and practice learning/employer partners.

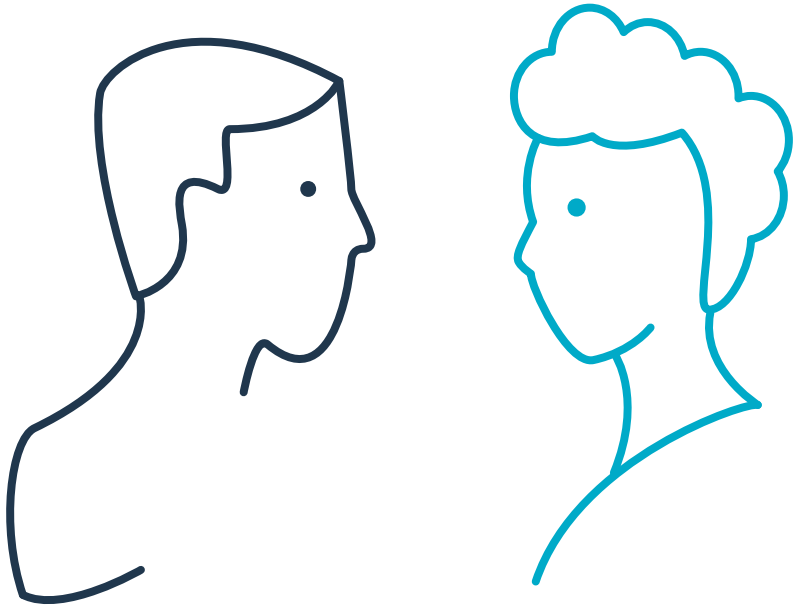
122. A representative sample of colleagues that QA visitors could expect to meet include:

- AEI /education institution: dean/ head of school/faculty; QA lead for school/faculty; senior representative from the AEI/education institution executive team (the latter relates to a new education institution/and/or new provider of pre-registration nursing, midwifery, or pre-registration nursing associate education);
- Educators: those with responsibility for planning, sequencing, managing, and delivering the programme including all theory delivery and liaison with practice learning opportunities for example, programme team, lecturers, programme leads, researchers;
- Practice leads: those with responsibility for planning, managing, and delivering the practice learning aspects of the programme and providing support to practice supervisors and practice assessors, for example, placement liaison team, practice education facilitators, interdisciplinary practice leads. For approvals of apprenticeship routes, senior members of staff from a selection of apprenticeship employer partners such as Directors of Nursing are expected to attend the approval event, or arrangements made for them to be contactable. The QA visitor will select the employer partners they wish to attend in advance of the visit;
- Practice supervisors and practice assessors including practice supervisors (NMC registrants and interdisciplinary registrants) and NMC registrant practice assessors;
- People who use services and carers who have been involved in programme development and delivery. The programme approval will not be able to take place without people who use services and carers being met; and
- Students: from all years of the existing programme (where applicable), including those students who will transfer to the new programme. If more than one field of nursing is being explored, then each field should be represented.

3.12 Purpose of the approval visit

123. The purpose of the approval visit is to ensure:

- there is the opportunity to speak with all stakeholders to confirm there are strong and effective partnerships between the AEI or education institution and their practice learning/employer partners, people who use services and carers; students, and all other stakeholders;
- the range, and QA of practice learning environments, including arrangements for preparation and provision of academic assessors, practice supervisors and practice assessors and other persons supporting practice learning to support students to achieve the standards of proficiency;
- facilities and resources are in place to deliver safe and effective learning opportunities and practice based experiences for students to achieve their programme learning outcomes, standards of proficiency and be capable of demonstrating the professional behaviours in The Code (NMC, 2018);
- curricula and assessment will enable students to achieve the outcomes required to practise safely and effectively in line with the relevant standards of proficiency;
- students are provided with timely and accurate information about curriculum, approaches to teaching and learning, supervision, assessment, practice placements and other information relevant to their programme;
- routes within the pre-registration nursing, midwifery, nursing associate or return to practice programmes, which may include; undergraduate, postgraduate; or apprenticeship routes; and one or more fields of nursing practice (pre-registration nursing programme only) are explicit and understood by students, educators, supervisors, and assessors;
- appropriately qualified and experienced external examiners consider and report on the quality of theory and practice learning; and
- AEI or education institution policies and procedures applied to the programme are compatible with our standards and requirements.

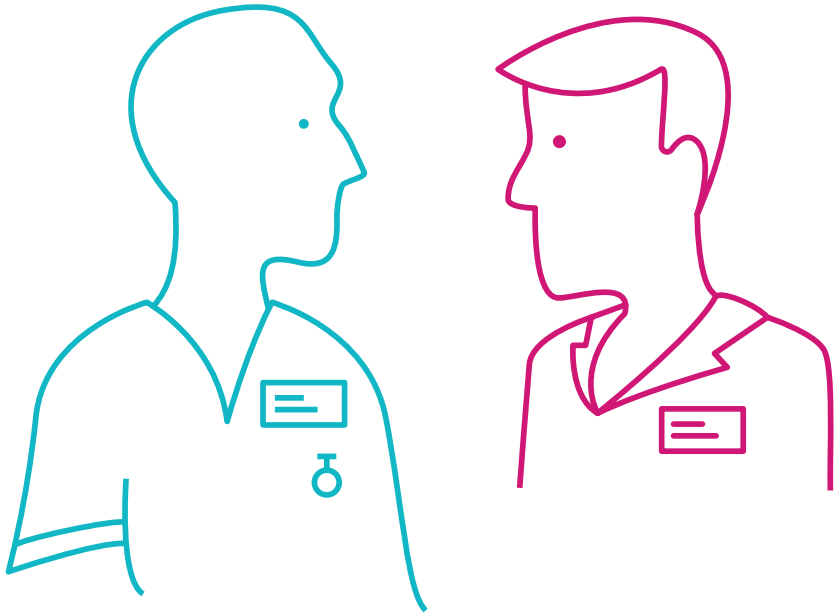


3.13 Approval briefing meeting

124. The senior AEI or education institution representative who will chair the meeting of the approval panel, will discuss the issues to be explored with panel members, and agree who will lead on each issue.

125. At the start of the briefing meeting the QA visitor(s) must:

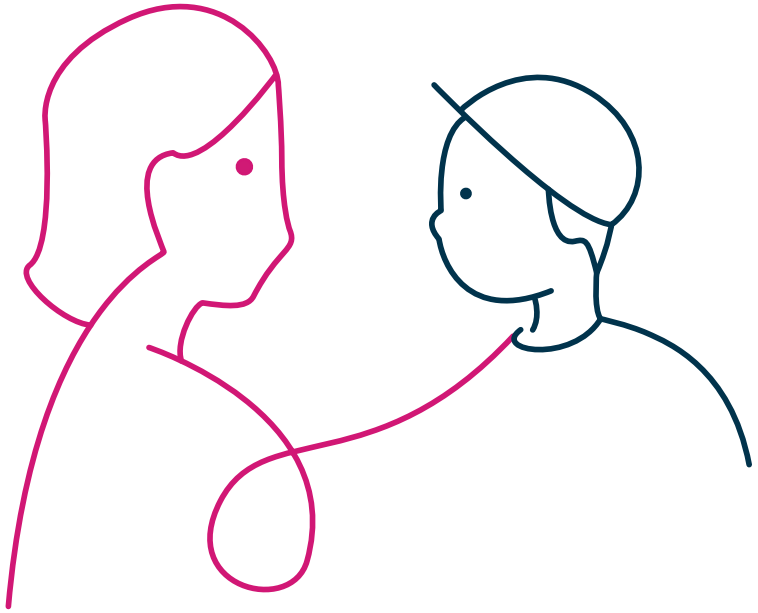
- explain their role and responsibilities as a representative of the NMC and the implications of conjoint approval;
- explain it is their responsibility to assess whether the programme meets all of the regulatory standards and requirements and unless these are met, it will not be possible to recommend the programme for approval to us;
- explain the possible outcomes of the approval event that can be recommended to us include that:
  - the programme is approved unconditionally as all of our standards have been met;
  - the programme may be recommended for approval at a future date subject to the successful completion of clear, unambiguous, and timely conditions that demonstrate that our standards have been met; and
  - the programme approval is refused as not all the standards have been met.
- be explicit that any decision on a QA visitor's recommendation for approval or refusal to approve the programme lies with us;
- explain that any conditions must be agreed and stated as AEI/education institution in nature or specific to our standards or both;
- state if regulatory (NMC) conditions exceed five in number, including any condition subsections, then questions must be raised as to the validity of the programme meeting our standards, and the need for the AEI or education institution to re-submit their proposals; and
- inform the panel that should a major issue be raised where the QA visitor(s) needs to obtain advice about a specific requirement, the Chair will adjourn the meeting for this to occur. The QA visitor will contact the QAD or QADD for advice who will inform us, if necessary.



3.14 Outcome of the approval visit

126. Members of the approval panel will meet at the end of the approval visit to share findings and reach a collective decision regarding the outcome of the visit. The QA visitor(s) acting on behalf of us can make judgements and recommendations relating to whether our standards have been met, however, the final decision is made by us. In this meeting, one of the following outcomes will be made by the QA visitors:

1. ***Programme is recommended to the NMC for approval*:** If the programme meets all (NMC) regulatory standards and requirements, the outcome of the approval visit will be that the programme is recommended to us stating that our standards necessary for programme approval are met. We will review the recommendation and make the decision whether to give indefinite approval.



2. ***Programme is recommended for approval after conditions are met***: If the findings of the approval panel identify failures of the programme to meet some aspects of regulatory standards and requirements for the protection of the public, or academic regulatory requirements then the programme will not be recommended for approval until specific conditions are met.

   A. If outcome 2 results, the panel must:

   - identify and state clear and unambiguous statements of the conditions to be met;
   - agree a realistic date by which the condition(s) is to be met; and,
   - identify persons as responsible for reporting the completion of the work to meet the conditions.

3. ***Programme is recommended for refusal:*** If the panel is not satisfied that the required standards have been met, if our visitors disagree with the internal panel, where there are significant concerns that public safety may be compromised, or more than five conditions have been attached. We will review the recommendation and may make the decision to refuse to give programme approval.

   A. QA visitors must discuss the recommended outcome to refuse approval of the programme with the QAD or QADD at Mott MacDonald on the day of the approval visit. The QAD or QADD will inform us of the decision **within two working days**.

127. It should be noted that conditions must only relate to where standards are not being met. If not satisfactorily addressed, these issues would prevent the programme from being approved and therefore running.

128. AEI/education institution specific conditions will be noted as distinct from those which relate to meeting a NMC standard and/or requirement.

129. AEIs/education institutions must provide evidence that any joint or university conditions are signed off by the university by the date set at the approval/modification visit.

130. QA visitors must advise the AEI or education institution that they may recruit to a new programme if their own academic regulations permit but may not enrol students until formal notification of our decision to approve is received. As the visitor's decision is subject to approval by us, the decision to recruit is at the institutions risk. It is important to note that the programme is not approved until final confirmation is received from us.

131. The AEI or education institution are required to produce a response to conditions providing evidence that the conditions have been met within the agreed timeframe.

3.15 Recommendations

132. It is customary in the higher education sector to make recommendations for the enhancement and continuing improvement of the programme, where best practice goes further than the threshold standard.

133. A QA visitor(s) may make a recommendation(s) to enhance the programme, which reflects the gathering of information related to new standards.

134. The approval panel must be advised that it is necessary to maintain a clear distinction between mandatory conditions to those recommendations for enhancement and continuing improvement of the programme.

135. The record of the recommendations in the programme approval report made by the QA visitor(s) will note if the recommendations are AEI/education institution in nature or relate to our standards.

3.16 Reporting outcomes of an approval visit

136. QA visitors must ensure they make an accurate record of the wording of conditions agreed and stated at the approval panel meeting. Where two or more QA visitors are present they must agree the outcome for each standard of the programme, with the nominated lead registrant visitor taking overall responsibility for this.

137. The AEI or education institution will take notes or minutes of the approval visit which must be agreed between all panel members. The notes or minutes should also reflect the roles and place of work of all participants and stakeholders attending the approval visit. Once agreed the AEI or education institution must deposit a copy of the minutes of the approval visit in the Ad-hoc Evidence Request area in the QA Link. Once deposited, the registrant visitor should have sight and agree that the minutes are an accurate representation of the discussions had during the visit.

138. For approvals where a QA lay visitor is present, on completion of the approval visit the QA lay visitor will complete their sections of the NMC programme approval report **within two working days** and submit via the QA Link. The QA registrant visitor(s) will collate the QA lay visitor's report and include content within a draft NMC programme approval report which will be agreed by the QA lay visitor. This draft NMC programme approval report must be submitted in the QA Link **within seven working days** of the approval visit for internal QA checks by Mott MacDonald.

139. The programme approval report will:

- identify the academic award(s) as well as the NMC programme(s) and routes reviewed;
- decide the level of achievement for each standard on the following basis:
  - **Standards met**: The programme meets all regulatory standards and requirements and enables students to achieve stated NMC standards of proficiency and learning outcomes for theory and practice; or
  - **Standards not met**: Failures of the programme to meet some and /or all aspects of NMC standards and requirements necessary for the protection of the public, or academic regulatory requirements. The QA visitor(s) must provide clarity on where and why the standards are not met. Urgent improvement may be required to ensure that the standards are met, and public protection is assured.
- provide an accurate record of the wording of all conditions and clearly identify which programme/field/pathway/route they relate to, if appropriate to the programme approval;
- ensure that conditions are cited in the report against the relevant NMC standard and identify if they are our conditions, AEI/education institution conditions or both;
- provide an evaluative summary describing the evidence which supports the approval outcome recommendation that will be submitted to us;
- confirm which stakeholder groups were present at the meeting and the programme team:
- the number, cohort year and programme of study of any students;
- and confirm whether the programme contains a fall-back award.

140. Guidance notes for completing an NMC programme approval report are provided on the Mott MacDonald **website**.

141. Mott MacDonald will complete internal QA checks on the NMC programme approval report and feedback to the QA visitor(s).

142. Mott MacDonald will share the draft final programme approval report with the AEI or education institution, and we will be notified. Where the AEI or education institution wishes to make observations on the report they have one calendar month to submit their observations.

143. Observations can be used to ensure factual accuracy where there might be an error. This should include ensuring that all programme title(s) and academic level(s) that lead to eligibility to apply for NMC registration are correct.

144. If an AEI does not respond within the observation period of one calendar month, it will be inferred that the AEI agrees with the report and that it's factually correct.

145. Mott MacDonald will submit the final programme approval report to us via the QA Link, noting the final recommendation to approve or refuse approval being made following the final response to any conditions set.

146. If an AEI wishes to provide feedback about any aspect of the approvals process then this should be via the evaluation template that is provided post the gateway 4 event.

3.17 Conditions set at approval meeting

147. If the programme is recommended for approval after conditions are met, the QA visitor(s) will complete the programme approval report and enter the conditions and due date into the relevant sections of the report before submitting to the QA Link. This draft NMC programme approval report must be completed and submitted via the QA Link within seven working days of the approval visit.

148. Mott MacDonald will complete internal QA checks on the approval report, and feedback to the QA visitor, if necessary.

149. The draft report will be shared with the AEI or education institution, and we will be notified. Where the AEI or education institution wishes to make observations on the report they have one calendar month to submit their observations[5].

[5] Article 16(9) of the Order

150. *AEI and education institution response to conditions*

151. At or before the due date for conditions to be met, the AEI or education institution will provide the QA visitor(s) with their response to conditions via the QA Link, providing evidence of how they have met the conditions, including confirmation that any joint or university conditions have been signed off by the university.

152. The QA visitor(s) will review the evidence provided against the relevant programme standard and requirement. If the QA visitor(s) finds that the evidence demonstrates that all of the conditions have been met, they must confirm this with the AEI or education institution within **five working days**.

153. The QA visitor(s) must complete our programme approval report evidencing that conditions are met and submit the report via the QA Link within **five working days** of the due date for conditions to be met.

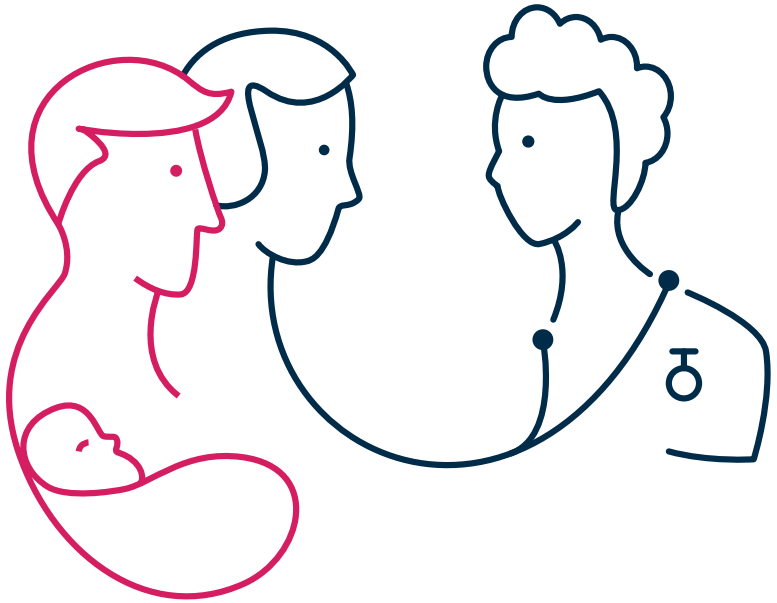
154. Any request for an extension to the agreed date to meet conditions by the AEI or education institution must be agreed by the QA visitor who will have consulted and agreed a new date with Mott MacDonald's QAD or QADD. We will be consulted if the extension exceeds **five working days**.

155. QA visitors must advise the AEI or education institution that they may recruit to a new programme, subject to our approval but **must not** enrol students until and unless our approval is granted. The AEI or education institution should also be advised that the decision to recruit is at their own risk.

156. *Evidence does not demonstrate conditions have been met*

157. If the evidence submitted by the AEI and education institution **does not** demonstrate that all of the conditions have been met, to the satisfaction of the whole panel, the QA visitor(s) must inform the AEI or education institution and Mott MacDonald **within five working days**. The QA visitor must also contact Mott MacDonald for guidance on the offering of an extension to ensure satisfactory achievement of the conditions set.

158. If the AEI or education institution fails to provide evidence of meeting conditions within the agreed time frame, the conditions will be deemed to be **not met** and the QA visitor must contact Mott Macdonald for guidance on action to be taken **within two working days** of the agreed time frame.



159. Mott Macdonald will contact the AEI or education institution to explain the ramifications of failing to produce the required documentation and will, in exceptional circumstances, agree a revised date for submission of no more than **five working days**.

160. The AEI or education institution will send the QA visitor(s) and Mott MacDonald further evidence of meeting the conditions set within the agreed and final extended time frame. If the evidence demonstrates that the conditions have been met, the QA visitor(s) will confirm this with the AEI or education institution and Mott MacDonald **within five working days**.

161. The approval visit is a conjoint event and therefore confirmation that all NMC and AEI/education institution conditions are met must be agreed by all approval panel members; the QA visitors are responsible for the conditions which relate to our standards and requirements.

162. If the further evidence submitted by the AEI or education institution **still does not** demonstrate to the satisfaction of the approval panel that the conditions have been met, the QA visitor(s) must inform the AEI or education institution and the QAD or QADD **within five working days**.

163. In this situation the conditions will be deemed to be **not met**. Mott MacDonald will submit the report to us outlining that the conditions have not been met and that the programme is therefore not recommended for approval.

3.18 NMC decision

164. AEIs/education institutions and practice learning/employer partners must meet all of our standards to be granted approval.

165. Following the receipt of the AEI/education institution's observations and confirmation by the registrant visitor that the conditions are met, Mott MacDonald will carry out their quality assurance checks on the report before sending submitting the report to our QA team.

166. On receipt of the QA visitors' report and the recommendation regarding approval from Mott MacDonald, we will complete our internal scrutiny checks on the narrative in the report and the conclusions reached, and take into account any other relevant information, including any observations by the institution, when deciding to approve or refuse approval for a programme[6]. This process should take **no longer than 10 working da**ys.

167. ***NMC approves programme***

168. If satisfied, we will send a decision letter to the AEI or education institution normally within 20 working days from the date of which the decision to approve the programme takes effect[7]. We will publish the final report and any observations made by the AEI or education institution.

[6] Article 18(1) of the Order, [7] Article 16(12) of the Order,

169. *NMC refuses programme approval*

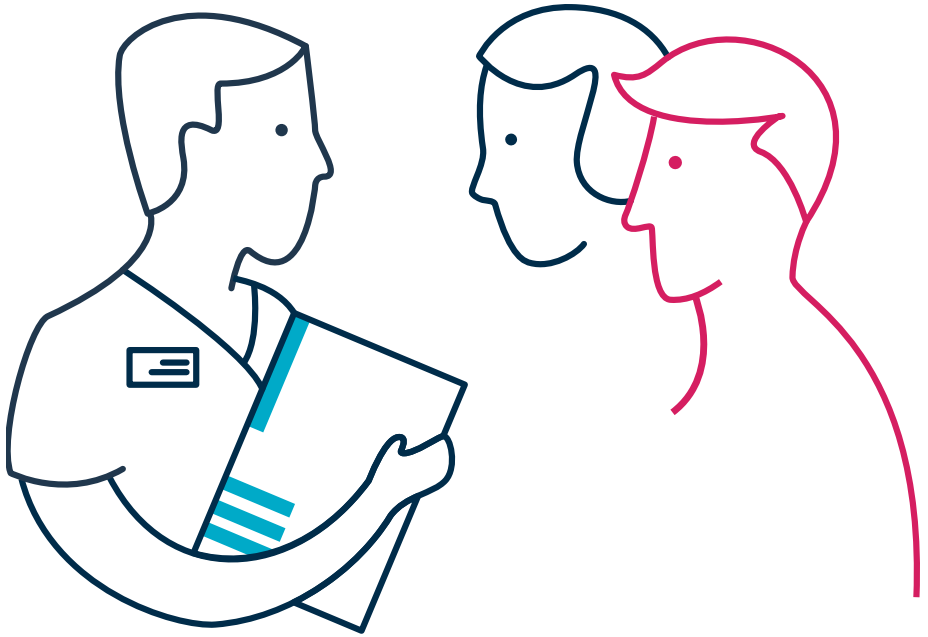
170. If we are not satisfied that the AEI or education institution can meet our standards, we will notify the AEI or education institution that we are minded to refuse approval, giving our reason[8].

171. The AEI or education institution then has **one calendar month** to make observations following our notification[9].

172. We will consider any observations made by the AEI or education institution alongside all information considered when making the final decision to approve or refuse a programme[10].

173. We will then notify the AEI or education institution of the decision and the date from which the decision takes effect[11].

174. Following this, we will publish the final report which includes any education institution observations[12].



[8] Article 18(4) of the Order, [9] Article 18(7) of the Order,
[10] Article 18(6) of the Order [11] Article 18(7) of the Order, [12] Article 16(12) of the Order

Section 4: Programme modifications

4.1 Modification to an existing approved education programme

175. An AEI may need to request a programme modification to an approved programme. How these are managed depends on the extent of change to the programme. If unsure, it's best to check with Mott MacDonald at nmc@mottmac.com Significant changes which would require a major modification might include:

- Changes to learning outcomes designed to meet our outcomes and proficiencies/competencies;
- Changes to assessment to meet new learning outcomes;
- Other changes that impact on any of our regulatory requirements;
- Introduction of another field of practice;
- Introduction of another academic route;
- Introduction of an apprenticeship route;
- Adding a new employer partner to an apprenticeship route; and
- Adding a satellite site or additional campuses.

4.2 Minor modifications

176. Under the QA Framework, AEIs do not have to submit information regarding a minor modification through the QA Link. However, AEIs need to have robust governance processes in place to internally agree, monitor and record these changes.

177. AEIs will manage minor modifications through their own internal QA policies, processes, and procedures. A record of minor modifications and decisions made must be kept by the AEI in case we need to review the decisions made and the impact on the approval of the programme. We expect AEIs to report on their minor modification decisions in the annual self-assessment report.

4.3 Major Modifications

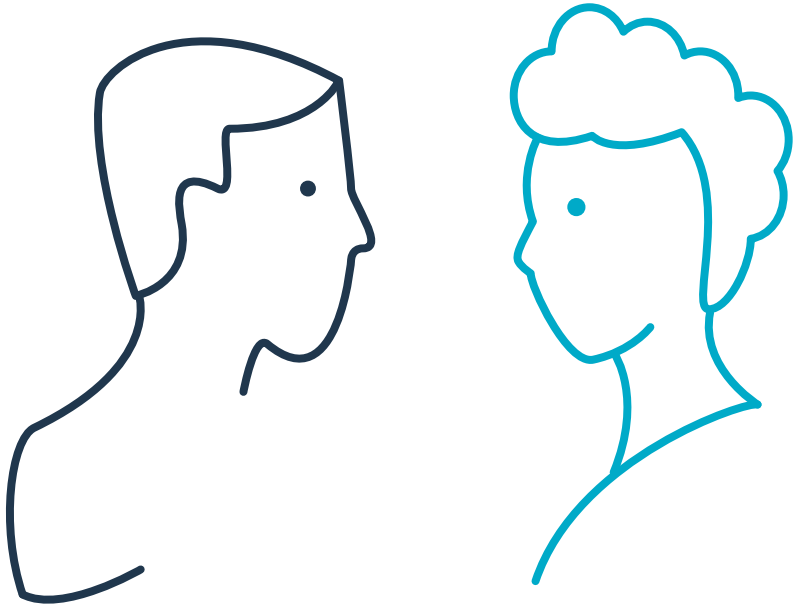
178. ***What the AEI must do***

179. The AEI must submit a major modification event request through the QA Link providing a rationale and summary of the proposed change(s) to the approved programme, and the impact on our standards and requirements. If the proposed change impacts on Gateway 2 Standards for student supervision and assessment, this must be detailed in the major modification request including indicating within the request form that Gateway 2 isn't up to date and needs unlocking. The AEI will provide three preferred dates for the major modification event, normally allowing **20 weeks** from the event request to the proposed date for the major modification review. When an AEI submits an event request, they are declaring that they will be prepared for the visit to go ahead on those dates. These dates will only be able to be changed in exceptional circumstances.

180. If the major modification impacts on the Standards for student supervision and assessment, Gateway 2 will be unlocked in the QA Link and the AEI will be provided with a mapping tool to demonstrate that all the standards and requirements for student supervision and assessment continue to be met as a result of the proposed major modification to the programme. Updates to gateway 2 should only be those directly related to the proposed modification. The AEI will also signpost QA visitors to where the evidence is located in the uploaded programme documentation.

181. A mapping tool for the major modification for Gateway 3 programme standards will also be released in the QA Link for the AEI to complete.

182. The AEI has a maximum of **four weeks** to complete the mapping tool to demonstrate which standards and requirements are affected by the major modification. They will provide narrative and upload documentary evidence in the QA Link to demonstrate how these affected programme standards and requirements will continue to be met. The AEI will clearly signpost the QA visitor(s) to the uploaded documentation which demonstrates the major change to the approved programme and supports the continuing achievement of the programme standards.



4.4 Types of visits for major modifications

183. The major modification request will be reviewed by a member of the Mott MacDonald professional team and a decision made as to the type of major modification event which will be followed. This will be either a major modification desktop review or a major modification visit.

184. Major modification by documentary (or desktop) review

185. ***What the QA visitor will do***

186. Where modifications introduce changes to the approved programme which can be reviewed by documentary analysis the QA visitor will review the mapping tool and uploaded programme documentation provided by the AEI (Gateway 3, and where necessary Gateway 2).

187. The evidence provided against each of our standards and requirements the major modification impacts on will be reviewed, against the original approved programme, to provide assurance of continued compliance with the relevant NMC standards.

188. If necessary, the QA visitor will contact the AEI to arrange a teleconference or equivalent with the programme leader/representative to discuss any issues which require further clarification (normally no other stakeholders are required).

189. Complete an initial draft major modification report and submit via the QA Link. This draft report should be submitted **two weeks prior** to the arranged teleconference.

190. Note: If the documentary evidence indicates that the AEI is not in a state of readiness to proceed, the QA visitor(s) will inform the QAD or QADD and the AEI will be informed that the modification request and teleconference are deferred. The AEI will be requested to resubmit the modification proposal via the QA Link when all documentation and evidence to support the standard(s) has been completed.

191. ***What the AEI will do***

192. The AEI will review any issues raised by the QA visitor in the draft major modification report and provide a response to the issues through the QA Link, uploading any additional documentary evidence.

193. The AEI will provide the response to the issues raised by the QA visitor at least **one week prior** the teleconference to enable further scrutiny by the QA visitor.

194. Following the teleconference, the QA visitor will advise the programme leader/AEI representative of the outcome of the documentary review.

195. The QA visitor will submit the major modification report through the QA Link within **seven working days** of the teleconference.

196. In the report the QA visitor will:

- Record the level of achievement for each standard affected by the modification on the following basis:
  - **Standards met:** The programme modification meets all regulatory standards and requirements and enables students to achieve our stated standards of proficiency and learning outcomes for theory and practice.
  - **Standards not met:** Failures of the programme modification to meet some or all aspects of our standards and requirements necessary for the protection of the public, or academic regulatory requirements. The QA visitor(s) must provide clarity on where and why the standards are not met. Significant and urgent improvement is required to ensure that the standards are met, and public protection is assured.

197. Major modification by visit to the AEI

198. Where modifications introduce more significant changes to the approved programme it may be necessary for the QA visitor(s) to participate in the AEI's internal QA processes in order to provide assurance of continued compliance with the relevant NMC standards. This will be undertaken as a visit to the AEI.

199. If the major modification is to introduce a new field of practice in the approved pre-registration nursing programme, or to propose a satellite site or partnership for delivery of a programme, it may be necessary to undertake placement visits relevant to the field of nursing practice. This decision will be made by a member of the Mott MacDonald professional team during the initial review of the major modification request.

200. The AEI will complete a programme specific mapping tool identifying the programme standards affected by the modification and signposting the QA visitor to relevant documentation which must be uploaded in the QA Link **eight weeks** prior to the major modification visit.

201. AEIs cannot expect QA visitor(s) to review documentation provided immediately prior to, or tabled at, the visit.

202. ***What the QA visitors will do***

- scrutinise the documentation and assess the evidence provided against each of our standards and requirements that the change impacts on using the QA criteria;
- complete a draft major modification report to reflect the findings;
- state clearly in the evaluative summary what the proposed modification is;
- report only on the standards which are affected by the proposed major modification;
- identify on the draft major modification report where there is insufficient evidence which must be pursued before or during the major modification visit;
- agree the agenda for the modification visit with the AEI;
- ensure the draft major modification report is available to the nominated representative of the AEI **at least two weeks** before the visit through the QA Link to inform the AEI of any issues or further requested documentation; and
- ensure that they notify the AEI which employer partners are selected to attend the Gateway 4 visit for apprenticeship route major modifications, at **least three weeks** before the visit

203. ***What the AEI will do***

- respond to any issues or requests raised in the QA visitor's draft major modification report through the QA Link **one week** prior to the modification visit. This will inform the agenda for the major modification visit;
- finalise the agenda for the modification visit and deposit in the QA Link for agreement by the QA visitor;
- inform the employers partners who are selected to attend the Gateway 4 visit for apprenticeship route major modifications at least **three weeks** before the visit.

204. The management of the modification visit will follow the AEI's internal QA processes. The panel membership will be consistent with the AEI's QA requirements. The modification event will normally be chaired by a senior member of the School/Faculty.

205. Partnership between an AEI and its PLP's is central to programme development and proposed delivery, and this should be reflected in the major modification process. Depending on the NMC programme standards affected by the modification(s), and to triangulate documentary evidence, the QA visitor(s) should meet with representatives from the AEI and their practice learning/employer partners.

206. A representative sample from the following groups will include:

- Educators: those with responsibility for planning, sequencing, managing, and delivering the programme including all theory delivery and liaison with practice learning opportunities for example, programme team, lecturers, programme leads, researchers;
- Practice leads: those with responsibility for planning, managing, and delivering the practice learning aspects of the programme and providing support to practice supervisors and assessors, for example, placement liaison team, practice education facilitators, interprofessional practice leads;
- Practice supervisors and assessors including practice supervisors (our registrants and other professions) and NMC registrant practice assessors;
- People who use services and carers who have been involved in the proposed modification(s) to the approved programme. The approval of the modification to the programme will not be able to take place without people who use services and carers being met; and
- Students: from all years of the existing programme (where applicable).
- For major modifications to add apprenticeship routes: senior members of staff from a selection of apprenticeship employer partners are expected to attend the major modification visit, or arrangements made for them to be contactable. The QA visitor will select the employer partners they wish to attend in advance of the visit.

207. If a practice learning environment visit is made, it is also necessary to pursue any issues with practice learning/ employer partners. This must inform and assist the approval panel in making an evidence-based decision regarding the outcome of the major modification approval visit and gateway approval process.

208. The recommended outcome of the major modification proposal will be communicated to the panel and programme team at the end of the visit.

209. The QA visitor will submit the major modification report via the QA Link **within seven working days of the visit**.

4.5 Introduction of a new apprenticeship employer partner to an approved apprenticeship route

210. Information about adding a new employer partner to an approved apprenticeship programme can be found on our website.

211. If an AEI approved to deliver an apprenticeship route wants to add a new employer partner so that they can start apprentices on the programme, they'll need to submit an apprenticeship modification form to us **at least six weeks** prior to the student starting their programme. This is also required where an approved employer partner wants to add students to another apprenticeship programme at the same AEI.

212. We don't retrospectively agree changes to an approved programme. Therefore, AEIs and new employer partners can't start apprentices on the apprenticeship programme until this process has been completed.

213. The AEI and their new employer partner will need to complete an apprenticeship modification form and email it to qateam@nmc-uk.org. Both the AEI and employer partner will need to sign this form to affirm that they'll meet our standards. We'll review the declaration and decide if the employer partner represents a potential risk to our standards and requirements. We'll base this decision primarily on known, publically available information, such as reported adverse outcomes of national system regulator reviews, independent investigative panel reports, and police investigations.

214. If the standards will continue to be met, then no further action will be required. In some cases we may need further information to evidence that the standards and requirements continue to be met. In this instance we'll ask Mott MacDonald to undertake a major modification. This will require the AEI to submit a major modification request via the QA Link. AEI's will need to take into consideration that the major modification process can take **20 weeks** to complete. QA visitors will seek to gather further information from the new apprenticeship employer partner and the AEI through a phone call or a visit, as required.

215. As part of our ongoing monitoring of approved programmes, we'll also assess the working relationship between AEIs and their apprenticeship employer partners during new programme monitoring and annual self-reporting.

4.6 Satellite sites or partnerships approval

216. Some education institutions will operate over multiple campuses to run the same programme. Others may wish to work in partnership with other organisations such as colleges or NHS Trusts to deliver the theoretical components of their programmes at different sites. This is typically where the same programme will be run in parallel at different geographical locations.

217. Where an AEI wants to add a new campus or satellite site, or new partner organisation for an approved programme a major modification visit must be undertaken. A major modification request should also be submitted where an AEI wishes to add a new programme/route for delivery at an approved campus, satellite site or partner organisation.

218. A satellite site or partnership must always be based in the United Kingdom, For a site in the Channel Islands or the Isle of Man, please see the section on endorsements.

219. Alongside ensuring our standards are being met, and that there are appropriate governance and oversight processes in place, the NMC also expect that the fundamental premise of satellite site or partnership approval is that the student experience is equivalent/has parity across all sites of delivery.

220. If the new site is due to a new partnership then the AEI who confers the degree is responsible for ensuring that the appropriate systems are in place for managing multiple sites and any associated risks, and that processes such as exceptional reporting are appropriately followed.

221. Approval of a new site or new partnership will normally be undertaken as a major modification visit, so that QA visitor(s) can tour the educational facilities as part of their review of the infrastructure to deliver the intended programme and explore issues around capacity and student numbers.

222. As part of the modification visit, meetings should be arranged with a range of personnel from the practice learning/employer partners to determine the organisational commitment and support in providing high quality practice learning experiences and practice assessors and practice supervisors to support student learning.

4.7 Programme endorsement

223. An endorsement is the approval to run an NMC approved programme in another UK country or other specified location outside the UK such as the Channel Islands and the Isle of Man. Information on the endorsement process can be found on our website.

224. The process of endorsement does not allow a programme to be approved in the UK for sole delivery outside the UK. It is intended to apply to a programme being delivered in the UK, which may also be delivered outside the UK using comparable programme arrangements.

225. AEIs must be responsible for the delivery of the endorsed programme and cannot nominate another institution to deliver it on its behalf.

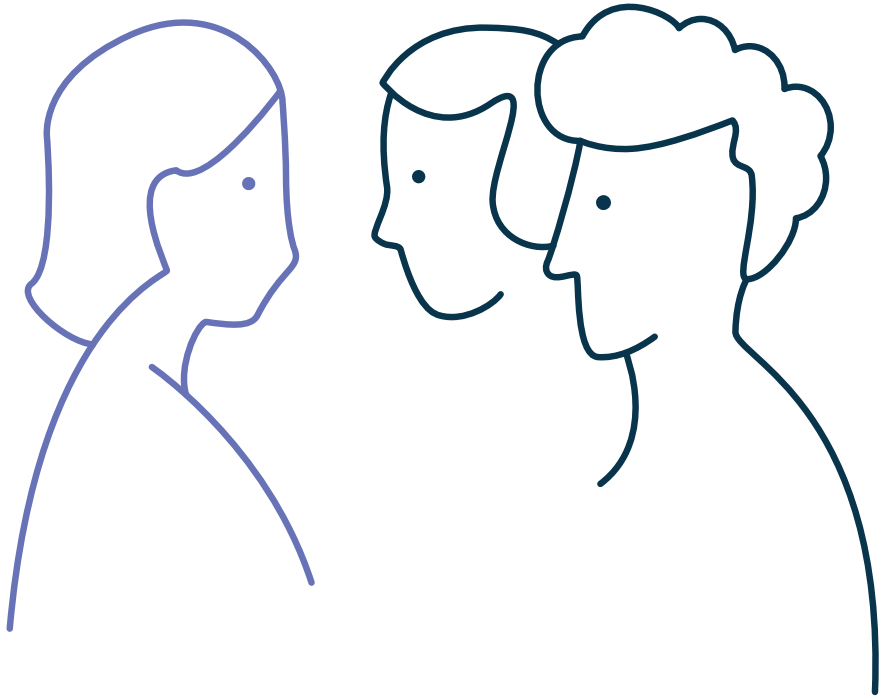
226. In principle, a programme presented for approval in one UK country may be approved to be delivered in any of the other UK countries without further action, subject to the following arrangements:

- the intention to offer a new programme in more than one country must be requested at the same time as the initial approval event request by the AEI;
- a new delivery site or campus in another UK country must be processed via a major modification and,
- systems must be in place to support such implementation at approval.

227. AEIs may choose to deliver parts of approved programmes outside the UK[13]. The UK-based AEI is accountable for this local delivery as part of their overall assurance to us.

228. We will need robust evidence of how the programme meets our standards in all non-UK settings. This **must** include, but is not limited to, evidence of strategic and operational partnerships with practice learning partners, resources, risks and controls.

229. QA visitors may be required to participate in the process of approval and endorsement of programmes although this process is infrequent. However, the details are presented for completeness and to ensure that all who may be involved are aware of the process.



[13] Article 15(7) of the Order

230. Endorsement of programmes initially approved in the UK for subsequent delivery in specified locations outside the UK

231. Where a programme has been initially approved in the UK and the AEI requests an endorsement for subsequent delivery in specified locations outside the UK, the AEI remains fully responsible for delivering the programme in all the approved locations.

232. ***The AEI seeking an endorsement will***

- submit an endorsement proposal request via the QA Link; and
- complete the policy questions and information required by us which must be completed by the AEI and submit.

233. This proposal is then directed to us for our internal scrutiny to determine whether the location specified outside the UK meets the criteria to be considered for endorsement.

234. We may:

- request clarification or further information;
- reject the request based on insufficient evidence, or the endorsement is not supported by us, in which case we will liaise with the AEI, as necessary; or,
- agree that the endorsement can proceed to gateway approval.

235. When we agree, the endorsement can proceed to approval.

236. The AEI will submit an endorsement event request form via the QA Link.

237. Mott MacDonald will co-ordinate an endorsement visit to be held in the location outside the UK where the programme is to be delivered to confirm that the necessary framework is in place to provide the programme in that location.

238. The AEI and their practice learning partners will provide documentary evidence to support the following for an endorsement:

- Infrastructure to deliver the programme in the specific country, including academic and practice learning placement arrangements
- Partnership between the AEI, geographical locality where AEI based learning will take place and practice learning partner
- Policy context/country and cultural specific requirements
- QA mechanisms/processes including arrangements for educational audit and governance arrangements in accordance with Gateway 1: Standards framework for nursing and midwifery education
- Written confirmation by the AEI and practice learning partners that resources are in place to deliver the programme which meets our Standards for student supervision and assessment
- Assurances are required that programmes are delivered by NMC registered nurses and midwives or other suitably qualified health and care professionals and within a context of UK healthcare, in an environment where the supervision and assessment of students in practice is undertaken by appropriately prepared NMC registrants, which meets our Standards for student supervision and assessment

239. The process will follow Gateway 2, 3 and 4.

240. Should conditions of endorsement be applied, all conditions must be met prior to the programme being approved by us before being offered in the relevant country.

241. Any conditions made in respect of one country must not compromise programme delivery and/or programme approval in another country or outside the UK.

242. A report of the endorsement visit will be produced by the QA visitor(s) and shared with the AEI.

243. Mott MacDonald will report the recommendation of the outcome of programme endorsement to us. We will make a decision and notify the AEI of the outcome of the endorsement.

244. ***What the AEI must do***

245. Following confirmation by us that the AEI can proceed with an endorsement to the programme presented for approval the AEI must provide:

- the specific arrangements and processes relating to the intention to deliver the programme in more than one country; and
- supporting information and evidence to support the intentions in the programme submission document presented for approval (Gateway 3 and 4).

246. This includes:

1. evidence of confirmation that the programme has the support in each country where the programme is to be delivered;
2. evidence of the commitment to actively engage people who use services and carers, in programme development and the proposed programme delivery; and,
3. written confirmation by the AEI and associated practice learning/employer partners that resources are in place to support the programme intentions on specified sites.

4.8 Programme discontinuation

247. AEIs must inform us in writing if they are no longer running a programme and want to discontinue it.

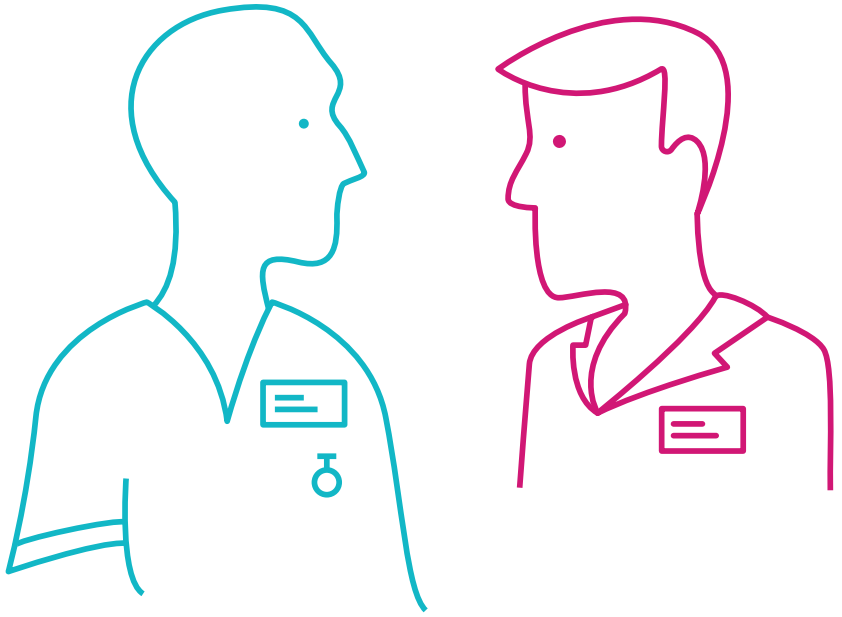
248. We should be informed by email from the AEI (qateam@nmc-uk.org) and discontinuations should also be notified through annual self-reporting.

249. If an AEI wishes to start the programme again they will need to go through a full approval process before they can admit students to the programme.

250. The programme discontinuation request will initially be reviewed by the QA team and a decision will be made to approve the request.

251. NMC Council will be made aware of discontinuation of programmes through our annual reporting process.

252. The QA team will notify the AEI in writing of the approval of discontinuation.



Section 5: Monitoring

253. Once programmes are approved, we undertake monitoring of institutions and their programmes to ensure our standards continue to be met. This includes activities such as exceptional reporting, annual self-reporting, new programme monitoring, enhanced scrutiny, listening events, monitoring visits and extraordinary reviews.

5.1 Exceptional reporting

254. We expect AEIs to tell us any concerns about an approved programme, in particular issues which might affect the student learning environment or where there may be a patient safety concern. If there's the potential that our standards are not being met then this should be raised with us via our exceptional reporting form.

255. The need to protect the public guides how we will respond to concerns. We will assess the nature of possible risks and combine this with the assurance we receive from AEIs and practice learning/employer partners about how they manage risks when they arise. Our response to risks ensures that there are measures in place to protect the public when issues affect nursing, midwifery or nursing associate education.

256. AEIs manage the delivery of educational programmes in accordance with all of our standards for education. When risks emerge, AEIs and their practice learning/employer partners are expected to respond quickly to manage risks appropriately.

257. ***When to make a report***

258. When new, emerging and escalating risks occur outside of routine reporting times AEIs must respond quickly to manage risks appropriately. AEIs will report these risks to us via an exceptional reporting form. All exceptional reports should be sent to exceptional.reporting@nmc-uk.org.

259. You should make an exceptional report if:

- there's an immediate or impending risk to the safety of students, members of the public or patients
- an unexpected or unexplained death has occurred
- a major incident has occurred
- a practice learning partner or apprenticeship employer partner has been rated as "inadequate" by the Care Quality Commission (CQC), Health Inspectorate Wales, Healthcare Improvement Scotland or Regulation and Quality Improvement Authority - you do not need to do this if they have been rated by the CQC as "requires improvement"
- significant concerns have been raised by a member of the public
- students have raised any complaints leading to an internal investigation
- there's significant public interest in the incident.

260. We expect to receive the following information from exceptional reporting:

- a brief description of the risk
- immediate actions taken
- individual and shared responsibility between the AEI and practice learning/employer partner of the risk and planned actions, together with additional support mechanisms planned or in place.

261. We will acknowledge and respond to exceptional reporting and we will assess the risks presented. Any subsequent necessary actions will follow the risk-based criteria process.

262. ***What we will do***

263. We need to assess whether the AEI is addressing any risks and that the AEI and programme(s) continue to meet our standards and requirements. To help us with this assessment we may need to ask you for more information. We can request this information in a number of ways, such as by meeting - either online or face to face, a listening event, a monitoring visit, enhanced scrutiny or an extraordinary review, depending on the nature and severity of the concern. These interventions allow the AEI to demonstrate how they have addressed the issues raised with them and how their programme and the AEI continue to meet our standards and requirements.

264. If we ask for more information, you need to send this to us within **seven working days**. If you're not able to provide the information in this time, then you need to let us know why[14].

265. We may also need to speak to other relevant NMC departments to make sure that any concerns that could impact them are dealt with. If a concern impacts on another AEI, we'll also tell them about the identified risk. However, we won't share any sensitive or personal information.

266. ***Actions we can take***

267. If we decide that an AEI has not appropriately dealt with a concern, we can consider whether it's proportionate to withdraw approval of the AEI and/or the programme(s). However, if we determine that there's no longer a risk to the student learning environment or to patient safety and our standards are being met, we'll take the necessary steps to close your concern. We'll aim to update you **within two weeks** of receiving your exceptional report form. If we're still dealing with your concern after that period, we'll let you know why and what further information we need.

5.2 Responding to concerns and handling complaints about AEIs

268. Where concerns are identified with us which could be through exceptional reporting, whistleblowing, or through system regulator and media reports we use a risk-based criteria to accurately assess any risk to programme approval and public protection. Concerns are categorised as minor, major and critical:

- **Minor**: issue that has **minimal impact** on and causes **minimal disruption** to student learning and safety and/ or public safety and protection; minimal impact in NMC confidence (eg. minor issue raised at system partner meeting)
- **Major**: issue has **potential moderate impact** on and causes **moderate disruption** to student learning and safety and/ or public safety and protection; potential impact in NMC confidence (eg. concern raised through NMC media scanning, which has potential to impact student safety)
- **Critical**: issue has **potential significant serious impact** on and cause **significant serious disruption** to student learning and safety and/ or public safety and protection; national press coverage (eg. public inquiry, concerns raised from other regulators); potential serious impact in NMC confidence. Please see **Annexe 7.9** for further information on concerns grading.

[14] Article 17 of the Order

269. We will investigate and, if necessary, act on concerns raised about AEIs. We will deal with concerns and complaints fairly and consistently. Our duties around managing and acting on information provided through whistleblowing are set out in the Public Interest Disclosure Act 1998.

270. ***What we will do***

271. Where we have concerns, we need to assess whether the AEI is addressing any risks and that the AEI and programme(s) continue to meet our standards and requirements. To help us with this assessment we may need to ask you for more information. We can request this information in a number of ways, such as by meeting - either online or face to face, a listening event, monitoring visit, enhanced scrutiny or an extraordinary review, depending on the nature and severity of the concern. These interventions allow the AEI to demonstrate how they have addressed the issues raised with them and how their programme and the AEI continue to meet our standards and requirements.

272. If we ask for more information, you need to send this to us within **seven working days**. If you're not able to provide the information in this time, then you need to let us know why[15].

273. Where further information is received, we will assess this using our ratings assurance process to assess whether the information provides us with assurance that the AEI is managing the concern.

274. We may also need to speak to other relevant NMC departments to make sure that any concerns that could impact them are dealt with. If a concern impacts on another AEI, we'll also tell them about the identified risk. However, we won't share any sensitive or personal information.

275. Where appropriate, we will redirect any concerns about systems or practice to system regulators, our fitness to practise teams, or other professional regulators.

276. ***What we will do***

277. We may ask an AEI to provide us with an action plan identifying how concerns are being addressed. We may also ask for regular updates on action or improvement plans and will contact an AEI for more information if required. If we decide that an AEI has not appropriately dealt with a concern, we can consider whether it's proportionate to withdraw approval of the AEI and/or the programme(s). However, if we determine that there's no longer a risk to the student learning environment or to patient safety and our standards are being met, we'll take the necessary steps to close your concern. We will let you know within **two weeks** of closing your concern.

[15] Article 17 of the Order

5.3 Interventions and evidence for concerns

278. This Table provides grading categories for quality concerns, suggested QA team interventions and potential evidence which may be provided by AEIs to assure us that concerns are being managed appropriately.

Grading Category	Normal QA Intervention	AEI potential evidence/actions
Minor	• Email request for clarification/ assurance • Call from QA Officer	• Provide evidence of numbers of students affected by programme and practice learning area • Provide evidence of mitigation/monitoring, if requested • Student evaluations/feedback (may be at the time concern raised, but may also be more generally, or requested at further time points)
Major	As for minor plus • Call from Education QA Manager • Call or face to face meeting with Head of Education and QA • Action plans/ intervention monitoring • Listening event • Monitoring visit • Enhanced scrutiny	As above, plus • Evidence of immediate actions taken • Evidence of support mechanisms in place- students are safe and their wellbeing protected • Evidence of action plans, mitigations and AEI and practice learning partner working to mitigate concerns (eg. Working groups, new or developed safety committees, cross-regulatory groups) • Provide regular updates on actions/intervention/monitoring and mitigations as requested • Student feedback around concerns, including support given and action taken (these may be requested at regular intervals) • Timely response to requests for further information • Educational re-audit when requested
Critical	As for major plus • Extraordinary review • Withdrawal of approval	As above, plus • Evidence of thresholds for removal of students from area • Contingency plan for student replacement to area • Regular updates with Head of education and QA until satisfactory mitigations have resulted in risk reduction • Evidence of student engagement to address concerns

5.4 Assurance Ratings for Concerns

279. Assurance will be rated for each concern, along with risk to education standards, providing evidence of improvement or deterioration.

280. The QA Team will rate our assurance according to the evidence provided by an AEI based on the following:

281. Strong Assurance

- Evidence presented provides assurance that our standards have been or continue to be met;
- There are no identified areas of weakness;
- Action plans/mitigations are appropriate to manage risk;
- The information provided meets or exceeds our expectations;
- Evidence presented assures of relevant stakeholder engagement;
- Evidence of consideration of students safety and wellbeing in action plans;
- Relevant oversight of the concern and/or action plans, with responsibilities and actions against named job titles.

282. Good Assurance

- Evidence presented provides some assurance that our standards have been or continue to be met, but there remains a lack of clarity;
- The action plan lacks operational detail but clearly demonstrates the approach being adopted;
- Detail can be rectified swiftly(e.g. minor immediate actions to make adjustments to existing plans);
- Information provided is sufficient for the moment in time, but will require further follow up;
- Evidence of some engagement with relevant stakeholders, but further may be required;
- Student support is mentioned in the plans for monitoring the concern, but without operational detail;
- Evidence of relevant oversight of the concern and/or action plans.

283. Weak Assurance

- Evidence presented does not provide assurance that our standards are being met;
- The action plan provides little evidence of addressing concerns and mitigations are unclear (eg. Major work required to provide appropriate action plan to address concerns);
- The AEI does not meet NMC request deadlines;
- Lack of evidence of engagement with relevant stakeholders to address concerns
- Lack of evidence of student engagement;
- Lack of evidence of appropriate oversight of the concern or action plans.

5.5 Critical Concerns

284. Where a critical concern is identified we will do the following:

- Set up an initial meeting (usually via virtual/remote means) between the AEI and the Head of education and/or QA or education and QA manager. This meeting may also include the relevant PLP/EP and/or education body.
- This initial meeting will outline the reason that the concern has been categorised as **critical** and outline the process for managing critical concerns. This process will include:
    - The AEI will receive a written summary of the initial meeting, outlining actions and next steps, including the approach to further QA activities/interventions should they be required;
    - The AEI will be required to develop and share an action plan which includes: the perceived level of risk, number of students affected, student and service user feedback, education audit data, partnership working between AEI/PLP or EP, alternative placement plans (should these be required);
    - Regular meetings will follow between the AEI and PLP/EP/education body and the Head of education and QA or the education and QA manager to discuss the action plan implementation and evidence of how it is being monitored and evaluated.

285. AEIs will be made aware of escalation/de-escalation and any planned QA activities/interventions.

286. This information will be used to provide updates, assurance and recommendations to QA Board.

287. AEIs will remain on our critical concerns register until we are assured that there is no longer a risk to student learning, public safety and our standards being met.

288. Where we do not receive the assurance that a concern is being appropriately managed we may undertake a listening event, monitoring visit or extraordinary review, and can withdraw the approval of a programme and/or AEI.

289. Where we determine that there's no longer a risk to the student learning environment or to patient safety and our standards are being met, we'll take the necessary steps to close your concern. We will let you know **within two weeks** of closing your concern.

5.6 Data driven approach to concerns and risk

290. We are data driven in our approach to the management of concerns and risks. This includes looking at data on AEIs, their programmes and their practice learning/employer partners. The data we receive will help inform any regulatory interventions we take ensuring we are robust, targeted, and proportionate.

5.7 Annual self reporting

291. We expect all AEIs to submit an annual self-assessment report and confirm that they continue to meet our standards and requirements across all approved programmes. The declaration made by the AEI must be agreed in partnership with their practice learning/employer partners. Any specific requirements of the self-assessment report will be provided by us and included in the self-report template which will be shared with AEIs annually in November.

292. We will advise AEIs by email of the deadline for the submission of the self- assessment report. If you're not able to provide the information in this time, then you need to let us know why.

[15] Article 16 of the Order

293. The self-assessment includes an evaluative account of how the AEI manages its key risks. It also provides an opportunity for AEIs to give examples or case studies of positive or innovative practice, and to indicate any areas of provision that they are aiming to enhance. Questions are also included on specific themes of interest that may have arisen through monitoring mechanisms.

294. We will provide AEIs with National Student Survey scores (where appropriate) and AEIs are required to provide narrative related to red scores and actions taken to address these.

295. The self-declaration requires the AEI to confirm that all approved programmes continue to meet our standards framework for nursing and midwifery education; that all programme modifications have been notified to us and that all key risks are managed.

296. AEIs must submit their annual self-report by the NMC confirmed deadline. Extensions will only be given in exceptional circumstances.

297. Mott MacDonald will review the individual AEI self-assessment reports. Mott MacDonald will inform us of any AEIs who do not provide assurance that key risks are managed.

298. Where an AEI does not provide assurance that key risks are being managed they will be asked to resubmit their self-assessment report.

299. The self-assessment report is reviewed again following re-submission to assess if assurance is provided that our key risks are managed. We are then informed of the outcome

300. An analysis is undertaken of all annual self-reports and shared with our quality assurance board and Council.

301. We also share a webinar of the analysis, key themes, good or innovative practice with AEIs. As well as a webinar to share the upcoming annual self-report and answer any questions.

5.8 New programme monitoring

302. New programme monitoring applies to any new AEI or new pre-registration programme, through which we will request additional information and updates about how the new programmes are being delivered. New programme monitoring provides the opportunity for us to support new AEIs and/or programme teams, develop key contacts and relationships, as well as identify any risks or concerns and support AEIs to manage these.

303. AEIs will be required to complete a report to provide information and this will be followed up with a meeting with our QA Team to discuss the information provided.

304. New programme monitoring will apply from the point of programme approval being granted. It is intended to end at the point the first students of the first cohort, from newly approved programme(s), complete their programme and join the register. Decisions to remove programmes from new programme monitoring will be made by our QA Board.

305. Information collated through these processes will inform our data driven monitoring approach and move towards our insight-based quality assurance framework as a whole.

306. ***What the AEI and their practice learning/employer partners must do***

307. Institutions undergoing new programme monitoring will need to submit new programme monitoring reports twice annually. One of these reports will be included within the template of the annual self-assessment report. Those submissions will be assessed by us and follow-up actions may be taken.

308. The kinds of information that an AEI will have to provide will comprise both numerical data and narrative commentary, and will include:

- details of input by student bodies and people who use health and care services and carers into programme implementation and continuous improvement activity;
- scrutiny of the partnerships, relationships, communication channels and shared reporting between the AEI and their practice learning/employer partners, and how they are contributing to the strength of the local management and assurance of the programme(s) as a whole; and
- follow-up on actions proposed to manage risks identified through exceptional reporting.

309. The above list is an indication rather than an exhaustive list. The particulars of the annual self reporting themes for new programme monitoring reporting may vary year on year but will always link back to our standards for nursing and midwifery education standards.

310. The AEI will be required to meet with a member of the QA Team. This meeting may take place online or face to face. AEIs are required to ensure that student, practice learning partner/employer partner and people who use health and care services representatives are present at this meeting. There should be no more than **10 people** at the meeting.

311. Where a need for any further improvements are identified through the formal assessment of the new programme monitoring reports, the AEI will have to follow up and take actions as required, and provide details of progress against their actions at subsequent review points.

312. ***What we will do***

313. We will be directly responsible for undertaking activity and applying scrutiny as part of new programme monitoring.

314. Following the submission of new programme monitoring reports, AEIs will be required to meet with a member of the QA Team. This meeting should include stakeholder representatives as outlined in 310 and may take place online or face to face.' At this meeting key points from the report will be discussed including roll out, delivery, local management and oversight of the new programme/s.

315. We will inform AEIs of the exact dates for both submission of reports and of follow-up meetings to allow sufficient time to prepare for them, and will also provide the details of the responsible NMC QA Team member in advance of the meeting in advance as a named contact. The specifics for this will be stated as part of our confirmation of the programme approval.

316. In these calls our QA Team member will discuss any points relevant to the mitigation of risks inherent in the implementation, roll out and delivery of new programme(s). This may include:

- following up on exceptional reporting;
- themes emerging from the regular reporting;
- details of how the new programme is being delivered, assured and managed locally;
- points for clarification in regards to the standards for pre-registration education and training and proficiency standards;
- experience and involvement of people who use health and care services within the programme;
- student experience of the programme, how they are supported in the university and practice leaning environment, how concerns are raised and managed;
- the governance in place to support collaborative working between the AEI and practice learning/employer partners and the experience of the practice learning/employer partners.

317. We will follow up on these updates and provide feedback as required to enable actions and improvements in programme delivery and management of risks. We will review any concerns about approved programme(s) and take action in line with their published processes, which may range from seeking further information, through to instructing Mott MacDonald to conduct a monitoring visit or extraordinary review. This would be the only input from Mott MacDonald in the conduct of new programme monitoring.

318. We may extend the duration of new programme monitoring for a further period, should circumstances change within the AEI and/or practice learning/employer partners, or if we do not receive sufficient assurance of the management of risks or where delays occur to any of our requests for additional information and updates regarding the approved programme.

319. At the end of this period, we will evaluate whether new programme monitoring can be removed from the programme(s) in question, and the AEI will normally be notified within the **final two months** before the expected conclusion date of the new programme monitoring period.

320. The outcomes of the process as a whole will be notified to Council as part of annual reporting mechanisms.

5.9 Enhanced scrutiny

321. Programmes may be placed on enhanced scrutiny as part of our concerns process and data driven approach to quality assurance.

322. Enhanced scrutiny means we will request additional information and updates from the AEI about how their programme/s are being delivered and how risks to the public and the student learning environment are being managed. This is in order to gain further information and assurance on providers and/or programmes. An appropriate schedule of meetings will be agreed, to enable adequate scrutiny to be applied and to allow the AEI to be removed from ES in a timely manner, once assurance has been gained.

323. Where a programme is placed on enhanced scrutiny, we will write to the AEI outlining the rationale. An appropriate schedule of meetings will be agreed, to enable adequate scrutiny to be applied and to allow the AEI to be removed from enhanced scrutiny in a timely manner, once assurance has been gained.

324. When an existing AEI (who has not previously met the criteria for enhanced scrutiny) has had an extraordinary review in line with our published criteria, we may decide to apply enhanced scrutiny to that AEI in addition to all actions being taken to mitigate risks to programme delivery.

325. Information collated through these processes will inform our data driven monitoring approach and move towards our insight-based quality assurance framework as a whole.

326. ***What the AEI and their practice learning/employer partners must do***

327. Institutions undergoing enhanced scrutiny will need to submit programme monitoring reports twice annually. One of these reports will be included within the template of the annual self-assessment report. Those submissions will be assessed by us and follow-up actions may be taken proportionate to the level of concern we have.

328. The kinds of information that an AEI will have to provide will comprise both numerical data and narrative commentary, and will include:

- details of input by student bodies and people who use health and care services and public bodies into programme implementation and continuous improvement activity;
- scrutiny of the partnerships, relationships, communication channels and shared reporting between the AEI and their practice learning/employer partners, and how they are contributing to the strength of the local management and assurance of the programme(s) as a whole; and
- follow-up on actions proposed to manage risks identified through exceptional reporting.

329. The above list is an indication rather than an exhaustive list. The particulars of the annual self reporting themes for enhanced scrutiny reporting may vary year on year. But will always link back to our standards for nursing and midwifery education standards.

330. The AEI will be required to meet with a member of the QA Team. This meeting may take place online or face to face. AEIs may be required to include student, practice learning partner/ employer partner and people who use health and care services representatives are present at this meeting.

331. Where a need for any further improvements are identified through the formal assessment of the enhanced scrutiny reports, the AEI will have to follow up and take actions as required, and provide details of progress against their actions at subsequent review points.

332. ***What the NMC will do***

333. We will be directly responsible for undertaking activity and applying scrutiny as part of enhanced scrutiny.

334. Following the submission of enhanced scrutiny reports, AEIs will be required to meet with a member of the QA Team. This meeting may include stakeholder representatives and take place online or face to face.' At this meeting key points from the report will be discussed and clarification sought where required

335. We will inform AEIs of the exact dates for both submission of reports and of follow-up meetings to allow sufficient time to prepare for them.

336. In these calls our QA Team member will discuss any points relevant to the mitigation of risks inherent in the implementation, roll out and delivery of programme(s). This may include:

- following up on exceptional reporting
- themes emerging from the regular reporting
- details of how the programme is being delivered, assured and managed locally
- how the risks are being managed, including actions, monitoring and evaluation
- discussion of impact on student learning and progression
- points for clarification in regards to the standards for pre-registration education and training and proficiency standards.

337. We will follow up on these updates and provide feedback as required to enable actions and improvements in programme delivery and management of risks.

338. We will review any concerns about approved programme(s) and take action in line with their published processes, which may range from seeking further information, through to instructing Mott Macdonald to conduct a listening event, monitoring visit or an extraordinary review. This would be the only input from Mott MacDonald in the conduct of enhanced scrutiny.

339. The duration of enhanced scrutiny will be dependent on the seriousness of the risk and the actions taken by the AEI to mitigate and manage these risks and the engagement of the AEI with us throughout this process. We will work to ensure that AEIs can be removed from enhanced scrutiny as soon as possible, where assurance has been given.

340. We will provide updates to QA Board about programmes on enhanced scrutiny and QA Board will make the decision as to whether a programme can be removed form enhanced scrutiny.

5.10 Listening events

341. Undertaking listening events

342. A Listening Event can be undertaken as part of NMC legislation: Article 16 of the Nursing and Midwifery Order (2001) which allows the NMC to appoint visitors to carry out a visit to education institutions where a relevant course of education or training is given.

343. If we have concerns, or intelligence suggests our standards aren't being met we may direct Mott MacDonald to carry out a listening event. The level of concern will help to determine the appropriate and proportionate intervention. A listening event will generally be undertaken where we feel we need additional information on the scale of a concern/s and/or where we feel that we need more information on the student experience of their education and training.

344. A listening event enable us to gather intelligence about an approved programme directly from students and practice learning/employer partners. This intelligence gathering includes information about students' experience of their education and training, how they are being supported in both the university and practice learning environments and practice learning governance and partnership working to support student learning and progression. This intelligence is an important consideration as to whether an approved programme is being delivered in line with our education standards.

345. A listening event will always take place with students but may include practice representatives or a combination of both groups. A listening event will normally involve a physical visit to the AEI and include meetings with students in different cohorts/year groups.

346. Prior to the listening event

347. A decision to conduct a listening event will be made by our QA Board. We will instruct Mott MacDonald to organise and appoint QA visitors to undertake listening events. A listening event will be undertaken by QA Visitor/s with appropriate regard for the programme under review and will always include a lay visitor/s.

348. A listening event will have a defined scope in response to a specific concern or number of concerns and this will be shared with the QA visit team and the AEI ahead of the listening event. We will also notify the relevant commissioning/ government education body in the relevant country.

349. Article 17 (3) of the Nursing and Midwifery Order (2001) requires AEIs to provide us with information in relation to the monitoring of education and training programmes. We will contact students directly and invite them to attend a listening event. We will draft a letter to be sent to all students by the AEI, where students will have the opportunity to 'opt out' of being contacted directly by us. We will then email students providing a link to sign up to a listening event session with a QA Visitor/s. The AEI will provide details of the times and locations to the students for the listening event sessions. We will comply with all GDPR regulations throughout and will delete student email addresses once the QA Board has considered the listening event report.

350. During the listening event

351. AEIs will be required to provide an appropriate environment for the listening event and meeting with relevant individuals. AEIs should provide appropriate support and wellbeing for students during and after the event, in case this is required.

352. At a listening event the QA visitors will not make or record any outcome or judgment about whether our Standards are met by the programme. The purpose of a listening event is to gather intelligence which will be discussed at QA Board and triangulated with other sources of evidence in order to make a decision on future QA activities and/or interventions and/or outcomes.

353. The visit team will conclude their findings under the agreed scope of the visit, in response to the risks identified against NMC education standards. At the end of the visit, Mott MacDonald will inform the AEI that they will hear back in writing within 14 working days. High level feedback will be provided to the AEI at the conclusion of the visit. This will include next steps and timelines but will not provide an opportunity for questions from the AEI to the visit team.

354. Reporting and next steps

355. The report of the listening event will be sent to the AEI by Mott MacDonald **within 14 working** days of the listening event. We will be notified of the report being sent to the AEI at this point. The AEI then has a period of **one calendar month** to make observations. These observations must be submitted on the NMC dedicated AEI visit SharePoint site and may be submitted at any point during the **one calendar month** observation period. On submission, AEIs must state that all observations have been provided, which means that the observation period closes.

356. We will take no further regulatory action until the observation period closes, as outlined in 355.

357. Following closure of the observation period, our QA Board will consider the report, any observations made by the AEI and any other relevant information, before deciding on whether further monitoring activities, such as a monitoring visit, follow up meetings and/or interventions are required. We may also use draw on the intelligence provided through the listening event at any time. This meeting will be held as soon as is practically possible for QA Board to do so after the observation period closes.

358. Once our QA Board has completed its review, we will write to you with any decisions and next steps. The letter will ask the AEI to confirm whether they want us to publish their observations alongside the report, on our website. Following communication with the AEI, the report will be published on our website.

5.11 Monitoring visits

359. Undertaking monitoring visits

360. If concerns are raised, or our intelligence suggests potential non-compliance with our standards and requirements, in particular as part of our data driven approach, we may direct Mott MacDonald to carry out a monitoring visit[16]. The level of concern will help to determine the appropriate and proportionate intervention.

361. Monitoring visits may also take place where there are no specific concerns, in order for us to gain assurance over the overall population of approved programmes. Through this approach we are able to test whether data driven monitoring is providing appropriate information and assurance.

[16] Article 16 of the Order

362. A monitoring visit may have a defined scope in response to a specific concern, or in some cases will involve a more general review of compliance against our standards. It will always include a physical visit to an AEI and/or practice learning / employer partner.

363. If a monitoring visit identifies or confirms concerns then we will expect the AEI and its practice learning/employer partners to put an action plan in place to mitigate these concerns.

364. A decision to conduct a monitoring visit will be made by our QA Board. We will instruct Mott MacDonald to organise and appoint QA visitors to undertake monitoring visits.

365. The organisation(s) subject to the monitoring visit will be informed about the visit together with the terms of reference for the visit. A review plan will be produced and circulated to the review team and the AEI. The QA visit team will include a registrant QA visitor/s as well as a lay visitor/s.

366. The review team will conclude their findings under a specifically agreed scope in response to the risks identified against NMC standards, if applicable. At the end of the visit, Mott MacDonald will inform the AEI that they will hear back in writing **within 15 working days**. High level outcomes will be given to the AEI at the completion of the monitoring visit.

367. Reporting and outcomes

368. The report and recommendations of the monitoring visit will be sent to the AEI by Mott MacDonald. We will be notified at this point. If an action plan is required, Mott MacDonald will be responsible for agreeing this action plan and the AEI will be required to submit this action plan to the Lead QA visitor **20 working days** after the monitoring visit. The action plan will be submitted to the NMC **25 working days** after the monitoring visit.

369. The AEI then has a period of **one calendar month** to make observations. These may be submitted to Mott MacDonald at any point during the **one calendar month** observation period. On submission, AEIs are able to state that all observations have been provided, which means that the observation period closes. During the observation period we will take no further action.

370. Within **13 working days** of the observation period closing, Mott MacDonald will provide us with the final report and any observations made by the AEI. Where an AEI has an action plan in place, as part of our critical concerns monitoring, any new actions will be incorporated and monitored as part of this process.

371. Our QA Board will meet to consider the report, any observations made by the AEI and any other relevant information, before making a decision on whether or not our standards of education are being met.

372. Once our QA Board has completed its review and considered input where appropriate from Legal, a letter from the Director of Professional Practice should be sent will be sent to the AEI confirming the outcome of the visit and next steps. The letter will ask the AEI to confirm whether they want us to publish their observations alongside the report, on our website. Immediately following communication with the AEI, the report will be published on our website.

373. If the monitoring visit identifies concerns then the AEI and its practice learning/employer partners will require an action plan to mitigate these concerns. We may undertake further QA activities and/or interventions and this may include further listening events, enhanced scrutiny, a further monitoring visit and/or follow up meetings.

[17] Article 15(7) and Article 16(1) of the Order

374. If appropriate, an extraordinary review may be undertaken and we have the right to withdraw approval of the programme or AEI status.

5.12 Extraordinary reviews

375. If someone raises concerns, a serious incident takes place, or our intelligence suggests that an AEI or a programme is no longer meeting our standards and requirements, we may direct Mott MacDonald to carry out an extraordinary review[17].

376. Undertaking extraordinary review visits enables us to identify if there are serious risks to student learning and our standards of education and training being met, which may result in students being unable to achieve the standards of proficiency to be admitted to the register. The review will identify if the AEI and its practice learning/employer partners continue to meet our standards.

377. Further to this, we will also consider the AEIs agility in responding to concerns, situations and events that impact on all aspects of nursing, midwifery and nursing associate programme delivery.

378. A decision to conduct an extraordinary review will be made by our QA Board. We will instruct Mott MacDonald to organise and appoint QA visitors to undertake the extraordinary review.

[18] Article 16(6) of the Order
[19] Article 16(9) of the Order

379. Undertaking extraordinary review visits

380. We will instruct Mott MacDonald to organise and appoint QA visitors to undertake an extraordinary review visit. The scope and notice of this extraordinary visit will depend on the issue or concerns and the notice period will reflect the risk to the public. The QA review team will include QA registrant visitors with due regard for the programme(s) under review and at least one lay visitor[18]. Mott MacDonald will provide the team with a detailed briefing before the review visit.

381. Relevant organisations will be informed about the visit together with the focus and terms of reference of the visit. A review plan will be produced and circulated to the QA review team and the AEI. A targeted and proportionate approach will be taken should there be a need to conduct a joint extraordinary review visit with a system regulator.

382. Reporting and outcomes

383. The review team will conclude their findings against criteria for each review in response to the risks identified, our standards and key risk areas. At the end of the visit, Mott MacDonald will inform the AEI that they will hear back in writing **within 15 working days**. High level feedback will be given to the AEI on completion of the extraordinary review.

384. The report and recommendations of the extraordinary review visit will be sent to the AEI for observations which include factual accuracy[19]. If an action plan is required, Mott MacDonald will be responsible for agreeing this action plan and the AEI will be required to submit this action plan to the Lead QA visitor **20 working days** after the monitoring visit. The action plan will be submitted to the NMC **25 working days** after the monitoring visit

385. **Within 13 working days** of the observation period closing, Mott MacDonald will provide us with the final report and any observations made by the AEI. Where an AEI has an action plan in place, as part of our critical concerns monitoring, any new actions will be incorporated and monitored as part of this process.

386. Following the observation period, we will consider the QA visitors report, any observations made by the AEI and any other relevant information before making a decision on whether or not our standards are met. We will directly inform and liaise with the AEI giving clear instructions on any action required.

387. If the programme(s) meets our standards, or will do so following completion of an action plan, the AEI may be subject to enhanced scrutiny and/or future programme monitoring. If the programme(s) do not meet our standards, approval may be withdrawn.

388. Once our QA Board has completed its review and considered input where appropriate from Legal colleagues, a letter from the Director of Professional Practice will be sent to the AEI informing them of the outcome of the review and next steps. Next steps may include further monitoring acclivities and/or interventions. The letter will ask the AEI to confirm whether they want us to publish their observations alongside the report, on our website. Immediately following communication with the AEI, the report will be published on our website.

[22] Article 17(4) of the Order
[23] Article 17(5) of the Order

5.13 Whistleblowing

389. If a third party raises a concern about the safe and effective delivery of an approved programme, we will tell the AEI concerned within five working days so it can manage the risk locally, where possible. We will take action when these risks are not being effectively managed locally.

390. We will also contact the third party to make sure they understand the risk and information correctly. We will deal with concerns and complaints fairly and consistently.

5.14 Withdrawing approval of an approved programme

391. If an AEI or its practice learning/employer partners are not meeting (or will not meet) our standards or requirements for any approved programme, we may seek to withdraw the programme approval[22]. We may also seek to withdraw approval after we receive a QA visitor's report.

392. Where appropriate we will initially look for the AEI to put steps in place to address the concern. However, if a concern remains, we will tell the AEI that we plan to withdraw approval, specifying the extent of the withdrawal. We will explain the reasons for withdrawing approval in writing. The AEI will have **one month** from the day they are told to make any observations and objections[23].

393. We will take no further action until the deadline, or until the AEI submits any observations or objections to us. We will acknowledge any correspondence they get within **five working days**.

394. If the AEI cannot assure us that they are mitigating and managing the risks, we will write to the AEI, specifying the date that we are withdrawing approval.

395. If we withdraw approval of a programme, this will not have an effect on the registration status of anyone awarded a qualification from that institution or programme prior to the point of withdrawal.

396. We will work collaboratively with education bodies to ensure that the impact on students is managed appropriately.

Section 6: Complaints and data protection

6.1 Concerns and complaints about the QA delivery partner Mott MacDonald

397. We will investigate and, if necessary, act upon concerns which may be raised about Mott MacDonald. We will aim to ensure that concerns and complaints are dealt with in fair and consistent manner.

398. It is not within our remit to consider complaints regarding the judgement of QA visitors undertaking QA activity.

399. We would ask that the complainant should make every attempt to resolve their complaint or concern directly with Mott MacDonald prior to consideration by us. You can visit the Mott MacDonald website for information or contact their team at nmc@mottmac.com.

400. If you feel that your complaint needs to be escalated to us after you've raised this with Mott MacDonald in the first instance, then please contact us using our corporate complaints process. If you choose to make an anonymous complaint, we may not be able to take any further action as we cannot ask for more information.

401. On receipt of a formal complaint, we will formally acknowledge its receipt within **two working days** if the complainant's name and contact details are known. We will also provide feedback on how the complaint has been handled.

6.2 How we use data

402. We may collect information about individuals if they work for an AEI or practice learning/employer partner or take part in our education QA processes.

403. We will collect the individual's name and contact information. If they take part in one of our QA visits we will also collect details of their professional experience.

404. During QA reviews, AEIs, education institutions and practice learning/employer partners may give the QA visitors a significant amount of supporting documentation. This documentation sometimes contains personal information like the CVs of academic staff or minutes of meetings. The only people who will read this personal information are those who need to see it as part of our QA activity. We occasionally share personal information with third parties.

405. Normally, we process personal information because we have a legal obligation to do so or because it is necessary for the exercise of our statutory functions or any other functions in the public interest.

406. AEIs and education institutions are advised that any documentation submitted via the QA Link that does not have clear relevance to the programme being reviewed will be permanently deleted to ensure compliance with general data protection regulations (GDPR).

Section 7: Annexes

7.1 Glossary

Annual Self-assessment Report (ASR): A report completed annually by the AEI to confirm that there have been no changes or challenges to their NMC approved programmes and that they and their practice learning/employer partners are controlling key risk areas.

Approval: A process whereby the approved education institution and the practice learning/employer partners present their programme for external scrutiny (or validation) which, if successful, leads to conjoint approval by the Nursing and Midwifery Council (NMC) and the approved education institution.

Approved education institutions (AEIs): the status awarded to an institution, part of an institution, or a combination of institutions that work in partnership with practice learning providers after the NMC have approved a programme. AEIs will have assured the NMC that they're accountable and capable of delivering approved education programmes.

Due regard: Due regard is a term relates to the requirement under Article 16(6) of the Nursing and Midwifery Order 2001 and is used in NMC QA processes to denote the allocation of QA visitors working on the same part of the NMC register as the programme under review.

Education institutions: institutions seeking NMC approval of a programme.

Educators: in the context of NMC standards for education and training, educators are those who deliver, support, supervise and assess theory or practice learning.

Employer partner: organisations that employ apprentices as part of apprenticeship routes. A selection of these will have to be present at approval of apprenticeship routes. Addition of any further employer partners requires an apprenticeship modification.

Enhanced scrutiny: This is the process through which the NMC will request additional information and updates from the AEI about how their programme(s) are being delivered and how risks to the public and the student learning environment are being managed. This is in order to gain further information and assurance on providers and/or programmes. Programmes may be placed on enhanced scrutiny as part of the NMC's concerns processes and data driven approach to quality assurance.

Endorsement: This is the process of approving the delivery of an already approved programme outside the UK.

Extraordinary reviews: Reviews conducted to identify if the AEI and practice placements continue to meet NMC standards, if concerns or intelligence suggest that an AEI or a programme is no longer meeting our standards and requirements.

Field of nursing practice: Some parts of the NMC register have more than one field of practice for example adult, mental health, learning disabilities and children's nursing, or health visiting, school nursing and occupational health specialist community public health nursing.

(Good) health and character requirements: as stipulated in NMC legislation (Articles 9(2)(b) and 5(2)(b) of the Nursing and Midwifery Order 2001) 'good health' means that the applicant is capable of safe and effective practice either with or without reasonable adjustments. It does not mean the absence of a health condition or disability. Each applicant seeking admission to the register or to renew registration, whether or not they have been registered before, is required to declare any pending charges, convictions, police cautions and determinations made by other regulatory bodies.

Lay visitor: is a member of the public who is not registered with the NMC, has not been registered with the NMC in the past, or has a qualification enabling registration with the NMC. The lay visitor is appointed by Mott MacDonald, on behalf of the NMC, to undertake QA activities.

Learning environments: Includes any physical location where learning takes place as well as the system of shared values, beliefs and behaviour in these places.

Lead midwives for education (LME): LMEs are based at and employed by the educational institutions providing pre-registration midwifery education. They are experienced practising midwife teachers leading on development, delivery and management of midwifery education programmes.

New programme monitoring: New programme monitoring is an aspect of the NMC QA Framework through which the NMC will request additional information and updates from the AEI about how the new pre-registration programme(s) are being delivered and how risks to the public and the student learning environment are being managed. This is in order to gain further information and assurance on new providers and/or programmes.

Nurse and midwife prescribing programmes: The programme that a registered nurse or midwife in the UK completes to acquire the proficiencies needed to meet our criteria for an annotation on our register.

Nursing associate: A nursing associate is a member of the nursing team who will care for, and support people. Nursing associate is a standalone role in its own right and will provide a progression route into graduate level nursing.

Nursing degree apprenticeship: The nursing degree apprenticeship will enable people to train to become a graduate registered nurse through an apprentice route. Apprentices will be released by their employer to study part time in an AEI and will train in a range of practice learning settings. They will be expected to achieve the same standards as other student nurses.

Official correspondent (OC): The named contact at an AEI at which our correspondence will be sent to.

People who use services and carers: Anyone who uses the services of a nurse, midwife, nursing associate, or any other relevant health or social care service.

Practice learning partners: organisations that provide practice learning necessary for supporting pre-registration and post- registration students in meeting proficiencies and programme outcomes.

Pre-registration nursing programme: The programme that a nursing student in the UK completes to acquire the proficiencies needed to meet NMC criteria for registration.

Pre-registration nursing associates programme: The programme that a nursing associate student in the UK completes to acquire the proficiencies needed to meet NMC criteria for registration.

Pre-registration midwifery programme: The programme that a midwifery student in the UK completes to acquire the proficiencies needed to meet NMC criteria for registration.

Programme monitoring: Monitoring is the process by which the NMC is assured that approved programmes continue to be delivered in accordance with NMC standards and additional agreements made at programme approval and that NMC key risks are controlled.

Programme standards: The standards the NMC set for all nursing, midwifery and nursing associate programmes.

Protected learning time: time to facilitate learning. This may include supernumerary status that enables students to be supported safely and effectively in achieving proficiency. Supernumerary status applies to Nursing Associate students; students in practice or work placed learning must be supported to learn without being counted as part of the staffing required for safe and effective care in that setting. For apprentices, this includes practice placements within their place of employment; this does not apply when they are working in their substantive role.

QA Link: The online portal that AEIs will access to submit documentation i.e. during the approval gateway process.

Quality assurance (QA): processes for making sure all AEIs and their approved education programmes comply with NMC standards of education and training.

Recognition of prior learning (RPL): a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes, this means it includes both theory and practice achievement.

Registrant visitor: is an individual who has current registration on one or more parts of the NMC register and works in nursing and/or midwifery and/or nursing associate education and/or practice. The registrant visitor is appointed by MM, on behalf of the NMC, to undertake QA activities.

Reasonable adjustments: where a student requires reasonable adjustment related to a disability or adjustment relating to any protected characteristics as set out in the equalities and human rights legislation.

Simulation: an artificial representation of a real world practice scenario that supports student development through experiential learning with the opportunity for repetition, feedback, evaluation and reflection. Effective simulation facilitates safety by enhancing knowledge, behaviours and skills.

Stakeholders: Any person, group or organisation that has an interest or concern in the situation in question, and may affect or is affected by its actions, objectives or policies. In the context of NMC standards for education and training this includes students, educators, practice learning partner organisations, patients, families, carers, employers, other professionals, other regulators and education commissioners.

Students: any individual enrolled onto an NMC approved education programme whether full time or less than full time.

Supernumerary: students in practice or work placed learning must be supported to learn without being counted as part of the staffing required for safe and effective care in that setting. For apprentices, this includes practice placements within their place of employment; this does not apply when they are working in their substantive role. Placements should enable students to learn to provide safe and effective care, not merely to observe; students can and should add real value to care. The contribution students make will increase over time as they gain proficiency and they will continue to benefit from ongoing guidance and feedback. Once a student has demonstrated that they are proficient, they should be able to fulfil tasks without direct oversight. The level of supervision a student needs is based on the professional judgement of their supervisors, taking into account any associated risks and the students' knowledge, proficiency and confidence.

The Nursing and Midwifery Order 2001 (the Order): Legislation that establishes the NMC and sets out their primary purpose of protecting the public, their structure, and their functions and activities.

7.2 Mott MacDonald Code of Conduct – QA registrant visitor

This Code of Conduct underpins NMC and Mott MacDonald QA policies and procedures, which are designed to assure quality and consistency. For that reason, we require every QA registrant visitor to sign and return a copy of this statement, thereby declaring their commitment to abide by it.

In your work as a NMC QA registrant visitor it is expected that you will:

1. Take full responsibility for maintaining your registration in accordance with all the requirements of the NMC.
2. Conform to the requirements of The Code: Professional standards of practice and behaviour for nurses and midwives (NMC, 2015, updated October 2018).
3. At all times, when acting on behalf of the NMC, behave in a way which upholds the reputation of the NMC, maintain the highest standards of professional behaviour, be and be seen to be credible by stakeholders and the NMC.
4. Ensure that the highest standards are maintained when representing both Mott MacDonald and the NMC. It is a requirement that all QA visitors follow the processes and procedures as laid down in the MM process guidance notes and other Mott MacDonald /NMC QA Framework approved documentation.
5. Undertake QA activity with integrity, treating all those encountered with courtesy and professional respect.
6. Safeguard the confidentiality of any information and comply with data protection requirements.
7. Ensure national consistency by following the agreed procedures, processes and timelines at all times, including completing the relevant paperwork to the required standard, and in the format required, via the online QA Link.
8. Facilitate the QA role of Mott MacDonald and take account of professional advice given to you by their staff.
9. Respond to communications and complete all documents within the expected timescales (generally **two working days**), notify Mott MacDonald promptly of any changes in arrangements, and comply with all other administrative requirements.
10. Have regard to the requirement that QA visitors attending programme approval visits, do not regularly give instruction or have any significant connection with the education institution in question, in compliance with Article16(4) of the Nursing and Midwifery Order 2001. Where the QA visitor has doubts about conflict of interest, then these must be discussed with the Mott MacDonald management team.
11. Ensure that situations do not occur which would allow a neutral observer to question the impartiality of the QA visitor.
12. Notify the Mott MacDonald/NMC QA team, if offered an inducement by anyone in connection with your work as a QA visitor.
13. Be available to attend initial and update training/briefing at the reasonable request of Mott MacDonald.
14. Consent to Mott MacDonald holding personal details, including CVs, contact details and equal opportunity data will be held on the Mott MacDonald database. MM operate under GDPR regulations and this database and the information contained within it, will not be released to any organisation other than Mott MacDonald. Contact details will be used only for the purpose of contacting with visitors for QA activity.

15. Submit all invoices and expense claims within 20 days of an event.
16. All expenses exceeding £100 should be approved in advance of the event by requesting an AT code from the operational team.

I accept the Statement of Conduct and terms and conditions as laid out above. I understand that Mott MacDonald reserve the right to remove me from the list of QA visitors available for deployment without further warning if at any time my work falls below the standards outlined in this Code of Conduct.

QA Lay Visitor name: (please print name)

Signed:

Date:

7.3 Mott MacDonald Code of Conduct – QA lay visitor

This Code of Conduct underpins NMC and Mott MacDonald QA policies and procedures, which are designed to assure quality and consistency. For that reason, we require every QA lay visitor to sign and return a copy of this Statement, thereby declaring their commitment to abide by it.

In your work as a NMC QA lay visitor it is expected that you will:

1. At all times, when acting on behalf of the NMC, behave in a way which upholds the reputation of the NMC, maintain the highest standards of professional behaviour, be and be seen to be credible by stakeholders and the NMC.
2. Ensure that the highest standards are maintained when representing both Mott MacDonald and the NMC. It is a requirement that all QA visitors follow the processes and procedures as laid down in the Mott MacDonald process guidance notes and other Mott MacDonald/NMC QA Framework approved documentation.
3. Undertake QA activity with integrity, treating all those encountered with courtesy and professional respect.
4. Safeguard the confidentiality of any information and comply with data protection requirements.
5. Ensure national consistency by following the agreed procedures, processes and timelines at all times, including completing the relevant paperwork to the required standard, and in the format required, via the online QA Link.
6. Facilitate the QA role of Mott MacDonald and take account of professional advice given to you by their staff.
7. Respond to communications and complete all documents within the expected timescales (generally **two working days**), notify Mott MacDonald promptly of any changes in arrangements, and comply with **all** other administrative requirements.
8. Have regard to the requirement that QA visitors attending programme approval, do not regularly give instruction or have any significant connection with the education institution in question, in compliance with Article 16(4) of the Nursing and Midwifery Order 2001. Where the QA visitor has doubts about conflict of interest, then these must be discussed with the Mott MacDonald management team.
9. Ensure that situations do not occur which would allow a neutral observer to question the impartiality of the QA visitor.
10. Notify the Mott MacDonald/NMC QA Framework Management Team, if offered an inducement by anyone in connection with your work as a QA visitor.
11. Be available to attend initial and update training/briefing at the reasonable request of Mott MacDonald.
12. Consent to Mott MacDonald holding personal details, including CVs, contact details and equal opportunity data will be held on the Mott MacDonald database. MM operate under GDPR regulations and this database and the information contained within it, will not be released to any organisation other than Mott MacDonald. Contact details will be used only for the purpose of contacting with visitors for QA activity.
13. Submit all invoices and expense claims within 20 days of an event.
14. All expenses exceeding £100 should be approved in advance of the event by requesting an AT code from the operational team.

MAHI - STM - 212 - 132

I accept the Statement of Conduct and terms and conditions as laid out above. I understand that Mott MacDonald reserve the right to remove me from the list of QA visitors available for deployment without further warning if at any time my work falls below the standards outlined in this Code of Conduct.

QA Lay Visitor name: (please print name)

Signed:

Date:

7.4 Model agenda for conjoint NMC and AEI/education institution programme approval panel

Mott MacDonald will work together with AEIs and education institutions providing or seeking to provide nursing and midwifery education against NMC standards to ensure effective and robust QA mechanisms. This model agenda is offered for consideration and adaptation to local situations. It indicates the appropriate composition of approval panels and programme development teams, the level of input which is taken to demonstrate the AEI/education institution's commitment to a proposed programme.

Effective partnership between the AEI or education institution and key stakeholders at all levels is a key principle underpinning the NMC QA Framework, including the commitment to actively engage people who use services and carers and the public in programme development and the proposed programme delivery.

The approval visit provides the opportunity for QA visitors to speak to representatives from practice learning/employer partners, students, people who use services and carers, and other key stakeholders, as part of the final triangulation of the documentary analysis of the programme standards, and to test out the effectiveness of the partnerships.

The agenda is flexible and illustrates the areas which must be addressed.

Approval panel:

- Senior representative from the AEI/education institution (Chair)
- Administrator for teaching quality, at the AEI/education institution
- Lecturer at the AEI/education institution (not directly involved in the programme)
- NMC QA registrant visitor (s) with due regard to programme(s) being approved, and a lay visitor
- External subject specialist(s) – Please note: not from a partner AEI
- People who use services and carer representatives
- Student representative (not studying the programme under review)

Examples of personnel who may comprise the programme development team and key stakeholders to meet with QA visitors:

- Lead programme developer
- Lead midwife for education (midwifery programmes)
- Educators including programme team, lecturers, programme leads, researchers, academic assessors
- Library/learning resources representative
- Practice representatives e.g. practice supervisors, practice assessors,

Key stakeholder groups:

- Student representatives (all years of programme, students who wish to transfer to new programme)
- Representatives from practice learning/employer partners including for example: chief nurse, education lead, practice education facilitator, head of midwifery (midwifery programmes)
- Representatives from employers (for nurse degree apprenticeships, nursing associates, midwives, SCPHN and SPQ DN apprenticeships).

Although encouraged, if the following groups are unable to attend, and they or another suitable replacement cannot be contacted on the day, the visit may still go ahead:

- People who use services and carer representatives
- Student representatives
- Practice representatives e.g. practice supervisors, practice assessors

MAHI - STM - 212 - 134

Agenda

The timescales and order of events can be adjusted as appropriate, e.g. to take account of visits to practice learning environments, if necessary

30 mins

- Panel to meet and discuss the proposed programme.
- Agree themes for discussion, areas to be addressed, allocate roles and responsibilities

45 mins–1 hour

- Presentation by the programme development team
- To provide overview and address areas identified by panel members prior to the visit

45 mins–1 hour

- Questions from the panel
- To address all members of the programme development team

1 hour

- Lunchbreak and private panel meeting to discuss findings and clarify further requirements

30–40 mins

- Meeting with students (to include students transferring into the new programme) Discussion of academic, practice learning and practice support supervision and assessment processes.

30–40 mins

- Meeting with people who use services and carers involved in programme development and delivery
- Discussion of preparation for their role, involvement in programme development, recruitment of students, delivery and evaluation of programme, assessment of students (see guidance on NMC website)

30–40 mins

- Meeting with representatives from practice learning partners and employers (look to separate strategic and operational practice representative if possible to encourage speaking freely).
- Discussion of practice issues, supervision and assessment processes Employers support for the programme, and resources to support learning in practice.

30 mins

- Panel meet to discuss findings and agree recommendation to the NMC and conditions if necessary

30 mins

- Feedback to the programme development team
- Clear outline of findings and any conditions, agree realistic timescales for achievement of conditions

7.5 Key information for the chair of a conjoint approval/ major modification visit

The chair must be a senior academic representative for the AEI/education institution who has no direct involvement in the programme.

The chair must be informed that the NMC require all approval/major modification visits to be a conjoint process (see section 2.3).

The chair must be informed that QA visitor(s) are representing the NMC at the visit and will be making a recommendation to the NMC regarding whether the programme should be approved (subject to any conditions being met).

Specific aspects of the role of chair:

- The chair must ensure that the QA visitor(s) can outline key information at the start of the visit.
- The chair must ensure that the visit is conjoint, and that the university reaches an outcome regarding whether to approve the programme on the day of the visit.
- In the spirit of a conjoint visit, the chair must encourage university panel members to seek responses to their lines of enquiry and not leave all questions to the QA visitor(s). At the start of the visit the chair must discuss the issues to be explored with panel members and agree who will lead on each issue.
- The chair must ensure that QA visitor(s) have the time to seek assurance related to all their lines of enquiry even if this means extending the time allocated to a stakeholder group meeting.
- Should the QA visitor(s) need to seek guidance during the visit from a member of the Mott MacDonald professional team, the chair must adjourn the meeting to enable this to happen.
- The chair must agree the wording of any university conditions and/or recommendations (to include any that are joint with the NMC) at the end of the visit and ensure a date is set for the programme team to provide a response to the conditions.
- The chair must ensure that the programme team do not attempt to challenge the outcome of the visit. The QA visitor(s) decision on any conditions and recommendations is final.
- Post visit, the chair must sign off any university conditions and provide evidence of their approval on the date set at the visit. This may require the programme team to provide a response to any university conditions before the date set at the visit.

7.6 Model agenda for visits to practice learning environments during approval visit

Mott MacDonald will work together with AEI, education institutions and their practice learning/employer partners to ensure NMC principles for practice learning are upheld and are consistent with the NMC QA Framework, 2020, Standards framework for nursing and midwifery education, Standards for student supervision and assessment and relevant programme standards. The model agenda is offered for consideration and adaptation to local situations. Effective partnership between the AEI or education institution and key stakeholders at all levels is a key principle underpinning the NMC QA Framework, 2020, including the commitment to actively engage people who use services and carers, in programme development and the proposed programme delivery.

Visits to practice learning environments will be undertaken by QA visitor(s) and other approval panel members deemed appropriate. Meetings should be arranged with a range of personnel from the practice learning/employer partners to determine the organisational commitment and support in providing high quality placements and practice assessors and supervisors to support student learning.

Where there are a range of practice learning environments, panel members may divide into small groups and visit different practice learning settings as appropriate. All visitors will be accompanied whilst conducting visits to practice learning environments.

Visit Agenda:

The timescales and order of events should be locally agreed.

15 minutes

- Discuss with senior practice learning partners/ managers relevant strategic issues and organisational commitment to the proposed programme and student placements.
- Explore how the practice learning partners will work with the AEI/education institution to meet the requirements in the Standards framework for nursing and midwifery education, Standards for student supervision and assessment to the deliver the programme and enable effective practice learning.

15 minutes

- Discuss with practice learning leads how the shared responsibilities for placement learning to meet the Standards framework for nursing and midwifery education, Standards for student supervision and assessment will be met, and how appropriate learning opportunities are determined and support students in achieving the required standards of proficiency.

30 – 45 minutes

- Visit to placement area, observation of learning environment.
- Explore with practice supervisors and assessors their understanding of their role and responsibilities.
- Explore how learning opportunities lead to the required standards of proficiency.
- Discuss with people who use services and carers how students have been involved in their care and if feedback is sought.

30 minutes

- Meet with students on similar or related programmes and discuss their experience of programme delivery, practice and educational support arrangements and any concerns they might have.

30 minutes

- Panel members discuss findings and clarify any further requirements.

7.7 Guidance for QA visitors for meetings with key stakeholders at approval visit

The focus of these meetings with key stakeholders is for QA visitors to triangulate their findings from the documentary review of the programme presented for approval. The key areas presented as topics for discussion focus on preparation for roles, practice learning, supervision, and assessment of students, and, students meeting proficiencies.

Note: the topics are for guidance only for use by QA visitors and are not to be used as a tick list of questions.

Meeting with senior staff in the AEI or an education institution, for example: Dean, Head of School, Vice Chancellor, or nominated senior representative (the latter would be for an education institution seeking AEI status).

Topics for discussion may include:

- Examples of shared outcomes achieved through partnership working with practice learning/employer partners.
- Examples of employer's support to the programme.
- Arrangements in place with their practice learning/employer partners to identify, manage and mitigate any risks to student learning and student safety.
- Assurance that there are sufficient and appropriate resources in practice learning settings to support the programme/ students will gain a variety of practice experiences to meet the programme requirements.
- Deployment of academic staff resource to support learning in practice and how this resource is sustained.
- Assurance that the supernumerary status of students is maintained and/or protected learning time for nursing associate students.
- Support for transferring students to meet any shortfall in the new programme requirements.
- Arrangements for supervision and assessment in practice learning settings.
- Mechanisms in place with practice learning/employer partners to monitor and review how the NMC standards for supervision and assessment are met.

Meeting with students, including students transferring from the existing programme to the new programme

Topics for discussion (appropriate to the programme being considered for approval) may include:

- Students involvement in the development of the new programme.
- Examples of how student feedback and evaluation has influenced the design and development of the new programme.
- Students practice learning experience/placements. What they have learnt about communication skills and managing relationships: with colleagues and with people they are caring for.
- Examples of clinical nursing procedures for which students have been assessed as proficient.
- Practice learning environments proposed in the new programme including:
  - the appropriateness of the practice learning experience to enable students to meet the holistic needs of people of all ages from conception to death.
  - the practice learning experience in the students' chosen field of practice and exposure to the other fields of clinical practice.

- Examples of any individual student's personal circumstances that needed consideration when arranging a practice learning opportunity.
- Students' experience of any reasonable adjustments which have been made in relation to a disability or an individual need.
- The role of practice learning/employer partners in supporting students who require reasonable adjustments.
- Students' experience of supernumerary status/protected learning time
- Support, supervision, and assessment of students in practice learning environments.
- Students awareness of the Standards for student supervision and assessment and the differences in support, supervision, learning and assessment for students in practice learning environments when the standards are implemented.
- Examples of support received when students have had a difficulty or concern during practice learning.
- Examples of support students receive from academic staff.
- Discuss students experience of receiving feedback and the impact on their learning and progress on the programme.
- People who use services and carers involvement in the programme and whether they provide feedback to students on their nursing skills and contribution to care.
- Students experience of how they are able to meet the standards of proficiency/new standards of proficiency for their field of practice and support available if they have concerns about achieving proficiencies for their field of clinical practice.
- Programmes in Wales: support in using the Welsh language.

Students transferring from existing programme to new programme

- Students understanding of the key differences between their current programme and the new programme.
- Implications for students in transferring to the new programme.

Meeting with educators: those who deliver, support, supervise and assess theory or practice learning for example: programme team, lecturers, programme leads, academic assessors, researchers.

Topics for discussion (appropriate to the programme being considered for approval) may include:

- Examples of partnership working with practice learning providers to deliver and monitor the programme.
- Ensuring the support, supervision, learning and assessment of students complies with the NMC Standards framework for nursing and midwifery education.
- Ensuring and monitoring students deliver safe and effective care, and measures in place if safe care is put at risk.
- Arrangements in place with placement learning partners to identify and mitigate any risks to student learning and student safety.
- How learning opportunities are addressed across the four fields of practice (pre-registration nursing programmes) in the programme design and delivery.
- How the programme provides practice learning opportunities to allow students to develop and meet the holistic needs of people of all ages from conception to death.
- The process to ensure practice learning environments provide students with opportunities to learn communication and relationship management skills and nursing procedures, as set out in the Standards of proficiency for registered nurses, within their chosen fields of clinical practice.

- The assessment of proficiency in communication and relationship management skills and nursing procedures.
- How students' individual needs are taken into account in allocating practice learning experiences.
- Processes for determining and making reasonable adjustments for students, including the involvement and support by practice learning/employer partners.
- Examples of how the programme meets the NMC Standards for student supervision and assessment.
- Arrangements for the supervision and assessment of students in practice.
- Arrangements for identifying, preparing and supporting other registered health and social care professionals, including nursing associates to supervise and contribute to the assessment and progression of nursing students.
- Approaches used to give students constructive feedback throughout the programme to support their development.
- Preparation and support provided for practice supervisors and practice assessors regarding supernumerary status and direct and indirect supervision.
- Arrangements for academic assessors to receive feedback about students from practice supervisors and practice assessors and make decisions about student progression.
- Processes and responsibility of individuals to monitor the student's progress towards meeting proficiencies for their chosen field of practice.
- Process which is followed if the assessment of the student does not confirm proficiency for professional practice.
- Support arrangements for students transferring to the new programme.

Meeting with practice leads/employer leads - those with responsibility for planning managing and delivering the practice learning aspects of the programme and support to practice supervisors and assessors. For example: placement liaison team, practice education facilitators, inter disciplinary clinical leads.

Topics for discussion (appropriate to the programme being considered for approval) may include:

- Examples of shared outcomes that they have achieved through partnership working with the AEI/education institution related to ensuring safe and effective practice learning.
- How they ensure students deliver safe and effective care, and the processes which are in place if safe care is put at risk.
- Arrangements with the AEI/education institution to identify, manage and mitigate any risks to student learning and student safety.
- How they ensure that there are sufficient and appropriate resources in practice learning settings to support the programme.
- How they ensure, with the AEI / education institution that the support, supervision, learning and assessment of students complies with the NMC Standards framework for nursing and midwifery education.
- How they ensure that the support, supervision, learning and assessment of students in practice complies with the NMC Standards for student supervision and assessment.
- Arrangements for the supervision and assessment of students in practice.
- Preparation and support provided to practice supervisors and assessors to enable them to support students to achieve their required proficiencies.

- Arrangements for identifying, preparing and supporting other registered health and social care professionals, including nursing associates to supervise and contribute to the assessment and progression of nursing students.
- Preparation and support provided for practice supervisors and assessors regarding supernumerary status and direct and indirect supervision of students.
- Partnership arrangements and support provided to students and practice supervisors and assessors if any concerns are raised in the practice learning environment.
- Arrangements for practice supervisors and practice assessors to provide feedback to academic assessors about student achievement and make decisions about student progression.
  - Provision of learning opportunities across the four fields of practice (pre-registration nursing). Provision of practice learning opportunities in the programme to enable students to develop and meet the holistic needs of people of all ages from conception to death.
- Opportunities for students to learn the communication and relationship management skills and nursing procedures, as set out in Standards of proficiency for registered nurses, within their selected fields of clinical practice.
- Ensuring students' individual needs are taken account of during practice learning.
- The role of and support for practice supervisors and assessors when supporting students who need reasonable adjustments in practice learning environments.

Meeting with practice supervisors/assessors

Topics for discussion (appropriate to the programme being considered for approval) may include:

- Preparation for the practice supervisor/assessor role to ensure that the support, supervision, learning and assessment they provide to students complies with the NMC Standards framework for nursing and midwifery education and Standards for student supervision and assessment.
- How they ensure their work as a practice supervisor/assessor in supporting students complies with the Standards for student supervision and assessment.
- How they ensure students deliver safe and effective care, and the measures in place if safe care is put at risk.
- How they are made aware of a student's individual needs and any requirements for reasonable adjustments and how they support these students.
- How they ensure the supernumerary status of students.
- How they determine when to allow students to undertake skills and procedures without direct supervision.
- How supervisors support students' learning and enable them to work as part of the team and become proficient.
- How they ensure that students gain a variety of practice experiences to meet the holistic needs of people of all ages from conception to death.
- How they provide support to students and provide learning opportunities across the four fields of nursing practice.
- Their role in ensuring that students meet the Standards of proficiency for registered nurses and programme outcomes for the fields of nursing practice.

- How they facilitate students to meet the communication and relationship management skills and nursing procedures, as set out in Standards of proficiency for registered nurses, within the chosen field of nursing practice.
- How they assess if the student is proficient in these skills and procedures.
- How they provide students with constructive feedback to support their development.
- How practice assessors get feedback on a student's achievement from practice supervisors, and other people in the learning environment.
- Arrangements for practice supervisors and practice assessors to provide feedback to academic assessors about a student's achievement and make decisions about student progression.
- The responsibility for ensuring the assessment of students to confirm proficiency in preparation for professional practice as a registered nurse, including who is responsible and where and when the decision is made.
- The process to follow if the assessment of the student does not confirm proficiency for professional practice.
- Responsibility for recording proficiencies in the ORA/PAD.
- Supporting students in ensuring all proficiencies are recorded in an ORA to demonstrate the achievement of proficiencies and skills set out in Standards of proficiency for registered nurses.

Meeting with people who use services and carers

Involvement of patients, people who use services and carers is an important part of the education and training of student nurses/ nursing associates from programme design, student selection, learning, teaching, assessing, feedback evaluation and the student experience in practice placement.

Topics for discussion (appropriate to the programme being considered for approval) may include:

- Preparation for their role. Participation in any specific training for specific aspects of the role.
- Examples of any aspects of the programme they/or other people who use services were involved in developing.
- Examples of any specific aspects of the programme delivery they have /will be involved in.
- The support provided by the AEI for their role. Feedback received on their contribution to the programme.
- Their confidence that the programme provider ensures that students selected to join and progress through the programme to completion are suitable people to become NMC registrants
- Person centred care is an essential part of care delivery - how they/other people who use services and carers ensure that this is a key feature of the programme.
- How they assist the programme providers in balancing the need for students to learn and become proficient in delivering care and ensuring the safety of the public.
- The involvement of people who use services/carers in the assessment of students.
- Their involvement in designing and implementing practice learning opportunities that allow students to develop the communication and relationship management skills required for NMC registrants.
- Their involvement in designing and implementing practice learning opportunities that allow students to become proficient in nursing, midwifery and nursing associate procedures.
- Plans for their future involvement in the delivery and evaluation of the programme.

7.8 Complaints regarding quality of all QA activities – Mott MacDonald

Complaints

We take complaints about work, staff and levels of service very seriously. If you are dissatisfied with any aspect of our work, please contact us immediately to discuss your concerns on: 01223 463441. If, following a verbal conversation, you are still dissatisfied and wish to take the matter further, please follow the process for raising a formal complaint.

Formal complaints

All stakeholder complaints will be handled consistently and in line with the formal complaints procedure. This procedure is also published on our website.

How to make a formal complaint

All formal complaints must be made in writing. Complaints may be sent by post or by email.

Write to:
NMC Complaints Manager
Mott MacDonald
22 Station Road
Cambridge
CB1 2JD

Email:
nmc@mottmac.com

To enable us to commence an investigation, please provide us with:

- a clear, detailed description of what the complaint is about, including personnel involved and providing dates and times (where relevant)
- copies of any correspondence relating to the complaint

What happens next?

The complaints manager will:

- log the complaint in the correspondence log;
- write a letter/send an email of acknowledgement to the complainant within two working days;
- investigate the complaint

The complaints manager will institute an investigation, with the aim of providing a full response to the complainant within **20 working days**.

The complaints manager may refer the complaint to the project director or the director of QA who may seek further assistance from other relevant staff to assist in the investigation. The investigation will involve seeking evidence from the QA visitor(s) or staff member about whose performance the complaint has been made, and from any other relevant sources; such as quality assurance (QA) records.

The process will normally be completed within **20 working days** of receipt of the complaint. In exceptional circumstances (for example, where the issues involved are particularly complex and/or the relevant personnel are not readily available for reasons beyond our control), it may be necessary to extend the period of the investigation. Where this proves necessary, the complainant will be provided with a progress report within **20 working days**.

At the conclusion of the investigation, the investigating officer will conclude whether the complaint is:

- upheld;
- not upheld, or
- not proven.

This decision will be final. The investigating officer will write a report outlining the reasons for the decision. The complaints manager will send a copy of the report, together with a covering letter, to the complainant and all other stakeholders involved. A copy will also be placed on file.

If a complaint is upheld, then the investigating officer will consider, in consultation as appropriate with other members of the project team, what if any, corrective and/or disciplinary action should be taken in respect of an individual. For example, a QA visitor might be subjected to enhanced QA strategies including observations and additional monitoring or, in the case of a serious complaint, immediate removal from the pool of QA visitors available for deployment.

For a not upheld or not proven complaint, the investigating officer will nonetheless consider, in consultation as appropriate with other members of the project team, whether there are lessons to be learned and actioned. These will be addressed as part of the normal QA process. All feedback received either positive or negative will be used to inform our continuous cycle of improvement.

If the complaint is about Mott MacDonald as the QA contractor this should be made directly to the

7.9 Concerns grading

Grading	Risk	Additional considerations
Minor	• **The risk or potential risk to the student learning environment and/or a breach of the education standards is low. For example:** – The AEI and practice learning partner / employer partner are proactively providing the NMC with timely information and ongoing updates (indicating that the AEI has robust internal QA processes in place and is managing the situation appropriately). – The incident is isolated or a one off and risks have been managed; suggesting that the issue is unlikely to be recurring. – The concerns are recent and have been addressed / managed already (but we continue to monitor)	• Risks with a higher grading may be lowered to 'Minor' after enquiries have been sufficiently addressed, for example: • Another regulator/ system partner reports/highlights concerns, but the AEI can demonstrate action/ intervention and ongoing mitigation • Consideration should be given to whether information needs to be shared with system partners (HEE, GMC, CQC, NHSE/I) according to governance processes. • Where further information emerges that increases the risks associated, the concern may be upgraded to 'Major'.

Grading	Risk	Additional considerations
Major	• **The risk or potential risk to the student learning environment and/or a breach of the education standards is medium.** • **There is a risk or potential risk to student and/ or public safety and wellbeing. For example:** – Previous reports relating to this matter or a similar past incident, indicate an ongoing issue. – The AEI is managing the risks but further monitoring and information is required before we can consider the risks mitigated. – Action plans may not be delivering sustainable improvement at the pace required or an action plan is outstanding. – There is a lack of engagement from AEI which is impacting progress. – Public/media interest – exposure of an incident in the press indicates a serious concern and requirement for the NMC to take action as soon as possible- ie contact the AEIs giving them the opportunity to explain how they are mitigating any risks. – Other AEIs may be at risk as a result of the issue. – The concern may have attracted public/media interest. – Actions required to address an identified risk have not been taken/an action plan is outstanding. – There may be an inquiry/investigation in progress (investigation by another regulator/authority and re-opening of cases suggests there may be more emerging information relating to the incident or issues that might affect the learning environment.	• 'Major' applies where an incident occurs or concerns are raised, appropriate action may be being taken, but further assurance is required whilst actions are ongoing. • 'Major' risks are appropriate where incomplete reporting has been provided and more information is required in order to fully assess the risk. • Where AEIs provide sufficient information regarding steps taken to mitigate risks, the concern may be downgraded to 'Minor' or may be closed. • Where further information emerges that increases the risks associated, the concern may be upgraded to 'Critical'. • Consideration should be given to whether information needs to be shared with system partners (HEE, GMC, CQC, NHSE/I) according to governance processes.

Critical	• **The risk or potential risk to the student learning environment and/or a breach of the education standards is high and likely.** • **There is a current or potential serious risk to student and/ or public safety and wellbeing. For example:** – Education standards have or appear to have been breached – Student learning and/or progression has been impacted by significant changes in the learning environment (serious incident involving qualified staff). – There is a need for the NMC to take action urgently in order to mitigate any risks. – There may have been avoidable deaths / injuries (potentially several incidents suggesting a pattern). – There is public interest or the matter is likely to be of significant public interest if more widely known. – There is or likely to be a public inquiry/ investigation related to the concerns – The AEI is deemed to be either unaware of the adverse incident or not to have implemented all necessary actions to control the risks emerging from the incident.	• Critical concerns should be brought to the attention of the Head of Education and Quality Assurance as soon as possible. • Classification and oversight of 'Critical' risks is the responsibility of the Head of Education and QA, reporting to the Assistant Director, Professional Practice (Operations) • Further information that emerges (from system partners and/or other regulators, the media), should be acted upon swiftly. • All critical concerns and updates will be discussed at QA Board. • Critical concerns should be shared with system partners (HEE, GMC, CQC, NHSE/I) according to governance processes.

Nursing & Midwifery Council

Standards for education and training

Part 2:

Standards for student supervision and assessment

Original publication **17 May 2018**
Newly published **25 April 2023**

Contents

These standards were approved by Council at their meeting on 28 March 2018 and were updated on 8 October 2018 to include the regulation of pre-registration nursing associate programmes.

These standards were newly published on 25 April 2023 to align with the publication of the updated standards for education and training that were approved at the Council meeting on 25 January 2023.

About our standards

Our standards for education and training include the Standards framework for nursing[1] and midwifery education, Standards for student supervision and assessment, and programme standards specific to each approved programme.

Our standards for education and training are set out in three parts:

Part 1: Standards framework for nursing and midwifery education

Part 2: Standards for student supervision and assessment

Part 3: Programme standards:

- Standards for pre-registration nursing programmes
- Standards for pre-registration midwifery programmes
- Standards for pre-registration nursing associate programmes
- Standards for prescribing programmes
- Standards for post-registration programmes: programmes leading to specialist community public health nurse qualifications and programmes leading to community nursing specialist practice qualifications
- Standards for return to practice programmes

Supporting information for our Standards for student supervision and assessment is on our website.

These standards help nursing and midwifery students achieve NMC proficiencies and programme outcomes. All nursing and midwifery professionals must practise in line with the requirements of the Code, the professional standards of practice, values and behaviours that nurses, midwives and nursing associates are expected to uphold.

1 We have used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession in England with their own part of our register, but they are part of the nursing team.

Introduction

Our Standards for student supervision and assessment set out our expectations for the learning, support and supervision of students in the practice environment. They also set out how students are assessed for theory and practice.

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order') requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The Standards for student supervision and assessment are established under the provision of Article 15(1) of the Order.

These standards aim to provide Approved Education Institutions (AEIs) and practice learning partners with the flexibility to develop innovative approaches to nursing and midwifery education, while being accountable for the local delivery and management of approved programmes in line with our standards. Public safety is central to our standards. Students will be in contact with people throughout their education and it's important that they learn in a safe and effective way.

The Standards for student supervision and assessment apply to all NMC approved programmes and should be read with the NMC Standards framework for nursing and midwifery education and the programme standards specific to the programme that is being delivered. There must be compliance with all these standards for an education institution to be approved and run NMC approved programmes.

Our Standards for student supervision and assessment are set out under the following three headings:

Effective practice learning (section 1)

These standards describe what needs to be in place to deliver safe and effective learning experiences for nursing and midwifery students in practice.

Supervision of students (sections 2 to 5)

Here we describe the principles of student supervision in the practice environment, and the role of the practice supervisor.

Assessment of students and confirmation of proficiency (sections 6 to 10)

In these standards we set out what we require from educators who are assessing and confirming students' practice and academic achievement. We describe the role and responsibilities of the practice assessor and the academic assessor.

Each of the described roles must be in place for education institutions and practice learning partners to meet our standards. Additional roles may be introduced in line with local or national requirements. Programme leaders will confirm the achievement of proficiencies by each student on a programme as set out in the Standards framework for nursing and midwifery education and the programme standards specific to the programme

The Standards for student supervision and assessment are outcome-focused and allow for local innovation in programme delivery; they are designed to work across all programmes and in all settings. Student supervision and assessment can be flexible, provided the education institutions and practice learning partners meet our standards. Students in practice or work-placed learning must be supported to learn. This may include being supernumerary, meaning that they are not counted as part of the staffing required for safe and effective care in that setting. The decision on the level of supervision provided for students should be based on the needs of the individual student. The level of supervision can decrease with the student's increasing proficiency and confidence. Students must be provided with adjustments in accordance with relevant equalities and human rights legislation in all learning environments and for supervision and assessment.

Effective practice learning

All students are provided with safe, effective and inclusive learning experiences. Each learning environment has the governance and resources needed to deliver education and training. Students actively participate in their own education, learning from a range of people across a variety of settings.

1. Organisation of practice learning

Approved education institutions, together with practice learning partners, must ensure that:

1.1 practice learning complies with the NMC Standards framework for nursing and midwifery education

1.2 practice learning complies with specific programme standards

1.3 practice learning is designed to meet proficiencies and outcomes relevant to the programme

1.4 there are suitable systems, processes, resources and individuals in place to ensure safe and effective coordination of learning within practice learning environments

1.5 there is a nominated person for each practice setting to actively support students and address student concerns

1.6 students are made aware of the support and opportunities available to them within all learning environments

1.7 students are empowered to be proactive and to take responsibility for their learning

1.8 students have opportunities to learn from a range of relevant people in practice learning environments, including users of services, registered and non-registered individuals, and other students as appropriate

1.9 learning experiences are inclusive and support the diverse needs of individual students

1.10 learning experiences are tailored to the student's stage of learning, proficiencies and programme outcomes, and

1.11 all nurses, midwives and nursing associates contribute to practice learning in accordance with the Code.

Supervision of students

Practice supervision enables students to learn and safely achieve proficiency and autonomy in their professional role. All NMC registered nurses, midwives and nursing associates are capable of supervising students, serving as role models for safe and effective practice. Students may be supervised by other registered health and social care professionals.

2. Expectations of practice supervision

Approved education institutions, together with practice learning partners, must ensure that:

2.1 all students on an NMC approved programme are supervised while learning in practice

2.2 there is support and oversight of practice supervision to ensure safe and effective learning

2.3 the level of supervision provided to students reflects their learning needs and stage of learning

2.4 practice supervision ensures safe and effective learning experiences that uphold public protection and the safety of people

2.5 there is sufficient coordination and continuity of support and supervision of students to ensure safe and effective learning experiences

2.6 practice supervision facilitates independent learning, and

2.7 all students on an NMC approved programme are supervised in practice by NMC registered nurses, midwives, nursing associates, and other registered health and social care professionals.

3. Practice supervisors: role and responsibilities

Approved education institutions, together with practice learning partners, must ensure that practice supervisors:

3.1 serve as role models for safe and effective practice in line with their code of conduct

3.2 support learning in line with their scope of practice to enable the student to meet their proficiencies and programme outcomes

3.3 support and supervise students, providing feedback on their progress towards, and achievement of, proficiencies and skills

3.4 have current knowledge and experience of the area in which they are providing support, supervision and feedback, and

3.5 receive ongoing support to participate in the practice learning of students.

4. Practice supervisors: contribution to assessment and progression

Approved education institutions, together with practice learning partners, must ensure that practice supervisors:

4.1 contribute to the student's record of achievement by periodically recording relevant observations on the conduct, proficiency and achievement of the students they are supervising

4.2 contribute to student assessments to inform decisions for progression

4.3 have sufficient opportunities to engage with practice assessors and academic assessors to share relevant observations on the conduct, proficiency and achievement of the students they are supervising, and

4.4 are expected to appropriately raise and respond to student conduct and competence concerns and are supported in doing so.

5. Practice supervisors: preparation

Approved education institutions, together with practice learning partners, must ensure that practice supervisors:

5.1 receive ongoing support to prepare, reflect and develop for effective supervision and contribution to student learning and assessment, and

5.2 have understanding of the proficiencies and programme outcomes they are supporting students to achieve.

Assessment of students and confirmation of proficiency

Student assessments are evidence based, robust and objective. Assessments and confirmation of proficiency are based on an understanding of student achievements across theory and practice. Assessments and confirmation of proficiency are timely, providing assurance of student achievements and competence.

6. Assessor roles

Approved education institutions, together with practice learning partners, must ensure that:

6.1 all students on an NMC approved programme are assigned to a different nominated academic assessor for each part of the education programme

6.2 all students on an NMC approved programme are assigned to a nominated practice assessor for a practice placement or a series of practice placements, in line with local and national policies

6.3 nursing students are assigned to practice and academic assessors who are NMC registered nurses with appropriate equivalent experience for the student's field of practice

6.4 midwifery students are assigned to practice and academic assessors who are NMC registered midwives

6.5 specialist community public health nurse (SCPHN) students are assigned to practice and academic assessors who are NMC registered SCPHNs with appropriate equivalent experience for the student's field of practice

6.6 nursing associate students are assigned to practice and academic assessors who are either an NMC registered nursing associate or an NMC registered nurse

6.7 students studying for an NMC approved post-registration qualification are assigned to practice and academic assessors in accordance with relevant programme standards

6.8 practice and academic assessors receive ongoing support to fulfil their roles, and

6.9 practice and academic assessors are expected to appropriately raise and respond to concerns regarding student conduct, competence and achievement, and are supported in doing so.

7. Practice assessors: responsibilities

Approved education institutions, together with practice learning partners, must ensure that:

7.1 practice assessors conduct assessments to confirm student achievement of proficiencies and programme outcomes for practice learning

7.2 assessment decisions by practice assessors are informed by feedback sought and received from practice supervisors

7.3 practice assessors make and record objective, evidenced-based assessments on conduct, proficiency and achievement, drawing on student records, direct observations, student self-reflection, and other resources

7.4 practice assessors maintain current knowledge and expertise relevant for the proficiencies and programme outcomes they are assessing

7.5 a nominated practice assessor works in partnership with the nominated academic assessor to evaluate and recommend the student for progression for each part of the programme, in line with programme standards and local and national policies

7.6 there are sufficient opportunities for the practice assessor to periodically observe the student across environments in order to inform decisions for assessment and progression

7.7 there are sufficient opportunities for the practice assessor to gather and coordinate feedback from practice supervisors, any other practice assessors, and relevant people, in order to be assured about their decisions for assessment and progression

7.8 practice assessors have an understanding of the student's learning and achievement in theory

7.9 communication and collaboration between practice and academic assessors is scheduled for relevant points in programme structure and student progression

7.10 practice assessors are not simultaneously the practice supervisor and academic assessor for the same student, and

7.11 practice assessors for students on NMC approved prescribing programmes support learning in line with the NMC Standards for prescribing programmes.

8. Practice assessors: preparation

Approved education institutions, together with practice learning partners, must ensure that practice assessors:

8.1 undertake preparation or evidence prior learning and experience that enables them to demonstrate achievement of the following minimum outcomes:

- **8.1.1** interpersonal communication skills, relevant to student learning and assessment
- **8.1.2** conducting objective, evidence based assessments of students
- **8.1.3** providing constructive feedback to facilitate professional development in others, and knowledge of the assessment process and their role within it

8.2 receive ongoing support and training to reflect and develop in their role

8.3 continue to proactively develop their professional practice and knowledge in order to fulfil their role, and

8.4 have an understanding of the proficiencies and programme outcomes that the student they assess is aiming to achieve.

9. Academic assessors: responsibilities

Approved education institutions, together with practice learning partners, must ensure that:

9.1 academic assessors collate and confirm student achievement of proficiencies and programme outcomes in the academic environment for each part of the programme

9.2 academic assessors make and record objective, evidence-based decisions on conduct, proficiency and achievement, and recommendations for progression, drawing on student records and other resources

9.3 academic assessors maintain current knowledge and expertise relevant for the proficiencies and programme outcomes they are assessing and confirming

9.4 the nominated academic assessor works in partnership with a nominated practice assessor to evaluate and recommend the student for progression for each part of the programme, in line with programme standards and local and national policies

9.5 academic assessors have an understanding of the student's learning and achievement in practice

9.6 communication and collaboration between academic and practice assessors is scheduled for relevant points in programme structure and student progression, and

9.7 academic assessors are not simultaneously the practice supervisor and practice assessor for the same student.

10. Academic assessors: preparation

Approved education institutions, together with practice learning partners, must ensure that academic assessors:

10.1 are working towards or hold relevant qualifications as required by their academic institution and local and national policies

10.2 demonstrate that they have achieved the following minimum outcomes:

10.2.1 interpersonal communication skills, relevant to student learning and assessment

10.2.2 conducting objective, evidence based assessments of students

10.2.3 providing constructive feedback to facilitate professional development in others, and

10.2.4 knowledge of the assessment process and their role within it

10.3 receive ongoing support and training to reflect and develop in their role

10.4 continue to proactively develop their professional practice and knowledge in order to fulfil their role, and

10.5 have an understanding of the proficiencies and programme outcomes that the student they confirm is aiming to achieve.

Glossary

Approved Education Institutions (AEIs): the status awarded by the NMC to an institution, or part of an institution, or combination of institutions that works in partnership with practice placement and work placed learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

Co-produced: when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered, acknowledging that people who use social care and health services (and their families) have knowledge and experience that can be used to help make services better. Co-production is one of the principles of the Care Act 2014.

Educators: in the context of the NMC standards for education and training educators are those who deliver, support, supervise and assess theory, practice and/or work placed learning.

Equalities and human rights legislation: prohibits unlawful discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and other characteristics. Anti-discrimination laws can be country specific and there are some legally binding international protections.

Learning environments: includes any environment in terms of physical location where learning takes place as well as the system of shared values, beliefs and behaviours within these places.

People: individuals or groups who receive services from nurses and midwives, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and others within and outside the learning environment.

Practice learning partners: organisations that provide practice learning opportunities necessary for supporting pre-registration and post-registration students in meeting proficiencies and programme outcomes.

Quality assurance: NMC processes for making sure all AEIs and their approved education programmes comply with our standards.

Reasonable adjustments: changes in the way services are offered to prevent students with disabilities from being placed at a substantial disadvantage, ensuring a fair and equal chance of accessing services as set out in equalities and human rights legislation.

Recognition of prior learning: a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes and requirements; this means it includes both theory and practice achievement.

Simulation: an educational method which uses a variety of modalities to support students in developing their knowledge, behaviours and skills, with the opportunity for repetition, feedback, evaluation and reflection to achieve their programme outcomes and be confirmed as capable of safe and effective practice.

Stakeholders: any person, group or organisation that has an interest or concern in the situation in question, and may affect or is affected by its actions, objectives or policies. In the context of the NMC standards for education and training this includes students, educators, partner organisations, people who use services, carers, employers, other professionals, other regulators and education commissioners.

Student: any individual enrolled onto an NMC approved education programme whether full-time or less than full-time.

Supported learning time: time to facilitate learning. This may include supernumerary status[2] that enables students to be supported in safely and effectively achieving proficiency.

Users of services: people accessing health or social care services, and anyone supporting the needs and circumstances of these people.

2 Supernumerary: see Standards for student supervision and assessment and specific programme standards.

What we do

Our vision is safe, effective and kind nursing and midwifery practice that improves everyone's health and wellbeing. As the independent regulator of more than 771,000 nursing and midwifery professionals, we have an important role to play in making this a reality

Our core role is to regulate. First, we promote high education and professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects a tiny minority of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed

To regulate well, we support our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to influence health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions

Nursing & Midwifery Council

23 Portland Place,
London W1B 1PZ
+44 20 7637 7181
www.nmc.org.uk
@nmcnews @nmcuk

Nursing & Midwifery Council

Standards for education and training

Part 1:

Standards framework for nursing and midwifery education

Original publication **17 May 2018**
Newly published **25 April 2023**

Contents

These updated standards were approved by Council at their meeting on 25 January 2023.

About our standards

Our standards for education and training include the Standards framework for nursing[1] and midwifery education, Standards for student supervision and assessment, and programme standards specific to each approved programme.

Our standards for education and training are set out in three parts:

Part 1: Standards framework for nursing and midwifery education

Part 2: Standards for student supervision and assessment

Part 3: Programme standards:

- Standards for pre-registration nursing programmes
- Standards for pre-registration midwifery programmes
- Standards for pre-registration nursing associate programmes
- Standards for prescribing programmes
- Standards for post-registration programmes: programmes leading to specialist community public health nurse qualifications and programmes leading to community nursing specialist practice qualifications
- Standards for return to practice programmes

Supporting information for our Standards for student supervision and assessment is on our website.

These standards help nursing and midwifery students achieve NMC proficiencies and programme outcomes. All nursing and midwifery professionals must practise in line with the requirements of the Code, the professional standards of practice, values and behaviours that nurses, midwives and nursing associates are expected to uphold.

1 We have used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession in England with their own part of our register, but they are part of the nursing team.

Introduction

Our Standards framework for nursing and midwifery education applies to all Approved Education Institutions (AEIs) and their practice learning partners that are running NMC approved programmes.

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order')[2] requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The Standards framework for nursing and midwifery education is established under the provision of Article 15(1) of the Order.

These standards aim to provide AEIs and practice learning partners with the flexibility to develop innovative approaches to all education for nurses, midwives and nursing associates, while being accountable for the local delivery and management of approved programmes in line with our standards. Pre-registration nursing and midwifery programmes and post-registration programmes may offer various academic and flexible routes to registration and annotation when seeking approval in line with our standards.

These standards should be read with the Standards for student supervision and assessment, and the programme standards which are specific for each pre-registration and post-registration educational programme. Together these are the NMC standards for education and training for the nursing and midwifery professions. Education institutions must be approved against these standards to run any NMC approved programmes.

AEIs are responsible for working with practice learning partners to manage the quality of their educational programmes. Overall responsibility for the day-to-day management of the quality of any educational programme lies with an AEI in partnership with practice learning partners who provide opportunities for practice experience to nursing and midwifery students.

Before a programme can be run, an approval process takes place through which we check that the proposed programme meets our standards.

Public safety is central to our standards. Students will be in contact with people throughout their education and it's important that they learn in a safe and effective way.

2 SI 2002/253

Through our quality assurance processes we check that education programmes meet our standards, and that education institutions and practice learning partners are managing risks effectively. Using internal and external intelligence we monitor risks to quality in education and training; this intelligence gathering includes analysis of system regulator reports.

Approved education providers are monitored and we have processes for collecting, analysing and responding to any risk intelligence we receive regarding educational programmes, including concerns raised with us directly by students. Approved education providers are also required to self-report any risks or concerns that could affect the quality of programme delivery and, therefore, public protection.

We strongly encourage people to take part in quality assurance events, where they will be asked to share experiences of nurse and midwifery education and suggest improvements.

AEIs must seek permission for approval for programme endorsement for programmes approved in the UK, to be delivered in a specified location outside the UK. This must be done in line with the NMC quality assurance framework.

Our Standards framework for nursing and midwifery education is set out under the following five headings:

1. Learning culture

We will only approve programmes where the learning culture is ethical, open and honest, is conducive to safe and effective learning that respects the principles of equality and diversity, and where innovation, inter-professional learning and team working are embedded

2. Educational governance and quality

We expect education providers to comply with all legal and regulatory requirements

3. Student empowerment

We want students to be empowered and provided with the learning opportunities they need to achieve the desired proficiencies and programme outcomes

4. Educators and assessors

We will seek assurance that those who support, supervise and assess students are suitably qualified, prepared and skilled, and receive the necessary support for their role

5. Curricula and assessment

We set standards for curricula and assessment that enable students to achieve the outcomes required to practise safely and effectively in their chosen area

We use these standards to assess the safety and effectiveness of all learning environments.

1 Learning culture

Standards

1.1 The learning culture prioritises the safety of people, including carers, students and educators, and enables the values of the Code to be upheld.

1.2 Education and training is valued in all learning environments.

Requirements

Approved education institutions, together with practice learning partners, must:

1.1 demonstrate that the safety of people is a primary consideration in all learning environments

1.2 prioritise the wellbeing of people promoting critical self-reflection and safe practice in accordance with the Code

1.3 ensure people have the opportunity to give and if required, withdraw, their informed consent to students being involved in their care

1.4 ensure educators and others involved in supervision, learning and assessment understand their role in preserving public safety

1.5 ensure students and educators understand how to raise concerns or complaints and are encouraged and supported to do so in line with local and national policies without fear of adverse consequences

1.6 ensure any concerns or complaints are investigated and dealt with effectively

1.7 ensure concerns or complaints affecting the wellbeing of people are addressed immediately and effectively

1.8 ensure mistakes and incidents are fully investigated and learning reflections and actions are recorded and disseminated

1.9 ensure students are supported and supervised in being open and honest with people in accordance with the professional duty of candour

1.10 ensure the learning culture is fair, impartial, transparent, fosters good relations between individuals and diverse groups, and is compliant with equalities and human rights legislation

1.11 promote programme improvement and advance equality of opportunity through effective use of information and data

1.12 ensure programmes are designed, developed, delivered, evaluated and co-produced with people who use services and other stakeholders

1.13 work with service providers to demonstrate and promote inter-professional learning and working, and

1.14 support opportunities for research collaboration and evidence-based improvement in education and service provision.

2 Educational governance and quality

Standards

2.1 There are effective governance systems that ensure compliance with all legal, regulatory, professional and educational requirements, differentiating where appropriate between the devolved legislatures of the United Kingdom, with clear lines of responsibility and accountability for meeting those requirements and responding when standards are not met, in all learning environments.

2.2 All learning environments optimise safety and quality, taking account of the diverse needs of, and working in partnership with, service users, students and all other stakeholders.

Requirements

Approved education institutions, together with practice learning partners, must:

2.1 comply with all relevant legal, regulatory, professional and educational requirements

2.2 ensure programmes are designed to meet proficiencies and outcomes relevant to the programme

2.3 comply with NMC programme standards specific to the programme being delivered

2.4 comply with NMC Standards for student supervision and assessment

2.5 adopt a partnership approach with shared responsibility for theory and practice supervision, learning and assessment, including clear lines of communication and accountability for the development, delivery, quality assurance and evaluation of their programmes

2.6 ensure that recruitment and selection of students is open, fair and transparent and includes measures to understand and address underrepresentation

2.7 ensure that people who use services and representatives from relevant stakeholder groups are engaged in partnership in student recruitment and selection

2.8 ensure that for students below the age of 18 on admission to their intended programme, appropriate safeguarding measures and any necessary programme adjustments are in place to support them and the people in their care

2.9 demonstrate a robust process for recognition of prior learning and how it has been mapped to the programme learning outcomes and proficiencies

2.10 provide students with the information and support they require in all learning environments to enable them to understand and comply with relevant local and national governance processes and policies

2.11 have robust, effective, fair, impartial and lawful fitness to practise procedures to swiftly address concerns about the conduct of students that might compromise public safety and protection

2.12 confirm that students meet the required proficiencies and programme outcomes in full, demonstrating their fitness for practice and eligibility for academic and professional award

2.13 provide all information and evidence required by regulators

2.14 regularly review all learning environments and provide assurance that they are safe and effective

2.15 have the capacity, facilities and resources in place to deliver safe and effective learning opportunities and practical experiences for students as required by their programme learning outcomes

2.16 be compliant with the NMC standards for education and training[3] for all periods of learning undertaken outside the UK

2.17 improve quality, manage risk and disseminate effective practice through the proactive seeking and appropriate sharing of information and data

2.18 proactively identify and act on any areas for improvement, regularly measuring programme performance and outcomes against the NMC standards and requirements, and other recognised quality frameworks in education

2.19 appoint appropriately qualified and experienced people for programme delivery

2.20 identify programme leaders to confirm that all proficiencies have been met by each student by the end of their programme, and

2.21 ensure appropriately qualified and experienced external examiners consider and report on the quality of theory and practice learning.

---

3 NMC standards for education and training, standards established by NMC Council as necessary to achieve the standards of proficiency for admission to the register. Includes parts 1, 2 and relevant standards in part 3 and proficiencies.

3 Student empowerment

Standards

3.1 Students are provided with a variety of learning opportunities and appropriate resources which enable them to achieve proficiencies and programme outcomes and be capable of demonstrating the professional behaviours in the Code.

3.2 Students are empowered and supported to become resilient, caring, reflective and lifelong learners who are capable of working in inter-professional and inter-agency teams.

Requirements

Approved education institutions, together with practice learning partners, must ensure that all students:

3.1 have access to the resources they need to achieve the proficiencies and programme outcomes required for their professional role

3.2 are provided with timely and accurate information about curriculum, approaches to teaching, supervision, assessment, practice placements and other information relevant to their programme

3.3 have opportunities throughout their programme to work with and learn from a range of people in a variety of practice placements, preparing them to provide care to people with diverse needs

3.4 are enabled to learn and are assessed using a range of methods, including technology enhanced and simulation learning appropriate for their programme as necessary for safe and effective practice

3.5 are supervised and supported in practice learning in accordance with the NMC Standards for student supervision and assessment

3.6 are supervised according to their individual learning needs, proficiency and confidence

3.7 are allocated and can make use of supported learning time when in practice

3.8 are assigned and have access to a nominated practice assessor for a practice placement or a series of practice placements in addition to a nominated academic assessor for each part of the education programme, in accordance with the NMC Standards for student supervision and assessment

3.9 have the necessary support and information to manage any interruptions to the study of programmes for any reason

3.10 are provided with timely and accurate information regarding entry to NMC registration or annotation of their award

3.11 have their diverse needs respected and taken into account across all learning environments, with support and **adjustments** provided in accordance with equalities and human rights legislation and good practice

3.12 are protected from discrimination, harassment and other behaviour that undermines their performance or confidence

3.13 are provided with information and support which encourages them to take responsibility for their own mental and physical health and wellbeing

3.14 are provided with the learning and pastoral support necessary to empower them to prepare for independent, reflective professional practice

3.15 are well prepared for learning in theory and practice having received relevant inductions

3.16 have opportunities throughout their programme to collaborate and learn with and from other professionals, to learn with and from peers, and to develop supervision and leadership skills

3.17 receive constructive feedback throughout the programme from stakeholders with experience of the programme to promote and encourage reflective learning, and

3.18 have opportunities throughout their programme to give feedback on the quality of all aspects of their support and supervision in both theory and practice.

4 Educators and assessors

Standard

4.1 Theory and practice learning and assessment are facilitated effectively and objectively by appropriately qualified and experienced professionals with necessary expertise for their educational and assessor roles.

Requirements

Approved education institutions, together with practice learning partners, must ensure that all educators and assessors:

4.1 comply with all standards and requirements in the NMC standards for education and training

4.2 act as professional role models at all times

4.3 receive relevant induction, ongoing support and access to education and training which includes training in equality and diversity

4.4 have supported time and resources to enable them to fulfil their roles in addition to their other professional responsibilities

4.5 respond effectively to the learning needs of individuals

4.6 are supportive and objective in their approach to student supervision and assessment

4.7 liaise and collaborate with colleagues and partner organisations in their approach to supervision and assessment

4.8 are expected to respond effectively to concerns and complaints about public protection and student performance in learning environments and are supported in doing so

4.9 receive and act upon constructive feedback from students and the people they engage with to enhance the effectiveness of their teaching, supervision and assessment

4.10 share effective practice and learn from others, and

4.11 appropriately share and use evidence to make decisions on student assessment and progression.

5 Curricula and assessment

Standard

5.1 Curricula and assessments are designed, developed, delivered and evaluated to ensure that students achieve the proficiencies and outcomes for their approved programme.

Requirements

Approved education institutions, together with practice learning partners, must ensure:

5.1 curricula fulfil NMC programme standards, providing learning opportunities that equip students to meet the proficiencies and programme outcomes[4]

5.2 curricula remain relevant in respect of the contemporary health and social care agenda

5.3 curricula weigh theory and practice learning appropriately to the programme

5.4 curricula are developed and evaluated by suitably experienced and qualified educators and practitioners who are accountable for ensuring that the curriculum incorporates relevant programme outcomes

5.5 curricula are co-produced with stakeholders who have experience relevant to the programme

5.6 curricula provide appropriate structure and sequencing that integrates theory and practice at increasing levels of complexity

5.7 curricula are structured and sequenced to enable students to manage their theory and practice learning experience effectively

5.8 assessment is fair, reliable and valid to enable students to demonstrate they have achieved the proficiencies for their programme

5.9 adjustments are provided in accordance with relevant equalities and human rights legislation for assessments in theory and practice

5.10 students are assessed across practice settings and learning environments as required by their programme

5.11 assessment is mapped to the curriculum and occurs throughout the programme to determine student progression

4 Applies equally to all programmes whether delivered as full time or less than full time.

5.12 practice assessment is facilitated and evidenced by observations and other appropriate methods

5.13 students' self-reflections contribute to, and are evidenced in, assessments

5.14 a range of people including people who use services contribute to student assessment

5.15 assessment of practice and theory is weighted appropriately to the programme, and

5.16 there is no compensation in assessments across theory and practice.

Glossary

Approved Education Institutions (AEIs): the status awarded by the NMC to an institution, or part of an institution, or combination of institutions that works in partnership with practice placement and work placed learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

Co-produced: when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered, acknowledging that people who use social care and health services (and their families) have knowledge and experience that can be used to help make services better. Co-production is one of the principles of the Care Act 2014.

Educators: in the context of the NMC standards for education and training educators are those who deliver, support, supervise and assess theory, practice and/or work placed learning.

Equalities and human rights legislation: prohibits unlawful discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and other characteristics. Anti-discrimination laws can be country specific and there are some legally binding international protections.

Learning environments: includes any environment in terms of physical location where learning takes place as well as the system of shared values, beliefs and behaviours within these places.

People: individuals or groups who receive services from nurses and midwives, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and others within and outside the learning environment.

Practice learning partners: organisations that provide practice learning opportunities necessary for supporting pre-registration and post-registration students in meeting proficiencies and programme outcomes.

Quality assurance: NMC processes for making sure all AEIs and their approved education programmes comply with our standards.

Reasonable adjustments: changes in the way services are offered to prevent students with disabilities from being placed at a substantial disadvantage, ensuring a fair and equal chance of accessing services as set out in equalities and human rights legislation.

Recognition of prior learning: a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes and requirements; this means it includes both theory and practice achievement.

Simulation: an educational method which uses a variety of modalities to support students in developing their knowledge, behaviours and skills, with the opportunity for repetition, feedback, evaluation and reflection to achieve their programme outcomes and be confirmed as capable of safe and effective practice.

Stakeholders: any person, group or organisation that has an interest or concern in the situation in question, and may affect or is affected by its actions, objectives or policies. In the context of the NMC standards for education and training this includes students, educators, partner organisations, people who use services, carers, employers, other professionals, other regulators and education commissioners.

Student: any individual enrolled onto an NMC approved education programme whether full-time or less than full-time.

Supported learning time: time to facilitate learning. This may include supernumerary status[5] that enables students to be supported in safely and effectively achieving proficiency.

Users of services: people accessing health or social care services, and anyone supporting the needs and circumstances of these people.

5 Supernumerary: see Standards for student supervision and assessment and specific programme standards.

What we do

Our vision is safe, effective and kind nursing and midwifery practice that improves everyone's health and wellbeing. As the independent regulator of more than 771,000 nursing and midwifery professionals, we have an important role to play in making this a reality

Our core role is to regulate. First, we promote high education and professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects a tiny minority of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed

To regulate well, we support our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to influence health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions

Nursing & Midwifery Council

23 Portland Place,
London W1B 1PZ
+44 20 7637 7181
www.nmc.org.uk
@nmcnews @nmcuk

Nursing & Midwifery Council

Standards for education and training

Part 3:

Standards for pre-registration nursing programmes

Original publication **17 May 2018**
Newly published **25 April 2023**

Contents

These updated standards were approved by Council at their meeting on 25 January 2023.

About our standards

Our standards for education and training include the Standards framework for nursing[1] and midwifery education, Standards for student supervision and assessment, and programme standards specific to each approved programme.

Our standards for education and training are set out in three parts:

Part 1: Standards framework for nursing and midwifery education

Part 2: Standards for student supervision and assessment

Part 3: Programme standards:

- Standards for pre-registration nursing programmes
- Standards for pre-registration midwifery programmes
- Standards for pre-registration nursing associate programmes
- Standards for prescribing programmes
- Standards for post-registration programmes: programmes leading to specialist community public health nurse qualifications and programmes leading to community nursing specialist practice qualifications
- Standards for return to practice programmes

Supporting information for our Standards for student supervision and assessment, and our Standards for pre-registration nursing programmes, can be found on our website.

These standards help nursing and midwifery students achieve NMC proficiencies and programme outcomes. All nursing and midwifery professionals must practise in line with the requirements of the Code, the professional standards of practice, values and behaviours that nurses, midwives and nursing associates are expected to uphold.

1 We have used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession in England with their own part of our register, but they are part of the nursing team.

Introduction

Our Standards for pre-registration nursing programmes set out the legal requirements, entry requirements, availability of recognition of prior learning, length of programme, requirements for supervision and assessment and information on the award for all pre-registration nursing education programmes.

Student nurses must successfully complete an NMC approved pre-registration programme to meet the Standards of proficiency for registered nurses and be eligible to apply for entry to the NMC register.

Public safety is central to our standards. Students will be in contact with people throughout their education and it's important that they learn in a safe and effective way.

These programme standards should be read with the NMC's Standards framework for nursing and midwifery education and Standards for student supervision and assessment, both of which apply to all NMC approved programmes. NMC Approved Education Institutions (AEIs) intending to deliver pre-registration nursing programmes must comply with all these standards to run an approved programme.

Education providers structure their educational programmes to comply with our programme standards. They also design their curricula around the published proficiencies for a particular programme and students are assessed against these proficiencies to make sure they are capable of providing safe, effective and kind care that improves health and wellbeing.

Proficiencies are the knowledge, skills and behaviours that nurses, midwives and nursing associates need in order to practise. We publish standards of proficiency for the nursing and midwifery professions as well as proficiencies for NMC approved post-registration qualifications.

Our standards for education and training highlight the need for programmes to adopt an inclusive approach to recruitment, selection and progression, ensuring admissions and all other academic processes are open, fair, transparent and demonstrate an understanding of and take measures to address underrepresentation.

Through our quality assurance processes we check that education programmes meet all of our standards regarding the structure and delivery of educational programmes, that the programme outcomes relate to the expected proficiencies for particular qualifications and that AEIs and practice learning partners are managing risks effectively. Using internal and external intelligence we monitor risks to quality in education and training, this intelligence gathering includes analysis of system regulator reports.

Before any programme can be run, we make sure it meets our standards. We do this through an approvals process, in accordance with our quality assurance framework.

Overall responsibility for the day-to-day management of the quality of any educational programme lies with an AEI in partnership with practice learning partners.

Legislative framework

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order')[2] requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The Standards for pre-registration nursing programmes are established under the provision of Article 15(1) of the Order.

2 SI 2002/253

Four fields of nursing practice

In accordance with the Nurses & Midwives (Part and Entries in the Register) Order of Council 2004 (SI 2004/1765), which states that entries in the register are to include a registrant's field of practice, UK students that qualify in a specific field of practice as a level 1 nurse may apply to enter the NMC register as a nurse in one or more of the four fields of nursing practice: adult, children, learning disabilities and mental health.

AEIs and their practice learning partners have ownership and accountability for the development, delivery and management of pre-registration nursing programme curricula. Pre-registration nursing programmes may offer various routes to registration, however, all programmes leading to registration must include routes within the programme specific to the relevant fields of nursing practice for which approval is being sought.

The Standards framework for nursing and midwifery education and these programme requirements give AEIs in partnership with practice partners the flexibility to design their own curriculum and the autonomy to decide on the proportion of generic and field specific hours provided. In designing curricula for dual award (that is, a programme of study that leads to registration in two fields of nursing practice) the NMC expects the AEI to design and deliver a programme of suitable length that ensures the student is proficient in delivering safe and effective care in both fields of nursing.

Programme curricula must cover the outcomes set out in platforms 1-7 of Standards of proficiency for registered nurses and the communication and relationship management skills and nursing procedures set out in the Annexes to that document. All nursing students across all fields of nursing must have the necessary learning supervision and assessment in preparation for professional practice as a registered nurse.

We believe that involving people who use services and members of the public in the planning and delivery of curricula will promote public confidence in the education of future nurses. We expect the use of supportive evidence and engagement from people who have experienced care by adult, children's, learning disabilities or mental health nurses to inform programme design and delivery for all fields of nursing practice.

Nursing students will learn and be assessed in theory, **simulation** and practice environments and settings. AEIs and practice placement partners must ensure that students meet the proficiencies relevant to their anticipated field(s) of nursing practice by the end of the programme. On successful completion of a programme students will be registered by the NMC as qualifying in one or more field of nursing practice.

The student journey

Standards for pre-registration nursing programmes follow the student journey and are grouped under the following five headings:

1. Selection, admission and progression

Standards about an applicant's suitability and continued participation in a pre-registration nursing programme

2. Curriculum

Standards for the content, delivery and evaluation of the pre-registration nursing programme

3. Practice learning

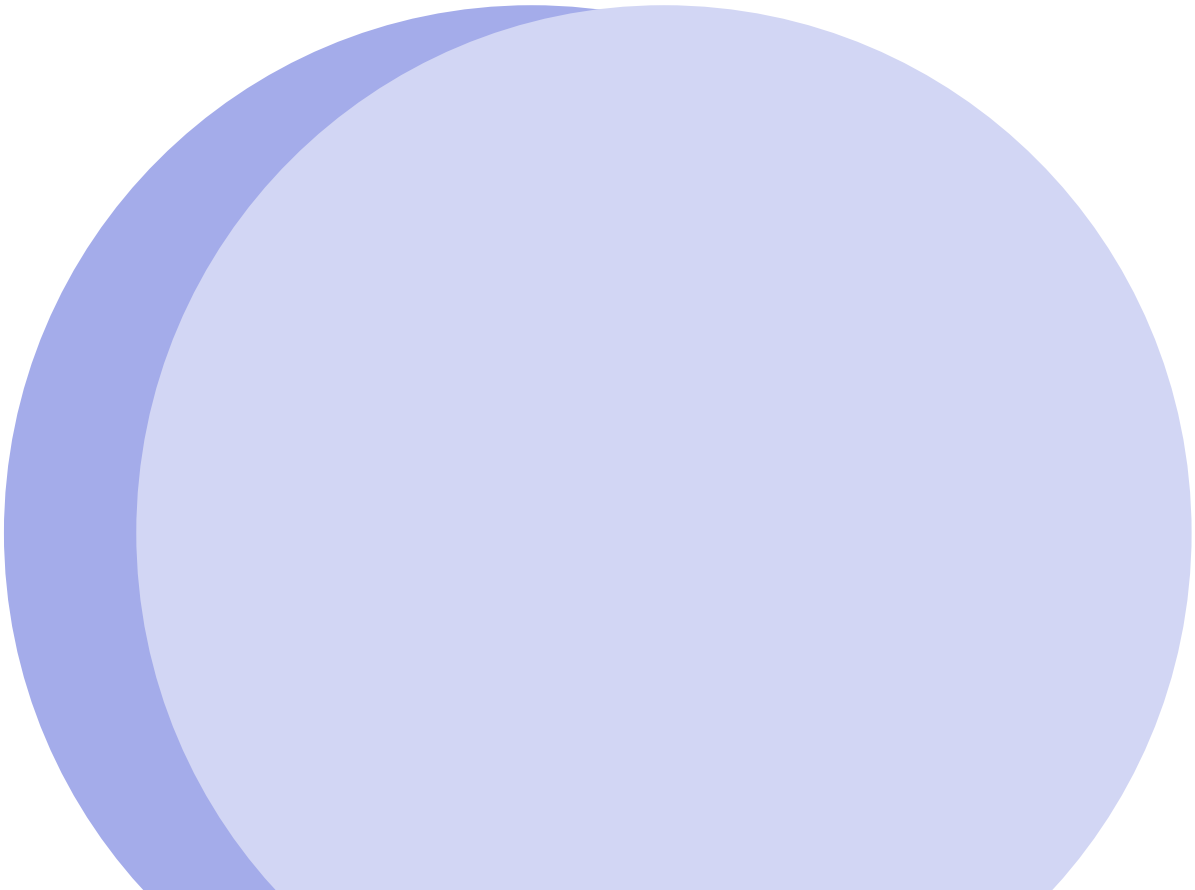
Standards specific to pre-registration learning for nurses that takes place in practice settings

4. Supervision and assessment

Standards for safe and effective supervision and assessment for pre-registration nursing programmes

5. Qualification to be awarded

Standards which state the award and information for the NMC register.



1 Selection, admission and progression

Approved education institutions, together with practice learning partners, must:

1.1 Confirm on entry to the programme that students:

- **1.1.1** meet the entry criteria for the programme as set out by the AEI and are suitable for their intended field of nursing practice: adult, mental health, learning disabilities and children's nursing
- **1.1.2** demonstrate values in accordance with the Code
- **1.1.3** have capability to learn behaviours in accordance with the Code
- **1.1.4** have capability to develop numeracy skills required to meet programme outcomes
- **1.1.5** can demonstrate proficiency in English language
- **1.1.6** have capability in literacy to meet programme outcomes
- **1.1.7** have capability for digital and technological literacy to meet programme outcomes.

1.2 ensure students' health and character are sufficient to enable safe and effective practice on entering the programme, throughout the programme and when submitting the supporting declaration of health and character in line with the NMC's health and character decision-making guidance[3]. This includes satisfactory occupational health assessment and criminal record checks

1.3 ensure students are fully informed of the requirement to declare immediately any police charges, cautions, convictions or conditional discharges, or determinations that their fitness to practise is impaired made by other regulators, professional bodies and educational establishments, and ensure that any declarations are dealt with promptly, fairly and lawfully

3 Guidance on health and character

1.4 ensure the registered nurse responsible for directing the educational programme or their designated registered nurse substitute is able to provide supporting declarations of health and character for students who have completed a pre-registration nursing programme[4]

1.5 permit recognition of prior learning that is capable of being mapped to the Standards of proficiency for registered nurses and programme outcomes, up to a maximum of 50 percent of the programme

1.6 for NMC registered nurses permit recognition of prior learning that is capable of being mapped to the Standards of proficiency for registered nurses and programme outcomes that may be more than 50 percent of the programme, and

1.7 support students throughout the programme in continuously developing their abilities in numeracy, literacy and digital and technological literacy to meet programme outcomes.

4 Rule 6(1)(a)(i) of the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004 (SI 2004/1767).

2 Curriculum

Approved education institutions, together with practice learning partners, must:

2.1 ensure that programmes comply with the NMC Standards framework for nursing and midwifery education

2.2 comply with the NMC Standards for student supervision and assessment

2.3 ensure that programme learning outcomes reflect the Standards of proficiency for registered nurses and each of the four fields of nursing practice: adult, mental health, learning disabilities and children's nursing

2.4 design and deliver a programme that supports students and provides exposure across all four fields of nursing practice: adult, mental health, learning disabilities and children's nursing

2.5 state routes within their pre-registration nursing programme that allows students to enter the register in one or more of the specific fields of nursing practice: adult, mental health, learning disabilities or children's nursing

2.6 set out the general and professional content necessary to meet the Standards of proficiency for registered nurses and programme outcomes

2.7 set out the content necessary to meet the programme outcomes for each field of nursing practice: adult, mental health, learning disabilities and children's nursing

2.8 ensure that field-specific content in relation to the law, safeguarding, consent, pharmacology and medicines administration and optimisation is included for entry to the register in one or more fields of nursing practice

2.9 ensure the curriculum provides an equal balance of 50 percent theory and 50 percent practice learning using a range of learning and teaching strategies

2.10 ensure technology and simulation opportunities are used effectively and proportionately across the curriculum to support supervision, learning and assessment

2.11 ensure that programmes delivered in Wales comply with legislation which supports use of the Welsh language

2.12 ensure that all pre-registration nursing programmes meet the equivalent of minimum length of three (academic) years for full time programmes, which consist of a minimum of 4,600 hours

2.13 ensure programmes leading to registration in two fields of nursing practice are of suitable length to ensure proficiency in both fields of nursing, and

2.14 ensure programmes leading to nursing registration and registration in another profession are of suitable length and nursing proficiencies and outcomes are achieved in a nursing context.

3 Practice learning

Approved education institutions, together with practice learning partners, must:

3.1 provide practice learning opportunities that allow students to develop and meet the Standards of proficiency for registered nurses to deliver safe and effective care to a diverse range of people across the four fields of nursing practice: adult, mental health, learning disabilities and children's nursing

3.2 ensure that students experience the variety of practice expected of registered nurses to meet the holistic needs of people of all ages

3.3 provide practice learning opportunities that allow students to meet the communication and relationship management skills and nursing procedures, as set out in Standards of proficiency for registered nurses, within their selected fields of nursing practice: adult, mental health, learning disabilities and children's nursing

3.4 provide no less than 2300 practice learning hours, of which a maximum of 600 hours can be in simulated practice learning

3.5 take account of students' individual needs and personal circumstances when allocating their practice learning including making reasonable adjustments for students with disabilities

3.6 ensure students experience the range of hours expected of registered nurses, and

3.7 ensure that students are supernumerary.

4 Supervision and assessment

Approved education institutions, together with practice learning partners, must:

4.1 ensure that support, supervision, learning and assessment provided complies with the NMC Standards framework for nursing and midwifery education

4.2 ensure that support, supervision, learning and assessment provided complies with the NMC Standards for student supervision and assessment

4.3 ensure they inform the NMC of the name of the registered nurse responsible for directing the education programme

4.4 provide students with constructive feedback throughout the programme to support their development

4.5 ensure throughout the programme that students meet the Standards of proficiency for registered nurses and programme outcomes for their fields of nursing practice: adult, mental health, learning disabilities and children's nursing

4.6 ensure that all programmes include a health numeracy assessment related to nursing proficiencies and calculation of medicines which must be passed with a score of 100 percent

4.7 ensure that students meet all communication and relationship management skills and nursing procedures within their fields of nursing practice: adult, mental health, learning disabilities and children's nursing

4.8 assess students to confirm proficiency in preparation for professional practice as a registered nurse

4.9 ensure that there is equal weighting in the assessment of theory and practice, and

4.10 ensure that all proficiencies are recorded in an ongoing record of achievement which must demonstrate the achievement of proficiencies and skills set out in Standards of proficiency for registered nurses.

5 Qualification to be awarded

Approved education institutions, together with practice learning partners, must:

5.1 ensure that the minimum award for a pre-registration nursing programme is a bachelor's degree, and

5.2 notify students during and before completion of the programme that they have five years[5] to register their award with the NMC. In the event of a student failing to register their qualification within five years they will have to undertake additional education and training or gain such experience as specified in our standards.

5 Standards and guidance on the requirements for those who first apply for registration more than five years after being awarded an approved qualification

Glossary

Approved Education Institutions (AEIs): the status awarded by the NMC to an institution, or part of an institution, or combination of institutions that works in partnership with practice placement and work placed learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

Educators: in the context of the NMC standards for education and training educators are those who deliver, support, supervise and assess theory, practice and/or work placed learning.

Equalities and human rights legislation: prohibits unlawful discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and other characteristics. Anti-discrimination laws can be country specific and there are some legally binding international protections.

Health and character requirements: as stipulated in NMC legislation (Articles 9(2)(b) and 5(2)(b) of the Nursing and Midwifery Order 2001) 'good health' means that the applicant is capable of safe and effective practice either with or without reasonable adjustments. It does not mean the absence of a health condition or disability. Each applicant seeking admission to the register or to renew registration, whether or not they have been registered before, is required to declare any pending charges, convictions, police cautions and determinations made by other regulatory bodies.

People: individuals or groups who receive services from nurses and midwives, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and others within and outside the learning environment.

Practice learning partners: organisations that provide practice learning necessary for supporting pre-registration and post-registration students in meeting proficiencies and programme outcomes.

Quality assurance: NMC processes for making sure all AEIs and their approved education programmes comply with our standards.

Reasonable adjustments: where a student requires reasonable adjustment related to a disability or adjustment relating to any protected characteristics as set out in **equalities and human rights legislation**.

Recognition of prior learning: a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes, this means it includes both theory and practice achievement.

Simulation: an educational method which uses a variety of modalities to support students in developing their knowledge, behaviours and skills, with the opportunity for repetition, feedback, evaluation and reflection to achieve their programme outcomes and be confirmed as capable of safe and effective practice.

Stakeholders: any person, group or organisation that has an interest or concern in the situation in question, and may affect or is affected by its actions, objectives or policies. In the context of the NMC standards for education and training this includes students, educators, partner organisations, people who use services, carers, employers, other professionals, other regulators and education commissioners.

Student: any individual enrolled onto an NMC approved education programme whether full-time or less than full-time.

Supernumerary: students in practice or work placed learning must be supported to learn without being counted as part of the staffing required for safe and effective care in that setting. For apprentices, this includes practice placements within their place of employment; this does not apply when they are working in their substantive role.

Placements should enable students to learn to provide safe and effective care, not merely to observe; students can and should add real value to care. The contribution students make will increase over time as they gain proficiency and they will continue to benefit from ongoing guidance and feedback.

Once a student has demonstrated that they are proficient, they should be able to fulfil tasks without direct oversight. The level of supervision a student needs is based on the professional judgement of their supervisors, taking into account any associated risks and the students' knowledge, proficiency and confidence.

What we do

Our vision is safe, effective and kind nursing and midwifery practice that improves everyone's health and wellbeing. As the independent regulator of more than 771,000 nursing and midwifery professionals, we have an important role to play in making this a reality.

Our core role is to **regulate**. First, we promote high education and professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects a tiny minority of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.

To regulate well, we support our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to influence health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

Nursing & Midwifery Council

23 Portland Place,
London W1B 1PZ
+44 20 7637 7181
www.nmc.org.uk
@nmcnews @nmcuk

Nursing & Midwifery Council

Guidance on health and character

Published on 23 January 2019

Contents

Section 1 – Introduction

Who is this document for?

1. We've produced this document to provide guidance about how we assess the health and character of people who apply to, or are on, our register.[1]

2. You may find it useful if you're:

   2.1 applying to join or re-join the register

   2.2 renewing your registration through revalidation

   2.3 practising as a registered nurse, midwife or nursing associate[2]

   2.4 considering training to become a nurse, midwife or nursing associate

   2.5 working in education and considering applications to study to become a registered nurse, midwife or nursing associate

   2.6 working in education and considering advising students on their applications for registration.

3. This guidance explains when you need to tell us about any relevant health conditions and character issues.

4. This guidance sets out the information we take into account when deciding whether or not an applicant meets the health and character requirements to be registered with us. It also provides you with information about how we make decisions related to cases in registration involving health and character issues.

About us

5. The Nursing and Midwifery Council (NMC) is the independent regulator for nurses and midwives in the UK and nursing associates in England.

6. Better and safer care for people is at the heart of what we do. We make sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, or a nursing associate in England.

7. Our role, functions and powers are set out in the Nursing and Midwifery Order 2001 ('the Order').

[1] Our register is divided in to the following parts – nurses, midwives, nursing associates and specialist community public health nurses.
[2] The specialist community public health nursing (SCPHN) part of the register is for registered nurses and midwives working in public health roles. SCPHN programmes can only be undertaken by individuals who are already on our register as a nurse or midwife.

Section 2 – Health and character requirements

Legal framework for health and character requirements

8. Our principal functions are:

   8.1 establishing standards for education, training, conduct and performance for nurses, midwives and nursing associates and

   8.2 making sure those standards are maintained.[3]

9. We make sure standards are maintained by:

   9.1 holding a register of nurses, midwives and nursing associates

   9.2 quality assurance of education for nursing and midwifery programmes

   9.3 taking action if concerns are raised about whether a nurse, midwife or nursing associate is fit to practise.

10. When exercising our functions we have to consider our overarching objective which is the protection of the public and involves:

    10.1 protecting, promoting and maintaining the health, safety and wellbeing of the public

    10.2 promoting and maintaining public confidence in the professions and

    10.3 promoting and maintaining proper professional standards and conduct for members of those professions.[4]

Our register

11. In order to be on our register a nurse, midwife or nursing associate must meet our professional standards, our health and character requirements and have appropriate professional indemnity insurance in place.[5]

12. The people on our register are part of a profession with nationally recognised **standards** set by law. This also means they are entitled to use the relevant titles of ‘registered nurse’, ‘midwife’ or ‘nursing associate’ for their profession. When we say that someone is capable of safe and effective practice, we mean that they have the skills, knowledge, character and health to work in their profession safely and effectively.

[3] Article 3(2) of the Order
[4] Article 3(4A) of the order
[5] Article 9(2)(aa) of the Order

13. Nurses, midwives and nursing associates who are seeking to join or re-join our register, or renew their registration through revalidation must make declarations about their health and character.[6]

Approving education programmes

14. Part of our role includes approving education programmes. Nurses and midwives across the UK and nursing associates in England must complete these programmes to become registered with us.

15. However, completing an approved programme doesn't guarantee that someone will be able to register with us. Sometimes a student who has completed an education programme declares information which may mean that we reject their application for registration.

16. This happens only very rarely when the information is so significant that we can't be satisfied that the applicant is capable of safe and effective practice.

Our standards of proficiency

17. The standards of proficiency state that at the point of registration, registered nurses, midwives and nursing associates must understand the professional responsibility to adopt a healthy lifestyle to maintain the level of fitness and wellbeing required to meet people's needs for mental and physical care.

Our standards for education and training

18. We require all student nurses, midwives and nursing associates seeking registration to be of good health and good character to satisfy to us that they are capable of safe and effective practice.

The Code

19. Our Code sets the standards of health and character expected of a registered nurse, midwife and nursing associate when they are on the register. When applying to join the register or during revalidation, nurses, midwives and nursing associates must commit to uphold the Code. This commitment includes a promise to *'Uphold the reputation of your profession at all times'.*[7] To achieve this, you must:

    19.1 keep to and uphold the standards and values set out in the Code (20.1)

    19.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment (20.2)

    19.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people (20.3)

[6] Articles 9 and 10 of the Order and Rule 6 of the Registration Rules
[7] Paragraph 20 of the Code

19.4 keep to the laws of the country in which you are practising (20.4)

19.5 maintain the level of health you need to carry out your professional role (20.9).

Our duties under the Equality Act 2010

20. The Equality Act 2010 ('the Act') is legislation that applies in England, Wales and Scotland. It protects people from discrimination, harassment and victimisation. It does this by specifying a number of 'protected characteristics'. It is against the law to discriminate against anyone because of:

- age
- gender reassignment
- being married or being in a civil partnership
- being pregnant or in the maternity period
- disability
- race, including colour, nationality, ethnic or national origin
- religion, belief, or lack of religion or belief
- sex
- sexual orientation.

21. 'Disability' is defined in the Act as a physical or mental impairment that has a substantial or long-term negative effect on a person's ability to do normal daily activities. In the Act, 'substantial' is defined as more than minor or trivial and long-term is defined as 12 months or more. This means that people with a range of health conditions are included in this definition.

22. Under the Act, we fall into the category of a 'qualifications body'. This is because we award registration which allows people to practise in the professions that we regulate.

23. Under the Act we are required to make sure our processes are fair and don't discriminate against disabled people. Everyone applying to join our register must meet our registration requirements, however, reasonable adjustments can be made in relation to how the requirements are met. For example, providing documents in accessible formats.

24. Like education providers, the 'public sector duty' also applies to us. As a public body, we must comply with the requirements of the Act including the public sector equality duty. In complying with the public sector equality duty, we have due regard to three main aims:

24.1 eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010

24.2 advancing equality of opportunity between people who share a relevant protected characteristic and people who don't share it

24.3 fostering good relations between people who share a relevant protected characteristic and people who don't share it.

25. The application processes for registration or renewal (revalidation) of registration are open to all who meet the standards of education, training, conduct and performance that are applicable to their profession.

26. We will provide adjustments for individuals who require support in meeting revalidation requirements. For example, we can give you more time to get help to fill in the revalidation application form or give you a paper application form. For more information please see our How to revalidate guidance on our website.

Disability Discrimination Act for Northern Ireland

27. The Equality Act 2010 doesn't apply in Northern Ireland, but they have very similar equality requirements under different legislation. The Disability Discrimination Act 1995 continues to apply, as modified by the Disability Discrimination (Northern Ireland) Order 2006. This is supplemented by other orders, including the Special Education Needs and Disability Order (Northern Ireland) 2005, which relates to education.

How decisions on registration applications are made

28. During all registration applications nurses, midwives and nursing associates are asked to complete a number of declarations in relation to their health and character. This helps the Registrar decide whether your health and character means you are capable of safe and effective practice.

29. The Registrar will consider each application on a case-by-case basis, taking into account all the relevant circumstances. We can request any other relevant information which the Registrar needs in order to consider your application including information from you, your GP, your employer, the police and courts.

30. To be able to process your application quickly, we recommend that you provide all relevant information as early as possible. If information is outstanding then this will delay consideration of your application.

31. If you tell us about a health or character concern when we receive an application to join the register or at renewal, we may refer your application to a team to obtain further information (the Registration Appeals Support Team – RAST). The Registrar will then consider your application.

32. We won't investigate a referral[8] if you aren't on the NMC register at the time a concern is raised with us. However, if you apply for readmission to our register,

[8] A referral can be made to the NMC when someone tells us they have a concern about a nurse, midwife or nursing associate which could put the safety of patients at risk or damage the public's confidence in the nursing, midwife or nursing associate profession.

the Registrar will consider the referral and whether it means you are capable of safe and effective practice.

Section 3 – How we approach health issues

The health declaration

33. We need to know that people applying to join, renew or be readmitted to the register meet our requirements for health to ensure they can practise safely and effectively.

34. Our focus is whether you have a health condition and/or disability which may affect your practice. This is because we need to be able to assess whether it may place at risk the safety of people in your care.[9]

35. Our legislation requires applicants to make a self-declaration as to their 'good health' in order for them to meet the requirements for registration.[10] It's important to remember that when we talk about 'good health' we mean that you are capable of safe and effective practice as a nurse, midwife or nursing associate either with or without reasonable adjustments and adjustments which your employer has made.

36. It doesn't mean the absence of a health condition and/or disability. Many people with disabilities and health conditions are able to practise with or without adjustments put in place by their employer to support them.

37. If you have a disability or a health condition, it is the responsibility of your employer to discuss what reasonable adjustments they can provide to support you to provide safe and effective practice with or without direct supervision. You may wish to seek additional advice from your representative body or a medical professional as to what support would be suitable.

38. As part of your application we ask you to tell us about any health condition which has affected or could affect the safety of the people and patients you may care for and/or those you work with and/or your ability to practise safely and effectively. This includes whether you consider yourself to have a 'health condition' or a 'disability'.

39. We will ask you to complete the following declarations in your application:

    A) Do you have a health condition and/or disability that currently affects or could affect your ability to practise safely and effectively?

    If you answer yes to the above you will be asked to complete a further declaration:

[9] Article 3(4) & (4A) of the Order sets out NMC's overarching objectives to protect, promote and maintain the health, safety and wellbeing of the public.
[10] Rule 5(1)(a) and 6 and Schedule 3 of Registration Rules.

B) Are you managing your health condition and/or disability so that you can practise safely and effectively?

40. By ‘practise’ we do not mean your ability to do any particular job but that you are capable of safe and effective practice in your profession.

41. By ‘managed appropriately’ we mean that you have sought medical advice and treatment from Occupational Health, a GP or other medical professional/specialist and where appropriate, support to manage your practice safely and effectively or you have taken steps to adapt, limit or stop your practice if your health condition and/or disability does affect you.

42. If you think you are able to practise safely and effectively but are unable to tick ‘yes’ to declaration B, you are still able to proceed with your application. If this applies we will request further information in relation to your health condition and/or disability.

43. This means that you only need to tell us about your health condition and/or disability if:

43.1 you believe that your health condition and/or disability does affect your ability to practise safely and effectively, or

43.2 you believe that your health condition and/or disability could affect your ability to practise safely and effectively, and

43.3 you aren’t sure you will be able to adapt, limit or stop your practice if your health condition and/or disability does or could affect you, and/or

43.4 you haven’t made your employer or education provider aware of your health condition and/or disability but need their support in order to ensure that colleagues, people in your care or the public aren’t placed at risk.

44. If you tick ‘no’ to declaration B you will be asked to provide further information and a supporting statement with your application which the Registrar will take into account when assessing your application. It would assist us if you provide information to cover the following areas:

- Nature and seriousness of the health condition and/or disability.
- Pattern of a condition (is it active or relapsing).
- Management of your health condition and/or disability.
- An explanation on why you feel that your health condition and/or disability is not currently being managed appropriately or won’t be managed appropriately in the future.
- Whether or not you have informed your employer/education provider about your health condition and/or disability.
- Medical or other supporting information (for example, therapeutic interventions) commenting on how your health condition and/or disability does or could affect your ability to practise safely and effectively and what

steps you (or your employer, if applicable) can take to enable you to practise safely.
- Your level of insight and understanding into your health condition and/or disability and how it could affect your ability to practise safely.[11]

45. To be able to process your application quickly, we recommend that you speak to your GP, occupational health department or a medical professional as soon as possible.

46. 'Safe practice' means practice that doesn't put you or those in your care at undue risk. If you have an understanding of your health condition and/or disability and its impact on your practice you will be more likely to adapt your practice where necessary to reduce any risk to yourself or those in your care.

The implications of telling us about your health condition and/or disability

47. When we ask you if you have a health condition and/or disability that could affect your practice we are trusting you to exercise your own reasoned judgement. The Registrar will make the final decision on whether you are capable of safe and effective practice.

48. It is up to you to decide whether your health allows you to be capable of safe and effective practice. You may decide it is in your best interests to take yourself off our register and to concentrate on improving your health before you apply for readmission to the register.

49. You should answer the declarations as they apply to you so we can determine whether we require any further information regarding your health condition and/or disability. If we do require further information from you, this doesn't mean your application will be refused but simply that we will require some further information before a decision is made. If we find out that you didn't tell us about a health condition and/or disability which is affecting your ability to practise safely and effectively, we will investigate your fitness to practise and it could affect your registration.

Public protection and the information you give us about your health

50. We only need to know about a health condition and/or disability which may affect your ability to practise safely and effectively.

51. We don't need to know about information that isn't relevant to protecting the public.

52. If you tell us about an ongoing health condition and/or disability, we won't usually need to know your full medical history.

[11] By 'insight and understanding' we mean that you have a realistic, informed idea of the limits of your safe practice.

I have been diagnosed with a health condition and/or a disability which may or could affect my ability to practise

53. If you are already registered with us and have a health condition and/or disability which you think is affecting your ability to practise safely and effectively and you are unable to manage the impact of it effectively (with or without support from your employer), you should tell us as soon as reasonably possible rather than wait until renewal. This may mean that your fitness to practise is impaired. You can do this by making a referral to our Fitness to Practise team.
54. Please email newreferrals@nmc-uk.org with your full name, Pin and details of your health condition and/or disability and how it affects your ability to practise safely and effectively. Our Fitness to Practise team will get in touch to explain what will happen next.
55. If you delay and continue to practise, this could affect your registration, and you may be placing yourself or others' safety at risk.
56. However, if you are able to manage your health condition and/or disability, then you don't have to self-refer to our Fitness to Practise team.

How we consider information supplied to us through health self-declarations

57. All applications to join the register, return to the register or to renew your registration where a health condition and/or disability is disclosed are treated on a case-by-case basis.

58. The Registrar won't make decisions on registration based solely on the nature of your health condition and/or disability, but based on evidence about the effect and your management of the health condition and/or disability to ensure safe and effective practice. This may vary from person to person, and may also be affected by the impact of your health condition and/or disability, the help you may be receiving, and how much insight you have into its effect on your practice. We don't have a list of conditions or impairments that would automatically 'bar' an applicant from registration.

59. We recognise that your ability to work safely can be enhanced by the support network you have, whether that is your employer, trade union representative, training provider, at home or from the medical professional(s) treating you.

60. Although it isn't a requirement to tell your employer about your health condition and/or disability, we would encourage you to do so as they can discuss what support and reasonable adjustments they can offer to you to help manage your health condition and/or disability.

61. Any assessment relating to a disability will focus on what reasonable adjustments and adjustments can be made by your employer to support you to enter and remain on our register.

62. We may ask for further information to assist the Registrar when making their decision if necessary.

63. For more information on how we handle the personal information of anyone involved in our registration process, please read our 'Registration and Revalidation information handling guidance'.[12]

What should I do if I have a temporary injury or health condition?

64. If you sustain a temporary injury such as a broken leg or a sprain or are suffering from a temporary health condition such as a cold or flu, we recognise that it is unlikely to affect your ability to practise safely and effectively.

65. You must however ensure that colleagues, people in your care or the public aren't placed at risk and you should adapt, limit or stop your practice if it does or could affect your ability to practise safely and effectively until there is no longer that risk.

How we consider a long term health condition

66. We recognise that many nurses, midwives and nursing associates may have a long term health condition which will vary over time. Some conditions may be ongoing and some will relapse from time to time.

67. When you make your declaration you should consider whether you have in place adjustments to manage periods when your condition affects you more than others, or when relapses happen, so that you ensure you practise safely and effectively. If you are able to manage your long term health condition, then you don't have to tell us.

68. If, however, you think your long term health condition is affecting your ability to practise safely and effectively and it isn't currently being managed or you won't be able to manage it appropriately, we will consider your long term health condition in the same way as any other health condition declared to us.

69. We look at the overall picture, including the insight you show and the support you have in place, to assess whether you are able to practise safely and effectively.

How we consider mental health conditions

70. We recognise that one in four people will have mental health needs each year[13] and that this can happen to anyone at any point throughout their life. If your mental health does or may affect your ability to practise safely and effectively you should tell us about it.

71. Some health needs and/or conditions may be ongoing and some will relapse from time to time. When you make your declaration you should consider whether you have in place adjustments to manage periods when your condition affects

[12] www.nmc.org.uk/globalassets/sitedocuments/data-protection/registration-and-revalidation-information-handling-guidance.pdf

[13] McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: results of a household survey. The NHS Information Centre for health and social care.

you more, or when relapses happen, so that you practise safely and effectively. If you are able to manage your mental health condition, then you don't have to tell us.

72. If, however, you think your mental health condition is affecting your ability to practise safely and effectively and it isn't currently being managed or you won't be able to manage it appropriately, we will consider a mental health condition in the same way as any other health condition and/or disability declared to us.

73. We look at the overall picture, including the insight you show and the support you have in place, to assess whether you are able to practise safely and effectively.

If you're a student or an apprentice

74. You must tell your education institution about any health conditions and/or disability when you apply to study to be a nurse, midwife or nursing associate which could affect your ability to practise safely and effectively.

75. Your education institution will provide a supporting declaration for you when you join the register in relation to your health and character. Therefore in order to be able to provide this declaration, they will need to be aware of any health condition and/or disability which could affect your ability to practise safely and effectively.

76. When we assess your health condition and/or disability, we will check whether you have disclosed your health condition and/or disability to your education institution.

Information for education providers

77. The Standards for education and training set out the requirements that institutions and their practice learning partners must have in place in order to be able to provide a supporting declaration for nurses, midwives and nursing associates who are seeking to join the register.

78. Guidance on the process can be found in the AEI portal guidance – https://nmc.mottmac.com/Training-resources/portalguidance

Fitness to practise panels at programme providers

79. Since 2009 all programme providers[14] have been required to have a local fitness to practise panel to consider health or character issues, and to protect the public.

80. Local fitness to practise panels should only be used if a student's health or disability is likely to compromise or has compromised their ability to meet the required competencies and practise safely.

[14] Where we have referred to programme providers we are referring to both approved education institutions (AEIs) and their partnering practice learning providers.

Section 4 – How we approach character issues

The character declaration

81. If you are seeking to join or re-join the register you are required to tell us about any police charges, police cautions, convictions or conditional discharges unless they are protected. You don't need to tell us about youth cautions (given at age 17 or younger). Reference to 'police caution', conditional caution' or 'caution' in this guidance refers to cautions given to those aged 18 or over.

82. As with health, our legislation also requires applicants to provide a declaration as to their 'good character'.[15] By 'good character' we mean that your character is such that you are capable of safe and effective practice as a nurse, midwife or nursing associate. This includes a consideration of any:

- criminal proceedings
- findings by another regulatory body (including health and social care)
- conduct which may amount to a breach of the requirements of the Code.

83. We will ask you to complete the following character declaration in your application:

Do you declare that you are of good[16] character which enables you to practise safely and effectively?

84. We will then ask you complete the following character questions in your application.

85. You don't need to tell us about a police charge, caution, conviction or conditional discharge which the NMC has previously considered or a police charge which resulted in no further action being taken by the police. We will ask you:
Have you received a police charge, caution, conviction or conditional discharge other than a protected caution or conviction?

86. You are also required to tell us if you've had a determination made by other regulatory bodies other than the NMC (this includes any regulatory bodies in the UK or overseas). We will ask you:
Have you ever had a finding that your fitness to practise is impaired by a body responsible for regulating or licensing a profession (including health and social care), which the NMC are not aware of?

[15] Rules 5(1)(a) and 6 and Schedule 3 of the Registration Rules
[16] By 'good' character, we mean that your character is such that you are capable of safe and effective practice as a nurse, midwife or nursing associate.

87. On application for admission or readmission onto the register you will be asked if you have worked in a role which requires registration with us when you weren't on our register. We will ask you:

Have you ever worked in a role which requires registration with the NMC when you did not have effective registration?

Declaring police charges, cautions, convictions and conditional discharges

88. If you're on the register when you receive a police charge, caution, conviction or conditional discharge, you must tell us and your employer as soon as you can. This is in keeping with the Code (paragraph 23.2).

89. If you're **not** on the register when you are subject to a criminal investigation but you receive a police charge, caution, conviction or conditional discharge when you're on the register, you must tell us as soon as you can after receiving it. This is in keeping with the Code (paragraph 23.2).

90. Please email newreferrals@nmc-uk.org with your full name, Pin and details of the charge, caution, conviction or conditional discharge. Our Fitness to Practise team will get in touch to tell you what will happen next.

91. You shouldn't wait until renewal to tell us about a police charge, caution, conviction or conditional discharge. The Code requires that you tell us **'as soon as you can'**. A failure to disclose a police charge, caution, conviction or conditional discharge may call into question your fitness to practise even if the offence itself was not serious.

If your registration is lapsed and you receive a charge, caution, conviction or conditional discharge

92. If you aren't currently on the register because your registration has lapsed, you are required to tell us about any charges, cautions, convictions or conditional discharges when you apply for readmission.

If you're a student or an apprentice

93. You will be required to tell your education institution of any police charges, cautions, convictions or conditional discharges when you apply to study to be a nurse, midwife or nursing associate. Please refer to your education institution if you have any questions about what you need to declare to them.

94. If you are charged with a criminal offence or receive a caution, conviction or conditional discharge while you are studying, you must tell your education institution. The education institution will then investigate the charge, caution, conviction or conditional discharge to decide if it calls into question whether you are of good character and if you can remain on your course.

95. Your education institution will provide a supporting declaration for you when you join the register. When we assess the character of a student applying for registration who has disclosed to us a police charge, caution, conviction or conditional discharge**,** we will check whether the student has disclosed it to their education institution. A failure to disclose a police charge, caution, conviction or conditional discharge will be considered by the Registrar when assessing whether you are of good character to be capable of safe and effective practice.

96. If you remain on the course, you must declare the charge, caution, conviction or conditional discharge to us when applying to join the register. We will decide whether you are capable of safe and effective practice, taking into account the charge, caution, conviction or conditional discharge. The Registrar may make a different decision to your education institution.

Information for education providers

97. The standards for education and training set out the requirements that institutions and their practice learning partners must have in place in order to be able to provide a supporting declaration for nurses, midwives and nursing associates who are seeking to join the register.

98. Guidance on the process can be found in the AEI portal guidance – https://nmc.mottmac.com/Training-resources/portalguidance

Fitness to practise panels at programme providers

99. Since 2009 all programme providers[17] have been required to have a local fitness to practise panel to consider health or character issues, and to protect the public.

100. If during your pre-registration programme you are charged with a criminal offence or receive a caution, conviction or conditional discharge you must notify your education institution immediately.

101. If necessary a local fitness to practise panel will meet to make a decision about your suitability to remain on the programme. This would apply if your attitude or behaviour is such that it calls into question your good character.

99. Since 2009 all programme providers[17] have been required to have a local fitness to practise panel to consider health or character issues, and to protect the public.

100. If during your pre-registration programme you are charged with a criminal offence or receive a caution, conviction or conditional discharge you must notify your education institution immediately.

101. If necessary a local fitness to practise panel will meet to make a decision about your suitability to remain on the programme. This would apply if your attitude or behaviour is such that it calls into question your good character.

Which charges, cautions, convictions and conditional discharges should be disclosed?

102. You must disclose all cautions, convictions or conditional discharges to us, unless they are protected or if we have already been made aware of them.. Guidance on protected cautions, convictions and conditional discharges is set out below, but you should always check the details of your caution, conviction, or conditional discharge and guidance from the DBS[18] and/or Disclosure Scotland[19] (DS) when deciding whether you need to disclose an offence. You can also seek advice from your representative organisation.

103. Listed offences[20] are never protected (aside from those where a youth caution is given) and must always be declared to us. See the **full list from the DBS** for England, Wales and Northern Ireland. In Scotland, the checking and barring service is operated by **Disclosure Scotland (DS)**.

[17] Where we have referred to programme providers we are referring to both approved education institutions (AEIs) and their partnering practice learning providers.

[18] https://www.gov.uk/government/publications/dbs-filtering-guidance/dbs-filtering-guide

[19] mygov.scot/browse/working-jobs/finding-a-job/disclosure

[20] These are usually of a serious violent or sexual nature, or are relevant for safeguarding children and vulnerable adults.

Charges

104. You don't need to tell us about a police charge which the NMC has previously considered. You also don't need to tell us about a police charge which resulted in no further action by the police which occurred before you were on the register or during a period where your registration had lapsed. However, as set out above at paragraph [88], you do need to tell us about any charge you receive while you are on the register.

Cautions

105. Cautions in Scotland and Northern Ireland aren't protected.

106. A caution in England and Wales is protected if six years have passed since the date of the caution. A youth caution (if the person was under 18 at the time of offence) is protected from the date of the caution and does not need to be disclosed.

Convictions

107. A conviction in England, Wales or Northern Ireland is protected if:

- it's 11 years or more since the date of conviction (or five and a half years if the person was under 18 at the time of the offence)
- it is the person's only offence
- it didn't result in a custodial sentence (including a suspended sentence), a sentence of imprisonment or service detention; and
- it's not for a 'listed' offence (please see hyperlink at paragraph 103).

108. A conviction in Scotland is protected if:

- it's spent and appears in the list of offences to disclose subject to rules, and either:
    - the sentence imposed by the court was an admonition or an absolute discharge, or
    - it's 15 years since the date of the offence (or seven and a half years if the person was under 18 at the time of the offence). Please see hyperlink at paragraph 103.

109. Under Scottish law, there is an additional list of convictions which can't be protected because they are too serious.

Conditional discharges

110. A conviction which results in a discharge being given (either conditional or absolute) is protected in the same way as other convictions. Please refer to paragraph 102 above[21].

Disclosure of driving offences and penalty fares

111. You don't need to tell us about a motoring offence unless it has resulted in a disqualification.

112. You don't need to tell us if you have been disqualified from driving if you have built up 12 or more penalty points within a three-year period.

113. If you're a new driver and your licence has been revoked because you received six or more points within two years of passing your test, you don't need to declare this to us.

114. If you have been charged or convicted of a drink driving offence, you are required to tell us.

Cautions, convictions and conditional discharges (which are not protected) before 2004

115. In 2016 we introduced revalidation. This includes a requirement that we are informed of any cautions, convictions and conditional discharges that we have not already considered.

116. If you have historic cautions, convictions or conditional discharges that you haven't told us about and which aren't protected, you are expected to declare them. We will consider each on a case by case basis but if there has been no further concerns since, it is unlikely that we would refuse an application for registration in light of a caution, conviction or conditional discharge prior to 2004.

117. Not telling us about a charge, caution, conviction or conditional discharge is a clear breach of the Code. If there is evidence that you are dishonest when you apply to join our register or renew your registration, we'll have to investigate the circumstances to determine if this affects your registration.

Determinations from other regulatory bodies

118. If another regulatory body has decided that your fitness to practise is impaired you must tell us. This includes a determination by the Care Quality Commission (CQC) that you are not a fit and proper person. We will request formal confirmation of the determination from the regulatory body, and any other relevant documentation.

[21] NACRO advice document 'What do I need to disclose?'

Any other matters

119. The Registrar may consider any other matters which appear to be relevant when considering the good character of any applicant to the register.

120. This includes:

- absolute discharges
- an admonition in Scotland
- conduct that would breach the requirements of the Code, whether or not it has resulted in criminal proceedings.

Absolute discharges and admonitions

121. We will consider the underlying circumstances of the offending in order to determine if it affects your ability to practise safely and effectively.

Conduct that would breach the requirements of the Code, whether or not it has resulted in criminal proceedings

122. The Code sets the professional standards of practice and behaviour expected of a registered nurse, midwife or nursing associate. When joining our register, and then renewing your registration, you commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. You should use the Code to promote safe and effective practice and for reflection on your practice.

123. When declaring that you are of good character you should consider whether you have been involved in conduct which would breach the requirements of the Code. You can read the Code on our website: www.nmc.org.uk/standards/code

124. If you have been involved in conduct which may breach the requirements of the Code, when you were not registered with us, and a finding about this conduct has been made, you need to tell us about this. This concerns conduct both inthe UK and overseas.

125. If you are applying for registration for the first time, you will only need to declare to us any findings made against you since you received your qualification.

126. Revalidation is not an assessment of a nurse, midwife or nursing associate's fitness to practise. Employers and individuals on our register have a responsibility to refer matters to us through our fitness to practise referrals process when appropriate and not to wait until the point of revalidation. Revalidation is about registered practice and therefore we do not require you to tell us about any findings which may breach the requirements of the Code during your revalidation application.

127. If you are applying for readmission, we only need to know about any findings made against you in the time period between when you left the register and your application for registration. This is up to a period of 5 years.

128. If a finding was made against you that happened more than 5 years ago, then you don't need to tell us but you will be required to complete a return to practice course.

129. The Registrar can request any further information and consider any further matters which appear relevant when considering if you are of good character to be capable of safe and effective practice

Working without registration

130. You can't work as a nurse or midwife in the UK, or nursing associate in England, without registration with us.

131. You may commit a criminal offence if you work in a role requiring registration with us when you aren't registered.

132. If your registration has lapsed, you should stop working as a nurse, midwife or nursing associate immediately and tell your employer or trade union representative that you no longer have registration.

133. Maintaining your registration is your personal and professional responsibility. If we become aware you have been practising as a nurse, midwife or nursing associate without being registered the Registrar may refuse your application for registration. If you are on the register, we may open a fitness to practise investigation.

134. We will consider the factors outlined in paragraph 138 if you worked in a role without registration.

Factors that we take into account when considering character cases

135. Each application is considered on a case-by-case basis, taking into account all the relevant circumstances relating to the conduct and the applicant.

136. The test of whether someone is of good character to be admitted to the register is a high one.

137. The Registrar will look at your application and the factors which will be taken into account are as follows:

- Your age when the conduct took place.
- How long ago the conduct took place.
- Whether it was an isolated incident.
- Whether the incident(s) were linked to nursing or midwifery practice or employment.
- Whether the use of drugs or alcohol was a factor in the conduct.
- Reflection and insight about the conduct and obligations as a registered nurse, midwife or nursing associate.
- Personal mitigation.

- Any explanation offered for the conduct having occurred.

138. We make an assessment and may ask for further information to help the Registrar make a decision if necessary.

139. It is for you to provide sufficient evidence to satisfy the Registrar that you are capable of safe and effective practice.

Assessing the seriousness of police charges, cautions, convictions and conditional discharges

140. If the criminal offending was directly linked to your professional practice, it is more likely that it may call into question your ability to practise safely and effectively by reason of your character.

141. If the criminal offending took place in your private life, and there's no clear risk to patients or members of the public, then it is unlikely it will affect your ability to practise safely and effectively.

142. If we decide that the charge, caution, conviction or conditional discharge would be serious enough to call into question your good character, we'll seek police information to verify the details of the matter referred to us and a statement from you regarding the circumstances.

143. It is unlikely you will meet the character requirements for admission, readmission to the register or renewal of registration if you have been involved in any of the following:

- Serious sexual misconduct (including child pornography).
- Conduct involving dishonesty, fraud or deception.
- Offences that involved neglecting, exploiting, assaulting or otherwise harming patients/people, which are so serious that it may be harder for a nurse, midwife or nursing associate to remediate.
- Conduct involving hostility to others based on their race or ethnicity, religion, sexual orientation, gender identity or disability.
- Conduct involving a breach of trust and/or abuse of position.
- If you received a custodial sentence (this includes suspended sentences), or the conviction was for a **specified offence.** Please visit our website for further information.[22]

Driving offences

144. Motoring offences which result in disqualification will be considered on a case by case basis. They will only affect a registration application if they are closely linked to your practice, or suggest there may be a concern about your health. For further information on the disclosure of driving offences please see paragraph

[22] https://www.nmc.org.uk/ftp-library/understanding-fitness-to-practise/fitness-to-practise-allegations/criminal-convictions-and-cautions/directly-referring-specified-offences-to-the-fitness-to-practise-committee/

111–114.

Drug and alcohol offences

145. This includes the following types of offences:

- Offences where alcohol or drugs are part of the offence itself, for example driving with excess alcohol or possession of controlled drugs.
- Offences committed while under the influence of alcohol or drugs, for example an assault committed when under the influence of alcohol.
- Offences committed in order to obtain alcohol or drugs, for example theft of alcohol or medication.

146. Drink and alcohol offences may affect your application if:

- the offence occurred either in the course of your professional duties, driving to or from those duties, or during on-call or standby arrangements
- there are aggravating circumstances connected with the offence, or
- it is a repeat offence.

147. If you have been convicted of a drink-driving or drug offence, we will need to explore any underlying issues that may indicate a health condition or addiction.

148. If you tell us about a drug or alcohol offence, we will ask you to send us a reference from your GP or occupational health physician. The reference should confirm whether the practitioner is aware of any history of drug or alcohol use and whether, in their opinion, you are capable of safe and effective practice.

149. It is your responsibility to satisfy the Registrar that you are capable of safe and effective practice.

In what circumstances will the Registrar consider referring my case to Fitness to Practise?

150. In exceptional circumstances we may decide that the health or character concern which has been declared to us during a renewal application raises a serious public protection risk and is likely to meet the interim order threshold. This may mean your registration needs to be suspended or subject to conditions. If this happens, we'll refer you to our Fitness to Practise team. The test for interim orders is:

- necessary to protect the public,
- otherwise in the public interest, or
- in the interests of the nurse, midwife or nursing associate.

151. We will write to you and inform you of this. This is only in cases where you are already on the register and make an application to renew your registration. If information is received prior to your revalidation application then your matter will automatically be dealt with by our Fitness to Practise team.

Section 5 – Other useful publications

- **The Code** - https://www.nmc.org.uk/standards/code/
- **The standards for education and training** www.nmc.org.uk/standards-for-education-and-training/
- **The standards of proficiencies**
  Nurses – www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/
  Midwives – www.nmc.org.uk/standards/standards-for-midwives/standards-of-competence-for-registered-midwives/
  Nursing associates – www.nmc.org.uk/standards/nursing-associates/standards-for-nursing-associates/
- **How to revalidate** revalidation.nmc.org.uk/download-resources/guidance-and-information
- **Enabling professionalism** www.nmc.org.uk/globalassets/sitedocuments/other-publications/enabling-professionalism.pdf

Glossary of terms

Disability – The term ‘disability’ covers learning difficulties, physical impairments and mental impairments that have a substantial and a long-term effect on the person’s ability to carry out normal day-to-day activities. A long-term effect is one that has lasted, or is expected to last, at least 12 months or the rest of the person’s life.

A disability may be visible or non-visible, may be permanent or temporary and may have a minimal or substantial impact on a person's abilities.

Equality Act 2010 – The Equality Act came into operation on 1 October 2010. The equality duty was created by the Equality Act and replaces the race, disability and gender equality duties. The duty came into force in April 2011 and covers age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation. These are referred to as protected characteristics. The Equality Act only applies in England, Scotland and in Wales and not in Northern Ireland and the Islands.

Registration –. You must be registered with the NMC in order to practise as a nurse or midwife in the UK and nursing associate in England. We maintain a register of over 690,000 nurses, midwives and nursing associates. It’s our aim to make sure that your registration is completed as efficiently and quickly as possible.

Revalidation – This is the process that allows you to maintain your registration with the NMC, demonstrates your continued ability to practise safely and effectively, and is a continuous process that you will engage with throughout your career. Revalidation is the responsibility of nurses, midwives and nursing associates themselves.

Renewal date – The date on which your registration will be renewed if you have successfully completed your revalidation application. It is the last day of the month in which your registration expires.

Nursing & Midwifery Council

Standards of proficiency for pre-registration nursing education

Protecting the public through professional standards

Introduction

This booklet has been developed from *Requirements for pre-registration nursing programmes* which was published by the former United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in April 2001, and by incorporating some content previously published in *Statutory Instruments and Council policy*. The publication *Requirements for preregistration nursing programmes* was revised in April 2002, following the establishment of the new Nursing and Midwifery Council (NMC), and again in August 2004 to bring it in line with changes to the rules brought about by the Nursing and Midwifery Order 2001. The standards and guidance for pre-registration nursing education, which are contained in this booklet, have been developed by combining all of these resources into one comprehensive publication.

Contents

Section 1 – Standards of proficiency for pre-registration nursing education

Introduction

The Nursing and Midwifery Council (NMC) is required by the Nursing and Midwifery Order 2001[1] (the Order) to establish and maintain a register of qualified nurses and midwives [Article 5(1)], and from time to time to establish standards of proficiency to be met by applicants to different parts of the register, being the standards it considers necessary for safe and effective practice [Article 5(2)(a)].

This booklet provides the standards of proficiency and standards of education required for pre-registration nursing education programmes. These have been developed in support of the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules[2] 2004 (the Registration Rules). These rules and standards of proficiency replace all previous requirements for pre-registration nursing programmes of education issued by the NMC or previously the UKCC and the four National Boards for Nursing, Midwifery and Health Visiting for England, Northern Ireland, Scotland and Wales (National Boards). Their status is mandatory, in accordance with statutory legislation.

Establishment of the NMC

The NMC was established under the Order and came into being on 1 April 2002 as the successor to the UKCC and the four National Boards. At that time the NMC adopted the existing rules and standards of the UKCC and, where relevant, those of the National Boards. In addition to the Registration Rules, new rules for fees, midwifery and fitness to practise[3–5] have also been developed. These all came into force on 1 August 2004.

The NMC register

The NMC has determined that there shall be three parts to the register for nurses, midwives and specialist community public health nurses. Additionally that the nurses' part will be divided into two sub-parts to distinguish first and second level nurses, and that a further distinction will be applied in respect of nursing registrants to indicate – by mark of the entry – the branch in which the standards of proficiency have been met.

---

[1] *The Nursing and Midwifery Order 2001* (SI 2002/253). The Stationery Office, Norwich, www.hmso.gov.uk

[2] *Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004* (SI 2004/1767). The Stationery Office, Norwich, www.hmso.gov.uk

[3] *Nursing and Midwifery Council (Fees) Rules 2004* (SI 2004/1654). The Stationery Office, Norwich, www.hmso.gov.uk

[4] *Nursing and Midwifery Council (Midwives) Rules 2004* (SI 2004/1764). The Stationery Office, Norwich, www.hmso.gov.uk

[5] *Nursing and Midwifery Council (Fitness to Practise) Rules 2004* (SI 2004/1761). The Stationery Office, Norwich, www.hmso.gov.uk

Standards of proficiency for nursing

The standards of proficiency define the overarching principles of being able to practise as a nurse; the context in which they are achieved defines the scope of professional practice[a]. Applicants for entry to the nurses' part of the register must achieve the standards of proficiency in the practice of adult nursing, mental health nursing, learning disabilities nursing or children's nursing. They are specified on the following page.

- Manage oneself, one's practice, and that of others, in accordance with *The Code Professional standards of practice and behaviour for nurses and midwives* (NMC, 2015)[7] recognising one's own abilities and limitations.

- Practise in accordance with an ethical and legal framework which ensures the primacy of patient and client interest and well-being and respects confidentiality.

- Practise in a fair and anti-discriminatory way, acknowledging the differences in beliefs and cultural practices of individuals or groups.

- Engage in, develop and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills.

- Create and utilise opportunities to promote the health and well-being of patients, clients and groups.

- Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities.

- Formulate and document a plan of nursing care, where possible in partnership with patients, clients, their carers and family and friends, within a framework of informed consent.

- Based on the best available evidence, apply knowledge and an appropriate repertoire of skills indicative of safe nursing practice.

- Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences.

- Evaluate and document the outcomes of nursing and other interventions.

- Demonstrate sound clinical judgement across a range of differing professional and care delivery contexts.

- Contribute to public protection by creating and maintaining a safe environment of care through the use of quality assurance and risk management strategies.

---

[a] The standards of proficiency for the first level of the nursing register were initially defined as competencies in SI 2004/254[6]

[6] *Nurses, Midwives and Health Visitors (Training) Amendment Rules Approval Order 2000* (SI 2004/2554). The Stationery Office, Norwich, www.hmso.gov.uk

[7] *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC, 2015) Nursing and Midwifery Council, London, www.nmc.org.uk

- Demonstrate knowledge of effective inter-professional working practices which respect and utilise the contributions of members of the health and social care team.

- Delegate duties to others, as appropriate, ensuring that they are supervised and monitored.

- Demonstrate key skills.

- Demonstrate a commitment to the need for continuing professional development and personal supervision activities in order to enhance knowledge, skills, values and attitudes needed for safe and effective nursing practice.

- Enhance the professional development and safe practice of others through peer support, leadership, supervision and teaching.

The second level of the nurses' part of the register is open only for those nurses previously qualified in the UK who continue to practise as second level nurses, and to second level nurses from the European Economic Area (EEA) who wish to exercise their right to freedom of movement. The Council no longer approves educational programmes for entry to the second level of the nurses' part of the register.

The standards of proficiency for second level nursing are known as threshold standards; they enable second level nurses to undertake care under the direction of a first level registered nurse, but do not imply an immutable limit on the practice of second level registered nurses. The second level standards of proficiency provide opportunities for these registrants to:

- assist in carrying out comprehensive observation of the patient and help in assessing their care requirements

- develop skills to enable them to assist in the implementation of nursing care under the direction of a person registered as a first level nurse

- accept delegated nursing tasks

- assist in reviewing the effectiveness of the care provided

- work in a team with other nurses, and with medical and para-medical staff and social workers related to the care of the particular type of patient with whom they are likely to come into contact when registered at this level of the nurses' part of the register. The standards of proficiency must have been achieved within the context of the area of practice in which the student has qualified.

Rules, standards and guidance

Rules are established through legislation and they provide the legal strategic framework from which the NMC develops standards. The standards support the rules being put into practice. The standards are mandatory and gain their authority from the legislation, in this case the Order and the rules. The guidance is provided by the NMC to enable interpretation of the rules and standards, supporting their implementation.

All of the content of the standards in this booklet has either been consulted on, in accordance with article 3(14) of the Order, or has been transferred from previous rules, standards and guidance. Where appropriate, terminology has been updated to bring it in line with the requirements of the Order.

The standards reflect the requirements of the European Community (EC) Second Nursing Directive 77/453/EEC (updated by 89/595/EEC) in relation to those intending to register as adult nurses. Detailed information of such requirements is in Schedule 1 of the Registration Rules, and within Standard 6 in this booklet.

The standards of proficiency should be read in conjunction with the Registration Rules, and the relevant Schedules to these rules. The relevant part of Rule 3, education leading to registration and re-registration, is reproduced below:

3 – (1) Where an approved programme of education leads to the award of a qualification listed in the Annex to the Nursing Directive or Midwifery Directive, it shall comply with the training requirements in articles 1 and 2 of the second Nursing Directive or articles 1 and 3 of the second Midwifery Directive (the requirements of which are reproduced in paragraphs 1, 2(b), 3, 4, A and B of Schedule 1 and paragraphs 1, 2, 3, 4, A and B of Schedule 2).

(2) The requirements for entry to an approved programme of education shall include the requirements of article 1.2(a) of the second Nursing Directive or article 1.2 of the second Midwifery Directive, (the requirements of which are reproduced in paragraph 2(a) of Schedule 1 and paragraph 2 of Schedule 2).

Summary of the standards for pre-registration nursing

There are eight standards related to pre-registration nursing education. These cover admission to, and continued participation in, educational programmes; the structure and nature of programmes and standards of proficiency. The standards, and the section of this document in which they may be found, are as follows:

Standards for admission to, and continued participation in, pre-registration nursing programmes: in Section 2

Standard 1	Age of entry
Standard 2	General entry requirements for admission to approved pre-registration programmes for nursing education and entry to the register
Standard 3	Accreditation of prior (experiential) learning (AP(E)L)
Standard 4	Admission with advanced standing
Standard 5	Transfer with AP(E)L

Standards for the structure and nature of pre-registration nursing programmes: in Section	
Standard 6	Structure and nature of educational programmes

Standards of education to achieve the NMC standards of proficiency: in Section 4	
Standard 7	First level nurses – nursing standards of education to achieve NMC standards of proficiency
Standard 8	Second level nurses – nursing standards of proficiency

Section 2 – Standards for admission to, and continued participation in, pre-registration nursing programmes

Introduction

This section provides the standards and guidance related to admission to, and continued participation in, NMC approved pre-registration nursing programmes, in accordance with Article 15(1)(b) of the Order, which requires the NMC from time to time to establish:

> 'the requirements to be satisfied for admission to, and continued participation in, such education and training which may include requirements as to good health and good character;'

Standard 1 – Age of entry

UK and overseas applicants, including from the EEA, must meet the Council's requirements for age of entry. This is in keeping with the requirements of the EEA.

Standards	Guidance
Those entering a programme of pre-registration nursing education at an approved educational institution shall be not less than 17 years and six months of age on the first day of the commencement of the programme. In exceptional circumstances, and related to specific programmes, the Council may agree to an earlier age of entry, but this may not be less than 17 years of age.	The current age of entry has been agreed to comply with the completion of secondary education, which is set at 17 years and six months in England, Wales and Northern Ireland and 17 years in Scotland. The minimum age is in keeping with the European Directive 77/453/EEC, applicable to those following the adult branch, that states that applicants must have completed secondary school education, and be able to show that they have acquired the relevant qualifications before entering a nursing education programme (see Standard 6). The NMC is required to comply with the EC Directives as they change from time to time.

Standard 2 – General entry requirements for admission to approved pre-registration programmes for nursing education and entry to the register

UK and overseas applicants, including from the EEA, must meet the Council's general entry requirements for literacy, numeracy, good health and good character as shall from time to time be determined. Approved educational institutions shall set the educational requirements for entry and these should be comparable to entry to other diploma of higher education programmes or meet an institution's requirements for non-standard entrants. Approved educational institutions and their service partners must have systems in place that can be quality assured by the NMC, to satisfy the NMC that applicants meet the following requirements:

Standards	Guidance
Literacy and numeracy Approved educational institutions are required to ensure that applicants for pre-registration education have provided evidence of literacy and numeracy sufficient to undertake nursing education and practice at a minimum of diploma of higher education level. The NMC requires access to information about, and evidence of application of, the systems and policies developed to assess literacy and numeracy of applicants to nursing pre-registration education programmes for quality assurance purposes. Applicants to pre-registration programmes who hold an existing NMC registration may be deemed to have met the Council's requirements at their initial registration.	**Literacy and numeracy** Evidence of literacy and numeracy may be deduced from academic or vocational qualifications, through evidence to meet key skills abilities, or through the approved educational institutions' own processes, which may include portfolios or tests for those without formal qualifications.[b] Where the International English Language Testing System (IELTS) is offered as evidence[c], programme providers should apply the NMC requirements for overseas applicants to the register. For these applicants, the NMC accepts the IELTS examination (academic or general version) with an overall score of 6.5 and not less than 5.5 in any one section. The NMC requirements are to ensure, in the interests of public protection, that entrants to pre-registration programmes have a foundation of literacy and numeracy skills from which to develop, for example, proficiency in communication[d] and drug calculation skills relevant to professional requirements. Approved educational institutions are entitled to set their own specific educational entry requirements.

[b] These examples are for guidance only, approved educational institutions have the right to set their own standards but must satisfy the NMC that there is sufficient evidence to meet its requirements
[c] This would only apply to overseas applicants outside of the EEA
[d] Those wishing to practise in Wales must be able to demonstrate proficiency in the use of Welsh language where this is required

Good health and good character	Good health and good character
Applicants must demonstrate that they have good health[e] and good character, sufficient for safe and effective practice as a nurse, on entry to, and for continued participation in, programmes leading to registration with the NMC.	The NMC requires programme providers[f] to ensure that processes are in place for assessment of an applicant's/student's good health and good character at admission to, during, and on completion of pre-registration nursing programmes.
Applicants must declare any conviction or caution related to criminal offences that they might hold.	Such processes may involve a combination of self-assessment health questionnaires, self-declaration of good character, routine health screening, occupational health assessment, character references, Criminal Record Bureau checks and other measures agreed between the programme providers.
Approved educational institutions shall obtain evidence of the applicant's good health and good character as part of their selection, admission and ongoing monitoring processes.	Students who declare on application that they have a disability should submit a formal assessment of their condition and specific needs, from a GP or other medical or recognised authority, to the relevant Occupational Health department. The programme providers should apply local policy in accordance with the Disability Discrimination Act 1995[g8], for the selection and recruitment of students/ employees with disabilities. Where appropriate, the institution's student support services should also be involved. The NMC would require evidence of how such students would be supported in both academic and practice environments to ensure safe and effective practice sufficient for future registration.

[e] Overseas applicants must meet the good health and good character requirements as defined for UK applicants and additionally those requirements set by the UK government for health care workers from overseas

[f] The approved educational institutions and their service partners

[g] Amended by the Special Educational Needs and Disability Act 2001[9] with effect from October 2004

[8] *Disability Discrimination Act 1995*. The Stationery Office, Norwich, www.hmso.gov.uk

[9] *Special Educational Needs and Disability Act 2001*. The Stationery Office, Norwich, www.hmso.gov.uk

Entry to the register The NMC requires a self-declaration of good health and good character [Rule 5(1)(a)] from all of those entering the register for the first time. On successful completion of an NMC approved programme of education, students will submit this self-declaration. Rule 6(1)(a)(i) requires that this declaration be supported by the registered nurse, whose name has been notified to the Council, who is responsible for directing the educational programme at the approved educational institution, or her designated registered nurse substitute.	**Entry to the register** The registered nurse, confirming the student's declaration of good health and good character on completion of the programme must have knowledge of the student. She is accountable for her decision to sign the declaration. Approved educational institutions should put systems in place demonstrating the audit trail of evidence to support the signed declaration. Throughout the programme, the NMC would expect that students develop their practice in accordance with the Code and that they will work toward achieving the Council's requirements for accountability.

Standard 3 – Accreditation of prior (experiential) learning (AP(E)L)

The Council will permit accreditation of prior learning against any part of the programme where the applicant is able to demonstrate relevant prior learning to the satisfaction of the approved educational institution and in accordance with the Council's requirements and guidance on AP(E)L.

Standards	Guidance
Length of programmes A student may undertake a shorter programme of education where credit is given by an approved educational institution for previous academic or experiential learning. The Council has determined that this may, normally, be to a maximum of one-third of the normal length of the programme. Accreditation of prior (experiential) learning (AP(E)L) may be awarded provided that, through a combination of study and AP(E)L, the student meets all of the requirements and standards of proficiency that Council may from time to time determine.	**AP(E)L processes** The NMC recognises that approved educational institutions will have processes in place that comply with their internal policies and the QAA Code of Practice. The NMC requires that such processes, where necessary, be developed, to include a mapping process of how prior learning meets NMC outcomes and standards of proficiency. Such processes will be approved by the NMC as part of programme approval, and monitored through NMC quality assurance processes in relation to programmes leading to registration with the NMC. Such an award of credit must be supported by verifiable evidence, mapped against the outcomes and standards of proficiency of the pre-registration nursing programme. The Council requires robust quality assurance processes to monitor the implementation of this standard, both internally at the approved educational institution, adhering to the QAA Code of Practice and associated guidance, and externally by the NMC.

Standard 4 – Admission with advanced standing[h]

Where AP(E)L processes have been applied, or where applicants are entitled to a shortened programme by virtue of previous registration with the NMC, applicants may enter programmes with 'advanced standing' and undertake a shortened programme of preparation for registration as identified in the circumstances below.

Standards	Guidance
Application of AP(E)L to shorten programmes: (a) direct entry applicants with qualifications and/or experience in a relevant field of health or social study, or from a degree with relevant content and experience, that can be mapped against the outcomes and standards of proficiency defined by the Council, may be awarded AP(E)L by the approved educational institution, and undertake a programme which is a minimum length of two years (or 3,066 hours). (b) there is no required minimum length of a programme for those holding UK registration with the NMC as a nurse (level 1 or level 2) – the length of the programme should be determined following an assessment for AP(E)L. (c) the minimum length of a programme for those holding UK registration as a midwife is two years (or 3,066 hours). (d) the minimum length of a programme for those undertaking a dual nursing registration programme, where common content may contribute to either award, is four years (or 6,133 hours).	**Prior learning and experience** Appropriate prior learning may include National Vocational Qualifications at level 3, Cadet Nurse Schemes or Health Care Assistant programmes and experience where learning has been assessed, e.g. apprenticeship schemes, and relevant degrees which the approved educational institution can justify maps against the NMC outcomes and standards of proficiency. **Quality assurance** The NMC will seek evidence of effective AP(E)L systems as part of its quality monitoring process. Where AP(E)L processes are applied, then evidence must be available to demonstrate how the common foundation programme outcomes and branch standards of proficiency are met. **Length of programmes** The minimum lengths of programmes, where indicated in the standards, are carried forward from previous Statutory Instruments. Applicants with prior nursing experience may be awarded credit across the whole programme within the constraints identified in the standards.

[h] Advanced standing is where a student enters a programme, normally beyond the initial start point, as a result of the award of AP(E)L or prior registration, thus being able to undertake a shortened programme.

Standard 5 – Transfer with AP(E)L

Students may transfer their programme with credit for prior learning in the circumstances detailed below.

Standards	Guidance
	Decisions on transfer of programme
(a) the transfer is both from, and to, an NMC approved educational institution, and from and to an NMC approved pre-registration programme.	Approved educational institutions have full responsibility for deciding whether to accept an application for transfer based on their capacity to accommodate such a request.
	Good health and good character
(b) the NMC requirements for good health and good character for continued participation in an approved pre-registration nursing programme are met.	Where such an application is accepted for processing, the student applying for transfer should be assessed to ensure compliance with the good health and good character requirements of the new programme.
	Accreditation of prior learning
(c) their prior learning has been mapped against the programme to be completed to confirm that all the NMC requirements and the standards of proficiency for registration will be met.	Assessment of prior learning should be made to ensure that, through transfer to a new institution, the student will continue to meet all of the NMC required outcomes and standards of proficiency. The approved institution will then agree a programme of study that will meet both NMC requirements and their own programme outcomes.

Section 3 – Standards for the structure and nature of pre-registration nursing programmes

Introduction

This section provides the standards for education for pre-registration nursing programmes, in accordance with Article 15(1)(a) of the Order which requires the NMC to from time to time establish:

> ‘the standards of education and training necessary to achieve the standards of proficiency it has established under article 5(2);’

The standards are underpinned by guiding principles that establish the philosophy and values of the NMC’s requirements for programmes leading to entry to the register as a registered nurse. These principles provide the foundation for the outcomes/standards of proficiency for entry to the branch programmes and to the register and should be reflected in the pre-registration nursing programmes. The guiding principles relate to professional standards of proficiency and fitness for practice. As practice takes place in the real world of health care delivery it is inextricably linked to other aspects of fitness, that is – fitness for purpose, professional academic awards and professional standing.

Guiding principles

Preparation: fitness for practice

The primacy of practice underpins the requirements for standards of proficiency and must be reflected in all programmes of preparation for entry to the register.

Practice-centred learning

The primary aim in pre-registration nursing programmes is to ensure that students are prepared to practise safely and effectively to such an extent that the protection of the public is assured. On this basis, it is a fundamental principle that programmes of preparation are practice-centred and directed towards the achievement of professional proficiency.

Theory and practice integration

Safe and effective practice requires a sound underpinning of the theoretical knowledge, which informs practice, and is in turn informed by that practice. Such knowledge must therefore be directly related to, and integrated with, practice in all programmes leading to registration as a nurse. The standards of proficiency must therefore reflect a breadth of practice and of learning.

Evidence-based practice and learning

Within the complex and rapidly changing health care environment, it is essential that the best available evidence informs practice. This commitment is reflected in the standards of proficiency. It includes searching the evidence base, analysing, critiquing and using research and other forms of evidence in practice, disseminating research findings and adapting practice where necessary. This must be reflected throughout all programmes of preparation.

Service: fitness for purpose

Nursing must relate to the changing needs of the health services and the communities that they serve, responding to current and future need.

Provision of care

Orientation must be towards practice that is responsive to the needs of various client groups across different care settings. This will be reflected in the capacity to assess needs, diagnose and plan, implement and evaluate care in such circumstances. Care practice must not only reflect collaborative working with other members of the care team but must also empower patients and clients, and their carers, actively to participate in the planning, delivery and evaluation of care. These principles must be reflected in all programmes of preparation leading to entry to the register.

Management of care

The nursing role involves a capacity not only to participate actively in care provision but also to accept responsibility for the effective and efficient management of that care, practised within a safe environment. This involves the capacity to accept accountability, to take responsibility for the delegation of aspects of care to others, and effectively to supervise and facilitate the work of such carers. It also involves the capacity to work effectively within the nursing and wider multidisciplinary team, to accept leadership roles within such teams, and to demonstrate overall competence in care and case management.

A health for all orientation

In keeping with the orientation towards holistic care, the emphasis must be one that avoids a narrow disease-orientated perspective and instead encompasses a health promotion and health education perspective. This extends beyond a disease orientation to a commitment to health for all irrespective of class, creed, age, gender, sexual orientation, culture or ethnic background. Principles of equity and fairness are fundamental professional values that must be reflected in the standards of proficiency and addressed directly in all programmes of preparation.

Lifelong learning

The rapidly changing nature of health care reflects a need for career-wide continuing professional development and the capacity not only to adapt to change but to identify the need for change and to initiate change. The provision of safe and effective health care and appropriate responsiveness to the changing needs of services and patients or clients cannot be achieved by adhering to rigid professional boundaries. The standards of proficiency must, therefore, include the capacity to extend the scope of practice and to address lifelong learning skills within all programmes of preparation.

Quality and excellence

The practice-centred standards essential in nursing are not separate and insular professional aspirations. They are directly linked to the wider goals of achieving clinical effectiveness within health care teams and agencies, with the ultimate aim of achieving high quality health care. In this respect, assuring the quality of nursing care is one of the fundamental underpinnings of clinical governance. It is therefore necessary that nursing standards of proficiency encompass the capacity to contribute to this wider health care agenda and quality must be addressed within all programmes of preparation.

Recognition: fitness for award

Education for practice must be established at the level and pace of learning commensurate with the demands of complex and professional practice. Education for practice must be designed to meet the needs of the health services and communities and be structured to meet the specific needs of the profession.

Level of learning

The level of learning must be such as to facilitate the achievement of knowledge, understanding and skill acquisition, and the development of critical thinking, problem-solving and reflective capacities essential to complex professional practice. The NMC has set the level of learning essential for underpinning the achievement of the identified proficiencies to be at a minimum of diploma of higher education standard.

Nature of learning

Given the primacy of practice as the required focus of programmes of preparation, learning must involve the integration of relevant and sound theoretical knowledge with knowledge and experience derived from practice. The NMC values such learning as being the essence of professional education. Therefore, the NMC expects that the philosophy explicit in programmes of preparation reflects the value of practice-centred education.

Access and credit

All programmes of preparation should value prior learning and, by so doing, provide wide access to programmes and advanced standing through appropriate accreditation of relevant prior learning and experience for a maximum of one-third of the programme. Those already holding a registration as a nurse with the NMC may be entitled to a greater amount of credit according to the relevance of their prior learning and experience when mapped against the programme they undertake as a second registration.

Flexibility, integrity and progression

Programmes of preparation should provide flexibility without compromising overall integrity and progression. This is achieved through modular design and the structuring of the programme into a common foundation and branch element. The three conditions (flexibility, integrity and progression) serve to ensure that modularisation does not compromise cumulative learning, leading to progression to the branch at the end of year one and entry to the register at the end of year three. This allows for maximum flexibility and provides opportunities for stepping on or off the programme.

Educational quality

Programmes of preparation must be established upon sound academic and professional quality assurance processes that address professional learning and, in particular, the standard of proficiency to be achieved. In this respect, the NMC recognises that professional nurse education must be academically rigorous. Educational quality will be achieved through partnership and collaboration involving all stakeholders, including service users, education purchasers, service providers, educational institutions, higher education quality assurance agencies and the statutory regulatory system.

Responsibility: fitness for professional standing

The NMC values the rights implicit in the social contract between the profession and society to participate in the health care of individuals, families and communities. Such rights also carry obligations. These include not only the responsibility to provide competent, safe and effective care but, also responsibility for the highest standards of professional conduct and ethical practice.

Adherence to The Code: Professional standards of practice and behaviour for nurses and midwives (NMC, 2015).

An essential condition of entry to the profession is the acceptance and internalisation of the Code that all registered nurses and midwives must uphold. This Code provides the foundation for the standards of proficiency and must be reflected at all stages of programmes of preparation.

Responsibility and accountability

As members of a profession, registered nurses must take personal responsibility for their actions and omissions, and fully recognise their personal accountability. Each individual practitioner must be able to make sound decisions in respect of: their personal professional development; practising within the scope of their personal professional competence and extending this scope as appropriate; delegating aspects of care to others and accepting responsibility and accountability for such delegation; and working harmoniously and effectively with colleagues, patients and clients and their carers, families and friends.

Ethical and legal obligations

The Code requires all practitioners to conduct themselves and practise within an ethical framework based fundamentally upon respect for the well-being of patients and clients. While various rule orientated and principle-based ethical models may assist in informing ethical decisions, within modern health care settings ethical dilemmas are by definition complex. Practitioners must recognise their moral obligations and the need to accept personal responsibility for their own ethical choices within specific situations based on their own professional judgement. In making such choices, practitioners must be aware of, and adhere to, legal as well as professional requirements.

Respect for individuals and communities

All members of the profession must demonstrate an inviolable respect for persons and communities, without prejudice, and irrespective of orientation and personal, group, political, cultural, ethnic or religious characteristics. Care must be provided without prejudice and in an anti-discriminatory fashion. No member of the profession should convey any allegiance to any individual or group affiliations which oppose or threaten the human rights, safety or dignity of individuals or communities, irrespective of whether such individuals or groups are recipients of care.

Standard 6 – Structure and nature of educational programmes

Standards	Guidance
Length of programmes In accordance with EU agreements, programmes shall be no less than three years or 4,600 hours in length. Where delivered as a full time programme, they shall be completed in not more than five years, including interruptions, and where delivered part time, in not more than seven years, including interruptions.	The NMC will not accept less than three years and 4,600 hours in order to ensure that sufficient time is spent in practice to achieve the standards of proficiency for safe and effective practice. Opportunities should be provided to enable students to step on and off programmes. Such decisions should be made using appropriate AP(E)L processes (see Standard 3).
Structure of programmes Programmes shall comprise a Common Foundation Programme (CFP) of twelve months and a branch programme of two years in adult nursing, mental health nursing, learning disabilities nursing or children's nursing. Where the programme is delivered part time, each part of it shall be increased pro-rata up to the overall maximum length specified under length of programmes.	Where AP(E)L has been awarded, students will normally spend most of their time in the branch programme, only accessing the CFP where it is necessary to achieve any unmet outcomes of this part of the programme.
Balance of theory and practice The balance of learning shall be 50% practice[i] and 50% theory in both CFP and branch programmes. A period of clinical practice of at least three months, towards the end of the pre-registration programme, is required to enable students to consolidate their education and their competence in practice[j].	The practice part of the programme should provide the opportunities to experience 24-hour/7-day care to enable students to develop understanding of users' experiences of health care. The length of placements should be sufficient to enable students to achieve the standards of proficiency required, whilst also gaining a broad perspective of care environments.

[i] This is consistent with the requirements of EC Directive 77/453/EEC and 89/595/EEC that require 50% practice in direct patient care and at least one-third theoretical instruction

[j] Programmes preparing students to be registered as adult nurses must meet the requirements of European Directive 77/453/EEC as updated by 89/595/EEC

Teaching and learning strategies A variety of approaches should be used which may include simulation, but ensuring that the practice part of the programme involves direct patient care, as required by legislation for those following the adult branch.	 The final placement will benefit from as few interruptions as possible in order to ensure continuity. The placement might include study days, be interspersed with study blocks and/or be divided into a number of different placements, although none of these should be less than four weeks duration.
Academic standard of programmes As a minimum, pre-registration nursing programmes must culminate in the award of a diploma of higher education.	 It is a matter for programme providers (approved educational institutions and their service partners) to determine higher academic qualifications where appropriate.
Content The content of the curriculum shall be sufficient in depth and breadth to enable students to achieve the outcomes for entry to a branch programme; and subsequent achievement of the standards of proficiency sufficient for safe and effective practice for entry to the nurses' part of the register. The outcomes and standards for proficiency are set out in Section 3 of this document and should be read in conjunction with the guiding principles in this section.	**Content** The curriculum should provide opportunities to gain contemporary knowledge and skills within the changing context of health care delivery. It needs to prepare students for future practice roles and responsibilities, providing foundation knowledge and skills that will enable further development through lifelong learning, such as foundation knowledge for nurse prescribing and child protection.
	Programme design Programmes should reflect the requirements of the NMC, commissioners, service providers and academic award.
	Programme leadership The NMC would expect the programme leader to be registered with the NMC in an appropriate area of practice, to have a teaching qualification recorded with the NMC and relevant academic qualifications commensurate with the level of the programme.

Student support The NMC requires lecturers, practice educators and mentors to have been prepared to meet the outcomes defined in its *Standards to support learning and assessment in practice* (NMC, 2008)[10].	**Student support** Students should be supported in both academic and practice learning environments. Audits of practice learning environments should identify the number and nature of students that may be effectively supported.
Nature of programmes The CFP should provide the foundation for entry to any branch programme. Students should have experience of each designated area of practice (branch) during the CFP. The branch programme should further develop the theory and practice of nursing commenced during the CFP and, while specific to the area of practice (branch) in which registration is sought, provide opportunities for shared learning between the branches.	**Programme learning experiences** The programme should provide varied experiences commensurate with the range, level and context of the programme. In particular students should be able to access interprofessional learning and working. An introduction to the experiences of all four branches should be provided in the CFP to inform branch choice.
Branch programmes – area of practice Each branch programme should be directed towards a specific area of nursing practice; adults, people with mental health problems, people with learning disabilities, or children, and provide learning opportunities to enable students to become proficient in the practice of nursing in that area.	Learning for the specific area of practice chosen by the student should commence in the CFP and be developed in the branch programme, enabling achievement of the standards of proficiency within the context of the area of practice.

[10] *Standards to support learning and assessment in practice (NMC, 2008)*. Nursing and Midwifery Council, London, www.nmc.org.uk

Knowledge underpinning practice	Curriculum content
To provide a knowledge base for practice, contemporary theoretical perspectives should be explored with regard to: • professional, ethical and legal issues • the theory and practice of nursing • the context in which health and social care is delivered • organisational structures and processes • communication • social and life sciences relevant to nursing practice • frameworks for social care provision and care systems.	The curriculum should reflect contemporary knowledge and enable development of evidence-based practice. Strategies for integrating knowledge and skills gained in both academic and practice environments should be evident.
Assessment	
A range of assessment strategies should be used throughout the programme to test knowledge and standards of proficiency in all aspects of the nursing curriculum. These must include at least one unseen examination.	The principle of an unseen examination is for the students to demonstrate their own learning under invigilated conditions. It may be defined as an unseen piece of work that appropriately tests the students' theoretical knowledge, practical skills and attitudes, demonstrating their abilities to achieve the standards of proficiency for nursing. The form may vary, for example, for students with specific needs, e.g. those with dyslexia; or to meet subject needs, e.g. the use of Objective Structured Clinical Examinations.

Student status Students undertaking programmes of preparation for nursing will be directed throughout by the approved educational institution and shall have supernumerary status in practice settings to enable them to achieve the required standards of proficiency. Supernumerary status means that the student shall not as part of their programme of preparation be employed by any person or body under a contract of service to provide nursing care.	**Personal Tutors and Mentors** Students should have named registrants (from the same part of the register) to support their learning in both academic and practice environments. These persons would be involved in assessing their standards of proficiency to enter the register. Other members of the teaching and health care team may contribute to learning and assessment in both environments but would not undertake summative assessment of standards of proficiency for entry to the register. **Supernumerary status** Experiences should be educationally led and the supernumerary status of students maintained. Registrants acting as mentors are responsible for ensuring that public protection is paramount and are accountable for their decisions to delegate work to students.

European Directives

Programmes for registration as an adult nurse

The requirements of the European Directives 77/453/EEC and 89/595/EEC apply to all nurses undertaking programmes for adult nursing. These requirements have mandatory status. This includes those undertaking their first pre-registration nursing programme, overseas nurses undergoing retraining in the UK (those registered in their home country but who do not meet NMC requirements for UK registration) and those accessing a shortened programme due to previous registration as a nurse practising in a different branch or as a midwife (see Standard 4)

Content of programmes

Article 1 of 77/453/EEC requires that awards (certificates and diplomas) be made to general nurses subject to their passing an examination, which guarantees that during education the person has acquired:

a) adequate knowledge of the sciences on which general nursing is based, including sufficient understanding of the structure, physiological functions and behaviour of healthy and sick persons, and of the relationship between the state of health and physical and social environment of the human being

b) sufficient knowledge of the nature and ethics of the profession and of general principles of health and nursing

c) adequate clinical experience; such experience which should be selected for its training value, should be gained under the supervision of qualified nursing staff and in places where the number of qualified staff and equipment are appropriate for the nursing care of the patients

d) the ability to participate in the practical training of health personnel and experience of working with such personnel

e) experience of working with members of other professions in the health sector.

Practice experiences

The directive specifies that nursing programmes comprise a programme of three years or 4,600 hours, with a balance of theoretical and practical instruction. The latter must include nursing in relation to:

- general and specialist medicine
- general and specialist surgery
- child care and paediatrics
- maternity care
- mental health and psychiatry
- care of the old and geriatrics
- home nursing.

Balance of theory and practice

Directive 89/595/EEC qualifies the balance of theoretical and clinical instruction as not less than one-third theory and one-half practice[k], and amends the definitions of theoretical and clinical instruction as follows:

(a) 'theoretical instruction' shall be defined as:
that part of nursing training whereby student nurses acquire the knowledge, understanding and professional skills needed to plan, provide and assess total nursing care. This teaching is provided in nursing schools and other teaching environments chosen by the training institution, and given by a staff of nursing teachers and other competent persons.

(b) 'clinical instruction' shall be defined as:
that part of nursing training whereby student nurses as part of a team and in direct contact with a healthy or sick individual and/or a community learn to plan, provide and assess the required total nursing care on the basis of their acquired knowledge and skills. The student nurse learns not only to be a member of the team, but to be a team leader organizing total nursing care, including health education for individuals and small groups in the health institutions or the community.

Nature of experience

The Directive clarifies that clinical instruction takes place in hospitals and other health institutions and in the community, under the responsibility of teachers who are nurses and with the co-operation and assistance of other qualified nurses and other personnel.

[k] The NMC would expect that a programme would contain 2,300 hours of practice

Section 4 – Standards of education to achieve the NMC standards of proficiency

Introduction

This section presents the NMC standards of education to achieve the NMC standards of proficiency for nursing. These are provided for both first and second level nurses. The NMC sets the standards for pre-registration nursing programmes for the UK and, in assessing overseas nurses from outside of the European Economic Area, ensures that they have attained a comparable standard for entry to the NMC register as a nurse. There is no recognition of second level qualifications that have been gained outside of the EEA.

The standards of proficiency define the overarching principles of being able to practise as a nurse; the context in which they are achieved defines the scope of professional practice. Those undertaking education in the UK have the choice of four branch programmes, adult nursing, mental health nursing, learning disabilities nursing and children's nursing. They must achieve the NMC standards of proficiency in the context of practice in their chosen branch. The adult nursing branch must meet the requirements agreed by Member States of the European Community. Overseas nurses normally follow a programme of general nursing that is assessed on application to the NMC for its comparability to the adult nursing branch. Overseas nurses who have qualified and practised in mental health nursing, learning disabilities nursing or children's nursing are required to provide comparable evidence of achievement of proficiency in their area of practice when applying to the NMC for UK registration.

The NMC no longer approves programmes for entry to the second level of the nurses' part of the register. This level remains open only for those nurses in the UK who are already qualified and working at that level, and also for European nurses who may access it through their right to freedom of movement. The second level standards of proficiency are presented to inform employers and registrants of the standard that will have been achieved for entry to the register. The NMC expects that, through continuing professional development, second level nurses will advance their knowledge, skills and proficiency beyond that of initial registration.

All nurses on the second level of the nurses' register, who wish to do so, are able to enter a pre-registration nursing programme to enable them to become a first level nurse. They may seek appropriate accreditation of prior learning, in accordance with nursing Standards 3 and 4, to enable them to undertake a shortened programme of preparation.

First level nurses – nursing standards of education to achieve NMC standards of proficiency

Article 5(2)(a) of the Order requires the NMC to:

> 'establish the standards of proficiency necessary to be admitted to the different parts of the register being the standards it considers necessary for safe and effective practice under that part of the register;'

There are three parts of the register: nurses, midwives, and specialist community public health nurses. The nurses' part of the register has two sub-parts for level 1 and level 2 nurses. The nurses' part has marks to identify the branch of nursing practice in which the nurse has achieved the standards of proficiency. The NMC has previously used the term competency to describe "... the skills and ability to practise safely and effectively without the need for direct supervision ..." (Fitness for practice[12], 1999). These competencies have, after consultation, been adopted as standards of proficiency by the NMC.

Article 15(1)(a) of the Order requires the Council from time to time to establish:

> 'Standards of education and training necessary to achieve the standards of proficiency it has established under article 5(2)' (to be admitted to the register).

The standards of education enable the NMC standards of proficiency to be achieved for entry to the nurses' part of the register. They must be achieved within the context of practice in the branch programme followed by the student. This provides comparability of proficiency at the point of entry to the register, whilst ensuring that the specific knowledge, skills and proficiencies pertaining to each field of nursing are achieved for safe and effective practice.

The pre-registration nursing programme should be designed to prepare the student to be able, on registration, to apply knowledge, understanding and skills when performing to the standards required in employment and to provide the nursing care that patients and clients require, safely and effectively, and so assume the responsibilities and accountabilities necessary for public protection.

The development of nursing programmes arises from the premise that nursing is a practice-based profession, recognising the primacy of patient and client well-being and respect for individuals, and is founded on the principles that:

- evidence should inform practice through the integration of relevant knowledge
- students are actively involved in nursing care delivery under supervision
- *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC, 2015).
- skills and knowledge are transferable

[11] *Fitness for practice: The UKCC Commission for Nursing and Midwifery Education 1999*. Nursing and Midwifery Council, London, www.nmc.org.uk

- research underpins practice
- the importance of lifelong learning and continuing professional development is recognised.

The outcomes and standards of education expressed will be achieved under the direction of a registered nurse. This support will enable the standards of proficiency to enter the register as a nurse to be achieved within the practice of the branch programme studied.

The context of practice

Practice may be within one of four areas of nursing – adult, mental health, learning disabilities or children's. The NMC recognised that there was comparability between the standards of proficiency achieved by all nursing students and that it was the application of these standards to practise within different contexts of nursing that defined the scope of professional practice. The particular focus of each branch may be described as follows:

Adult nursing

This area requires the care of adults, from 18 year olds to elder people, in a variety of settings for patients with wide ranging levels of dependency. The ethos of adult nursing is patient centred and acknowledges the differing needs, values and beliefs of people from ethnically diverse communities. Nurses engage in and develop therapeutic relationships that involve patients and their carers in on-going decision-making that informs nursing care. Adult nurses have skills to meet the physical, psychological, spiritual and social needs of patients, supporting them through care pathways and working with other health and social care professionals to maximise opportunities for recovery, rehabilitation, adaptation to ongoing disease and disability, health education and health promotion. New ways of working provide enhanced opportunities for adult nurses to provide safe and effective care that meets the defined needs of this group in partnership with them. Their ability to be self-directed throughout their professional careers to support lifelong learning, in turn, contributes to continuous quality improvement in care delivery.

Mental health nursing

Mental health nurses care for people experiencing mental distress, which may have a variety of causative factors. The focus of mental health nursing is the establishment of a relationship with service users and carers to help bring about an understanding of how they might cope with their experience, thus maximising their potential for recovery. Mental health nurses use a well developed and evidence-based repertoire of interpersonal, psychosocial and other skills that are underpinned by an empathetic attitude towards the service user and the contexts within which their distress has arisen. Mental health difficulties can occur at any age and service users may be cared for in a variety of settings, including the community and their own homes. They may require care for an acute episode or ongoing support for an enduring illness. Mental health nurses work as part of multidisciplinary and multi-agency teams that seek to involve service users and their carers in all aspects of their care and treatment.

Learning disabilities nursing

The focus of learning disabilities nursing is influencing behaviours and lifestyles to enable a vulnerable client group to achieve optimum health, and to live in an inclusive society as equal citizens, and where their rights are respected. Learning disabilities nurses have the knowledge, skills, attitudes and abilities to work in partnership with people of all ages who have learning disabilities, their families and carers, to help individuals to develop individually and fulfil their potential in all aspects of their lives irrespective of their disabilities. In particular, they use expert communication skills to engage with vulnerable people and to interpret and understand behaviour to develop individual care packages. They work in a variety of residential, day and outreach service settings, adapting the level of support they provide according to the complex needs of individuals, families, carers and the settings they are in. Risk assessment and risk management are key components of their work and enable individuals to exercise their individual rights and choices. Learning disabilities nurses have a critical role in supporting the agenda for equality and equal access to all community and public services.

Children's nursing

The philosophy of children's nursing is based upon the principle of family centred care and the belief that children should be cared for by people they know and, wherever possible, within their home environment. Children's nurses understand the complex relationships between personal, socio-economic and cultural influences upon child health and child rearing practices. They develop nursing and technological competence through the application of professional knowledge, skills, values and attitudes in order to empower children and families in health decisions, promoting and providing safe, effective and informed care. Children's nurses work in a variety of settings, across and beyond traditional boundaries, and within a multi-disciplinary and multi-agency team. In particular they contribute to child protection, in collaboration with other key professionals, respecting and promoting the rights of the child.

Achieving the NMC standards of proficiency within the context of practice

The standards of proficiency provide high level outcomes that are developed as standards of education in programmes that are 50% theory and 50% practice. The NMC, through its quality assurance processes, approves the detailed programmes that demonstrate how the standards of education enable the NMC standards of proficiency to be achieved within the context of practice in each of the four branches of nursing. NMC quality assurance annual monitoring processes confirm that the standards of proficiency are being met in practice, and that the standards of education, as developed into a detailed NMC approved programme, enable acquisition of the particular knowledge, skills, values and attitudes pertaining to the area of practice. On completion of the programme, registrants, who have ensured that students have been supported and assessed in both academic and practice settings, confirm that students have met the required standards of proficiency within the practice of the particular area of nursing – adult, mental health, learning disabilities or children's.

Standards of education

The standards of education are those that have been approved to meet the previous ‘competencies’ for UK pre-registration nursing education. All nursing students study together for the first part of their programme, known as the Common Foundation Programme (CFP), and the standards of education include outcomes of the CFP required for entry to the second part of the programme which is called the branch programme. The standards of proficiency are reproduced in the section of outcomes of the branch programme, achievement of which allows entry to the register, in order to define the relationship between them and the standards of education necessary to achieve proficiency. The outcomes of the CFP are aligned to the requirements for entry to the register to demonstrate how proficiency is developed in particular domains of practice throughout the whole programme of education.

Format of Standard 7

The overarching standard of proficiency is presented above the standards of education, with related domains being identified. The domains may apply to one or more standards of proficiency. The outcomes to be achieved for entry to the branch programme include defined standards of education, in italics, with associated outcomes. These allow progress towards achieving the standards of proficiency that are the ultimate outcome of the whole programme. Outcomes that demonstrate achievement of these standards of proficiency are those identified for entry to the register.

Standard 7 – First level nurses – nursing standards of education to achieve the NMC standards of proficiency

Standard of proficiency for entry to the register: professional and ethical practice

Manage oneself, one's practice, and that of others, in accordance with *The Code:* Professional standards of practice and behaviour for nurses and midwives (NMC, 2015), recognising one's own abilities and limitations

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: professional and ethical practice
Professional and ethical practice	Discuss in an informed manner the implications of professional regulation for nursing practice • demonstrate a basic knowledge of professional regulation and self-regulation • recognise and acknowledge the limitations of one's own abilities • recognise situations that require referral to a registered practitioner. Demonstrate an awareness of *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC,2015) • commit to the principle that the primary purpose of the registered nurse is to protect and serve society • accept responsibility for one's own actions and decisions.	• practise in accordance with *The Code: professional standards of practice and behaviour, for nurses and midwives* • use professional standards of practice to self-assess performance • consult with a registered nurse when nursing care requires expertise beyond one's own current scope of competence • consult other health care professionals when individual or group needs fall outside the scope of nursing practice • identify unsafe practice and respond appropriately to ensure a safe outcome • manage the delivery of care services within the sphere of one's own accountability.

Standard of proficiency for entry to the register: professional and ethical practice

Practise in a fair and anti-discriminatory way, acknowledging the differences in beliefs and cultural practices of individuals or groups

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: professional and ethical practice
Professional and ethical practice	Demonstrate an awareness of, and apply ethical principles to, nursing practice • demonstrate respect for patient and client confidentiality • identify ethical issues in day to day practice. Demonstrate an awareness of legislation relevant to nursing practice • identify key issues in relevant legislation relating to mental health, children, data protection, manual handling, and health and safety, etc.	• demonstrate knowledge of legislation and health and social policy relevant to nursing practice • ensure the confidentiality and security of written and verbal information acquired in a professional capacity • demonstrate knowledge of contemporary ethical issues and their impact on nursing and health care • manage the complexities arising from ethical and legal dilemmas • act appropriately when seeking access to caring for patients and clients in their own homes.

Standard of proficiency for entry to the register: professional and ethical practice

Practise in a fair and anti-discriminatory way, acknowledging the differences in beliefs and cultural practices of individuals or groups

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: professional and ethical practice
Professional and ethical practice	Demonstrate the importance of promoting equity in patient and client care by contributing to nursing care in a fair and anti-discriminatory way • demonstrate fairness and sensitivity when responding to patients, clients and groups from diverse circumstances • recognise the needs of patients and clients whose lives are affected by disability, however manifest.	• maintain, support and acknowledge the rights of individuals or groups in the health care setting • act to ensure that the rights of individuals and groups are not compromised • respect the values, customs and beliefs of individuals and groups • provide care which demonstrates sensitivity to the diversity of patients and clients.

Standard of proficiency for entry to the register: care delivery

Engage in, develop and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care delivery
Care delivery	Discuss methods of, barriers to, and the boundaries of, effective communication and interpersonal relationships • recognise the effect of one's own values on interactions with patients and clients and their carers, families and friends • utilise appropriate communication skills with patients and clients • acknowledge the boundaries of a professional caring relationship. Demonstrate sensitivity when interacting with and providing information to patients and clients.	• utilise a range of effective and appropriate communication and engagement skills • maintain and, where appropriate, disengage from professional caring relationships that focus on meeting the patient's or client's needs within professional therapeutic boundaries.

Standard of proficiency for entry to the register: care delivery

Create and utilise opportunities to promote the health and well-being of patients, clients and groups

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care delivery
Care delivery	Contribute to enhancing the health and social well-being of patients and clients by understanding how, under the supervision of a registered practitioner, to: • contribute to the assessment of health needs • identify opportunities for health promotion • identify networks of health and social care services.	• consult with patients, clients and groups to identify their need and desire for health promotion advice • provide relevant and current health information to patients, clients and groups in a form which facilitates their understanding and acknowledges choice/ individual preference • provide support and education in the development and/or maintenance of independent living skills • seek specialist/expert advice as appropriate.

Standard of proficiency for entry to the register: care delivery

Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care delivery
Care delivery	Contribute to the development and documentation of nursing assessments by participating in comprehensive and systematic nursing assessment of the physical, psychological, social and spiritual needs of patients and clients • be aware of assessment strategies to guide the collection of data for assessing patients and clients and use assessment tools under guidance • discuss the prioritisation of care needs • be aware of the need to reassess patients and clients as to their needs for nursing care.	• select valid and reliable assessment tools for the required purpose • systematically collect data regarding the health and functional status of individuals, clients and communities through appropriate interaction, observation and measurement • analyse and interpret data accurately to inform nursing care and take appropriate action.

Standard of proficiency for entry to the register: care delivery

Formulate and document a plan of nursing care, where possible, in partnership with patients, clients, their carers and family and friends, within a framework of informed consent

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care delivery
Care delivery	Contribute to the planning of nursing care, involving patients and clients and, where possible, their carers; demonstrating an understanding of helping patients and clients to make informed decisions • identify care needs based on the assessment of a patient or client • participate in the negotiation and agreement of the care plan with the patient or client and with their carer, family or friends, as appropriate, under the supervision of a registered nurse • inform patients and clients about intended nursing actions, respecting their right to participate in decisions about their care.	• establish priorities for care based on individual or group needs • develop and document a care plan to achieve optimal health, habilitation, and rehabilitation based on assessment and current nursing knowledge • identify expected outcomes, including a time frame for achievement and/or review in consultation with patients, clients, their carers and family and friends and with members of the health and social care team.

Standard of proficiency for entry to the register: care delivery

Based on the best available evidence, apply knowledge and an appropriate repertoire of skills indicative of safe and effective nursing practice

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care delivery
Care delivery	Contribute to the implementation of a programme of nursing care, designed and supervised by registered practitioners • undertake activities that are consistent with the care plan and within the limits of one's own abilities. Demonstrate evidence of a developing knowledge base which underpins safe and effective nursing practice • access and discuss research and other evidence in nursing and related disciplines • identify examples of the use of evidence in planned nursing interventions. Demonstrate a range of essential nursing skills, under the supervision of a registered nurse, to meet individuals' needs, which include: maintaining dignity, privacy and confidentiality; effective communication and observational skills, including listening and taking physiological measurements; safety and health, including moving, and handling and infection control; essential first aid and emergency procedures; administration of medicines; emotional, physical and personal care, including meeting the need for comfort, nutrition and personal hygiene.	• ensure that current research findings and other evidence are incorporated in practice • identify relevant changes in practice or new information and disseminate it to colleagues • contribute to the application of a range of interventions which support and optimise the health and well-being of patients and clients • demonstrate the safe application of the skills required to meet the needs of patients and clients within the current sphere of practice • identify and respond to patients and clients' continuing learning and care needs • engage with, and evaluate, the evidence base that underpins safe nursing practice.

Standard of proficiency for entry to the register: care delivery

Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care delivery
Care delivery		• identify, collect and evaluate information to justify the effective utilisation of resources to achieve planned outcomes of nursing care.

Standard of proficiency for entry to the register: care delivery

Evaluate and document the outcomes of nursing and other interventions

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care delivery
Care delivery	Contribute to the evaluation of the appropriateness of nursing care delivered • demonstrate an awareness of the need to assess regularly a patient's or client's response to nursing interventions • provide for a supervising registered practitioner, evaluative commentary and information on nursing care based on personal observations and actions • contribute to the documentation of the outcomes of nursing interventions.	• collaborate with patients and clients and, when appropriate, additional carers to review and monitor the progress of individuals or groups towards planned outcomes • analyse and revise expected outcomes, nursing interventions and priorities in accordance with changes in the individual's condition, needs or circumstances.

Standard of proficiency for entry to the register: care delivery

Demonstrate sound clinical judgement across a range of differing professional and care delivery contexts

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care delivery
Care delivery	Recognise situations in which agreed plans of nursing care no longer appear appropriate and refer these to an appropriate accountable practitioner • demonstrate the ability to discuss and accept care decisions • accurately record observations made and communicate these to the relevant members of the health and social care team.	• use evidence based knowledge from nursing and related disciplines to select and individualise nursing interventions • demonstrate the ability to transfer skills and knowledge to a variety of circumstances and settings • recognise the need for adaptation and adapt nursing practice to meet varying and unpredictable circumstances • ensure that practice does not compromise the nurse's duty of care to individuals or the safety of the public.

Standard of proficiency for entry to the register: care management

Contribute to public protection by creating and maintaining a safe environment of care through the use of quality assurance and risk management strategies

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care management
Care management	Contribute to the identification of actual and potential risks to patients, clients and their carers, to oneself and to others, and participate in measures to promote and ensure health and safety • understand and implement health and safety principles and policies • recognise and report situations that are potentially unsafe for patients, clients, oneself and others.	• apply relevant principles to ensure the safe administration of therapeutic substances • use appropriate risk assessment tools to identify actual and potential risks • identify environmental hazards and eliminate and/or prevent where possible • communicate safety concerns to a relevant authority • manage risk to provide care which best meets the needs and interests of patients, clients and the public.

Standard of proficiency for entry to the register: care management

Demonstrate knowledge of effective inter-professional working practices which respect and utilise the contributions of members of the health and social care team

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care management
Care management	Demonstrate an understanding of the role of others by participating in inter-professional working practice • identify the roles of the members of the health and social care team • work within the health and social care team to maintain and enhance integrated care.	• establish and maintain collaborative working relationships with members of the health and social care team and others • participate with members of the health and social care team in decision-making concerning patients and clients • review and evaluate care with members of the health and social care team and others.

Standard of proficiency for entry to the register: care management

Delegate duties to others, as appropriate, ensuring that they are supervised and monitored

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care management
Care management		• take into account the role and competence of staff when delegating work • maintain one's own accountability and responsibility when delegating aspects of care to others • demonstrate the ability to co-ordinate the delivery of nursing and health care.

Standard of proficiency for entry to the register: care management

Demonstrate key skills

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: care management
Care management	Demonstrate literacy, numeracy and computer skills needed to record, enter, store, retrieve and organise data essential for care delivery	• literacy – interpret and present information in a comprehensible manner • numeracy – accurately interpret numerical data and their significance for the safe delivery of care • information technology and management – interpret and utilise data and technology, taking account of legal, ethical and safety considerations, in the delivery and enhancement of care • problem-solving – demonstrate sound clinical decision-making which can be justified even when made on the basis of limited information.

Standard of proficiency for entry to the register: personal and professional development

Demonstrate a commitment to the need for continuing professional development and personal supervision activities in order to enhance knowledge, skills, values and attitudes needed for safe and effective nursing practice

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: personal and professional development
Personal and professional development	Demonstrate responsibility for one's own learning through the development of a portfolio of practice and recognise when further learning is required • identify specific learning needs and objectives • begin to engage with, and interpret, the evidence base which underpins nursing practice. Acknowledge the importance of seeking supervision to develop safe and effective nursing practice	• identify one's own professional development needs by engaging in activities such as reflection in, and on, practice and lifelong learning • develop a personal development plan which takes into account personal, professional and organisational needs • share experiences with colleagues and patients and clients in order to identify the additional knowledge and skills needed to manage unfamiliar or professionally challenging situations • take action to meet any identified knowledge and skills deficit likely to affect the delivery of care within the current sphere of practice.

Standard of proficiency for entry to the register: personal and professional development

Enhance the professional development and safe practice of others through peer support, leadership, supervision and teaching

Domain	Outcomes to be achieved for entry to the branch programme	Standards of proficiency for entry to the register: personal and professional development
Personal and professional development		• contribute to creating a climate conducive to learning • contribute to the learning experiences and development of others by facilitating the mutual sharing of knowledge and experience • demonstrate effective leadership in the establishment and maintenance of safe nursing practise.

Access to the register by European second level nurses

Second level nurses trained in a European Economic Area country are eligible to apply for entry to the NMC register. Those who wish to work in the UK must first apply to the registering body (competent authority) in their own country who will confirm their eligibility under European Law to work in the UK. They may then apply to the NMC providing copies of their certificates, confirmation of good health and good character, verification in accordance with EU Directives, photocopy of passport or identity card and Register extract where appropriate. Nurses who are registered in another EEA State but who are not nationals of an EEA State will be treated as overseas applicants, taking into account that they have been registered in another EEA State.

Such nurses who register with the NMC will be deemed to have met the standards of proficiency for second level nurses. Once registered, they will have the right to access continuing professional development to advance their knowledge, skills and proficiency beyond that of initial registration. They may also enter a pre-registration nursing programme to enable them to become a first level nurse. They may seek appropriate accreditation of prior learning, in accordance with NMC nursing standards 3 and 4, to enable them to undertake a shortened programme of preparation.

Standard 8 – Second level nurses – nursing standards of proficiency

These standards of proficiency are known as threshold standards. They enable second level nurses to undertake care under the direction of a first level registered nurse, and provide opportunities for the student to develop proficiency to:

- assist in carrying out comprehensive observation of the patient and help in assessing her care requirements
- develop skills to enable her to assist in the implementation of nursing care under the direction of a person registered as a first level nurse
- accept delegated nursing tasks
- assist in reviewing the effectiveness of the care provided
- work in a team with other nurses, and with medical and para-medical staff and social workers

related to the care of the particular type of patient with whom they are likely to come into contact when registered at this level of the nurses' part of the register. The standards of proficiency must have been achieved within the context of the field of practice in which the student has qualified.

References to the Code have been updated to The Code (NMC, 2015)

Nursing & Midwifery Council

standards•02•04

23 Portland Place, London W1B 1PZ
Telephone 020 7637 7181 Fax 020 7436 2924 **www.nmc.org.uk**

Protecting the public through professional standards

Nursing & Midwifery Council

Standards for pre-registration nursing education

Contents

Section 1: Introduction

The term ‘pre-registration nursing education’ describes the programme that a nursing student in the United Kingdom undertakes in order to acquire the competencies needed to meet the criteria for registration with the Nursing and Midwifery Council (NMC). The standards set out below apply to the approval of all new pre-registration nursing programmes from September 2011.

This introduction aims to assist approved education institutions (AEIs) and their partner organisations understand the standards and how to meet them. It reviews briefly the background and context, and the location, design and delivery of programmes. You might find it helpful to begin by reading the *Pre-registration nursing education: Explanation of terms.* Throughout, you can access additional information by clicking on the blue hyperlinks.

Background and context

As the regulator of nurses and midwives in the UK, the mission of the NMC is to protect the public, as required by the Nursing and Midwifery Order 2001. We achieve this in various ways, primarily by:

- maintaining a register of nurses and midwives
- setting and maintaining standards of education, training and conduct
- ensuring that nurses and midwives keep their skills and knowledge up to date, and uphold the standards of their professional code
- ensuring that midwives are safe to practise by setting rules for their practice and supervision
- providing mandatory guidance and additional advice to people designing and developing education programmes.

Nursing education across the UK is responding to changing needs, developments, priorities and expectations in health and healthcare. Nurses who acquire the knowledge, skills and behaviors that meet our standards will be equipped to meet these present and future challenges, improve health and wellbeing and drive up standards and quality, working in a range of roles including practitioner, educator, leader and researcher. As autonomous practitioners, nurses will provide essential care to a very high standard and provide complex care using the best available evidence and technology where appropriate.

Our standards aim to enable nurses to give and support high quality care in rapidly changing environments. They reflect how future services are likely to be delivered, acknowledge future public health priorities and address the challenges of long-term conditions, an ageing population, and providing more care outside hospitals. Nurses must be equipped to lead, delegate, supervise and challenge other nurses and healthcare professionals. They must be able to develop practice, and promote and sustain change. As graduates they must be able to think analytically, use problem-

solving approaches and evidence in decision-making, keep up with technical advances and meet future expectations.

Professional values must underpin education as well as practice. All nurses and midwives are required to comply with *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC 2015).

The Code is central to all education programmes, and educators must enable students to understand, commit to and uphold it.

The public can be confident that all new nurses will:

- deliver high quality essential care to all
- deliver complex care to service users in their field of practice
- act to safeguard the public, and be responsible and accountable for safe, person-centred, evidence-based nursing practice
- act with professionalism and integrity, and work within agreed professional, ethical and legal frameworks and processes to maintain and improve standards
- practise in a compassionate, respectful way, maintaining dignity and wellbeing and communicating effectively
- act on their understanding of how people's lifestyles, environments and the location of care delivery influence their health and wellbeing
- seek out every opportunity to promote health and prevent illness
- work in partnership with other health and social care professionals and agencies, service users, carers and families ensuring that decisions about care are shared
- use leadership skills to supervise and manage others and contribute to planning, designing, delivering and improving future services.

Nurses must be able to meet all NMC requirements when they qualify and then maintain their knowledge and skills. Newly qualified nurses cannot be expected to have extensive clinical experience, specialist expertise, or highly developed supervision and leadership skills. Opportunities will be needed to develop these through preceptorship and ongoing professional development.

We are fully committed to promoting equality and diversity and this is reflected in the standards. Programme providers are reminded of the need to consider the learning needs of students with disabilities in both academic and practice settings.

Standards and requirements

We are required under the Nursing and Midwifery Order 2001 (the order) to establish **standards** – minimum requirements by which programme providers determine programme content, learning outcomes and assessment criteria. Our standards are

underpinned by **requirements**; a standard will be fully met only when all the requirements have been demonstrated**.** All AEIs and their partner practice learning providers are required to comply fully with these standards and requirements in all UK pre-registration nursing programmes.

The order also requires us to give and publish guidance on what we believe is best practice. Box 1 shows NMC descriptions of its standards and guidance. You will find it helpful to read the requirements and guidance in section 3 in conjunction with *Advice and supporting information for implementing NMC standards for pre-registration nursing education.*

Box 1: NMC standards and guidance

Standards	**The Nursing and Midwifery Council is required to establish standards.** **Requirements underpin the standards**. **Standards must be met and requirements must be demonstrated.**	A standard will be fully met only when all the requirements have been demonstrated.
Guidance	**The order requires the Nursing and Midwifery Council to give guidance and publish that guidance.** **Guidance reflects what the Nursing and Midwifery Council believes is best practice and should be followed.**	There is some flexibility in how guidance is applied to education programmes. Where it is not followed precisely, programme providers will need to account for this and explain how an alternative approach will produce a similar outcome.

These standards for pre-registration nursing education replace our 2004 *Standards of proficiency for pre-registration nursing education*.[1] Many are based on previous rules, standards and guidance. Others have been introduced after extensive consultation with stakeholders, in accordance with article 3(14) of the order incorporating the findings of our review *Nursing: Towards 2015 (NMC 2007)*, and key policies from the four UK government health departments including *Modernising nursing careers (DH, 2006)*.

Where appropriate, the standards are aligned with European Union Directive 2005/36/EC Recognition of professional qualifications (see annexe 1). Article 31 sets out the requirements for training nurses responsible for general care and establishes the baseline for general nursing in the EU. It includes specific requirements on programme length, content, and ratio of theory to practice, and the nature of practice learning and range of experience.

[1] The *Standards of proficiency for pre-registration nursing education* (NMC 2004) will continue to apply to programmes approved under those standards.

In the UK students qualify in a specific field of nursing practice and may apply to enter the NMC register as a nurse in one or more of four fields: adult, mental health, learning disabilities and children's nursing. Those in the adult field must meet EU requirements for training in general care, including the definition of practice (annexe 1), which must include direct contact with service users across a range of client groups and clinical specialities. For consistency, we have also applied the EU requirements for minimum programme length and ratio of theory to practice to all four fields. New nurses will be expected to meet the essential mental and physical health needs of people of all ages and conditions, as well as in their own field of practice.

Our standards are normally reviewed every five years, but we will also continue to seek ongoing feedback from nurses, the public and other stakeholders to ensure that they remain fit for purpose. As ever, we will work closely with the four UK government health departments, and with those who commission education and provide health services, to ensure that our standards are, and remain, sound and meet expectations.

The standards for competence and standards for education are set out below. The standards for competence address what nursing students must do and achieve during their programme, while the standards for education concern the framework within which programmes must be delivered.

Standards for competence

The standards for competence in section 2 identify the knowledge, skills and attitudes the student must acquire by the end of the programme, as set out in the degree-level competency framework. This framework comprises four sets of competencies, one for each field of practice: adult, mental health, learning disabilities and children's nursing. Each set comprises both generic competencies and field-specific competencies. The competencies are organised in four domains:

- professional values
- communication and interpersonal skills
- nursing practice and decision making
- leadership, management and team working.

The context in which the competencies are acquired in relation to the field of nursing defines the scope of professional practice at the point of registration.

Standards for education

The standards for education in section 3 comprise 10 standards for programme approval and delivery. They provide the framework within which programmes are delivered, and specify the requirements that all programmes must meet, including those relating to the teaching, learning and assessment of nursing students (see also *Standards to support learning and assessment in practice* (NMC 2008).

Nursing degrees

Our required minimum outcome award for a pre-registration nursing education programme is a degree in nursing. Degree-level registration underpins the level of practice needed for the future, and enables new nurses to work more closely and effectively with other professionals. The intellectual, professional, academic and practical competencies that nursing graduates must acquire are informed by the European Tuning project (2009, 3.2). The programme must also provide the programme hours specified in Directive 2005/36/EC and be at least equal to a first cycle (end of cycle) qualification of the European Higher Education Area (EHEA).

The institution that offers the programme makes the award and determines the title of the degree. It also decides whether to offer programmes at a higher academic level.

Length of programme

The programme can be no less than three years and must consist of at least 4,600 hours. There is no maximum time limit within which the programme must be completed. Responsibility for the management of course completion timescales rests with the AEI. The absence of maximum time limits does not have any impact on the level of proficiency required to complete a programme and be admitted to the register. Entry to the register is still subject to the individual meeting all of the proficiencies within the relevant education standards and the completion of their education programme. The AEI will still be responsible for confirming that the individual is fit and proper for admission to the register.

Some students may have previous relevant learning, including formal certificated learning such as an access course or another degree, or practice-based learning that was part of another course or gained through paid or voluntary work. Evidence of this learning may contribute to meeting some programme requirements, assessed through the AEI's own accreditation of prior learning (APL) process. Up to a maximum of 50 percent of the programme can be accredited in this way.

Location of programmes

Programmes are offered by AEIs across the UK. Sufficient learning opportunities must be provided to achieve the expected programme outcomes. Learning may take place in diverse environments in different, often widely spread locations, in a range of settings in the National Health Service (NHS) and elsewhere in the public, independent and voluntary sectors. Some aspects of the programme might be undertaken outside the UK for up to six months (or 17.5 percent) of the programme.

Approaches to learning

Programmes should offer a flexible, blended approach to learning, and draw on the full range of modern learning methods and modes of delivery in both academic and practice settings. There are learning opportunities wherever nurses practise. Learning should be shared with other nursing students, and also with students from other disciplines to improve teamwork and service integration. Students should become increasingly self-directed and independent, and able to make use of a variety of resources.

Overall the programme requires 50 percent theory (2300 hours) and 50 percent practice (2300 hours), with some flexibility in each part of the programme. AEIs determine the nature of theoretical learning, which may include independent study. As outlined above, learning in theory and practice for students intending to enter the adult field must comply with EU directives.

We set no specific requirements for the nature or range of practice learning, other than that it must enable the competencies to be acquired. Our standards require students to learn in a range of settings, with links to the service user's journey reflecting the future configuration of services. Most practice learning is required to be undertaken in direct care of clients, although under certain criteria up to 300 hours of practice learning may be undertaken through simulation, allowing the student to learn or practise skills in a safe situation that imitates reality.

Assessment of learning

There must be two progression points normally separating the programme into three equal parts. Progress in acquiring the competencies is mapped through the use of minimum progression criteria, based on safety and values (annexe 2), which the student must meet to progress from one part of the programme to the next. We set out minimum periods of practice learning towards the end of each progression point. The first progression point is normally at the end of year one. To pass the second progression point, normally at the end of year two, the student will need to demonstrate that they can be more independent and take more responsibility for their own learning and practice (annexe 2).

A nurse mentor who has completed specific preparation in assessing students is normally responsible for ongoing supervision and assessment in practice settings and in simulation. Other registered professionals who have been suitably prepared can supervise and contribute towards the assessment of nursing students. During a period of at least 12 weeks practice learning towards the end of the programme, a sign-off mentor (a nurse mentor who has met additional criteria), who is registered in the field of practice that the student intends to enter, makes a final judgement of competence (see *Standards to support learning and assessment in practice* (NMC 2008)). The evidence must show that the student is safe and effective in practice at the end of the programme.

We encourage innovative ways of achieving practice learning outcomes and enable flexibility in who can support and assess nursing students in practice settings, while maintaining continuity through the use of the nurse mentor system.

Direct links should be made between what is assessed in practice and academic settings, with the processes overseen by external examiners to ensure that theory and practice remain integrated. The assessment of theory and practice learning is given equal weighting. AEIs will use a range of assessment methods to meet the programme's academic requirements, including projects, essays, portfolios, assignments, formal tests and examinations.

Every student who steps off the programme before completion will receive a transcript of training giving details of learning achievements in theory and practice. This may lead directly to an alternative academic or vocational award, or it may contribute to a future award. The transcript may also be helpful to students transferring from one AEI to another, rejoining a programme after a break, when starting afresh, or be used to access employment opportunities.

Approval and monitoring of AEIs

AEIs and their partner practice learning providers are required to meet these standards and requirements in all UK pre-registration nursing programmes. Their performance in programme development and delivery will be measured against the standards through our quality assurance processes.

We ensure that programmes meet our standards through a robust procedure known as approval. Programmes are normally approved for up to five years. We check compliance before allowing the programme to run, following which it is subject to NMC monitoring.

Section 2: Standards for competence

Context

Competence is a requirement for entry to the NMC register. It is a holistic concept that may be defined as “the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions” (adapted from Queensland Nursing Council 2009).

The standards in this section relate to the competence required of all nursing students at the end of their pre-registration nursing programme, when they are at the point of registration. The standards have been informed by the Royal College of Nursing definition of nursing as “the use of clinical judgement in the provision of care to enable people to improve, maintain or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability until death” (Royal College of Nursing 2003).

The standards have also been informed by the European Tuning project (Tuning 2009), which adopted this definition of the nurse in 2003: “A professional person achieving a competent standard of practice at first cycle level following successful completion of an approved academic and practical course. The nurse is a safe, caring, and competent decision maker willing to accept personal and professional accountability for his/her actions and continuous learning. The nurse practises within a statutory framework and code of ethics delivering nursing practice (care) that is appropriately based on research, evidence and critical thinking that effectively responds to the needs of individual clients (patients) and diverse populations.”

The competency framework

The competency framework sets out the standards for competence and the related competencies that every nursing student must acquire before applying to be registered at first level on the nurses’ part of the register.

There are separate sets of competency requirements for each of the four fields of adult nursing, mental health nursing, learning disabilities nursing or children’s nursing. Each set is laid out under the following four domains:

1 professional values

2 communication and interpersonal skills

3 nursing practice and decision-making

4 leadership, management and team working.

Each domain is comprised of a generic standard for competence and a field standard for competence. It also includes the generic competencies that all nurses must achieve and the field competencies to be achieved in each specific field. The number of field competencies varies in number in each domain and between nursing fields of practice.

Before they can apply to be registered, nursing students must have acquired all the generic and field competency requirements within the context of their field at a minimum of degree level.

Included within the nursing practice and decision making domain for each field we have identified the wider range of people who may come into the nurses' care and the level at which we expect that care to be delivered.

Specific knowledge and skills

All nurses must apply knowledge and skills based on the best available evidence indicative of safe nursing practice. The knowledge and skills required have been integrated into the competencies throughout. Some are generic and some field-specific. Additional requirements and guidance are as follows:

- Knowledge and related aspects of practice are set out as programme content in section 3, standard 5 – structure, design and delivery of programmes.
- Theoretical and clinical instruction for general care, required for students undertaking the adult nursing field, is set out in EU Directive 2005/36/EC Annex V.2 (5.2.1). This can be found in annexe 1.
- Criteria for safety and professional values that must be achieved at the first progression point are set out in annexe 2.
- Essential skills clusters (ESCs) that should be reflected in learning outcomes at different points in the programme include skills for care, compassion and communication; organisational aspects of care; infection prevention and control; nutrition and fluid management; and medicines management (annexe 3).

Competencies for entry to the register: Adult nursing

Domain 1: Professional values

Generic standard for competence

All nurses must act first and foremost to care for and safeguard the public. They must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights. They must show professionalism and integrity and work within recognised professional, ethical and legal frameworks. They must work in partnership with other health and social care professionals and agencies, service users, their carers and families in all settings, including the community, ensuring that decisions about care are shared.

Field standard for competence

Adult nurses must also be able at all times to promote the rights, choices and wishes of all adults and, where appropriate, children and young people, paying particular attention to equality, diversity and the needs of an ageing population. They must be able to work in partnership to address people's needs in all healthcare settings.

Competencies

1 All nurses must practise with confidence according to *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC 2015), and within other recognised ethical and legal frameworks. They must be able to recognise and address ethical challenges relating to people's choices and decision-making about their care, and act within the law to help them and their families and carers find acceptable solutions.

1.1 **Adult nurses** must understand and apply current legislation to all service users, paying special attention to the protection of vulnerable people, including those with complex needs arising from ageing, cognitive impairment, long-term conditions and those approaching the end of life.

2 All nurses must practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion; recognises and respects individual choice; and acknowledges diversity. Where necessary, they must challenge inequality, discrimination and exclusion from access to care.

3 All nurses must support and promote the health, wellbeing, rights and dignity of people, groups, communities and populations. These include people whose lives are affected by ill health, disability, ageing, death and dying. Nurses must understand how these activities influence public health.

4 All nurses must work in partnership with service users, carers, families, groups, communities and organisations. They must manage risk, and promote health and wellbeing while aiming to empower choices that promote self-care and safety.

5 All nurses must fully understand the nurse's various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities and populations.

6 All nurses must understand the roles and responsibilities of other health and social care professionals, and seek to work with them collaboratively for the benefit of all who need care.

7 All nurses must be responsible and accountable for keeping their knowledge and skills up to date through continuing professional development. They must aim to improve their performance and enhance the safety and quality of care through evaluation, supervision and appraisal.

8 All nurses must practise independently, recognising the limits of their competence and knowledge. They must reflect on these limits and seek advice from, or refer to, other professionals where necessary.

9 All nurses must appreciate the value of evidence in practice, be able to understand and appraise research, apply relevant theory and research findings to their work, and identify areas for further investigation.

Domain 2: Communication and interpersonal skills

Generic standard for competence

All nurses must use excellent communication and interpersonal skills. Their communications must always be safe, effective, compassionate and respectful. They must communicate effectively using a wide range of strategies and interventions including the effective use of communication technologies. Where people have a disability, nurses must be able to work with service users and others to obtain the information needed to make reasonable adjustments that promote optimum health and enable equal access to services.

Field standard for competence

Adult nurses must demonstrate the ability to listen with empathy. They must be able to respond warmly and positively to people of all ages who may be anxious, distressed, or facing problems with their health and wellbeing.

Competencies

1 All nurses must build partnerships and therapeutic relationships through safe, effective and non-discriminatory communication. They must take account of individual differences, capabilities and needs.

2 All nurses must use a range of communication skills and technologies to support person-centred care and enhance quality and safety. They must ensure people receive all the information they need in a language and manner that allows them to make informed choices and share decision making. They must recognise when language interpretation or other communication support is needed and know how to obtain it.

3 All nurses must use the full range of communication methods, including verbal, non-verbal and written, to acquire, interpret and record their knowledge and understanding of people's needs. They must be aware of their own values and beliefs and the impact this may have on their communication with others. They must take account of the many different ways in which people communicate and how these may be influenced by ill health, disability and other factors, and be able to recognise and respond effectively when a person finds it hard to communicate.

   3.1 **Adult nurses** must promote the concept, knowledge and practice of self-care with people with acute and long-term conditions, using a range of communication skills and strategies.

4 All nurses must recognise when people are anxious or in distress and respond effectively, using therapeutic principles, to promote their wellbeing, manage personal safety and resolve conflict. They must use effective communication strategies and negotiation techniques to achieve best outcomes, respecting the dignity and human rights of all concerned. They must know when to consult a third party and how to make referrals for advocacy, mediation or arbitration.

5 All nurses must use therapeutic principles to engage, maintain and, where appropriate, disengage from professional caring relationships, and must always respect professional boundaries.

6 All nurses must take every opportunity to encourage health-promoting behaviour through education, role modelling and effective communication.

7 All nurses must maintain accurate, clear and complete records, including the use of electronic formats, using appropriate and plain language.

8 All nurses must respect individual rights to confidentiality and keep information secure and confidential in accordance with the law and relevant ethical and regulatory frameworks, taking account of local protocols. They must also actively share personal information with others when the interests of safety and protection override the need for confidentiality.

Domain 3: Nursing practice and decision-making

Generic standard for competence

All nurses must practise autonomously, compassionately, skilfully and safely, and must maintain dignity and promote health and wellbeing. They must assess and meet the full range of essential physical and mental health needs of people of all ages who come into their care. Where necessary they must be able to provide safe and effective immediate care to all people prior to accessing or referring to specialist services irrespective of their field of practice. All nurses must also meet more complex and coexisting needs for people in their own nursing field of practice, in any setting including hospital, community and at home. All practice should be informed by the best available evidence and comply with local and national guidelines. Decision-making must be shared with service users, carers and families and informed by critical analysis of a full range of possible interventions, including the use of up-to-date technology. All nurses must also understand how behaviour, culture, socioeconomic and other factors, in the care environment and its location, can affect health, illness, health outcomes and public health priorities and take this into account in planning and delivering care.

Field standard for competence

Adult nurses must be able to carry out accurate assessment of people of all ages using appropriate diagnostic and decision-making skills. They must be able to provide effective care for service users and others in all settings. They must have in-depth understanding of and competence in medical and surgical nursing to respond to adults' full range of health and dependency needs. They must be able to deliver care to meet essential and complex physical and mental health needs.

Competencies

1 All nurses must use up-to-date knowledge and evidence to assess, plan, deliver and evaluate care, communicate findings, influence change and promote health and best practice. They must make person-centred, evidence-based judgments and decisions, in partnership with others involved in the care process, to ensure high quality care. They must be able to recognise when the complexity of clinical decisions requires specialist knowledge and expertise, and consult or refer accordingly.

1.1 **Adult nurses** must be able to recognise and respond to the needs of all people who come into their care including babies, children and young people, pregnant and postnatal women, people with mental health problems, people with physical disabilities, people with learning disabilities, older people, and people with long term problems such as cognitive impairment.

2 All nurses must possess a broad knowledge of the structure and functions of the human body, and other relevant knowledge from the life, behavioural and social sciences as applied to health, ill health, disability, ageing and death. They must have an in-depth knowledge of common physical and mental health problems and treatments in their own field of practice, including co-morbidity and physiological and psychological vulnerability.

3 All nurses must carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement.

3.1 **Adult nurses** must safely use a range of diagnostic skills, employing appropriate technology, to assess the needs of service users.

4 All nurses must ascertain and respond to the physical, social and psychological needs of people, groups and communities. They must then plan, deliver and evaluate safe, competent, person-centred care in partnership with them, paying special attention to changing health needs during different life stages, including progressive illness and death, loss and bereavement.

4.1 **Adult nurses** must safely use invasive and non-invasive procedures, medical devices, and current technological and pharmacological interventions, where relevant, in medical and surgical nursing practice, providing information and taking account of individual needs and preferences.

4.2 **Adult nurses** must recognise and respond to the changing needs of adults, families and carers during terminal illness. They must be aware of how treatment goals and service users' choices may change at different stages of progressive illness, loss and bereavement.

5 All nurses must understand public health principles, priorities and practice in order to recognise and respond to the major causes and social determinants of health, illness and health inequalities. They must use a range of information and data to assess the needs of people, groups, communities and populations, and work to improve health, wellbeing and experiences of healthcare; secure equal access to health screening, health promotion and healthcare; and promote social inclusion.

6 All nurses must practise safely by being aware of the correct use, limitations and hazards of common interventions, including nursing activities, treatments, and the use of medical devices and equipment. The nurse must be able to evaluate their use, report any concerns promptly through appropriate channels and modify care where necessary to maintain safety. They must contribute to the collection of local and national data and formulation of policy on risks, hazards and adverse outcomes.

7 All nurses must be able to recognise and interpret signs of normal and deteriorating mental and physical health and respond promptly to maintain or improve the health and comfort of the service user, acting to keep them and others safe.

7.1 **Adult nurses** must recognise the early signs of illness in people of all ages. They must make accurate assessments and start appropriate and timely management of those who are acutely ill, at risk of clinical deterioration, or require emergency care.

7.2 **Adult nurses** must understand the normal physiological and psychological processes of pregnancy and childbirth. They must work with the midwife and other professionals and agencies to provide basic nursing care to pregnant women and families during pregnancy and after childbirth. They must be able to respond safely and effectively in an emergency to safeguard the health of mother and baby.

8 All nurses must provide educational support, facilitation skills and therapeutic nursing interventions to optimise health and wellbeing. They must promote self-care and management whenever possible, helping people to make choices about their healthcare needs, involving families and carers where appropriate, to maximise their ability to care for themselves.

8.1 **Adult nurses** must work in partnership with people who have long-term conditions that require medical or surgical nursing, and their families and carers, to provide therapeutic nursing interventions, optimise health and wellbeing, facilitate choice and maximise self-care and self-management.

9 All nurses must be able to recognise when a person is at risk and in need of extra support and protection and take reasonable steps to protect them from abuse.

10 All nurses must evaluate their care to improve clinical decision-making, quality and outcomes, using a range of methods, amending the plan of care, where necessary, and communicating changes to others.

Domain 4: Leadership, management and team working

Generic standard for competence

All nurses must be professionally accountable and use clinical governance processes to maintain and improve nursing practice and standards of healthcare. They must be able to respond autonomously and confidently to planned and uncertain situations, managing themselves and others effectively. They must create and maximise opportunities to improve services. They must also demonstrate the potential to develop further management and leadership skills during their period of preceptorship and beyond.

Field standard for competence

Adult nurses must be able to provide leadership in managing adult nursing care, understand and coordinate interprofessional care when needed, and liaise with specialist teams. They must be adaptable and flexible, and able to take the lead in responding to the needs of people of all ages in a variety of circumstances, including situations where immediate or urgent care is needed. They must recognise their leadership role in disaster management, major incidents and public health emergencies, and respond appropriately according to their levels of competence.

Competencies

1 All nurses must act as change agents and provide leadership through quality improvement and service development to enhance people's wellbeing and experiences of healthcare.

2 All nurses must systematically evaluate care and ensure that they and others use the findings to help improve people's experience and care outcomes and to shape future services.

3 All nurses must be able to identify priorities and manage time and resources effectively to ensure the quality of care is maintained or enhanced.

4 All nurses must be self-aware and recognise how their own values, principles and assumptions may affect their practice. They must maintain their own personal and professional development, learning from experience, through supervision, feedback, reflection and evaluation.

5 All nurses must facilitate nursing students and others to develop their competence, using a range of professional and personal development skills.

6 All nurses must work independently as well as in teams. They must be able to take the lead in coordinating, delegating and supervising care safely, managing risk and remaining accountable for the care given.

7 All nurses must work effectively across professional and agency boundaries, actively involving and respecting others' contributions to integrated person-centred care. They must know when and how to communicate with and refer to other professionals and agencies in order to respect the choices of service users and others, promoting shared decision making, to deliver positive outcomes and to coordinate smooth, effective transition within and between services and agencies.

Competencies for entry to the register: Mental health nursing

Domain 1: Professional values

Generic standard for competence

All nurses must act first and foremost to care for and safeguard the public. They must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights. They must show professionalism and integrity and work within recognised professional, ethical and legal frameworks. They must work in partnership with other health and social care professionals and agencies, service users, their carers and families in all settings, including the community, ensuring that decisions about care are shared.

Field standard for competence

Mental health nurses must work with people of all ages using values-based mental health frameworks. They must use different methods of engaging people, and work in a way that promotes positive relationships focused on social inclusion, human rights and recovery, that is, a person's ability to live a self-directed life, with or without symptoms, that they believe is meaningful and satisfying.

Competencies

1 All nurses must practise with confidence according to *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC 2015), and within other recognised ethical and legal frameworks. They must be able to recognise and address ethical challenges relating to people's choices and decision-making about their care, and act within the law to help them and their families and carers find acceptable solutions.

1.1 **Mental health nurses** must understand and apply current legislation to all service users, paying special attention to the protection of vulnerable people, including those with complex needs arising from ageing, cognitive impairment, long-term conditions and those approaching the end of life.

2 All nurses must practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion; recognises and respects individual choice; and acknowledges diversity. Where necessary, they must challenge inequality, discrimination and exclusion from access to care.

2.1 **Mental health nurses** must practise in a way that addresses the potential power imbalances between professionals and people experiencing mental health problems, including situations when compulsory measures are used, by helping people exercise their rights, upholding safeguards and ensuring minimal restrictions on their lives. They must have an in depth understanding of mental health legislation and how it relates to care and treatment of people with mental health problems.

3 All nurses must support and promote the health, wellbeing, rights and dignity of people, groups, communities and populations. These include people whose lives are affected by ill health, disability, inability to engage, ageing or death. Nurses must act on their understanding of how these conditions influence public health.

3.1 **Mental health nurses** must promote mental health and wellbeing, while challenging the inequalities and discrimination that may arise from or contribute to mental health problems.

4 All nurses must work in partnership with service users, carers, groups, communities and organisations. They must manage risk, and promote health and wellbeing while aiming to empower choices that promote self-care and safety.

4.1 **Mental health nurses** must work with people in a way that values, respects and explores the meaning of their individual lived experiences of mental health problems, to provide person-centred and recovery-focused practice.

5 All nurses must fully understand the nurse's various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities and populations.

6 All nurses must understand the roles and responsibilities of other health and social care professionals, and seek to work with them collaboratively for the benefit of all who need care.

7 All nurses must be responsible and accountable for keeping their knowledge and skills up to date through continuing professional development. They must aim to improve their performance and enhance the safety and quality of care through evaluation, supervision and appraisal.

8 All nurses must practise independently, recognising the limits of their competence and knowledge. They must reflect on these limits and seek advice from, or refer to, other professionals where necessary.

8.1 **Mental health nurses** must have and value an awareness of their own mental health and wellbeing. They must also engage in reflection and supervision to explore the emotional impact on self of working in mental health; how personal values, beliefs and emotions impact on practice, and how their own practice aligns with mental health legislation, policy and values-based frameworks.

9 All nurses must appreciate the value of evidence in practice, be able to understand and appraise research, apply relevant theory and research findings to their work, and identify areas for further investigation.

Domain 2: Communication and interpersonal skills

Generic standard for competence

All nurses must use excellent communication and interpersonal skills. Their communications must always be safe, effective, compassionate and respectful. They must communicate effectively using a wide range of strategies and interventions including the effective use of communication technologies. Where people have a disability, nurses must be able to work with service users and others to obtain the information needed to make reasonable adjustments that promote optimum health and enable equal access to services,

Field standard for competence

Mental health nurses must practise in a way that focuses on the therapeutic use of self. They must draw on a range of methods of engaging with people of all ages experiencing mental health problems, and those important to them, to develop and maintain therapeutic relationships. They must work alongside people, using a range of interpersonal approaches and skills to help them explore and make sense of their experiences in a way that promotes recovery.

Competencies

1 All nurses must build partnerships and therapeutic relationships through safe, effective and non-discriminatory communication. They must take account of individual differences, capabilities and needs.

1.1 **Mental health nurses** must use skills of relationship-building and communication to engage with and support people distressed by hearing voices, experiencing distressing thoughts or experiencing other perceptual problems.

1.2 **Mental health nurses** must use skills and knowledge to facilitate therapeutic groups with people experiencing mental health problems and their families and carers.

2 All nurses must use a range of communication skills and technologies to support person-centred care and enhance quality and safety. They must ensure people receive all the information they need in a language and manner that allows them to make informed choices and share decision making. They must recognise when language interpretation or other communication support is needed and know how to obtain it.

3 All nurses must use the full range of communication methods, including verbal, non-verbal and written, to acquire, interpret and record their knowledge and understanding of people's needs. They must be aware of their own values and beliefs and the impact this may have on their communication with others. They must take account of the many different ways in which people communicate and how these may be influenced by ill health, disability and other factors, and be able to recognise and respond effectively when a person finds it hard to communicate.

4 All nurses must recognise when people are anxious or in distress and respond effectively, using therapeutic principles, to promote their wellbeing, manage personal safety and resolve conflict. They must use effective communication strategies and negotiation techniques to achieve best outcomes, respecting the dignity and human rights of all concerned. They must know when to consult a third party and how to make referrals for advocacy, mediation or arbitration.

4.1 **Mental health nurses** must be sensitive to, and take account of, the impact of abuse and trauma on people's wellbeing and the development of mental health problems. They must use interpersonal skills and make interventions that help people disclose and discuss their experiences as part of their recovery.

5 All nurses must use therapeutic principles to engage, maintain and, where appropriate, disengage from professional caring relationships, and must always respect professional boundaries.

5.1 **Mental health nurses** must use their personal qualities, experiences and interpersonal skills to develop and maintain therapeutic, recovery-focused relationships with people and therapeutic groups. They must be aware of their own mental health, and know when to share aspects of their own life to inspire hope while maintaining professional boundaries.

6 All nurses must take every opportunity to encourage health-promoting behaviour through education, role modelling and effective communication.

6.1 **Mental health nurses** must foster helpful and enabling relationships with families, carers and other people important to the person experiencing mental health problems. They must use communication skills that enable psychosocial education, problem-solving and other interventions to help people cope and to safeguard those who are vulnerable.

7 All nurses must maintain accurate, clear and complete records, including the use of electronic formats, using appropriate and plain language.

8 All nurses must respect individual rights to confidentiality and keep information secure and confidential in accordance with the law and relevant ethical and regulatory frameworks, taking account of local protocols. They must also actively share personal information with others when the interests of safety and protection override the need for confidentiality.

Domain 3: Nursing practice and decision-making

Generic standard for competence

All nurses must practise autonomously, compassionately, skilfully and safely, and must maintain dignity and promote health and wellbeing. They must assess and meet the full range of essential physical and mental health needs of people of all ages who come into their care. Where necessary they must be able to provide safe and effective immediate care to all people prior to accessing or referring to specialist services irrespective of their field of practice. All nurses must also meet more complex and coexisting needs for people in their own nursing field of practice, in any setting including hospital, community and at home. All practice should be informed by the best available evidence and comply with local and national guidelines. Decision-making must be shared with service users, carers and families and informed by critical analysis of a full range of possible interventions, including the use of up-to-date technology. All nurses must also understand how behaviour, culture, socioeconomic and other factors, in the care environment and its location, can affect health, illness, health outcomes and public health priorities and take this into account in planning and delivering care.

Field standard for competence

Mental health nurses must draw on a range of evidence-based psychological, psychosocial and other complex therapeutic skills and interventions to provide person-centred support and care across all ages, in a way that supports self-determination and aids recovery. They must also promote improvements in physical and mental health and wellbeing and provide direct care to meet both the essential and complex physical and mental health needs of people with mental health problems.

Competencies

1 All nurses must use up-to-date knowledge and evidence to assess, plan, deliver and evaluate care, communicate findings, influence change and promote health and best practice. They must make person-centred, evidence-based judgments and decisions, in partnership with others involved in the care process, to ensure high quality care. They must be able to recognise when the complexity of clinical decisions requires specialist knowledge and expertise, and consult or refer accordingly.

1.1 **Mental health nurses** must be able to recognise and respond to the needs of all people who come into their care including babies, children and young people, pregnant and postnatal women, people with physical health problems, people with physical disabilities, people with learning disabilities, older people, and people with long term problems such as cognitive impairment.

2 All nurses must possess a broad knowledge of the structure and functions of the human body, and other relevant knowledge from the life, behavioral and social sciences as applied to health, ill health, disability, ageing and death. They must have an in-depth knowledge of common physical and mental health problems and treatments in their own field of practice, including co-morbidity and physiological and psychological vulnerability.

3 All nurses must carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement.

3.1 **Mental health nurses** must be able to apply their knowledge and skills in a range of evidence-based individual and group psychological and psychosocial interventions, to carry out systematic needs assessments, develop case formulations and negotiate goals.

4 All nurses must ascertain and respond to the physical, social and psychological needs of people, groups and communities. They must then plan, deliver and evaluate safe, competent, person-centred care in partnership with them, paying special attention to changing health needs during different life stages, including progressive illness and death, loss and bereavement.

4.1 **Mental health nurses** must be able to apply their knowledge and skills in a range of evidence-based psychological and psychosocial individual and group interventions to develop and implement care plans and evaluate outcomes, in partnership with service users and others.

5 All nurses must understand public health principles, priorities and practice in order to recognise and respond to the major causes and social determinants of health, illness and health inequalities. They must use a range of information and data to assess the needs of people, groups, communities and populations, and work to improve health, wellbeing and experiences of healthcare; secure equal access to health screening, health promotion and healthcare; and promote social inclusion.

5.1 **Mental health nurses** must work to promote mental health, help prevent mental health problems in at-risk groups, and enhance the health and wellbeing of people with mental health problems.

6 All nurses must practise safely by being aware of the correct use, limitations and hazards of common interventions, including nursing activities, treatments, and the use of medical devices and equipment. The nurse must be able to evaluate their use, report any concerns promptly through appropriate channels and modify care where necessary to maintain safety. They must contribute to the collection of local and national data and formulation of policy on risks, hazards and adverse outcomes.

6.1 **Mental health nurses** must help people experiencing mental health problems to make informed choices about pharmacological and physical treatments, by providing education and information on the benefits and unwanted effects, choices and alternatives. They must support people to identify actions that promote health and help to balance benefits and unwanted effects.

7 All nurses must be able to recognise and interpret signs of normal and deteriorating mental and physical health and respond promptly to maintain or improve the health and comfort of the service user, acting to keep them and others safe.

7.1 **Mental health nurses** must provide support and therapeutic interventions for people experiencing critical and acute mental health problems. They must recognise the health and social factors that can contribute to crisis and relapse and use skills in early intervention, crisis resolution and relapse management in a way that ensures safety and security and promotes recovery.

7.2 **Mental health nurses** must work positively and proactively with people who are at risk of suicide or self-harm, and use evidence-based models of suicide prevention, intervention and harm reduction to minimise risk.

8 All nurses must provide educational support, facilitation skills and therapeutic nursing interventions to optimise health and wellbeing. They must promote self-care and management whenever possible, helping people to make choices about their healthcare needs, involving families and carers where appropriate, to maximise their ability to care for themselves.

8.1 **Mental health nurses** must practise in a way that promotes the self-determination and expertise of people with mental health problems, using a range of approaches and tools that aid wellness and recovery and enable self-care and self-management.

9 All nurses must be able to recognise when a person is at risk and in need of extra support and protection and take reasonable steps to protect them from abuse.

9.1 **Mental health nurses** must use recovery-focused approaches to care in situations that are potentially challenging, such as times of acute distress; when compulsory measures are used; and in forensic mental health settings. They must seek to maximise service user involvement and therapeutic engagement, using interventions that balance the need for safety with positive risk-taking.

10 All nurses must evaluate their care to improve clinical decision-making, quality and outcomes, using a range of methods, amending the plan of care, where necessary, and communicating changes to others.

Domain 4: Leadership, management and team working

Generic standard for competence

All nurses must be professionally accountable and use clinical governance processes to maintain and improve nursing practice and standards of healthcare. They must be able to respond autonomously and confidently to planned and uncertain situations, managing themselves and others effectively. They must create and maximise opportunities to improve services. They must also demonstrate the potential to develop further management and leadership skills during their period of preceptorship and beyond.

Field standard for competence

Mental health nurses must contribute to the leadership, management and design of mental health services. They must work with service users, carers, other professionals and agencies to shape future services, aid recovery and challenge discrimination and inequality.

Competencies

1 All nurses must act as change agents and provide leadership through quality improvement and service development to enhance people's wellbeing and experiences of healthcare.

2 All nurses must systematically evaluate care and ensure that they and others use the findings to help improve people's experience and care outcomes and to shape future services.

3 All nurses must be able to identify priorities and manage time and resources effectively to ensure the quality of care is maintained or enhanced.

4 All nurses must be self-aware and recognise how their own values, principles and assumptions may affect their practice. They must maintain their own personal and professional development, learning from experience, through supervision, feedback, reflection and evaluation.

4.1 **Mental health nurses** must actively promote and participate in clinical supervision and reflection, within a values-based mental health framework, to explore how their values, beliefs and emotions affect their leadership, management and practice.

5 All nurses must facilitate nursing students and others to develop their competence, using a range of professional and personal development skills.

5.1 **Mental health nurses** must help raise awareness of mental health, and provide advice and support in best practice in mental health care and treatment to members of the multiprofessional team and others working in health, social care and other services and settings.

6 All nurses must work independently as well as in teams. They must be able to take the lead in coordinating, delegating and supervising care safely, managing risk and remaining accountable for the care given.

6.1 **Mental health nurses** must contribute to the management of mental health care environments by giving priority to actions that enhance people's safety, psychological security and therapeutic outcomes, and by ensuring effective communication, positive risk management and continuity of care across service boundaries.

7 All nurses must work effectively across professional and agency boundaries, actively involving and respecting others' contributions to integrated person-centred care. They must know when and how to communicate with and refer to other professionals and agencies in order to respect the choices of service users and others, promoting shared decision making, to deliver positive outcomes and to coordinate smooth, effective transition within and between services and agencies.

Competencies for entry to the register: Learning disabilities nursing

Domain 1: Professional values

Generic standard for competence

All nurses must act first and foremost to care for and safeguard the public. They must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights. They must show professionalism and integrity and work within recognised professional, ethical and legal frameworks. They must work in partnership with other health and social care professionals and agencies, service users, their carers and families in all settings, including the community, ensuring that decisions about care are shared.

Field standard for competence

Learning disabilities nurses must promote the individuality, independence, rights, choice and social inclusion of people with learning disabilities and highlight their strengths and abilities at all times while encouraging others do the same. They must facilitate the active participation of families and carers.

Competencies

1 All nurses must practise with confidence according to *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC 2015), and within other recognised ethical and legal frameworks. They must be able to recognise and address ethical challenges relating to people's choices and decision-making about their care, and act within the law to help them and their families and carers find acceptable solutions.

1.1 **Learning disabilities nurses** must understand and apply current legislation to all service users, paying special attention to the protection of vulnerable people, including those with complex needs arising from ageing, cognitive impairment, long-term conditions and those approaching the end of life.

2 All nurses must practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion; recognises and respects individual choice; and acknowledges diversity. Where necessary, they must challenge inequality, discrimination and exclusion from access to care.

2.1 **Learning disabilities nurses** must always promote the autonomy, rights and choices of people with learning disabilities and support and involve their families and carers, ensuring that each person's rights are upheld according to policy and the law.

3 All nurses must support and promote the health, wellbeing, rights and dignity of people, groups, communities and populations. These include people whose lives are affected by ill health, disability, inability to engage, ageing or death. Nurses must act on their understanding of how these conditions influence public health.

3.1 **Learning disabilities nurses** must use their knowledge and skills to exercise professional advocacy, and recognise when it is appropriate to refer to independent advocacy services to safeguard dignity and human rights.

4 All nurses must work in partnership with service users, carers, groups, communities and organisations. They must manage risk, and promote health and wellbeing while aiming to empower choices that promote self-care and safety.

4.1 **Learning disabilities nurses** must recognise that people with learning disabilities are full and equal citizens, and must promote their health and wellbeing by focusing on and developing their strengths and abilities.

5 All nurses must fully understand the nurse's various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities and populations.

6 All nurses must understand the roles and responsibilities of other health and social care professionals, and seek to work with them collaboratively for the benefit of all who need care.

7 All nurses must be responsible and accountable for keeping their knowledge and skills up to date through continuing professional development. They must aim to improve their performance and enhance the safety and quality of care through evaluation, supervision and appraisal.

8 All nurses must practise independently, recognising the limits of their competence and knowledge. They must reflect on these limits and seek advice from, or refer to, other professionals where necessary.

9 All nurses must appreciate the value of evidence in practice, be able to understand and appraise research, apply relevant theory and research findings to their work, and identify areas for further investigation.

Domain 2: Communication and interpersonal skills

Generic standard for competence

All nurses must use excellent communication and interpersonal skills. Their communications must always be safe, effective, compassionate and respectful. They must communicate effectively using a wide range of strategies and interventions including the effective use of communication technologies. Where people have a disability, nurses must be able to work with service users and others to obtain the information needed to make reasonable adjustments that promote optimum health and enable equal access to services,

Field standard for competence

Learning disabilities nurses must use complex communication and interpersonal skills and strategies to work with people of all ages who have learning disabilities and help them to express themselves. They must also be able to communicate and negotiate effectively with other professionals, services and agencies, and ensure that people with learning disabilities, their families and carers, are fully involved in decision-making.

Competencies

1 All nurses must build partnerships and therapeutic relationships through safe, effective and non-discriminatory communication. They must take account of individual differences, capabilities and needs.

1.1 **Learning disabilities nurses** must use the full range of person-centred alternative and augmentative communication strategies and skills to build partnerships and therapeutic relationships with people with learning disabilities.

2 All nurses must use a range of communication skills and technologies to support person-centred care and enhance quality and safety. They must ensure people receive all the information they need in a language and manner that allows them to make informed choices and share decision making. They must recognise when language interpretation or other communication support is needed and know how to obtain it.

2.1 **Learning disabilities nurses** must be able to make all relevant information accessible to and understandable by people with learning disabilities, including adaptation of format, presentation and delivery.

3 All nurses must use the full range of communication methods, including verbal, non-verbal and written, to acquire, interpret and record their knowledge and understanding of people's needs. They must be aware of their own values and beliefs and the impact this may have on their communication with others. They must take account of the many different ways in which people communicate and how these may be influenced by ill health, disability and other factors, and be able to recognise and respond effectively when a person finds it hard to communicate.

3.1 **Learning disabilities nurses** must use a structured approach to assess, communicate with, interpret and respond therapeutically to people with learning disabilities who have complex physical and psychological health needs or those in behavioural distress.

4 All nurses must recognise when people are anxious or in distress and respond effectively, using therapeutic principles, to promote their wellbeing, manage personal safety and resolve conflict. They must use effective communication strategies and negotiation techniques to achieve best outcomes, respecting the dignity and human rights of all concerned. They must know when to consult a third party and how to make referrals for advocacy, mediation or arbitration.

4.1 **Learning disabilities nurses** must recognise and respond therapeutically to the complex behaviour that people with learning disabilities may use as a means of communication.

5 All nurses must use therapeutic principles to engage, maintain and, where appropriate, disengage from professional caring relationships, and must always respect professional boundaries.

6 All nurses must take every opportunity to encourage health-promoting behaviour through education, role modelling and effective communication.

7 All nurses must maintain accurate, clear and complete records, including the use of electronic formats, using appropriate and plain language.

8 All nurses must respect individual rights to confidentiality and keep information secure and confidential in accordance with the law and relevant ethical and regulatory frameworks, taking account of local protocols. They must also actively share personal information with others when the interests of safety and protection override the need for confidentiality.

Domain 3: Nursing practice and decision-making

Generic standard for competence

All nurses must practise autonomously, compassionately, skilfully and safely, and must maintain dignity and promote health and wellbeing. They must assess and meet the full range of essential physical and mental health needs of people of all ages who come into their care. Where necessary they must be able to provide safe and effective immediate care to all people prior to accessing or referring to specialist services irrespective of their field of practice. All nurses must also meet more complex and coexisting needs for people in their own nursing field of practice, in any setting including hospital, community and at home. All practice should be informed by the best available evidence and comply with local and national guidelines. Decision-making must be shared with service users, carers and families and informed by critical analysis of a full range of possible interventions, including the use of up-to-date technology. All nurses must also understand how behaviour, culture, socioeconomic and other factors, in the care environment and its location, can affect health, illness, health outcomes and public health priorities and take this into account in planning and delivering care.

Field standard for competence

Learning disabilities nurses must have an enhanced knowledge of the health and developmental needs of all people with learning disabilities, and the factors that might influence them. They must aim to improve and maintain their health and independence through skilled direct and indirect nursing care. They must also be able to provide direct care to meet the essential and complex physical and mental health needs of people with learning disabilities.

Competencies

1 All nurses must use up-to-date knowledge and evidence to assess, plan, deliver and evaluate care, communicate findings, influence change and promote health and best practice. They must make person-centred, evidence-based judgments and decisions, in partnership with others involved in the care process, to ensure high quality care. They must be able to recognise when the complexity of clinical decisions requires specialist knowledge and expertise, and consult or refer accordingly.

1.1 **Learning disabilities nurses** must be able to recognise and respond to the needs of all people who come into their care including babies, children and young people, pregnant and postnatal women, people with mental health problems, people with physical health problems and disabilities, older people, and people with long term problems such as cognitive impairment.

2 All nurses must possess a broad knowledge of the structure and functions of the human body, and other relevant knowledge from the life, behavioural and social sciences as applied to health, ill health, disability, ageing and death. They must have an in-depth knowledge of common physical and mental health problems and treatments in their own field of practice, including co-morbidity and physiological and psychological vulnerability.

3 All nurses must carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement.

3.1 **Learning disabilities nurses** must use a structured, person-centred approach to assess, interpret and respond therapeutically to people with learning disabilities, and their often complex, pre-existing physical and psychological health needs. They must work in partnership with service users, carers and other professionals, services and agencies to agree and implement individual care plans and ensure continuity of care.

4 All nurses must ascertain and respond to the physical, social and psychological needs of people, groups and communities. They must then plan, deliver and evaluate safe, competent, person-centred care in partnership with them, paying special attention to changing health needs during different life stages, including progressive illness and death, loss and bereavement.

5 All nurses must understand public health principles, priorities and practice in order to recognise and respond to the major causes and social determinants of health, illness and health inequalities. They must use a range of information and data to assess the needs of people, groups, communities and populations, and work to improve health, wellbeing and experiences of healthcare; secure equal access to health screening, health promotion and healthcare; and promote social inclusion.

5.1 **Learning disabilities nurses** must lead the development, implementation and review of individual plans for all people with learning disabilities, to promote their optimum health and wellbeing and facilitate their equal access to all health, social care and specialist services.

6 All nurses must practise safely by being aware of the correct use, limitations and hazards of common interventions, including nursing activities, treatments, and the use of medical devices and equipment. The nurse must be able to evaluate their use, report any concerns promptly through appropriate channels and modify care where necessary to maintain safety. They must contribute to the collection of local and national data and formulation of policy on risks, hazards and adverse outcomes.

7 All nurses must be able to recognise and interpret signs of normal and deteriorating mental and physical health and respond promptly to maintain or improve the health and comfort of the service user, acting to keep them and others safe.

8 All nurses must provide educational support, facilitation skills and therapeutic nursing interventions to optimise health and wellbeing. They must promote self-care and management whenever possible, helping people to make choices about their healthcare needs, involving families and carers where appropriate, to maximise their ability to care for themselves.

8.1 **Learning disabilities nurses** must work in partnership with people with learning disabilities and their families and carers to facilitate choice and

maximise self-care and self-management and co-ordinate the transition between different services and agencies.

9 All nurses must be able to recognise when a person is at risk and in need of extra support and protection and take reasonable steps to protect them from abuse.

10 All nurses must evaluate their care to improve clinical decision-making, quality and outcomes, using a range of methods, amending the plan of care, where necessary, and communicating changes to others.

Domain 4: Leadership, management and team working

Generic standard for competence

All nurses must be professionally accountable and use clinical governance processes to maintain and improve nursing practice and standards of healthcare. They must be able to respond autonomously and confidently to planned and uncertain situations, managing themselves and others effectively. They must create and maximise opportunities to improve services. They must also demonstrate the potential to develop further management and leadership skills during their period of preceptorship and beyond.

Field standard for competence

Learning disabilities nurses must exercise collaborative management, delegation and supervision skills to create, manage and support therapeutic environments for people with learning disabilities.

Competencies

1 All nurses must act as change agents and provide leadership through quality improvement and service development to enhance people's wellbeing and experiences of healthcare.

1.1 **Learning disabilities nurses** must take the lead in ensuring that people with learning disabilities receive support that creatively addresses their physical, social, economic, psychological, spiritual and other needs, when assessing, planning and delivering care.

1.2 **Learning disabilities nurses** must provide direction through leadership and education to ensure that their unique contribution is recognised in service design and provision.

2 All nurses must systematically evaluate care and ensure that they and others use the findings to help improve people's experience and care outcomes and to shape future services.

2.1 **Learning disabilities nurses** must use data and research findings on the health of people with learning disabilities to help improve people's experiences and care outcomes, and shape of future services.

3 All nurses must be able to identify priorities and manage time and resources effectively to ensure the quality of care is maintained or enhanced.

4 All nurses must be self-aware and recognise how their own values, principles and assumptions may affect their practice. They must maintain their own personal and professional development, learning from experience, through supervision, feedback, reflection and evaluation.

5 All nurses must facilitate nursing students and others to develop their competence, using a range of professional and personal development skills.

6 All nurses must work independently as well as in teams. They must be able to take the lead in coordinating, delegating and supervising care safely, managing risk and remaining accountable for the care given.

6.1 **Learning disabilities nurses** must use leadership, influencing and decision-making skills to engage effectively with a range of agencies and professionals. They must also be able, when needed, to represent the health needs and protect the rights of people with learning disabilities and challenge negative stereotypes.

6.2 **Learning disabilities nurses** must work closely with stakeholders to enable people with learning disabilities to exercise choice and challenge discrimination.

7 All nurses must work effectively across professional and agency boundaries, actively involving and respecting others' contributions to integrated person-centred care. They must know when and how to communicate with and refer to other professionals and agencies in order to respect the choices of service users and others, promoting shared decision making, to deliver positive outcomes and to coordinate smooth, effective transition within and between services and agencies.

Competencies for entry to the register: Children's nursing

Domain 1: Professional values

Generic standard for competence

All nurses must act first and foremost to care for and safeguard the public. They must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights. They must show professionalism and integrity and work within recognised professional, ethical and legal frameworks. They must work in partnership with other health and social care professionals and agencies, service users, their carers and families in all settings, including the community, ensuring that decisions about care are shared.

Field standard for competence

Children's nurses must understand their role as an advocate for children, young people and their families, and work in partnership with them. They must deliver child and family-centred care; empower children and young people to express their views and preferences; and maintain and recognise their rights and best interests.

Competencies

1 All nurses must practise with confidence according to *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC 2015), and within other recognised ethical and legal frameworks. They must be able to recognise and address ethical challenges relating to people's choices and decision-making about their care, and act within the law to help them and their families and carers find acceptable solutions.

1.1 **Children's nurses** must understand the laws relating to child and parental consent, including giving and refusing consent, withdrawal of treatment and legal capacity.

2 All nurses must practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion; recognises and respects individual choice; and acknowledges diversity. Where necessary, they must challenge inequality, discrimination and exclusion from access to care.

2.1 **Children's nurses** must recognise that all children and young people have the right to be safe, enjoy life and reach their potential. They must practise in a way that recognises, respects and responds to the individuality of every child and young person.

3 All nurses must support and promote the health, wellbeing, rights and dignity of people, groups, communities and populations. These include people whose lives are affected by ill health, disability, inability to engage, ageing or death. Nurses must act on their understanding of how these conditions influence public health.

3.1 **Children's nurses** must act as advocates for the right of all children and young people to lead full and independent lives.

4 All nurses must work in partnership with service users, carers, groups, communities and organisations. They must manage risk, and promote health and wellbeing while aiming to empower choices that promote self-care and safety.

4.1 **Children's nurses** must work in partnership with children, young people and their families to negotiate, plan and deliver child and family-centred care, education and support. They must recognise the parent's or carer's primary role in achieving and maintaining the child's or young person's health and wellbeing, and offer advice and support on parenting in health and illness.

5 All nurses must fully understand the nurse's various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities and populations.

6 All nurses must understand the roles and responsibilities of other health and social care professionals, and seek to work with them collaboratively for the benefit of all who need care.

7 All nurses must be responsible and accountable for keeping their knowledge and skills up to date through continuing professional development. They must aim to improve their performance and enhance the safety and quality of care through evaluation, supervision and appraisal.

8 All nurses must practise independently, recognising the limits of their competence and knowledge. They must reflect on these limits and seek advice from, or refer to, other professionals where necessary.

9 All nurses must appreciate the value of evidence in practice, be able to understand and appraise research, apply relevant theory and research findings to their work, and identify areas for further investigation.

Domain 2: Communication and interpersonal skills

Generic standard for competence

All nurses must use excellent communication and interpersonal skills. Their communications must always be safe, effective, compassionate and respectful. They must communicate effectively using a wide range of strategies and interventions including the effective use of communication technologies. Where people have a disability, nurses must be able to work with service users and others to obtain the information needed to make reasonable adjustments that promote optimum health and enable equal access to services.

Field standard for competence

Children's nurses must take account of each child and young person's individuality, including their stage of development, ability to understand, culture, learning or communication difficulties and health status. They must communicate effectively with them and with parents and carers.

Competencies

1 All nurses must build partnerships and therapeutic relationships through safe, effective and non-discriminatory communication. They must take account of individual differences, capabilities and needs.

1.1 **Children's nurses** must work with the child, young person and others to ensure that they are actively involved in decision-making, in order to maintain their independence and take account of their ongoing intellectual, physical and emotional needs.

2 All nurses must use a range of communication skills and technologies to support person-centred care and enhance quality and safety. They must ensure people receive all the information they need in a language and manner that allows them to make informed choices and share decision making. They must recognise when language interpretation or other communication support is needed and know how to obtain it.

2.1 **Children's nurses** must understand all aspects of development from infancy to young adulthood, and identify each child or young person's developmental stage, in order to communicate effectively with them. They must use play, distraction and communication tools appropriate to the child's or young person's stage of development, including for those with sensory or cognitive impairment.

3 All nurses must use the full range of communication methods, including verbal, non-verbal and written, to acquire, interpret and record their knowledge and understanding of people's needs. They must be aware of their own values and beliefs and the impact this may have on their communication with others. They must take account of the many different ways in which people communicate and how these may be influenced by ill health, disability and other factors, and be able to recognise and respond effectively when a person finds it hard to communicate.

3.1 Children's nurses must ensure that, where possible, children and young people understand their healthcare needs and can make or contribute to informed choices about all aspects of their care.

4 All nurses must recognise when people are anxious or in distress and respond effectively, using therapeutic principles, to promote their wellbeing, manage personal safety and resolve conflict. They must use effective communication strategies and negotiation techniques to achieve best outcomes, respecting the dignity and human rights of all concerned. They must know when to consult a third party and how to make referrals for advocacy, mediation or arbitration.

5 All nurses must use therapeutic principles to engage, maintain and, where appropriate, disengage from professional caring relationships, and must always respect professional boundaries.

6 All nurses must take every opportunity to encourage health-promoting behaviour through education, role modelling and effective communication.

7 All nurses must maintain accurate, clear and complete records, including the use of electronic formats, using appropriate and plain language.

8 All nurses must respect individual rights to confidentiality and keep information secure and confidential in accordance with the law and relevant ethical and regulatory frameworks, taking account of local protocols. They must also actively share personal information with others when the interests of safety and protection override the need for confidentiality.

Domain 3: Nursing practice and decision-making

Generic standard for competence

All nurses must practise autonomously, compassionately, skilfully and safely, and must maintain dignity and promote health and wellbeing. They must assess and meet the full range of essential physical and mental health needs of people of all ages who come into their care. Where necessary they must be able to provide safe and effective immediate care to all people prior to accessing or referring to specialist services irrespective of their field of practice. All nurses must also meet more complex and coexisting needs for people in their own nursing field of practice, in any setting including hospital, community and at home. All practice should be informed by the best available evidence and comply with local and national guidelines. Decision-making must be shared with service users, carers and families and informed by critical analysis of a full range of possible interventions, including the use of up-to-date technology. All nurses must also understand how behaviour, culture, socioeconomic and other factors, in the care environment and its location, can affect health, illness, health outcomes and public health priorities and take this into account in planning and delivering care.

Field standard for competence

Children's nurses must be able to care safely and effectively for children and young people in all settings, and recognise their responsibility for safeguarding them. They must be able to deliver care to meet essential and complex physical and mental health needs informed by deep understanding of biological, psychological and social factors throughout infancy, childhood and adolescence.

Competencies

1 All nurses must use up-to-date knowledge and evidence to assess, plan, deliver and evaluate care, communicate findings, influence change and promote health and best practice. They must make person-centred, evidence-based judgments and decisions, in partnership with others involved in the care process, to ensure high quality care. They must be able to recognise when the complexity of clinical decisions requires specialist knowledge and expertise, and consult or refer accordingly.

1.1 **Children's nurses** must be able to recognise and respond to the essential needs of all people who come into their care including babies, pregnant and postnatal women, adults, people with mental health problems, people with physical disabilities, people with learning disabilities, and people with long term problems such as cognitive impairment.

1.2 **Children's nurses** must use recognised, evidence-based, child-centred frameworks to assess, plan, implement, evaluate and record care, and to underpin clinical judgments and decision-making. Care planning and delivery must be informed by knowledge of pharmacology, anatomy and physiology, pathology, psychology and sociology, from infancy to young adulthood.

2 All nurses must possess a broad knowledge of the structure and functions of the human body, and other relevant knowledge from the life, behavioural and social sciences as applied to health, ill health, disability, ageing and death. They must have an in-depth knowledge of common physical and mental health problems and treatments in their own field of practice, including co-morbidity and physiological and psychological vulnerability.

3 All nurses must carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement.

3.1 **Children's nurses** must carry out comprehensive nursing assessments of children and young people, recognising the particular vulnerability of infants and young children to rapid physiological deterioration.

4 All nurses must ascertain and respond to the physical, social and psychological needs of people, groups and communities. They must then plan, deliver and evaluate safe, competent, person-centred care in partnership with them, paying special attention to changing health needs during different life stages, including progressive illness and death, loss and bereavement.

5 All nurses must understand public health principles, priorities and practice in order to recognise and respond to the major causes and social determinants of health, illness and health inequalities. They must use a range of information and data to assess the needs of people, groups, communities and populations, and work to improve health, wellbeing and experiences of healthcare; secure equal access to health screening, health promotion and healthcare; and promote social inclusion.

5.1 **Children's nurses** must include health promotion, and illness and injury prevention, in their nursing practice. They must promote early intervention to address the links between early life adversity and adult ill health, and the risks to the current and future physical, mental, emotional and sexual health of children and young people.

6 All nurses must practise safely by being aware of the correct use, limitations and hazards of common interventions, including nursing activities, treatments, the calculation and administration of medicines, and the use of medical devices and equipment. The nurse must be able to evaluate their use, report any concerns promptly through appropriate channels and modify care where necessary to maintain safety. They must contribute to the collection of local and national data and formulation of policy on risks, hazards and adverse outcomes.

6.1 **Children's nurses** must have numeracy skills for medicines management, assessment, measuring, monitoring and recording which recognise the particular vulnerability of infants and young children in relation accurate medicines calculation.

7 All nurses must be able to recognise and interpret signs of normal and deteriorating mental and physical health and respond promptly to maintain or improve the health and comfort of the service user, acting to keep them and others safe.

8 All nurses must provide educational support, facilitation skills and therapeutic nursing interventions to optimise health and wellbeing. They must promote self-care and management whenever possible, helping people to make choices about their healthcare needs, involving families and carers where appropriate, to maximise their ability to care for themselves.

8.1 **Children's nurses** must use negotiation skills to ensure the best interests of children and young people in all decisions, including the continuation or withdrawal of care. Negotiation must include the child or young person, their family and members of the multidisciplinary and interagency team where appropriate.

9 All nurses must be able to recognise when a person is at risk and in need of extra support and protection and take reasonable steps to safeguard them against abuse.

9.1 **Children's nurses** must understand their central role in preventing maltreatment, and safeguarding children and young people. They must work closely with relevant agencies and professionals, and know when and how to identify and refer those at risk or experiencing harm.

10 All nurses must evaluate their care to improve clinical decision-making, quality and outcomes, using a range of methods, amending the plan of care, where necessary, and communicating changes to others.

Domain 4: Leadership, management and team working

Generic standard for competence

All nurses must be professionally accountable and use clinical governance processes to maintain and improve nursing practice and standards of healthcare. They must be able to respond autonomously and confidently to planned and uncertain situations, managing themselves and others effectively. They must create and maximise opportunities to improve services. They must also demonstrate the potential to develop further management and leadership skills during their period of preceptorship and beyond.

Field standard for competence

Children's nurses must listen and respond to the wishes of children and young people. They must influence the delivery of health and social care services to optimise the care of children and young people. They must work closely with other agencies and services to ensure seamless and well-supported transition to adult services.

Competencies

1 All nurses must act as change agents and provide leadership through quality improvement and service development to enhance people's wellbeing and experiences of healthcare.

1.1 **Children's nurses** must understand health and social care policies relating to the health and wellbeing of children and young people. They must, where possible, empower and enable children, young people, parents and carers to influence the quality of care and develop future policies and strategies.

1.2 **Children's nurses** must ensure that, wherever possible, care is delivered in the child or young person's home, or in another environment that suits their age, needs and preferences.

2 All nurses must systematically evaluate care and ensure that they and others use the findings to help improve people's experience and care outcomes and to shape future services.

3 All nurses must be able to identify priorities and manage time and resources effectively to ensure the quality of care is maintained or enhanced.

4 All nurses must be self-aware and recognise how their own values, principles and assumptions may affect their practice. They must maintain their own personal and professional development, learning from experience, through supervision, feedback, reflection and evaluation.

5 All nurses must facilitate nursing students and others to develop their competence, using a range of professional and personal development skills.

6 All nurses must work independently as well as in teams. They must be able to take the lead in coordinating, delegating and supervising care safely, managing risk and remaining accountable for the care given.

6.1 **Children's nurses** must use effective clinical decision-making skills when managing complex and unpredictable situations, especially where the views of children or young people and their parents and carers differ. They must recognise when to seek extra help or advice to manage the situation safely.

7 All nurses must work effectively across professional and agency boundaries, actively involving and respecting others' contributions to integrated person-centred care. They must know when and how to communicate with and refer to other professionals and agencies in order to respect the choices of service users and others, promoting shared decision making, to deliver positive outcomes and to coordinate smooth, effective transition within and between services and agencies.

7.1 **Children's nurses** must work effectively with young people who have continuing health needs, their families, the multidisciplinary team and other agencies to manage smooth and effective transition from children's services to adult services, taking account of individual needs and preferences.

Section 3: Standards for education

Standard 1: Safeguarding the public

Purpose To establish the essential safeguards on any action or act of omission committed or witnessed by a nursing or midwifery student that affects the safety or wellbeing of service users.

Responsibility Programme providers, students, mentors, practice teachers and teachers.

Standard **Nursing and midwifery education must be consistent with The Code: Professional standards of practice and behaviour for nurses and midwives (NMC, 2015).**

Requirement		**Guidance**	
R1.1	**Approved education institutions (AEIs) must be accountable to the NMC for the programme.**		
R1.1.1	The AEI must ensure that the programme meets all NMC standards and requirements for pre-registration nursing programmes in line with the code and relevant legislation, including Directive 2005/36/EC (annexe 1).		
R1.2	**Programme providers must make the needs of service users their first priority.**		
R1.2.1	Programme providers must ensure that no student activity or learning opportunity, or the performance, health or conduct of any individual student, puts people's safety at risk.	G1.2.1a	Programme providers should consider the impact of student learning on service users and respect their right to decline student care.

Requirement		**Guidance**	
		G1.2.1.b	Programme providers should refer to guidance, including: • Guidance issued by the UK health departments and other organisations on students' access to service users in all settings • Health and safety guidance and legislation.
R1.3	**Programme providers must have clear processes in place to deal with any concerns about the safety of service users.**		
R1.3.1	Programme providers must have systems in place to safeguard service users during student learning activities.	G1.3.1	Programme providers should have systems in place to allow prompt action to be taken where there are concerns that a student may not be receiving adequate supervision, or where the quality of the student's experience is in doubt. If necessary, the student should be withdrawn from that learning activity and their competence re-evaluated.
R1.3.2	Programme providers must make sure that students understand their responsibilities and know how to raise concerns when they believe the safety of service users is at risk.		

Requirement		Guidance	
R1.4	**Programme providers must have effective policies and procedures on fitness to practise.**		
R1.4.1	Programme providers must have systems in place to identify and address any concerns about the conduct or health of any nursing student.		

Standard 2: Equality and diversity

Purpose To address key aspects of equality and diversity including access and participation, provision of information, promotion of inclusion, and making reasonable adjustments for people with a disability.

Responsibility Programme providers.

Standard **Nursing and midwifery education must address key aspects of equality and diversity and comply with current legislation.**

Requirement		**Guidance**	
R2.1	**Programme providers must ensure that information about programmes is clear and easily obtainable, and gives sufficient information to allow an applicant to make an informed choice.**	G2.1a	Programme providers should include information about access to programmes for people with disabilities.
		G2.1b	Programme providers should offer guidance on what to do when a student's culture or religion might create difficulties in meeting programme requirements, for example, dress codes; caring for people of all genders; and the scheduling of learning activities, assessments and examinations.
R2.1.1	Programme providers must treat all students fairly, and ensure equality of opportunity regardless of race, gender, disability, age, religion or sexual orientation.		

R2.2	**Programme providers must ensure that programmes comply with current equality and diversity legislation, including making reasonable adjustments without compromising safety.**	G2.2	Programme providers should consider how reasonable adjustments can be made to ensure that applicants with disabilities can fully participate in both theory and practice aspects of the programme. In the case of increasing disability, it may not always be possible to make an adjustment or a further adjustment.
R2.3	**Programme providers must have clear policies, guidance and action plans that recognise and respond to the benefits of diversity, promote equality and address discrimination and harassment.**	G2.3	Programme providers should ensure that policies are regularly reviewed and made available to students and staff.

Standard 3: Selection, admission, progression and completion

Purpose To ensure that processes for selection, admission, progression and completion of nursing and midwifery education programmes are open and fair.

Responsibility Programme providers.

Standard **Processes for selection, admission, progression and completion must be open and fair.**

Requirement		**Guidance**	
R3.1	**AEIs must ensure that selection and admission criteria include evidence of a good command of written and spoken English, including reading and comprehension. For programmes delivered in Wales, selection and admission criteria must include evidence of a good command of written and spoken English or Welsh, including reading and comprehension.**		
R3.1.1	AEIs must ensure that selection and admission criteria include evidence of literacy, including the basic skills required to follow a pre-registration nursing programme at a satisfactory level.		

Requirement		Guidance	
R3.1.2	AEIs must ensure that selection and admission criteria include evidence of ability to communicate clearly and effectively in writing, including using a computer.	G3.1.2a	When applicants from outside the European Economic Area (EEA) offer the International English Language Testing System (IELTS) as evidence of literacy, AEIs should apply NMC requirements for overseas applicants to the register. In these cases, the NMC will accept IELTS examination results (academic or general) where the scores are at least 7.0 in the listening and reading sections and at least 7.0 in the writing and speaking sections, and where the overall average score is at least 7.0.
		G3.1.2b	AEIs should ensure that, wherever possible, applicants are given feedback on their level of literacy in relation to their application to support their developmental needs.
R3.2	**AEIs must ensure that selection and admission criteria include evidence of capacity to develop numeracy skills sufficient to meet the competencies required by the programme.**		
R3.2.1	AEIs must ensure that selection and admission criteria provide evidence of basic numeracy skills, such as the ability to use numbers accurately in respect of volume, weight and length. These skills must include addition, subtraction, division and multiplication; use of decimals, fractions and percentages; and the use of a calculator.	G3.2.1	AEIs should ensure, wherever possible, that applicants are given feedback on their level of numeracy in relation to their application to support their developmental needs.
R3.3	**AEIs must specify appropriate academic and professional entry requirements.**		

Requirement		Guidance	
R3.3.1	AEIs must ensure that selection and admission criteria for all programmes include certificated evidence of completion of general education of 10 years, as defined for nurses responsible for general care in article 40(2)(a)(b) of Directive 2005/36/EC on the recognition of professional qualifications.		
R3.4	**AEIs must ensure that students meet NMC requirements for good health and good character.**		
R3.4.1	AEIs must check evidence of students' good health and good character when they enter the programme. They must also check evidence of good health and good character at progression points and on completion. Good health and good character must also be checked when transferring from a nursing programme elsewhere, or when rejoining a programme after a lengthy break. AEIs must require students to immediately declare any cautions and convictions they receive, including charges pending, before entering and throughout the programme.		
R3.4.2	AEIs must ensure that students already registered as nurses or midwives, who are undertaking a further programme leading to a mark on the nurses' part of the register, comply with NMC requirements for good health and good character.		

Requirement		**Guidance**	
R3.4.3	AEIs must ensure that applicants from outside the UK meet the same requirements for good health and good character as UK applicants. Non-EU students must also meet UK government requirements for healthcare workers from overseas.		
R3.5	**Programme providers must ensure that programmes include opportunities for accreditation of prior learning (APL).**		
R3.5.1	Programme providers must have rigorous processes for accrediting both theory and practice learning.	G3.5.1a	AEIs should apply APL when accrediting previous learning in theory or practice for students who are: • starting a programme • transferring from one AEI to another • moving from one nursing field to another • returning to a programme after a lengthy break.
		G3.5.1b	AEIs should develop their own APL procedures based on best practice (for example *Guidelines on the accreditation of prior learning* (Quality Assurance Agency 2004) to be endorsed at programme approval.
		G3.5.1c	AEIs should show for each student how previous learning is mapped to programme outcomes and requirements. AEIs should determine the amount of learning accredited in both theory and practice (up to the permitted NMC maximum).

Requirement		Guidance	
		G3.5.1d	AEIs should be able to show how all programme outcomes and requirements have been met in both theory and practice by the end of the programme through a mix of prior learning and programme attendance. Students cannot be exempted from meeting any programme requirement.
		G3.5.1e	AEIs, when applying APL, should make sure that all progression criteria have been met in both theory and practice for the relevant parts of the programme.
R3.5.2	AEIs must have processes in place to allow APL for up to a maximum of 50 percent of the programme, provided all requirements are met in full. This can be done by combining accredited learning with learning undertaken as part of the approved programme.		
R3.5.3	AEIs must ensure that where APL is applied to students studying adult nursing programmes, the general care requirements of Directive 2005/36/EC are met in full (annexe 1).		
R3.5.4	AEIs receiving students who are transferring from one institution to another must ensure their previous learning is mapped against the new programme, so that they meet all necessary standards and requirements by the end of the programme.		

Requirement		**Guidance**	
R3.5.5	AEIs must have processes in place to consider unlimited APL for first and second level nurses registered with the NMC entering programmes that lead to qualification in the same or another field of practice, provided that all requirements are met in full.		
R3.5.6	AEIs must have processes in place to consider APL to a maximum of 50 percent of the programme for NMC registered midwives entering pre-registration nursing programmes, provided that all requirements are met in full.		
R3.6	**AEIs must ensure that the selection process provides an opportunity for face-to-face engagement between applicants and selectors.**		
R3.7	**AEIs must ensure that the selection process includes representatives from practice learning providers.**	G3.7a	AEIs should ensure that, where possible and appropriate, the selection process also includes nurses in current practice, service users, carers, nursing students and people with disabilities.
		G3.7b	AEIs should take account of the views of those directly involved in selection when making final decisions to accept or reject an applicant.
R3.8	**Programme providers must ensure that selection is conducted by people who have been trained in the principles of selection, anti-discriminatory behaviour and equal opportunities.**		
R3.9	**Programme providers must have processes to manage interruptions to programmes.**		

Requirement		**Guidance**	
R3.9.1	AEIs must ensure that they have in place processes to manage interruptions to the study of programmes for whatever reason.	G3.9.1	AEIs should note that 'interruptions' mean any absence from a programme of education other than statutory and public holidays and annual leave.
R3.9.2	AEIs must have arrangements in place for students who leave a programme early.		
R3.9.3	AEIs must provide students who leave a programme early with a transcript of their achievements in both theory and practice.	G3.9.3a	AEIs should ensure that the transcript is suitable for mapping previous learning against vocational and other awards.
		G3.9.3b	AEIs should ensure that, when a student has been asked to leave a programme, the reasons are included in the transcript.
R3.9.4	AEIs must have APL processes in place to consider whether a student may return to a programme in the same or a different field of nursing.		
R3.10	**AEIs must make explicit any arrangements for student progression.**		
R3.10.1	AEIs must ensure that, in normal circumstances, students can meet all required outcomes, including extra attempts, within the assessed period for that part of the programme.		

Requirement		**Guidance**	
R3.10.2	AEIs must ensure that, where exceptional circumstances prevent all outcomes being achieved within the assessed period for that part of the programme, any outstanding outcomes are met and confirmed within 12 weeks of the student entering the next part of the programme. The 12-week period includes holidays and any absences. Reasonable adjustments may be applied for students with a disability.		
R3.10.3	AEIs must ensure that students who fail to achieve the outstanding outcomes within the 12-week period must, depending on local assessment policy, either return to the previous part of the programme to meet the shortfall or be discontinued.		
R3.11	**AEIs must have processes in place to confirm achievement of all programme requirements.**		
R3.11.1	AEIs must ensure that students have met all theory and practice requirements before confirming that they have successfully completed the programme.		
R3.11.2	AEIs must ensure that programme leaders confirm to the AEI examination or assessment board that all NMC requirements have been met for each individual student by the end of the programme. This must include evidence of a sign-off in practice from a sign-off mentor or practice teacher.		

Requirement		Guidance	
R3.12	**AEIs must inform students when they complete a programme that they have five years in which to register or record a qualification leading to a mark on the NMC register.**		
R3.13	**AEIs must ensure that students comply with NMC requirements for good health and good character at completion.**		
R3.13.1	The AEI must identify a designated person who is a registered nurse responsible for directing the educational programme at the AEI. Their name, or that of their designated registered nurse substitute, must be given to the NMC. The designated person must confirm the student's good health and good character in support of the student's own self-declaration required for registration The designated person must know the student and be accountable for the decision to sign the declaration.		
R3.13.2	AEIs must inform applicants of additional requirements where there is a delay of six months or more between them completing the programme and applying to register. In these circumstances, their application must also be supported by a nurse registered in the same part of the register to which the applicant is applying. The registered nurse must have known the applicant for at least a year, and have been in contact with them during the previous six months. This is in addition to the confirmation of good health and good character supplied by the designated person at the AEI.		

Standard 4: Support of students and educators

Purpose To ensure that appropriate support is available to meet the professional development needs of students and their educators.

Responsibility Programme providers.

Standard **Programme providers must support students to achieve the programme outcomes, and support educators to meet their own professional development needs.**

Requirement		**Guidance**	
R4.1	**Programme providers must ensure that programmes include an induction period during which the requirements of the curriculum are explained.**		
R4.1.1	Programme providers must ensure there is an induction period at the start of each new learning experience.	G4.1.1	Programme providers should ensure that students understand how to make best use of learning experiences in both academic and practice settings, with particular emphasis on their own and others' safety.
R4.2	**Programme providers must ensure that students are allocated to an identified mentor, practice teacher or supervisor during practice learning.**		
R4.2.1	Practice learning providers must ensure that a mentor or practice teacher is available to the student for at least 40 percent of the time during periods of practice learning.		

Requirement		Guidance	
R4.2.2	Practice learning providers must ensure that students are supervised directly or indirectly at all times during practice learning by a mentor, practice teacher or other suitably prepared registered professional.	G4.2.2	Practice learning providers should note that in this context 'suitably prepared' means that the registered professional has received training and is competent in supporting students.
R4.3	**Programme providers must ensure that those who supervise students in practice are properly prepared and supported in that role.**		
R4.3.1	Programme providers must ensure that nurse and midwife practice teachers and mentors meet the *Standards to support learning and assessment in practice* (NMC 2008) in relation to preparation and support.		
R4.3.2	Programme providers must ensure that other professionals who supervise students in practice are suitably prepared (G4.2.2) and supported in that role.		
R4.4	**AEIs must ensure that support facilities, including learning support, are available to all enrolled students.**	**G4.4**	**AEIs should provide access to all enrolled students to support facilities such as learning support, a students' union and disability advice.**
R4.5	**Programme providers must give students access to pastoral support, occupational health facilities and disability specialists.**	**G4.5**	**Programme providers should ensure that student support includes making reasonable adjustments for students with disabilities in both theory and practice aspects of the programme.**
R4.6	**Programme providers must ensure that learning time is protected as specified.**		

Requirement		**Guidance**	
R4.6.1	Programme providers must ensure that students are supernumerary during all practice learning. Supernumerary means that the student will not, as part of their programme of preparation, be contracted by any person or body to provide nursing care.		
R4.7	**Programme providers must provide nurse and midwife teachers with time for professional development to enable them to remain up to date in their field of practice.**		
R4.7.1	Programme providers must ensure that nurse and midwife teachers meet the relevant requirements in *Standards to support learning and assessment in practice* (NMC 2008) as part of their professional development.		

Standard 5: Structure, design and delivery of programmes

Purpose To ensure that students are prepared to meet the outcomes, competencies and proficiencies of the approved programme required by the NMC.

Responsibility Programme providers and partners.

Standard **The programme must be structured, designed and delivered to meet NMC standards and requirements.**

Requirement		**Guidance**	
R5.1	**AEIs must ensure that programme development and delivery involves key stakeholders.**		
R5.1.1	AEIs must work in partnership with service providers, commissioners, disability specialists and others to design and deliver programmes.		
R5.1.2	Programme providers must clearly show how users and carers contribute to programme design and delivery.		
R5.2	**AEIs must specify the required hours, days or weeks of learning.**		
R5.2.1	AEIs must ensure that all pre-registration nursing programmes are no less than three years and 4,600 hours.		
R5.2.2	AEIs must ensure that full and part-time programmes meet the same requirements.		
R5.2.3	AEIs must ensure there are at least 2,300 hours of practice learning.		

Requirement		**Guidance**	
R5.2.4	AEIs must ensure that no more than 300 hours of the 2,300 hours of practice are used for clinical training in a simulated practice learning environment. This environment must support the development of direct care skills, and be audited by the AEI before it is used.		
R5.2.5	AEIs must ensure that the minimum length of programmes leading to registration in two fields of nursing is 6,133 hours over at least four years.		
R5.2.6	AEIs must ensure that in a programme leading to nursing registration together with registration in another profession, the nursing component takes at least 4,600 hours over at least three years, and that all outcomes are achieved in a nursing context.		
R5.3	**Programme providers must clearly set out the structure of the programme.**		
R5.3.1	AEIs must ensure that programmes lead to a mark on the nurses' part of the register indicating the field of practice as adult, mental health, learning disabilities or children's nursing.		
R5.3.2	Programme providers must ensure that there are two progression points, normally separating the programme into three equal parts.		
R5.3.3	Programme providers must ensure that there is a period of at least four weeks of continuous practice learning towards the end of the first and second parts of the programme.		

Requirement		**Guidance**	
R5.3.4	Programme providers must ensure that there is a period of practice learning of at least 12 weeks towards the end of the programme.		
R5.3.5	Programme providers must ensure that the 12-week period of practice learning enables safe judgements to be made regarding the achievement of the required standards of competence for safe and effective practice for entry to the NMC register.		
R5.3.6	Programme providers must ensure an equal balance between theory and practice learning is achieved by the end of the programme.	G5.3.6	Programme providers should ensure that the percentage of time spent in practice in each part of the programme is no less than 40 percent and no more than 60 percent.

Requirement		**Guidance**	
R5.3.7	AEIs must have formal arrangements in place with host partners before students start learning in academic or practice settings outside the UK. In total, this must not be more than six months (or exceed 17.5 percent) of the total programme. There are exceptions for programmes approved to be partly delivered in the Isle of Man, Channel Islands and in British Forces institutions. This may take the form of: • a period of theoretical and/or practice learning of not more than four weeks, which may include direct care but which is not summatively assessed, or • a period longer than four weeks of theoretical and/or practice learning which may include direct care that is summatively assessed and contributes to the overall achievement of programme outcomes.		
R5.3.8	AEIs must use relevant aspects of the NMC guidance for students learning outside of the UK to develop criteria for single periods of learning of four weeks or less. This is to ensure the safety of service users, students and staff and show how the intended programme outcomes are to be addressed. AEIs must fully apply the NMC guidance to all periods of learning undertaken outside of the UK that are longer than four weeks.	G5.3.8a	AEIs should ensure that the principles underpinning periods of learning to be undertaken outside of the UK that are longer than four weeks, form part of the approved programme.

Requirement		Guidance	
		G5.3.8b	AEIs should ensure that the period undertaken outside of the UK does not form any part of a period of continuous practice learning required to determine whether a student can progress from one part of the programme to another, or required to confirm that the student is safe and effective in practice at the end of the programme.
		G5.3.8c	AEIs should, wherever practicable, fully meet the *Standards to support learning and assessment in practice* (NMC 2008). Where adjustments are required to take account of the local context, these should be previously agreed by the programme board, fully documented and the detail made available for NMC monitoring.

Requirement		Guidance	
		G5.3.8d	AEIs should have arrangements in place for the safety of service users, students and staff ensuring that: • risk assessments have been completed and all identified risks addressed • audits of the learning environment confirm adequate levels of supervision and mentorship and that planned experience supports the intended programme outcomes • a suitable and experienced named person(s) is available to support the student throughout the period of learning in relation to the outcomes to be achieved • students have the essential language skills needed to participate in learning activities, and where relevant have the level of language required to safely and effectively engage in direct care • students are prepared for the environment in which learning is to be undertaken • students work within the scope of their UK approved programme and fitness to practise requirements, complying with the NMC *Standards for pre-registration nursing*. • measures are in place to act promptly where there are concerns about a students conduct or progress, or where safety, or learning is

Requirement		Guidance	
			compromised. • students have in place appropriate and adequate insurance against major risks including: professional liability, personal health and travel and where appropriate for vicarious liability.
R5.4	**Programme providers must state what teaching and learning methods will be used to support achievement of outcomes.**	**G5.4**	**Programme providers should ensure that teaching and learning methods address individual learning styles in order to achieve competence and safe and effective practice.**
R5.5	**Programme providers must ensure that learning opportunities are offered at an appropriate academic level using evidence-based sources.**		
R5.5.1	AEIs must ensure that the minimum programme award is a degree (see R7.2.1).		
R5.6	**Programme providers must specify essential content of the programme.**		

Requirement		**Guidance**	
R5.6.1	Programme providers must ensure that the following content is included and underpins key aspects of practice as listed in R5.6.2: • theories of nursing and theories of nursing practice • research methods and use of evidence • professional codes, ethics, law and humanities • communication and healthcare informatics • life sciences (including anatomy and physiology) • pharmacology and medicines management • social, health and behavioural sciences • principles of national and international health policy, including public health • principles of supervision, leadership and management • principles of organisational structures, systems and processes • causes of common health conditions and the interaction between physical and mental health and illness • best practice		

Requirement		Guidance	
	• healthcare technology • essential first aid and incident management.		
R5.6.2	Programme providers must ensure that programme content is applied within both a generic and field specific context enabling students to meet the essential and immediate needs of all people and the complex needs of people in their chosen field in relation to: • communication, compassion and dignity • emotional support • equality, diversity, inclusiveness and rights • identity, appearance and self-worth • autonomy, independence and self-care • public health and promoting health and wellbeing • maintaining a safe environment • eating, drinking, nutrition and hydration • comfort and sleep • moving and positioning • continence promotion and bowel and bladder care • skin health and wound management		

Requirement		Guidance	
	• infection prevention and control • clinical observation, assessment, critical thinking and decision-making • symptom management, such as anxiety, anger, thirst, pain and breathlessness • risk management • medicines management • information management • supervising, leading, managing and promoting best practice.		
R5.6.3	Programme providers must ensure that the content for general care in Directive 2005/36/EC Annex V.2. (4.2.1) is included in programmes leading to the adult field of practice (annexe 1).		
R5.6.4	Programme providers must ensure that content is developed and delivered at a suitable level for each part of the programme. They must also ensure it is sufficient to enable the student to acquire competencies at degree level in their chosen nursing field by the end of the programme.		
R5.7	**Programme providers must ensure that students have the opportunity to learn with, and from, other health and social care professionals.**	**G5.7**	**Where possible programme providers should give students opportunities to learn with, and from, other health and social care students in practice and academic settings.**

Standard 6: Practice learning opportunities

Purpose To facilitate practice learning opportunities for students.

Responsibility Programme providers.

Standard **Practice learning opportunities must be safe, effective, integral to the programme and appropriate to programme outcomes.**

Requirement		**Guidance**	
R6.1	**AEIs must provide students and those supporting practice learning with information that includes dates, outcomes to be achieved, and assessment documents for each period of practice learning.**		
R6.2	**Programme providers must ensure that mentors and practice teachers meet the relevant requirements within the *Standards to support learning and assessment in practice* (NMC 2008).**		
R6.3	**Programme providers must ensure that local registers of mentors and practice teachers are maintained according to *Standards to support learning and assessment in practice* (NMC 2008), including sign-off status of mentors, record of updates and date for triennial review.**		
R6.4	**Programme providers must use objective criteria and processes for approving new practice learning environments, and audit them at least every two years.**		

Requirement		**Guidance**	
R6.4.1	Programme providers must ensure that audits of practice learning environments show how the nature, scope and quality of the learning experience supports programme outcomes.		
R6.5	**Programme providers must ensure that students have access to a range of practice learning opportunities sufficient to meet programme outcomes.**		
R6.5.1	Programme providers must ensure that the 2,300 hours of practice learning gives students the opportunity to learn in direct contact with healthy and ill people and communities. Students will be required to use this experience to organise, deliver and evaluate their nursing care on the basis of the knowledge and skills they have acquired. Simulation may be used for up to 300 hours of practice learning (R5.2.4).		
R6.5.2	Programme providers must ensure that practice learning opportunities take place across a range of community, hospital and other settings.	G6.5.2	Programme providers should ensure that practice learning opportunities enable programme outcomes to be achieved in different settings with a range of service users over the duration of the programme. Wherever possible, there should be practice learning opportunities in hospital and community settings in each part of the programme.
R6.5.3	Programme providers must ensure that practice learning throughout the programme provides students with experience of 24-hour and 7-day care.	G6.5.3	Programme providers should take account of students' individual needs and personal circumstances when allocating their practice learning including making reasonable adjustments for students.with disabilities.

Requirement		**Guidance**	
R6.5.4	AEIs must carry out a risk assessment before anyone under 18 can enter a practice learning environment.	G6.5.4	AEIs should observe the most recent health and safety legislation for each UK country.
R6.5.5	Programme providers must ensure that the clinical instruction requirements for general care in Directive 2005/36/EC Annex V.2. (4.2.1) are included in adult nursing programmes (annexe 1).		

Standard 7: Outcomes

Purpose To establish the required theory and practice learning outcomes of the programme.

Responsibility Programme providers.

Standard **The programme outcomes must ensure that NMC standards for competence are met and that students are fit for practice and fit for award on completion.**

Requirement		**Guidance**	
R7.1	**Programme providers must ensure that the programme outcomes enable students to achieve the NMC standards for competence and that they are fit for practice and fit for award on completion.**		
R7.1.1	Programme providers must ensure that, by the end of the programme: • the generic standards for competence and generic competencies have enabled students to acquire the basic skills necessary to meet all people's essential needs • the generic and field-specific standards for competence and generic and field competencies have enabled students to acquire basic and complex skills in their field.		
R7.1.2	Programme providers must ensure that theory and practice learning outcomes are related to generic and field-specific competencies throughout the programme.	G7.1.2a	Programme providers should introduce generic and field-specific learning from the outset. Learning should become increasingly field-focused as the programme progresses.

Requirement		Guidance	
		G7.1.2b	Programme providers should create opportunities for shared generic and field-specific learning where appropriate.
R7.1.3	Theory and practice learning outcomes must take account of the essential physical and mental health needs of all people, including babies, children and young people, pregnant and postnatal women, adults and older people. This includes people with acute and long term conditions, people requiring end of life care, people with learning disabilities and people with mental health problems.	G7.1.3	Programme providers should find ways to enable students to have contact with all specified client groups.
R7.1.4	Providers of adult nursing programmes must have specific learning outcomes for theoretical and clinical instruction that meet the requirements of EU Directive 2005/36/EC Annex V.2 (5.2.1) (annexe 1).		
R7.1.5	Programme providers must develop learning outcomes that incorporate NMC criteria at the first and second progression points (annexe 2).	G7.1.5a	Programme providers should ensure that the criteria for the first progression point are normally met in practice, but may use simulation to meet some of the criteria where appropriate (annexe 2).
		G7.1.5b	Programme providers should use essential skills clusters (ESCs) when developing learning outcomes for the first and second progression points and those to be achieved by the end of the programme (annexe 3).
R7.1.6	AEIs must ensure that all the competencies are met in full by the end of the programme (section 2).		

Requirement		**Guidance**	
R7.2	**AEIs must make explicit requirements for the conferment of academic awards where applicable.**		
R7.2.1	AEIs must ensure that the minimum outcome award for a pre-registration nursing programme is nursing registration with a degree. It must deliver the programme hours in Directive 2005/36/EC (annexe 1) and be at least equal to a first cycle (end of cycle) qualification of the European Higher Education Area (EHEA).	G7.2.1	AEIs should ensure that the degree is at least a: • Scottish bachelor's degree of at least 360 SCOTCAT points, 60 of which must be at level 9 in the *Framework for qualifications of higher education institutions in Scotland* (SQA 2001) • bachelor's degree of at least 300 academic credits, 60 of which must be at level 6 in the *Framework for higher education qualifications in England, Wales and Northern Ireland* (QAA 2008a), and takes account of the *HE credit framework for England* (QAA 2008b).
R7.2.2	AEIs must ensure that there is no option to register if a degree level outcome cannot be achieved.		

Standard 8: Assessment

Purpose To ensure that the outcomes, competencies and proficiencies of the approved programme are tested using valid and reliable assessment methods.

Responsibility Programme providers, mentors and practice teachers.

Standard **Programme outcomes must be tested using valid and reliable assessment methods.**

Requirement		**Guidance**	
R8.1	**Programme providers must ensure that a variety of assessments are used to test the acquisition of approved outcomes, with reasonable adjustments for students with a disability.**		
R8.1.1	Programme providers must include at least one unseen invigilated examination in the assessment process.		
R8.1.2	Programme providers must ensure that there is equal weighting in the assessment of practice and theory in contributing to the final award.		
R8.1.3	AEIs must not compensate between theory and practice assessment.		
R8.1.4	Programme providers must make it clear how service users and carers contribute to the assessment process.		

Requirement		**Guidance**	
R8.1.5	Programme providers must ensure that there are periods of practice throughout the programme in which students are assessed in both hospital and community settings.	G8.1.5	Programme providers should, wherever possible, assess practice in hospital and community settings in each part of the programme.
R8.2	**Programme providers must ensure that assessment processes enable students to demonstrate fitness for practice and fitness for award.**		
R8.2.1	Programme providers must ensure that their assessment framework tests all programme outcomes.	G8.2.1	Programme providers should show that reasonable adjustments for students with a disability are applied in the assessment of both theory and practice.
R8.2.2	Programme providers must have arrangements in place for practice assessment throughout the programme, at progression points and for entry to the register, as in a, b, c and d below.		

Requirement		**Guidance**	
R8.2.2.a	Programme providers must ensure that practice assessment decisions regarding the achievement of skills and aspects of competence in each part of the programme are made by a registered nurse or, where these are transferable across professions, by an appropriate registered professional who has been suitably prepared.	G8.2.2a	Programme providers should apply the following where practice assessment decisions regarding skills and aspects of competence in each part of the programme are made by a registered professional who is not a nurse: • Appropriate - a registered professional competent in the skill or aspect of competency in which the student is being assessed. • Suitably prepared – the registered professional has undergone training and development that has enabled them to be competent to support and assess students.

Requirement		**Guidance**	
R8.2.2b	Programme providers must ensure that assessment decisions regarding achievement of practice requirements at the first progression point are normally made by a mentor who is a nurse registered in any of the four fields of practice.	G8.2.2b	Programme providers should apply the following criteria where the registered professional designated to assess achievement of all practice requirements needed for progression to the second part of the programme is not a registered nurse. The professional must • have been suitably prepared for the role • have had preparation to ensure they fully understand all the requirements for progression in the context of nursing – this may include undertaking the relevant parts of an NMC approved mentor programme • be listed on a register which confirms their ability to act in this capacity • be subject to similar requirements as those for mentors who are registered nurses, including annual updating and triennial review.
R8.2.2c	Programme providers must ensure that assessment decisions regarding achievement of practice requirements at the second progression point are made by a mentor who is a nurse registered in any of the four fields of practice.		

Requirement		**Guidance**	
R8.2.2d	Programme providers must ensure that assessment decisions regarding achievement of competence in practice for entry to the register must be made by a registered nurse sign-off mentor from the same nursing field as that which the student intends to enter.		
R8.2.3	Programme providers must ensure that an ongoing record of achievement, including comments from mentors, is passed from one named mentor to the next so that the student's progress can be judged. These requirements must be met: • Programme providers must obtain the student's consent to process or share confidential data between successive mentors and education providers when assessing fitness for practice. • Programme providers must ensure that processes are in place to address issues or concerns about a student's progress, and that these are dealt with fully and quickly. • Programme providers must help students deal with any issues and concerns using a clear, time-limited development plan within or across periods of practice learning. • Programme providers must ensure that where reasonable adjustments are made for students with disabilities, they are assessed appropriately and receive the support they need to meet the requirements of any development plan.	G8.2.3a	Programme providers should ensure that the ongoing record of achievement: • is part of the assessment of practice document • contains the detail needed to support safe judgments about overall achievement of the outcomes for each part of the programme at progression points, and for entry to the register.

Requirement		**Guidance**	
		G8.2.3b	Practice learning providers should ensure that mentors do not keep their own separate student progress records; everything should be recorded in the assessment of practice document.
R8.2.4	Programme providers must ensure that judgments about the overall assessment of practice outcome at the end of a part of the programme are based on all the learning achieved in that part. The ongoing achievement record and the assessment of practice document must be used to support the judgment.	G8.2.4	Programme providers should ensure that, where a sign-off mentor has concerns about a student's overall competence at the end of the programme, they draw on evidence from the ongoing achievement record and the assessment of practice document for the whole programme to make their final assessment decision.
R8.3	**AEIs must appoint external examiner(s) who can demonstrate currency in education and practice with due regard and engage with assessment of both theory and practice.**		

Standard 9: Resources

Purpose To identify the physical resources in sites used for education, whether theory or practice, and the human resources available to manage and deliver the programme.

Responsibility Programme providers.

Standard **The educational facilities in academic and practice settings must support delivery of the approved programme.**

Requirement		**Guidance**	
R9.1	**AEIs must ensure that the programme leader is a nurse or midwife with a teacher qualification recorded on the NMC register.**		
R9.1.1	AEIs must ensure that the programme leader responsible for a field of nursing is registered and has currency in that field.		
R9.2	**AEIs must ensure that teachers have appropriate qualifications and experience for their roles.**		
R9.2.1	AEIs must ensure that nurse and midwife teachers who make a major contribution to the programme hold, or are working towards, a teaching qualification recordable on the NMC register. This includes people seeking NMC recognition of a comparable teaching qualification; see *Standards to support learning and assessment in practice* (NMC 2008).		
R9.3	**Programme providers must ensure that sufficient staff are allocated to deliver the programme effectively.**		

Requirement		**Guidance**	
R9.3.1	AEIs must make sure that most of the teaching and academic input to the programme is delivered by registered nurses and that all learning is applied to nursing.	G9.3.1	AEIs should ensure that nurse teachers are able to spend part of their normal teaching hours supporting student learning in practice, as in *Standards to support learning and assessment in practice* (NMC 2008).
R9.3.2	Programme providers must make sure that any practice learning environment, where nursing care is delivered, has sufficient registered nursing staff and equipment to deliver safe and effective care.		
R9.3.3	Programme providers must ensure that mentors and practice teachers are able to meet the requirements of *Standards to support learning and assessment in practice* (NMC 2008) regarding: • roles and responsibilities • annual updating • triennial review • sign-off mentors having time allocated to reflect, give feedback and keep records of student achievement in their final period of practice learning, equivalent to one hour per student per week.	G9.3.3	Programme providers should make sure that, normally, mentors or other registered professionals supporting and assessing nursing students do not support more than three students from any discipline at any time.
R9.4	**Students must have access to appropriate learning approaches in a variety of formats on all sites.**		

Requirement		**Guidance**	
R9.4.1	AEIs must make sure that all students can access similar learning resources, in different academic and practice learning environments (including IT and library), to help them achieve the programme outcomes.	G9.4.1	These resources should be fully accessible to students with disabilities.

Standard 10: Quality assurance

Purpose To identify the quality management systems of education providers in AEIs and practice learning areas.

Responsibility Programme providers at local and strategic level.

Standard **Programme providers must use effective quality assurance processes in which findings lead to quality enhancement.**

Requirement		**Guidance**	
R10.1	**Programme providers' quality assurance processes must be aligned with the programme specification, programme evaluation and enhancement.**		
R10.1.1	AEIs must ensure that: • commissioners fully support the intention to develop, approve and deliver the programme • feedback from students and mentors is used to inform the programme and enhance the practice learning experience • partners at all levels are committed to and will contribute to quality assurance and enhancement • all practice learning experiences are of the same high standard • theory and practice are equally important, and external examiners consider and report on the quality of theory and practice learning.		

Requirement		Guidance	
R10.2	**AEIs must demonstrate that they use effective quality assurance processes including conjoint programme approval, approval of minor or major modifications, endorsement and annual monitoring.**		
R10.3	**Programme providers must allow the NMC and its agents access to monitor programmes.**		

Annexe 1: Extract from Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications

Training of nurses responsible for general care

Admission to training for nurses responsible for general care shall be contingent upon either:

(a) completion of general education of 12 years, as attested by a diploma, certificate or other evidence issued by the competent authorities or bodies in a Member State or a certificate attesting success in an examination of an equivalent level and giving access to universities or to higher education institutions of a level recognised as equivalent; or

(b) completion of general education of at least 10 years, as attested by a diploma, certificate or other evidence issued by the competent authorities or bodies in a Member State or a certificate attesting success in an examination of an equivalent level and giving access to a vocational school or vocational training programme for nursing.

Training of nurses responsible for general care shall be given on a full-time basis and shall include at least the programme described in Annex V, point 5.2.1.

The training of nurses responsible for general care shall comprise a total of at least three years of study, which may in addition be expressed with the equivalent ECTS credits, and shall consist of at least 4 600 hours of theoretical and clinical training, the duration of the theoretical training representing at least one third and the duration of the clinical training at least one half of the minimum duration of the training. Member States may grant partial exemptions to professionals who have received part of their training on courses which are of at least an equivalent level.

The Member States shall ensure that institutions providing nursing training are responsible for the coordination of theoretical and clinical training throughout the entire study programme.

Theoretical education is that part of nurse training from which trainee nurses acquire the professional knowledge, skills and competences required under paragraphs 6 and 7. The training shall be given by teachers of nursing care and by other competent persons, at universities, higher education institutions of a level recognised as equivalent or at vocational schools or through vocational training programmes for nursing.

Clinical training is that part of nurse training in which trainee nurses learn, as part of a team and in direct contact with a healthy or sick individual and/or community, to organise, dispense and evaluate the required comprehensive nursing care, on the basis of the knowledge, skills and competences which they have acquired. The trainee nurse shall learn not only how to work in a team, but also how to lead a team and organise overall nursing care, including health education for individuals and small groups, within health institutes or in the community.

This training shall take place in hospitals and other health institutions and in the community, under the responsibility of nursing teachers, in cooperation with and assisted by other qualified nurses. Other qualified personnel may also take part in the teaching process.

Trainee nurses shall participate in the activities of the department in question insofar as those activities are appropriate to their training, enabling them to learn to assume the responsibilities involved in nursing care.

Training for nurses responsible for general care shall provide an assurance that the professional in question has acquired the following knowledge and skills:

(a) comprehensive knowledge of the sciences on which general nursing is based, including sufficient understanding of the structure, physiological functions and behaviour of healthy and sick persons, and of the relationship between the state of health and the physical and social environment of the human being;

(b) knowledge of the nature and ethics of the profession and of the general principles of health and nursing;

(c) adequate clinical experience; such experience, which should be selected for its training value, should be gained under the supervision of qualified nursing staff and in places where the number of qualified staff and equipment are appropriate for the nursing care of the patient;

(d) the ability to participate in the practical training of health personnel and experience of working with such personnel;

(e) experience of working together with members of other professions in the health sector.

Formal qualifications as a nurse responsible for general care shall provide evidence that the professional in question is able to apply at least the following competences regardless of whether the training took place at universities, higher education institutions of a level recognised as equivalent or at vocational schools or through vocational training programmes for nursing:

(a) competence to independently diagnose the nursing care required using current theoretical and clinical knowledge and to plan, organise and implement nursing care when treating patients on the basis of the knowledge and skills acquired in accordance with points (a), (b) and (c) of paragraph 6 in order to improve professional practice;

(b) competence to work together effectively with other actors in the health sector, including participation in the practical training of health personnel on the basis of the knowledge and skills acquired in accordance with points (d) and (e) of paragraph 6;

(c) competence to empower individuals, families and groups towards healthy lifestyles and self-care on the basis of the knowledge and skills acquired in accordance with points (a) and (b) of paragraph 6;

(d) competence to independently initiate life-preserving immediate measures and to carry out measures in crises and disaster situations;

(e) competence to independently give advice to, instruct and support persons needing care and their attachment figures;

(f) competence to independently assure the quality of, and to evaluate, nursing care;

(g) competence to comprehensively communicate professionally and to cooperate with members of other professions in the health sector;

(h) competence to analyse the care quality to improve his own professional practice as a nurse responsible for general care.

Annex V.2. Nurse responsible for general care

5.2.1. Training programme for nurses responsible for general care

The training leading to the award of a formal qualification of nurses responsible for general care shall consist of the following two parts.

A. Theoretical instruction

a. Nursing:

- Nature and ethics of the profession
- General principles of health and nursing
- Nursing principles in relation to:
  - general and specialist medicine
  - general and specialist surgery
  - child care and paediatrics
  - maternity care
  - mental health and psychiatry
  - care of the old and geriatrics

b. Basic sciences:

- Anatomy and physiology
- Pathology
- Bacteriology, virology and parasitology
- Biophysics, biochemistry and radiology
- Dietetics
- Hygiene:
  - preventive medicine
  - health education
- Pharmacology

c. Social sciences:

- Sociology
- Psychology
- Principles of administration
- Principles of teaching
- Social and health legislation
- Legal aspects of nursing

B. Clinical instruction

- Nursing in relation to:
  - general and specialist medicine
  - general and specialist surgery
  - child care and paediatrics
  - maternity care
  - mental health and psychiatry
  - care of the old and geriatrics
  - home nursing.

One or more of these subjects may be taught in the context of the other disciplines or in conjunction therewith.

The theoretical instruction must be weighted and coordinated with the clinical instruction in such a way that the knowledge and skills referred to in this Annex can be acquired in an adequate fashion.

Annexe 2: Progression criteria

The NMC has set minimum requirements that **must be met by the first and second progression points**.

In addition to these, programme providers will identify their own outcomes that students must achieve by each progression point. These will be based on local need, programme design and organisation of learning in practice. They will make sure that a student is safe and adequately prepared to take part in the full range of practice learning opportunities without risk to the public. NMC quality assurance processes will confirm this through approval and monitoring.

First progression point

The NMC has identified skills and professional behaviours that a student must demonstrate by the first progression point. These criteria must normally be achieved during the student's practice learning but some may be met through simulation.

These criteria cover:

- safety, safeguarding and protection of people of all ages, their carers and their families
- professional values, expected attitudes and the behaviours that must be shown towards people, their carers, their families, and others.

The criteria reflect public expectations about nurses' basic skills and their ability to communicate effectively with people in vulnerable situations, ensuring their dignity is maintained at all times. The essential skills clusters in annexe 3 also address some of these concerns and form guidance within these standards.

If a student is unable to demonstrate these skills and behaviours by progression point one, through the assessment procedures set by the programme provider and their partners, they will not normally be allowed to progress to the second part of the programme. Most of the assessment will take place when providing direct care but some may be through simulation.

First progression point criteria

Criteria that must be met as a minimum requirement by progression point one in any practice setting where people are receiving care, or through simulation.

Areas associated with safety and safeguarding people of all ages, their carers and their families		**Related competency domains**
1	Demonstrates safe, basic, person-centred care, under supervision, for people who are unable to meet their own physical and emotional needs.	Professional values Communication and interpersonal skills Nursing practice and decision making
2	Meets people's essential needs in relation to safety and security, wellbeing, comfort, bowel and bladder care, nutrition and fluid maintenance and personal hygiene, maintaining their dignity at all times.	Professional values Communication and interpersonal skills Nursing practice and decision making
3	Seeks help where people's needs are not being met, or they are at risk.	Communication and interpersonal skills Nursing practice and decision making Leadership, management and team working
4	Is able to recognise when a person's physical or psychological condition is deteriorating, demonstrating how to act in an emergency and administer essential first aid.	Nursing practice and decision making Leadership, management and team working
5	Demonstrates an understanding of how to work within legal and professional frameworks and local policies to safeguard and protect people, particularly children, young people, and vulnerable adults.	Professional values

Areas associated with safety and safeguarding people of all ages, their carers and their families		Related competency domains
6	Is able to recognise, and work within, the limitations of their own knowledge and skills and professional boundaries, understanding that they are responsible for their own actions.	Professional values Nursing practice and decision making
7	Demonstrates the ability to listen, seek clarity, and carry out instructions safely.	Professional values Communication and interpersonal skills Nursing practice and decision making Leadership, management and team working
8	Uses and disposes of medical devices safely under supervision according to local and national policy, reporting any incidents or near misses.	Professional values Communication and interpersonal skills Nursing practice and decision making
9	Understands and works within the laws governing health and safety at work. Demonstrates safe manual handling techniques, and understands how nurses can help reduce the risk of infection, including effective hand washing.	Professional values Communication and interpersonal skills Nursing practice and decision making
10	Recognises signs of aggression and takes appropriate action to keep themselves and others safe.	Communication and interpersonal skills Nursing practice and decision making
11	Safely and accurately carries out basic medicines calculations.	Professional values Nursing practice and decision making

Areas associated with safety and safeguarding people of all ages, their carers and their families		Related competency domains
12	Demonstrates safe and effective communication skills, both orally and in writing.	Communication and interpersonal skills Nursing practice and decision making

Areas associated with professional values and expected attitudes and behaviours towards people, their carers and their families		Related competency domains
13	Displays a professional image in their behaviour and appearance, showing respect for diversity and individual preferences.	Professional values Communication and interpersonal skills Nursing practice and decision making
14	Demonstrates respect for people's rights and choices.	Professional values Communication and interpersonal skills Nursing practice and decision making
15	Acts in a manner that is attentive, kind, sensitive, compassionate and non-discriminatory, that values diversity and acts within professional boundaries.	Professional values Communication and interpersonal skills Nursing practice and decision making
16	Understands the principles of confidentiality and data protection. Treats information as confidential, except where sharing is required to safeguard and protect people.	Professional values Communication and interpersonal skills Nursing practice and decision making

Areas associated with professional values and expected attitudes and behaviours towards people, their carers and their families		Related competency domains
17	Practises honestly and with integrity, applying the principles of *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC, 2015).	Professional values Communication and interpersonal skills Nursing practice and decision making
18	Acts in a way that values the roles and responsibilities of others in the team and interacts appropriately.	Professional values Communication and interpersonal skills Nursing practice and decision making Leadership, management and team working

Second progression point

The NMC has set minimum requirements that **must be demonstrated by the second progression point**. Programme providers must set learning outcomes that allow the student to show that they can work more independently, with less direct supervision, in a safe and increasingly confident way to extend their knowledge and skills. Students must be allowed to demonstrate their ability to work as autonomous practitioners by the point of registration. This will also ensure that students are able to make safe and effective use of practice learning, which includes less direct supervision in the final part of the programme. This enables students to be confident and fit for practice by entry to the register. Students must demonstrate this before being allowed to progress to the third and final part of the programme.

Progression point two criteria

Criteria that must be met as a minimum requirement by the second progression point.

Criteria		**Related competency domains**
1	Works more independently, with less direct supervision, in a safe and increasingly confident manner.	Professional values Communication and interpersonal skills Nursing practice and decision making Leadership, management and team working
2	Demonstrates potential to work autonomously, making the most of opportunities to extend knowledge, skills and practice.	Professional values Communication and interpersonal skills Nursing practice and decision making Leadership, management and team working

Annexe 3: Essential skills clusters (2010) and guidance for their use (guidance G7.1.5b)

The essential skills clusters (ESCs) are to be used as guidance and should be incorporated into all pre-registration nursing programmes. How they are incorporated into programmes is left to local determination. Programme providers can use them to develop learning outcomes at different levels or to map them against existing programme learning outcomes. Some programme providers may wish to map them to specific competencies within the domains or use them to develop practice assessment tools. All the ESCs apply to all fields of nursing.

Skills have not been identified for all progression points, therefore not all columns in the ESC table have been filled. Where there is a gap, skills identified at a later progression point might be achieved at an earlier point. Where it is determined that a specific skill can be more appropriately achieved at a different progression point than that indicated the approved education institution (AEI) should show how and at what point it has been incorporated.

ESCs support the achievement of the competencies in section 3 and criteria for assessment at the first progression point in annexe 2. However, the ESCs do not include all the skills and behaviours required of a registered nurse.

There are five **essential skills clusters**:

- care, compassion and communication
- organisational aspects of care
- infection prevention and control
- nutrition and fluid management
- medicines management.

Guidance related to numerical assessment

Some ESCs identify the baseline skills needed to calculate medicines, nutrition, fluids and other areas where there is a need to use numbers. These appear in ESCs 9, 27, 28, 29, 31, 32, 33, 36 and 38. They are marked with an asterix **(*)**. Providers should incorporate all these health related numerical assessments, designed to test numeracy skills, into learning outcomes and assessment strategies.

- The focus should be on demonstration of competence and confidence with regard to judgements on whether to use calculations in a particular situation and, if so, what calculations to use, how to do it, what degree of accuracy is appropriate, and what the answer means in relation to the context.

- Providers can incorporate these health related numerical elements into their own learning outcomes and assessment strategies and should use the ESCs to underpin the nature and content of the assessment, including whether to assess through simulation. They should decide on their own pass mark and how many attempts are allowed in order to reach the first and second progression points.

- After the second progression point, and by the point of entry to the register, the ESCs should help programme providers decide the nature and content of numerical assessments where a 100 percent pass mark is required.

- Assessment should reflect competence across the full range of complexity, the different delivery modes and technical measurement issues. This may take place in a combination of settings, including computer lab and simulated practice, but must include assessment in the practice setting. The number of attempts should be decided by the programme provider.

Essential skills cluster: Care, compassion and communication

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

1 As partners in the care process, people can trust a newly registered graduate nurse to provide collaborative care based on the highest standards, knowledge and competence.

First progression point	Second progression point	Entry to the register
1 Articulates the underpinning values of *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC, 2015) 2 Works within limitations of the role and recognises own level of competence. 3 Promotes a professional image. 4 Shows respect for others. 5 Is able to engage with people and build caring professional relationships.	6 Forms appropriate and constructive professional relationships with families and other carers. 7 Uses professional support structures to learn from experience and make appropriate adjustments.	8 Demonstrates clinical confidence through sound knowledge, skills and understanding relevant to field. 9 Is self aware and self confident, knows own limitations and is able to take appropriate action. 10 Acts as a role model in promoting a professional image. 11 Acts as a role model in developing trusting relationships, within professional boundaries. 12 Recognises and acts to overcome barriers in developing effective relationships with service users and carers.

		13 Initiates, maintains and closes professional relationships with service users and carers. 14 Uses professional support structures to develop self awareness, challenge own prejudices and enable professional relationships, so that care is delivered without compromise.
2 People can trust the newly registered graduate nurse to engage in person centred care empowering people to make choices about how their needs are met when they are unable to meet them for themselves.		
First progression point	**Second progression point**	**Entry to the register**
1 Takes a person-centred, personalised approach to care.	2 Actively empowers people to be involved in the assessment and care planning process. 3 Determines people's preferences to maximise comfort & dignity. 4 Actively supports people in their own care and self care. 5 Considers with the person and their carers their capability for self care. 6 Provides personalised care, or makes provisions for those who are unable to maintain their own activities of living maintaining dignity at all times.	8 Is sensitive and empowers people to meet their own needs and make choices and considers with the person and their carer(s) their capability to care. 9 Ensures access to independent advocacy. 10 Recognises situations and acts appropriately when a person's choice may compromise their safety or the safety of others. 11 Uses strategies to manage situations where a person's wishes conflict with nursing interventions necessary for the person's safety.

	7 Assists people with their care.	12 Acts with dignity and respect to ensure that people who are unable to meet their activities of living have choices about how these are met and feel empowered to do as much as possible for themselves. 13 Works autonomously, confidently and in partnership with people, their families and carers to ensure that needs are met through care planning and delivery, including strategies for self care and peer support. 14 Actively helps people to identify and use their strengths to achieve their goals and aspirations.
3 People can trust the newly registered graduate nurse to respect them as individuals and strive to help them the preserve their dignity at all times.		
First progression point	**Second progression point**	**Entry to the register**
1 Demonstrates respect for diversity and individual preference, valuing differences, regardless of personal view. 2 Engages with people in a way that ensures dignity is maintained through making appropriate use of the		4 Acts professionally to ensure that personal judgements, prejudices, values, attitudes and beliefs do not compromise care. 5 Is proactive in promoting and maintaining dignity.

environment, self and skills and adopting an appropriate attitude. 3 Uses ways to maximise communication where hearing, vision or speech is compromised.		6 Acts autonomously to challenge situations or others when someone's dignity may be compromised. 7 Uses appropriate strategies to empower and support their choice.
4 People can trust a newly qualified graduate nurse to engage with them and their family or carers within their cultural environments in an acceptant and anti-discriminatory manner free from harassment and exploitation.		
First progression point	**Second progression point**	**Entry to the register**
1 Demonstrates an understanding of how culture, religion, spiritual beliefs, gender and sexuality can impact on illness and disability. 2 Respects people's rights. 3 Adopts a principled approach to care underpinned by The Code (NMC 2015)		4 Upholds people's legal rights and speaks out when these are at risk of being compromised. 5 Is acceptant of differing cultural traditions, beliefs, UK legal frameworks and professional ethics when planning care with people and their families and carers. 6 Acts autonomously and proactively in promoting care environments that are culturally sensitive and free from discrimination, harassment and exploitation. 7 Manages and diffuses challenging situations effectively.

5 People can trust the newly registered graduate nurse to engage with them in a warm, sensitive and compassionate way.		
First progression point	**Second progression point**	**Entry to the register**
1 Is attentive and acts with kindness and sensitivity. 2 Takes into account people's physical and emotional responses when engaging with them. 3 Interacts with the person in a manner that is interpreted as warm, sensitive, kind and compassionate, making appropriate use of touch. 4 Provides person centred care that addresses both physical and emotional needs and preferences. 5 Evaluates ways in which own interactions affect relationships to ensure that they do not impact inappropriately on others.		6 Anticipates how people might feel in a given situation and responds with kindness and empathy to provide physical and emotional comfort. 7 Makes appropriate use of touch. 8 Listens to, watches for, and responds to verbal and non-verbal cues. 9 Engages with people in the planning and provision of care that recognises personalised needs and provides practical and emotional support. 10 Has insight into own values and how these may impact on interactions with others. 11 Recognises circumstances that trigger personal negative responses and takes action to prevent this compromising care. 12 Recognises and acts autonomously to respond to own emotional discomfort or distress in self and others. 13 Through reflection and evaluation demonstrates commitment to personal

		and professional development and life-long learning.
6 People can trust the newly registered graduate nurse to engage therapeutically and actively listen to their needs and concerns, responding using skills that are helpful, providing information that is clear, accurate, meaningful and free from jargon.		
First progression point	**Second progression point**	**Entry to the register**
1 Communicates effectively both orally and in writing, so that the meaning is always clear. 2 Records information accurately and clearly on the basis of observation and communication. 3 Always seeks to confirm understanding. 4 Responds in a way that confirms what a person is communicating. 5 Effectively communicates people's stated needs and wishes to other professionals.	6 Uses strategies to enhance communication and remove barriers to effective communication minimising risk to people from lack of or poor communication.	7 Consistently shows ability to communicate safely and effectively with people providing guidance for others. 8 Communicates effectively and sensitively in different settings, using a range of methods and skills. 9 Provides accurate and comprehensive written and verbal reports based on best available evidence. 10 Acts autonomously to reduce and challenge barriers to effective communication and understanding. 11 Is proactive and creative in enhancing communication and understanding. 12 Uses the skills of active listening, questioning, paraphrasing and reflection to support a therapeutic intervention.

		13 Uses appropriate and relevant communication skills to deal with difficult and challenging circumstances, for example, responding to emergencies, unexpected occurrences, saying “no”, dealing with complaints, resolving disputes, de-escalating aggression, conveying ‘unwelcome news’.
7 People can trust the newly registered graduate nurse to protect and keep as confidential all information relating to them.		
First progression point	**Second progression point**	**Entry to the register**
1 Applies the principles of confidentiality. 2 Protects and treats information as confidential except where sharing information is required for the purposes of safeguarding and public protection. 3 Applies the principles of data protection.	4 Distinguishes between information that is relevant to care planning and information that is not.	5 Acts professionally and autonomously in situations where there may be limits to confidentiality, for example, public interest and protection from harm. 6 Recognises the significance of information and acts in relation to who does or does not need to know. 7 Acts appropriately in sharing information to enable and enhance care (carers, MDT and across agency boundaries). 8 Works within the legal frameworks for data protection including access to and storage of records. 9 Acts within the law when confidential

		information has to be shared with others.
8 People can trust the newly registered graduate nurse to gain their consent based on sound understanding and informed choice prior to any intervention and that their rights in decision making and consent will be respected and upheld.		
First progression point	**Second progression point**	**Entry to the register**
1 Seeks consent prior to sharing confidential information outside of the professional care team, subject to agreed safeguarding and protection procedures.	2 Applies principles of consent in relation to restrictions relating to specific client groups and seeks consent for care. 3 Ensures that the meaning of consent to treatment and care is understood by the people or service users.	4 Uses helpful and therapeutic strategies to enable people to understand treatments and other interventions in order to give informed consent. 5 Works within legal frameworks when seeking consent. 6 Assesses and responds to the needs and wishes of carers and relatives in relation to information and consent. 7 Demonstrates respect for the autonomy and rights of people to withhold consent in relation to treatment within legal frameworks and in relation to people's safety.

Essential skills cluster: Organisational aspects of care

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

9 People can trust the newly registered graduate nurse to treat them as partners and work with them to make a holistic and systematic assessment of their needs; to develop a personalised plan that is based on mutual understanding and respect for their individual situation promoting health and well-being, minimising risk of harm and promoting their safety at all times.

First progression point	Second progression point	Entry to the register
1 Responds appropriately when faced with an emergency or a sudden deterioration in a person's physical or psychological condition (for example, abnormal vital signs, collapse, cardiac arrest, self harm, extremely challenging behaviour, attempted suicide) including seeking help from an appropriate person.	2 Accurately undertakes and records a baseline assessment of weight, height, temperature, pulse, respiration and blood pressure using manual and electronic devices**. (*)** 3 Understands the concept of public health and the benefits of healthy lifestyles and the potential risks involved with various lifestyles or behaviours, for example, substance misuse, smoking, obesity. 4 Recognises indicators of unhealthy lifestyles. 5 Contributes to care based on an understanding of how the different stages of an illness or disability can impact on people and carers.	12 In partnership with the person, their carers and their families, makes a holistic, person centred and systematic assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk, and together, develops a comprehensive personalised plan of nursing care. 13 Acts autonomously and takes responsibility for collaborative assessment and planning of care delivery with the person, their cares and their family. 14 Applies research based evidence to practice.

	6 Measures and documents vital signs under supervision and responds appropriately to findings outside the normal range. **(*)** 7 Performs routine, diagnostic tests for example urinalysis under supervision as part of assessment process (near client testing). 8 Collects and interprets routine data, under supervision, related to the assessment and planning of care from a variety of sources. 9 Undertakes the assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk factors by working with the person and records, shares and responds to clear indicators and signs. 10 With the person and under supervision, plans safe and effective care by recording and sharing information based on the assessment. 11 Where relevant, applies knowledge of age and condition-related anatomy, physiology and development when interacting with people.	15 Works within the context of a multi-professional team and works collaboratively with other agencies when needed to enhance the care of people, communities and populations. 16 Promotes health and well-being, self care and independence by teaching and empowering people and carers to make choices in coping with the effects of treatment and the ongoing nature and likely consequences of a condition including death and dying. 17 Uses a range of techniques to discuss treatment options with people. 18 Discusses sensitive issues in relation to public health and provides appropriate advice and guidance to individuals, communities and populations for example, contraception, substance misuse, smoking, obesity. 19 Refers to specialists when required. 20 Acts autonomously and appropriately when faced with sudden deterioration in people's physical or psychological condition or emergency situations, abnormal vital signs, collapse, cardiac arrest, self-harm, extremely challenging behaviour, attempted suicide.

		21 Measures, documents and interprets vital signs and acts autonomously and appropriately on findings. 22 Works within a public health framework to assess needs and plan care for individuals, communities and populations.
10 People can trust the newly registered graduate nurse to deliver nursing interventions and evaluate their effectiveness against the agreed assessment and care plan.		
First progression point	**Second progression point**	**Entry to the register**
	1 Acts collaboratively with people and their carers enabling and empowering them to take a shared and active role in the delivery and evaluation of nursing interventions. 2 Works within the limitations of own knowledge and skills to question and provide safe and holistic care. 3 Prepares people for clinical interventions as per local policy. 4 Actively seeks to extend knowledge and skills using a variety of methods in order to enhance care delivery.	6 Provides safe and effective care in partnership with people and their carers within the context of people's ages, conditions and developmental stages. 7 Prioritises the needs of groups of people and individuals in order to provide care effectively and efficiently. 8 Detects, records and reports if necessary, deterioration or improvement and takes appropriate action autonomously. 9 Evaluates the effect of interventions, taking account of people's and carers' interpretation of physical, emotional, and behavioural changes.

	5 Detects, records, reports and responds appropriately to signs of deterioration or improvement.	10 Involves the person in review and adjustments to their care, communicating changes to colleagues.
11 People can trust the newly registered graduate nurse to safeguard children and adults from vulnerable situations and support and protect them from harm.		
First progression point	**Second progression point**	**Entry to the register**
1 Acts within legal frameworks and local policies in relation to safeguarding adults and children who are in vulnerable situations. 2 Shares information with colleagues and seeks advice from appropriate sources where there is a concern or uncertainty. 3 Uses support systems to recognise, manage and deal with own emotions.	4 Documents concerns and information about people who are in vulnerable situations.	5 Recognises and responds when people are in vulnerable situations and at risk, or in need of support and protection. 6 Shares information safely with colleagues and across agency boundaries for the protection of individuals and the public. 7 Makes effective referrals to safeguard and protect children and adults requiring support and protection. 8 Works collaboratively with other agencies to develop, implement and monitor strategies to safeguard and protect individuals and groups who are in vulnerable situations. 9 Supports people in asserting their human rights.

		10 Challenges practices which do not safeguard those in need of support and protection.
12 People can trust the newly registered graduate nurse to respond to their feedback and a wide range of other sources to learn, develop and improve services.		
First progression point	**Second progression point**	**Entry to the register**
1 Responds appropriately to compliments and comments.	2 Responds appropriately when people want to complain, providing assistance and support. 3 Uses supervision and other forms of reflective learning to make effective use of feedback. 4 Takes feedback from colleagues, managers and other departments seriously and shares the messages and learning with other members of the team.	5 Shares complaints, compliments and comments with the team in order to improve care. 6 Actively responds to feedback. 7 Supports people who wish to complain. 8 As an individual team member and team leader, actively seeks and learns from feedback to enhance care and own and others professional development. 9 Works within ethical and legal frameworks and local policies to deal with complaints, compliments and concerns.

13 People can trust the newly registered, graduate nurse to promote continuity when their care is to be transferred to another service or person.		
First progression point	**Second progression point**	**Entry to the register**
	1 Assists in preparing people and carers for transfer and transition through effective dialogue and accurate information. 2 Reports issues and people's concerns regarding transfer and transition. 3 Assists in the preparation of records and reports to facilitate safe and effective transfer.	
14 People can trust the newly registered graduate nurse to be an autonomous and confident member of the multi-disciplinary or multi agency team and to inspire confidence in others.		
First progression point	**Second progression point**	**Entry to the register**
1 Works within *The Code: Professional Standards of practice and behaviour for nurses and midwives* (NMC, 2015)	2 Supports and assists others appropriately. 3 Values others' roles and responsibilities within the team and interacts appropriately. 4 Reflects on own practice and discusses issues with other members	6 Actively consults and explores solutions and ideas with others to enhance care. 7 Challenges the practice of self and others across the multi-professional team.

	of the team to enhance learning. 5 Communicates with colleagues verbally, face-to-face and by telephone, and in writing and electronically in a way that the meaning is clear, and checks that the communication has been fully understood.	8 Takes effective role within the team adopting the leadership role when appropriate. 9 Act as an effective role model in decision making, taking action and supporting others. 10 Works inter-professionally and autonomously as a means of achieving optimum outcomes for people. 11 Safeguards the safety of self and others, and adheres to lone working policies when working in the community setting and in people's homes.
15 People can trust the newly registered graduate nurse to safely delegate to others and to respond appropriately when a task is delegated to them.		
First progression point	**Second progression point**	**Entry to the register**
1 Accepts delegated activities within limitations of own role, knowledge and skill.		2 Works within the requirements of The Code (NMC 2015) in delegating care and when care is delegated to them. 3 Takes responsibility and accountable for delegating care to others. 4 Prepares, supports and supervises those to whom care has been delegated.

		5 Recognises and addresses deficits in knowledge and skill in self and others and takes appropriate action.
16 People can trust the newly registered graduate nurse to safely lead, co-ordinate and manage care.		
First progression point	**Second progression point**	**Entry to the register**
		1 Inspires confidence and provides clear direction to others. 2 Takes decisions and is able to answer for these decisions when required. 3 Bases decisions on evidence and uses experience to guide decision-making. 4 Acts as a positive role model for others. 5 Manages time effectively. 6 Negotiates with others in relation to balancing competing and conflicting priorities.
17 People can trust the newly registered graduate nurse to work safely under pressure and maintain the safety of service users at all times.		
First progression point	**Second progression point**	**Entry to the register**
1 Recognises when situations are becoming unsafe and reports	3 Contributes as a team member.	7 Demonstrates effective time

appropriately. 2 Understands and applies the importance of rest for effective practice.	4 Demonstrates professional commitment by working flexibly to meet service needs to enable quality care to be delivered. 5 Uses supervision as a means of developing strategies for managing own stress and for working safely and effectively. 6 Adheres to safety policies when working in the community and in people's homes, for example, lone worker policy.	management. 8 Prioritises own workload and manages competing and conflicting priorities. 9 Appropriately reports concerns regarding staffing and skill-mix and acts to resolve issues that may impact on the safety of service users within local policy frameworks. 10 Recognises stress in others and provides appropriate support or guidance ensuring safety to people at all times. 11 Enables others to identify and manage their stress. 12 Works within local policies when working in the community setting including in people's homes and ensures the safety of others.
18 People can trust a newly registered graduate nurse to enhance the safety of service users and identify and actively manage risk and uncertainty in relation to people, the environment, self and others.		
First progression point	**Second progression point**	**Entry to the register**
1 Under supervision, works within clinical governance frameworks. 2 Reports safety incidents regarding	7 Contributes to promote safety and positive risk taking. 8 Under supervision works safely within	9 Reflects on and learns from safety incidents as an autonomous individual and as a team member and contributes

service users to senior colleagues. 3 Under supervision assesses risk within current sphere of knowledge and competence. 4 Follows instructions and takes appropriate action, sharing information to minimise risk. 5 Under supervision works within legal frameworks to protect self and others. 6 Knows and accepts own responsibilities and takes appropriate action.	the community setting taking account of local policies, for example, lone worker policy.	to team learning. 10 Participates in clinical audit to improve the safety of service users. 11 Assesses and implements measures to manage, reduce or remove risk that could be detrimental to people, self and others. 12 Assesses, evaluates and interprets risk indicators and balances risks against benefits, taking account of the level of risk people are prepared to take. 13 Works within legal and ethical frameworks to promote safety and positive risk taking. 14 Works within policies to protect self and others in all care settings including in the home care setting. 15 Takes steps not to cross professional boundaries and put self or colleagues at risk.
19 People can trust the newly registered graduate nurse to work to prevent and resolve conflict and maintain a safe environment.		
First progression point	**Second progression point**	**Entry to the register**
1 Recognises signs of aggression and responds appropriately to keep self		3 Selects and applies appropriate strategies and techniques for conflict

and others safe. 2 Assists others or obtains assistance when help is required.		resolution, de-escalation and physical intervention in the management of potential violence and aggression.
20 People can trust the newly registered graduate nurse to select and manage medical devices safely.		
First progression point	**Second progression point**	**Entry to the register**
1 Safely uses and disposes of medical devices under supervision and in keeping with local and national policy and understands reporting mechanism relating to adverse incidents.		2 Works within legal frameworks and applies evidence based practice in the safe selection and use of medical devices. 3 Safely uses and maintains a range of medical devices appropriate to the area of work, including ensuring regular servicing, maintenance and calibration including reporting adverse incidents relating to medical devices. 4 Keeps appropriate records in relation to the use and maintenance of medical devices and the decontamination processes required as per local and national guidelines. 5 Explains the devices to people and carers and checks understanding.

Essential skills cluster: Infection prevention and control

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

21 People can trust the newly registered graduate nurse to identify and take effective measures to prevent and control infection in accordance with local and national policy.

First progression point	Second progression point	Entry to the register
1 Follows local and national guidelines and adheres to standard infection control precautions.	2 Participates in assessing and planning care appropriate to the risk of infection thus promoting the safety of service users. 3 Participates in completing care documentation and evaluation of interventions to prevent and control infection. 4 Aware of the role of the Infection Control Team and Infection Control Nurse Specialist, and local guidelines for referral. 5 Recognises potential signs of infection and reports to relevant senior member of staff.	7 Works within *The Code: Professional standards of practice and behaviour for nurses and midwives (*NMC, 2015) and in collaboration with people and their carers to meet responsibilities for prevention and control of infection. 8 In partnership with people and their carers, plans, delivers and documents care that demonstrates effective risk assessment, infection prevention and control. 9 Identifies, recognises and refers to the appropriate clinical expert. 10 Explains risks to people, relatives, carers and colleagues and educates them in prevention and control of infection.

	6 Discusses the benefits of health promotion within the concept of public health in the prevention and control of infection for improving and maintaining the health of the population.	11 Recognises infection risk and reports and acts in situations where there is need for health promotion and protection and public health strategies.
22 People can trust the newly registered graduate nurse to maintain effective standard infection control precautions and apply and adapt these to needs and limitations in all environments.		
First progression point	**Second progression point**	**Entry to the register**
1 Demonstrates effective hand hygiene and the appropriate use of standard infection control precautions when caring for all people.	2 Applies knowledge of transmission routes in describing, recognising and reporting situations where there is a need for standard infection control precautions 3 Participates in the cleaning of multi-use equipment between each person. 4 Uses multi-use equipment and follows the appropriate procedures. 5 Safely uses and disposes of, or decontaminates, items in accordance with local policy and manufacturers' guidance and instructions.	7 Initiates and maintains appropriate measures to prevent and control infection according to route of transmission of micro-organism, in order to protect service users, members of the public and other staff. 8 Applies legislation that relates to the management of specific infection risk at a local and national level. 9 Adheres to infection prevention and control policies and procedures at all times and ensures that colleagues work according to good practice guidelines. 10 Challenges the practice of other care workers who put themselves and others at risk of infection.

	6 Adheres to requirements for cleaning, disinfecting, decontaminating of 'shared' nursing equipment, including single or multi-use equipment, before and after every use as appropriate, according to recognised risk, in accordance with manufacturers' and organisational policies.	11 Manages overall environment to minimise risk.
23 People can trust a newly registered graduate nurse to provide effective nursing interventions when someone has an infectious disease including the use of standard isolation techniques.		
First progression point	**Second progression point**	**Entry to the register**
	1 Safely delivers care under supervision to people who require to be nursed in isolation or in protective isolation settings. 2 Takes appropriate actions in any environment including the home care setting, should exposure to infection occur, for example, chicken pox, diarrhoea and vomiting, needle stick injury. 3 Applies knowledge of an 'exposure prone procedure' and takes appropriate precautions and actions.	5 Recognises and acts upon the need to refer to specialist advisers as appropriate. 6 Assesses the needs of the infectious person, or people and applies appropriate isolation techniques. 7 Ensures that people including colleagues are aware of and adhere to local policies in relation to isolation and infection control procedures. 8 Identifies suitable alternatives when isolation facilities are unavailable and principles have to be applied in unplanned circumstances

	4 Takes personal responsibility, when a student knowingly has a blood borne virus, to consult with occupational health before carrying out exposure prone procedures.	

24 People can trust a newly registered graduate nurse to fully comply with hygiene, uniform and dress codes in order to limit, prevent and control infection.

First progression point	Second progression point	Entry to the register
1 Adheres to local policy and national guidelines on dress code for prevention and control of infection, including: footwear, hair, piercing and nails. 2 Maintains a high standard of personal hygiene. 3 Wears appropriate clothing for the care delivered in all environments.		4 Acts as a role model to others and ensures colleagues work within local policy.

25 People can trust a newly registered graduate nurse to safely apply the principles of asepsis when performing invasive procedures and be competent in aseptic technique in a variety of settings.

First progression point	Second progression point	Entry to the register
	1 Demonstrates understanding of the principles of wound management, healing and asepsis.	3 Applies a range of appropriate measures to prevent infection including application of safe and effective

	Safely performs basic wound care using clean and aseptic techniques in a variety of settings. 2 Assists in providing accurate information to people and their carers on the management of a device, site or wound to prevent and control infection and to promote healing wherever that person might be, for example, in hospital, in the home care setting, in an unplanned situation.	aseptic technique. 4 Safely performs wound care, applying non-touch or aseptic techniques in a variety of settings. 5 Able to communicate potential risks to others and advise people on the management of their device, site or wound to prevent and control infection and to promote healing.
26 People can trust the newly qualified nurse to act, in a variety of environments including the home care setting, to reduce risk when handling waste, including sharps, contaminated linen and when dealing with spillages of blood and other body fluids.		
First progression point	**Second progression point**	**Entry to the register**
	1 Adheres to health and safety at work legislation and infection control policies regarding the safe disposal of all waste, soiled linen, blood and other body fluids and disposing of 'sharps' including in the home setting. 2 Ensures dignity is preserved when collecting and disposing of bodily fluids and soiled linen. 3 Acts to address potential risks within a timely manner including in the home setting.	4 Manages hazardous waste and spillages in accordance with local health and safety policies. 5 Instructs others to do the same.

Essential skills cluster: Nutrition and fluid management

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

27 People can trust the newly registered graduate nurse to assist them to choose a diet that provides an adequate nutritional and fluid intake.

First progression point	Second progression point	Entry to the register
	1 Under supervision helps people to choose healthy food and fluid in keeping with their personal preferences and cultural needs. 2 Accurately monitors dietary and fluid intake and completes relevant documentation. **(*)** 3 Supports people who need to adhere to specific dietary and fluid regimens and informs them of the reasons. 4 Maintains independence and dignity wherever possible and provides assistance as required. 5 Identifies people who are unable to or have difficulty in eating or drinking and reports this to others to ensure adequate nutrition and fluid intake is provided.	6 Uses knowledge of dietary, physical, social and psychological factors to inform practice being aware of those that can contribute to poor diet, cause or be caused by ill health. 7 Supports people to make appropriate the choices and changes to eating patterns, taking account of dietary preferences, religious and cultural requirements, treatment requirements and special diets needed for health reasons. 8 Refers to specialist members of the multi-disciplinary team for additional or specialist advice. 9 Discusses in a non-judgemental way how diet can improve health and the risks associated with not eating appropriately. 10 In liaison with a registered midwife

		provides essential advice and support to mothers who are breast feeding. 11 Provides support and advice to carers when the person they are caring for has specific dietary needs.
28 People can trust the newly registered graduate nurse to assess and monitor their nutritional status and in partnership, formulate an effective plan of care.		
First progression point	**Second progression point**	**Entry to the register**
	1 Takes and records accurate measurements of weight, height, length, body mass index and other appropriate measures of nutritional status. **(*)** 2 Assesses baseline nutritional requirements for healthy people related to factors such as age and mobility. 3 Contributes to formulating a care plan through assessment of dietary preferences, including local availability of foods and cooking facilities. 4 Reports to other members of the team when agreed plan is not achieved.	5 Makes a comprehensive assessment of people's needs in relation to nutrition identifying, documenting and communicating level of risk. **(*)** 6 Seeks specialist advice as required in order to formulate an appropriate care plan. 7 Provides information to people and their carers. 8 Monitors and records progress against the plan. 9 Discusses progress and changes in condition with the person, carers and the multi-disciplinary team. 10 Acts autonomously to initiate appropriate action when malnutrition is identified or where a person's

		nutritional status worsens, and report this as an adverse event.
29 People can trust a newly registered graduate nurse to assess and monitor their fluid status and in partnership with them, formulate an effective plan of care.		
First progression point	**Second progression point**	**Entry to the register**
	1 Applies knowledge of fluid requirements needed for health and during illness and recovery so that appropriate fluids can be provided. 2 Accurately monitors and records fluid intake and output. **(*)** 3 Recognises and reports reasons for poor fluid intake and output. 4 Reports to other members of the team when intake and output falls below requirements.	5 Uses negotiating and other skills to encourage people who might be reluctant to drink to take adequate fluids. 6 Identifies signs of dehydration and acts to correct these. **(*)** 7 Works collaboratively with the person their carers and the multi-disciplinary team to ensure an adequate fluid intake and output.

30 People can trust the newly qualified graduate nurse to assist them in creating an environment that is conducive to eating and drinking.		
First progression point	**Second progression point**	**Entry to the register**
1 Reports to an appropriate person where there is a risk of meals being missed. 2 Follows food hygiene procedures in accordance with policy.	3 Follows local procedures in relation to mealtimes, for example, protected mealtimes, indicators of people who need additional support. 4 Ensures that people are ready for the meal; that is, in an appropriate location, position, offered opportunity to wash hands, offered appropriate assistance.	5 Challenges others who do not follow procedures. 6 Ensures appropriate assistance and support is available to enable people to eat. 7 Ensures provision is made for replacement meals for anyone who is unable to eat at the usual time, or unable to prepare their own meals. 8 Ensures that appropriate food and fluids are available as required.
31 People can trust the newly qualified graduate nurse to ensure that those unable to take food by mouth receive adequate fluid and nutrition to meet their needs.		
First progression point	**Second progression point**	**Entry to the register**
	1 Recognises, responds appropriately and reports when people have difficulty eating or swallowing. 2 Adheres to an agreed plan of care that provides for individual difference, for example, cultural considerations, psychosocial aspects and provides	3 Takes action to ensure that, where there are problems with eating and swallowing, nutritional status is not compromised. 4 Administers enteral feeds safely and maintains equipment in accordance

	adequate nutrition and hydration when eating or swallowing is difficult.	with local policy. **(*)** 5 Safely, maintains and uses naso-gastric, PEG and other feeding devices. 6 Works within legal and ethical frameworks taking account of personal choice.
32 People can trust the newly registered graduate nurse to safely administer fluids when fluids cannot be taken independently.		
First progression point	**Second progression point**	**By entry to the register**
		1 Understands and applies knowledge of intravenous fluids and how they are prescribed and administered within local administration of medicines policy. 2 Monitors and assesses people receiving intravenous fluids. **(*)** 3 Documents progress against prescription and markers of hydration. **(*)** 4 Monitors infusion site for signs of abnormality, and takes the required action reporting and documenting signs and actions taken.

Essential skills cluster: Medicines management[2]

The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register.

33 People can trust the newly registered graduate nurse to correctly and safely undertake medicines[3] calculations.

First progression point	Second progression point	Entry to the register	Indicative content

1 Is competent in basic medicines calculations **(*)** relating to:
 	
• tablets and capsules
• liquid medicines
• injections including:
  • unit dose
  • sub and multiple unit dose
  • SI unit conversion.
		2 Is competent in the process of medication-related calculation in nursing field involving:
		
		• tablets and capsules
		• liquid medicines
		• injections
		• IV infusions including:
		  • unit dose
		  • sub and multiple unit dose
		  • complex calculations
		  • SI unit conversion.
			Numeracy skills, drug calculations required to administer medicines safely via appropriate routes including specific requirements for children and other groups.

2 Medicines management is “the clinical cost effective and safe use of medicines to ensure patients get maximum benefit from the medicines they need while at the same time minimising potential harm” (MHRA 2004). As the administration of a medicinal product is only part of the process, these ESCs reflect the process from prescribing, through to dispensing, storage, administration and disposal.

3 A Medicinal product is “Any substance or combination of substances presented for treating or preventing disease in human beings or in animals. Any substance or combination of substances which may be administered to human beings or animals with a view to making a medical diagnosis or to restoring, correcting or modifying physiological functions in human beings or animals is likewise considered a medicinal product” (Council Directive 65/65/EEC).

34 People can trust the newly registered graduate nurse to work within legal and ethical frameworks that underpin safe and effective medicines management.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Demonstrates understanding of legal and ethical frameworks relating to safe administration of medicines in practice. 2 Demonstrates an understanding of types of prescribing, types of prescribers and methods of supply. 3 Demonstrates understanding of legal and ethical frameworks for prescribing.	4 Applies legislation to practice to safe and effective ordering, receiving, storing administering and disposal of medicines and drugs, including controlled drugs in both primary and secondary care settings and ensures others do the same. 5 Fully understands all methods of supplying medicines, for example, Medicines Act exemptions, patient group directions (PGDs), clinical management plans and other forms of prescribing. 6 Fully understands the different types of prescribing including supplementary prescribing, community practitioner nurse prescribing and independent nurse prescribing.	Law, consent, confidentiality, ethics, accountability. Responsibilities under law, application of medicines legislation to practice, include: use of controlled drugs, exemption orders in relation to patient group direction (PGD).[4] Regulatory requirements: *Standards for medicines management* (NMC 2007), The Code (NMC 2015), *Standards of proficiency for nurse and midwife prescribers* (NMC 2006). Statutory requirements in relation to mental health, mental capacity, children and young people and medicines, national service frameworks and other country specific guidance.

4 Nursing students cannot supply or administer under a PGD (*Standards for medicines management* (NMC 2007)).

35 People can trust the newly registered graduate nurse to work as part of a team to offer holistic care and a range of treatment options of which medicines may form a part.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Demonstrates awareness of a range of commonly recognised approaches to managing symptoms, for example, relaxation, distraction and lifestyle advice. 2 Discusses referral options.	3 Works confidently as part of the team and, where relevant, as leader of the team to develop treatment options and choices with the person receiving care and their carers. 4 Questions, critically appraises, takes into account ethical considerations and the preferences of the person receiving care and uses evidence to support an argument in determining when medicines may or may not be an appropriate choice of treatment.	The principles of holistic care, health promotion, lifestyle advice, over-the-counter medicines, self-administration of medicines and other therapies. Observation and assessment. Effect of medicines and other treatment options, including distraction, positioning, alternative and complementary therapies. Ethical and legal frameworks.

36 People can trust the newly registered graduate nurse to ensure safe and effective practice in medicines management through comprehensive knowledge of medicines, their actions, risks and benefits.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Uses knowledge of commonly administered medicines in order to act promptly in cases where side effects and adverse reactions occur.	2 Applies knowledge of basic pharmacology, how medicines act and interact in the systems of the body, and their therapeutic action. 3 Understands common routes and techniques of medicine administration including absorption, metabolism, adverse reactions and interactions. 4 Safely manages drug administration and monitors effects. **(*)** 5 Reports adverse incidents and near misses. 6 Safely manages anaphylaxis.	Related anatomy and physiology. Drug pathways and how medicines act. Impacts of physiological state of patients on drug responses and safety, for example, the older adult, children, pregnant or breast feeding women and significant pathologies such as renal or hepatic impairments. Pharmaco-dynamics -the effects of drugs and their mechanisms of action in the body. Pharmaco-therapeutics – the therapeutic actions of certain medicines. Risks versus benefits of medication. Pharmaco-kinetics and how doses are determined by dynamics and systems in the body. Role and function of bodies that

			regulate and ensure the safety and effectiveness of medicines. Knowledge on management of adverse drug events, adverse drug reactions, prescribing and administration errors and the potential repercussions for safety.
37 People can trust the newly registered graduate nurse to safely order, receive, store and dispose of medicines (including controlled drugs) in any setting.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Demonstrates ability to safely store medicines under supervision.	2 Orders, receives, stores and disposes of medicines safely (including controlled drugs).	Managing medicines in hospital or primary care settings, for example, schools and the home care setting. Legislation that underpins practice related to a wide range of medicines such as controlled drugs, infusions and oxygen. Suitable conditions for storage, managing out-of-date stock, safe handling medication, managing discrepancies in stock, omissions.

38 People can trust the newly registered graduate nurse to administer medicines safely and in a timely manner, including controlled drugs.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Uses prescription charts correctly and maintains accurate records. 2 Utilises and safely disposes of equipment needed to draw up and administer medication, for example, needles, syringes, gloves. 3 Administers and, where necessary, prepares medication safely under direct supervision, including orally and by injection.	4 Safely and effectively administers and, where necessary, prepares medicines via routes and methods commonly used and maintains accurate records. **(*)** 5 Supervises and teaches others to do the same. 6 Understands the legal requirements.	Involvement of people receiving treatment, management of fear and anxiety, importance of non-verbal and verbal communication. Use of prescription charts including how to prepare, read and interpret them and record administration and non-administration. Use of personal drug record cards for controlled drugs. Preparing and administering medication in differing environments places, including the home care setting, hygiene, infection control, compliance aids, safe transport and disposal of medicines and equipment. Safety, checking person's identity, last dose, allergies, anaphylaxis, polypharmacy, monitoring of effect and record keeping. Where and how to report contra-

			indications, side effects, adverse reactions. Skills needed to administer safely via various means, for example, oral, topical, by infusion, injection, syringe driver and pumps. Aware of own limitations and when to refer on. Legal requirements, mechanisms for supply, sale and administration of medication, self-administration including controlled drugs.
39 People can trust a newly registered graduate nurse to keep and maintain accurate records using information technology, where appropriate, within a multi-disciplinary framework as a leader and as part of a team and in a variety of care settings including at home.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Demonstrates awareness of roles and responsibilities within the multi disciplinary team for medicines management, including how and in what ways information is shared within a variety of settings.	2 Effectively keep records of medication administered and omitted, in a variety of care settings, including controlled drugs and ensures others do the same.	Links to legislation, use of controlled drugs, the code in relation to confidentiality, consent and record keeping. Use of electronic records.

40 People can trust a newly registered graduate nurse to work in partnership with people receiving medical treatments and their carers.

First progression point	Second progression point	Entry to the register	Indicative content
	1 Under supervision involves people and carers in administration and self-administration of medicines.	2 Works with people and carers to provide clear and accurate information. 3 Gives clear instruction and explanation and checks that the person understands the use of medicines and treatment options. 4 Assesses the person's ability to safely self-administer their medicines. 5 Assists people to make safe and informed choices about their medicines.	Cultural, religious, linguistic and ethical beliefs, issues and sensitivities around medication. Ethical issues relating to compliance and administration of medicine without consent. Self-administration, assessment explanation and monitoring. Concordance. Meeting needs of specific groups including self-administration, for example, people with mental health needs, learning disabilities, children and young people, adolescents and older adults.

41 People can trust the newly registered graduate nurse to use and evaluate up-to-date information on medicines management and work within national and local policy guidelines.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Accesses commonly used evidence based sources relating to the safe and effective management of medicine.	2 Works within national and local policies and ensures others do the same.	Evidence based practice, identification of resources, the 'expert' patient and client. Using sources of information, national and local policies, clinical governance, formularies, for example, British National Formulary and the British National Formulary for Children.
42 People can trust the newly registered graduate nurse to demonstrate understanding and knowledge to supply and administer via a patient group direction.			
First progression point	**Second progression point**	**Entry to the register**	**Indicative content**
	1 Demonstrates knowledge of what a patient group direction is and who can use them.	2 **Through simulation and course work** demonstrates knowledge and application of the principles required for safe and effective supply and administration via a patient group direction including an understanding of role and accountability. 3 **Through simulation and**	National prescribing centre competency framework www.npc.co.uk

		course work demonstrates how to supply and administer via a patient group direction.	

Explanation of terms

Accreditation of prior learning (APL)

A process used in higher education to allow previous certificated or experiential learning to be accepted as meeting some programme outcomes and requirements. The NMC has previously used the term Accreditation of Prior (Experiential) Learning; however this has now been replaced with the term APL which encompasses all approaches to accreditation and recognition of prior learning.

Advocate

A person, group or organisation that supports and champions individuals or groups, ensuring that their views are considered and their rights upheld.

Advice

NMC advice helps nurses and midwives decide how best to meet the standards and guidance required of them in relation to their professional accountability and practice.

Annotated

This refers to the process for identifying which nurses and midwives are entered on the local register as sign-off mentors having the authority to make a final judgement about whether a student has achieved the overall standards of competence required for entry to the register at the end of an NMC approved programme.

Approved education institution (AEI)

A higher education institution recognised by the NMC as a provider of NMC approved programmes which lead to registration or a mark on the register, and preparatory programmes for individuals who will support learning and assessment in practice.

Augmentative and alternative communication (AAC)

Any method of communication that supplements (augmentative) or replaces (alternative) spoken or written communications when these are temporarily or permanently impaired and inadequate to meet all or some of a person's communication needs. Those commonly used in the field of learning disabilities include objects, pictures or drawings, photographs, electronic communication aids, symbols, gestures and signing.

Autonomy

The freedom to make binding decisions, within the scope of practice, that are based on professional ethics, expertise and clinical knowledge.

Carer

An individual providing personal care for a person or people who, due to illness, infirmity or disability, are unable to care for themselves without this help (Adapted from Care Standards Act 2000).

Care pathways

A system of care delivery that organises a service user's care from their first contact with health services to the end of their episode. Care pathways aim to improve continuity and coordination across different professions and sectors. Other types include integrated care pathways, clinical pathways, multidisciplinary pathways, care maps and collaborative care pathways.

Case formulation

A summary of a person's known mental health problems, based on a systematic, holistic, user-centred assessment process. It provides the basis for a plan of care and intervention, and aims to describe and explain (based on psychological theory) the relationships between known problems. This would include factors that may have created vulnerability or problems or that may be contributing to ongoing problems. It would also identify actions that might help the person cope with their problems.

Comorbidity

The presence of more than one health problem in one person at the same time.

Commissioners

Organisations that contract with programme providers and fund pre-registration nursing education programmes.

Community practice learning

The time students spend learning about, and experiencing care provided outside the hospital setting. It can take place in people's own homes, in general practice, nursing homes and other residential facilities, walk-in centres, schools and workplaces.

Competence and competencies

The term **competence** refers to the overarching set of knowledge, skills and attitudes required to practise safely and effectively without direct supervision. It has been defined as 'the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions' (adapted from Queensland Nursing Council 2009). The NMC specifies competence as a requirement for entry to the NMC register. Both generic competence and field-specific competence are required to practise in a specific field.

The term **competencies** replaces the term 'proficiencies' that describe the criteria students must meet in order to complete their programme successfully and apply for registration. The various competencies are acquired in stages during the pre-

registration nursing programme. Evidence that all competencies have been acquired is used to determine whether a nursing student is competent to practise as a nurse.

Currency

Being up to date with current policy and developments in education and practice.

Diversity

Valuing people and recognising them for their skills, talents and experiences, accepting that everyone is different (see also equality).

Domains

Frameworks for the four sets of competencies, which are organised in four domains: professional values; communication and interpersonal skills; nursing practice and decision-making; and leadership, management and teamwork.

Due regard

Relates to student assessment in pre-registration nursing programmes. If 'due regard' is required, the assessor must be registered on the same part of the NMC register and have a mark in the same field of practice that the student intends to enter.

Equality

Treating everyone fairly and providing equal opportunities for everyone regardless of their race, gender, disability, age, sexual orientation, religion and belief.

Essential skills clusters (ESCs)

Five essential skills clusters that support the development of learning outcomes for all nursing students. ESCs for pre-registration nursing programmes were introduced in 2008 (NMC Circular 07/2007). These include: care, compassion and communication, organisational aspects of care, infection prevention and control, nutrition and fluid management, and medicines management. They have been amended and form guidance within the *Standards for pre-registration nursing education (2010)*

European Directive 2005/36/EC

A directive is a European Union law that requires member states to achieve a particular result, without dictating the means of achieving it. Directive 2005/36/EC on the recognition of professional qualifications, sets out requirements for 'general care' for pre-registration nursing education for the adult field. The NMC requires some aspects of the directive, such as the length of programme, to be applied to all fields.

European Higher Education Area (EHEA)

The European Higher Education Area (EHEA) comprises 46 European countries that are participating in the Bologna Process. This allows students to choose from a wide

and transparent range of high quality courses while benefiting from smooth recognition procedures.

Face to face engagement

Where a person or people communicate in the presence of another person or people or through remote access such as videoconferencing.

Field competency

Encompasses the knowledge, skills and attitudes that nurses must acquire which together with the generic competencies must have been demonstrated in order to practise in a specific field of nursing. Learning outcomes for each field are derived from both generic and field-specific competencies.

Field of nursing

There are four recognised fields of nursing (see also *What nurses do*).

- Adult nursing: the care of people aged 18 or over
- Children's nursing: the care of children and young people from birth to late teens
- Learning disabilities nursing: the care of people of all ages who have learning disabilities
- Mental health nursing: the care of people of all ages who have mental health problems.

Fitness for practice

The student who is fit for practice is able to practise safely and effectively without supervision, and has met the standards for competence and all other requirements for registration.

Fitness to practise

A nurse or midwife's suitability to be on the NMC register without restriction.

Generic competency

Relates to the knowledge, skills and attitudes and technical abilities required of all nurses by the end of a pre-registration nursing programme.

Guidance

According to the Nursing and Midwifery Order 2001, the NMC must provide and publish guidance that reflects what it believes to be best practice. There is some flexibility in how guidance is applied to education programmes. Where it is not followed precisely, programme providers will need to account for this and explain how an alternate approach will produce a similar outcome.

Holistic

Concerning the whole person. A holistic approach to nursing considers physical, social, economic, psychological, spiritual and other factors when assessing, planning and delivering care.

Interprofessional learning

An interactive process of learning which is undertaken with students or registered professionals from a range of health and social care professions who learn with and from each other.

Learning outcomes

Statements of learning developed by programme providers which students must achieve to demonstrate that all programme competencies and requirements have been met.

Local register

A list of all current mentors and practice teachers eligible to supervise and assess students studying on NMC approved programme who have met NMC requirements to be entered and remain on the register.

Mentor

A nurse or midwife on the NMC register who, following successful completion of an NMC approved mentor preparation programme, is entered on a local register and is eligible to supervise and assess students in a practice setting. See also *sign-off mentor*.

Nurse

In the context of the standards, a nurse is defined as a person registered as a nurse with the Nursing and Midwifery Council. The European Tuning project defines the nurse as: ‘a professional person achieving a competent standard of practice at first cycle level following successful completion of an approved academic and practical course. The nurse is a safe, caring, and competent decision maker willing to accept personal and professional accountability for his/her actions and continuous learning. The nurse practises within a statutory framework and code of ethics delivering nursing practice (care) that is appropriately based on research, evidence and critical thinking that effectively responds to the needs of individual clients (patients) and diverse populations.’

Nursing student

A person enrolled on an NMC approved pre-registration nursing programme.

Nursing

'The use of clinical judgement in the provision of care to enable people to improve, maintain or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability until death' (Royal College of Nursing 2003).

Person-centred care

Care tailored to the individual needs and choices of the service user, taking into account diversity, culture, religion, spirituality, sexuality, gender, age, and disability. The principle is also applied to child-centred, family-centred and user-centred care.

Practice teacher

A nurse or midwife on the NMC register who following successful completion of an NMC approved practice teacher preparation programme, is entered on a local register and is eligible to supervise and assess nursing students in a practice setting.

Pre-registration nursing education

Describes the education programme undertaken by nursing students to acquire the competencies needed to meet the criteria for registration with the NMC. Students may apply for registration after they have successfully completed a pre-registration programme. NMC registration is required to practise as a nurse in the UK.

Preceptor

A registered nurse who helps newly qualified nurses develop confidence and reinforce their knowledge and skills after their initial registration.

Preceptorship

The support and guidance that enables qualified nurses to make the transition from being a student to becoming a more confident practitioner to practise in line with NMC standards.

Programme provider

The term used to describe approved education institutions (AEIs) and their partnering practice learning providers.

Progression point

There are two progression points that normally divide the pre-registration nursing programme into three equal parts. Students cannot normally move from one part to the next until they have met all the requirements for the current part.

Practice learning provider
Healthcare and other service organisations that provide opportunities for nursing students to learn in practice settings.

Psychosocial education

Involves sharing individualised information with service users and carers about the nature of mental health problems, including possible causes and outcomes, optimal treatments and specific strategies to minimise distress and disruption. It aims to improve their understanding of current problems, potential solutions and ways of coping. It also aims to reduce distress and promote social inclusion and recovery.

Public health

Public health encompasses preventing disease, prolonging life, promoting health and reducing recognised health inequalities through influencing and informing decisions by society, organisations, communities, families and individuals.

Reasonable adjustments

'The duty to make reasonable adjustments comprises three requirements which apply where a disabled person is placed at a substantial disadvantage in comparison with non-disabled people. The first requirement covers changing the way things are done (such as changing a practice), the second covers making changes to the built environment (such as providing access to a building), and the third covers providing auxiliary aids and services (such as providing special computer software or providing a different service).' (Equality Act 2010)

Recovery

A person's ability to live what they believe is a meaningful and satisfying life, with or without symptoms. Recovery means having control over and input into your own life.

Register (NMC register)

A public record maintained by the NMC of all nurses, midwives, and specialist community public health nurses eligible to practise in the UK. Individuals must register with the NMC in order to practise as a nurse, midwife or specialist community public health nurse in the UK, by demonstrating that they have met the minimum NMC requirements. A mark on the register identifies the nurse's field of practice: adult, child, mental health, or learning disabilities nursing.

Registered healthcare professional

A member of a profession in the health field that is regulated by a statutory regulator in the UK, such as the NMC, the Health Professions Council and the General Medical Council.

Requirements

NMC requirements must be met by all approved education institutions providing UK nursing and midwifery programmes. The requirements underpin the NMC standards that programme providers must meet.

Rights

Refers to rights enshrined in policy, law and values-based codes and frameworks, including human rights.

Safeguarding

Safeguarding in the context of healthcare regulation means acting in the best interests of people when they are using or needing the services of nurses and midwives.

It also has a wider meaning outside healthcare regulation which relates to protecting children, young people and vulnerable adults from abuse and neglect, but also actively promoting their welfare. (Adapted from LVSC 2010)

Self-care

Self-care is personal health maintenance. It is any individual, family or community activity that aims to improve or restore health, or treat or prevent disease. It includes all health decisions people make for themselves and their families.

Self-determination

The belief that people have the right, responsibility and ability to make their own choices about what is necessary and desirable to create a satisfying and meaningful life. In the context of nursing, this means that nurses should work with people to encourage and enable them to make informed decisions about their care and treatment and how they manage their lives.

Setting

Any environment where nursing care is delivered. This includes hospitals, community services and general practice, as well as service users' own homes and workplaces.

Service users

People of any age using any health or social care services in any sector who require the professional services of a nurse or midwife. Service users include in-patients, out-patients, clients, residents and all similar categories. Nurses also work with other individuals and groups to which the service user belongs or is closely connected. These include partners, families, significant others, carers, interest groups, communities, networks and populations. The term 'service users and others' encompasses any category that fits in with the service user's needs and circumstances.

Shared learning

A broad term that refers to opportunities for learning between students from different fields of nursing, and between nursing students and those from other professions.

Sign-off mentor

A nurse or midwife mentor who has met additional NMC requirements in order to be able to make judgements about whether a student has achieved the overall standards of competence required for entry to the register at the end of an NMC approved programme.

Standards

The NMC is required by the Nursing and Midwifery Order 2001 to establish standards of proficiency to be met by applicants to different parts of the register. These standards are considered to be necessary for safe and effective practice [Article 5(2) (a)]. These are set out within the standards for each part of the register (nursing, midwifery and community public health nursing). The standards have the full authority of the law.

Supervisor

A suitably prepared professional trained to support students in practice that meets NMC requirements.

Teacher

A nurse or midwife who, following successful completion of an NMC approved teacher preparation programme or its equivalent, is recorded on the NMC register. The NMC teacher standard is mandatory for those nurses and midwives based in higher education who make a major contribution to the learning and assessment of students on NMC approved programmes.

Transcript

A record of learning achieved in both theory and practice during a student's training. This is set out in a way that is suitable for mapping against other academic, professional or vocational awards. The reasons for leaving a programme are included in the transcript when a student has been asked to leave.

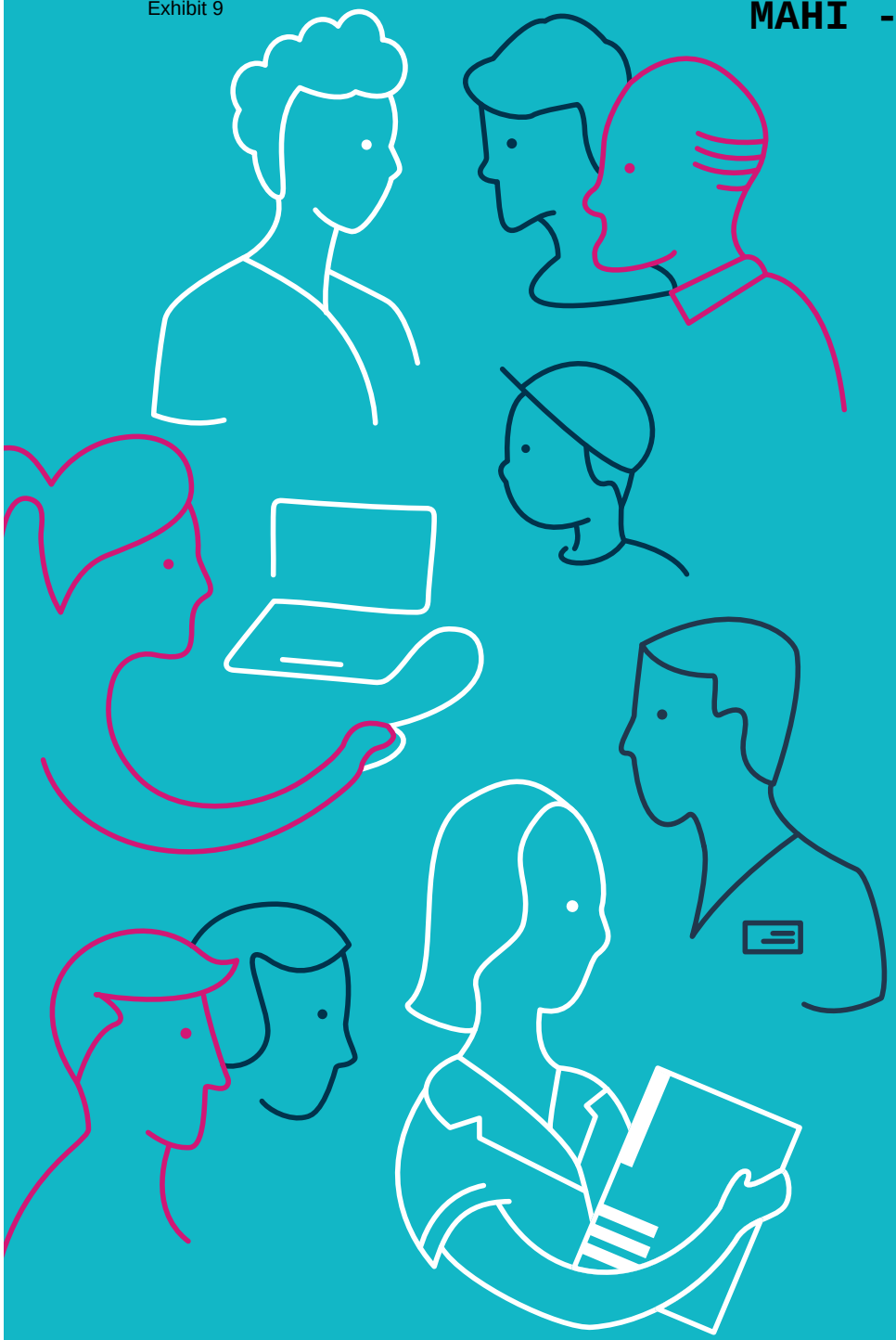
Tuning project

Tuning Educational Structures in Europe started in 2000 as a European Union project to link the political objectives of the Bologna Process and later the Lisbon Strategy to the higher educational sector. Over time it has developed into a process, an approach to (re)design, develop, implement, evaluate and enhance quality first, second and third cycle degree programmes. Higher education institutions are invited to test and use the outcomes and tools presented in a range of Tuning publications. A brochure for nursing has recently been published.

References to the Code have been updated to The Code (NMC, 2015)

Exhibit 9

MAHI - STM - 212 - 424



Nursing & Midwifery Council

Future nurse: Standards of proficiency for registered nurses

Published 17 May 2018

Contents

Future nurse: Standards of proficiency for registered nurses

Introduction

The Nursing and Midwifery Council has a duty to review the standards of proficiency it sets for the professions it registers on a regular basis to ensure that standards remain contemporary and fit for purpose in order to protect the public. In reviewing the standards, we have taken into account the changes that are taking place in society and health care, and the implications these have for registered nurses of the future in terms of their role, knowledge and skill requirements.

The proficiencies in this document therefore specify the knowledge and skills that registered nurses must demonstrate when caring for people of all ages and across all care settings. They reflect what the public can expect nurses to know and be able to do in order to deliver safe, compassionate and effective nursing care. They also provide a benchmark for nurses from the European Economic Area (EEA), European Union (EU) and overseas wishing to join the UK register, as well as for those who plan to return to practice after a period of absence.

The role of the nurse in the 21st century

Registered nurses play a vital role in providing, leading and coordinating care that is compassionate, evidence-based, and person-centred. They are accountable for their own actions and must be able to work autonomously, or as an equal partner with a range of other professionals, and in interdisciplinary teams. In order to respond to the impact and demands of professional nursing practice, they must be emotionally intelligent and resilient individuals, who are able to manage their own personal health and wellbeing, and know when and how to access support.

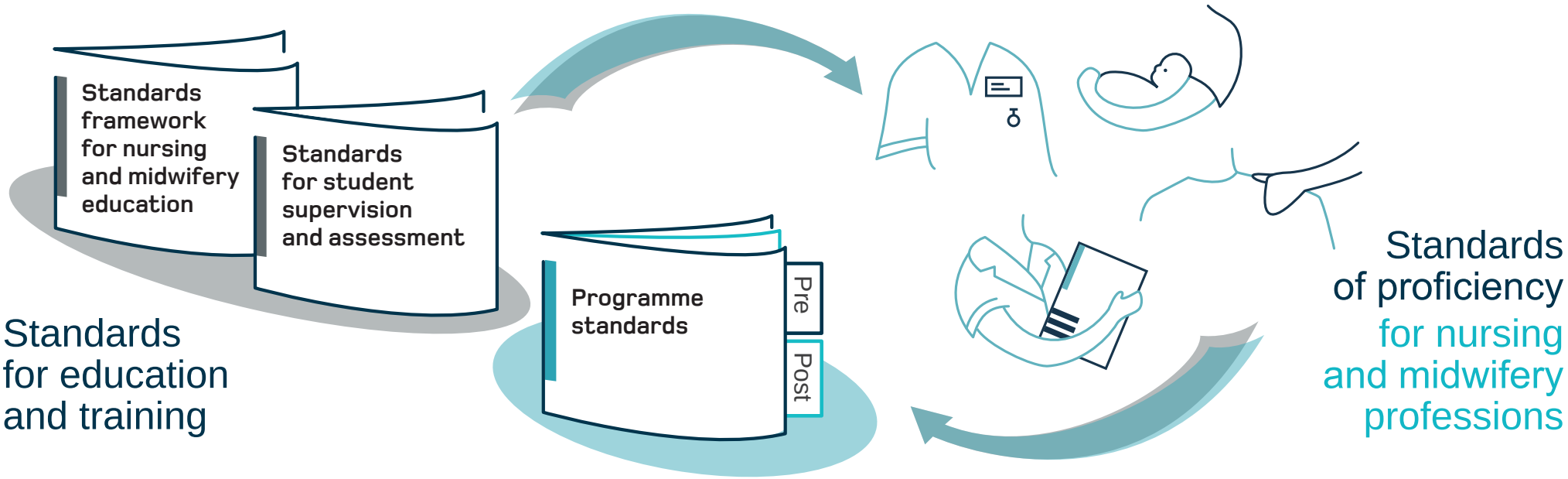
Registered nurses make an important contribution to the promotion of health, health protection and the prevention of ill health. They do this by empowering people, communities and populations to exercise choice, take control of their own health decisions and behaviours, and by supporting people to manage their own care where possible.

Registered nurses provide leadership in the delivery of care for people of all ages and from different backgrounds, cultures and beliefs. They provide nursing care for people who have complex mental, physical, cognitive and behavioural care needs, those living with dementia, the elderly, and for people at the end of their life. They must be able to care for people in their own home, in the community or hospital or in any health care settings where their needs are supported and managed. They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation, and rapidly evolving technologies. Increasing integration of health and social care services will require registered nurses to negotiate boundaries and play a proactive role in interdisciplinary teams. The confidence and ability to think critically, apply knowledge and skills, and provide expert, evidence-based, direct nursing care therefore lies at the centre of all registered nursing practice.

About these standards

These standards of proficiency apply to all NMC registered nurses. They should be read with *Realising professionalism: Standards for education and training* which set out our expectations regarding delivery of all pre-registration and post-registration NMC approved nursing and midwifery education programmes. These standards apply to all approved education providers and are set out in three parts: Part 1: *Standards framework for nursing and midwifery education*; Part 2: *Standards for student supervision and assessment*; and Part 3: *Programme standards*, which are the standards specific for each pre-registration or post-registration programme. Education institutions must comply with our standards to be approved to run any NMC approved programmes.

Together these standards aim to provide approved education institutions (AEIs) and their practice learning partners with the flexibility to develop innovative approaches to education for nurses, midwives and nursing associates, while being accountable for the local delivery and management of approved programmes in line with our standards.



Legislative framework

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order') requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The standards for nursing and midwifery education providers are established under the provision of Article 15(1) of the Order.

Article 5(2) of the Nursing and Midwifery Order 2001 requires the NMC to establish standards of proficiency necessary to be admitted to each part of the register and for safe and effective practice under that part of the register. The standards of proficiency have been established under this provision.

Future nurse: Standards of proficiency for registered nurses

How the proficiencies have been structured

The proficiencies are grouped under seven platforms, followed by two annexes. Together, these reflect what we expect a newly registered nurse to know and be capable of doing safely and proficiently at the start of their career.

Key components of the roles, responsibilities and accountabilities of registered nurses are described under each of the seven platforms. We believe that this approach provides clarity to the public and the professions about the core knowledge and skills that they can expect every registered nurse to demonstrate.

These proficiencies will provide new graduates into the profession with the knowledge and skills they need at the point of registration which they will build upon as they gain experience in practice and fulfil their professional responsibility to continuously update their knowledge and skills. For example, after they register with us registered nurses will already be equipped to progress to the completion of a prescribing qualification.

The platforms are:

1. Being an accountable professional
2. Promoting health and preventing ill health
3. Assessing needs and planning care
4. Providing and evaluating care
5. Leading and managing nursing care and working in teams
6. Improving safety and quality of care
7. Coordinating care

The outcome statements for each platform have been designed to apply across all four fields of nursing practice (adult, children, learning disabilities, mental health) and all care settings. This is because registered nurses must be able to meet the person-centred, holistic care needs of the people they encounter in their practice who may be at any stage of life and who may have a range of mental, physical, cognitive or behavioural health challenges. They must also be able to demonstrate a greater depth of knowledge and the additional more advanced skills required to meet the specific care needs of people in their chosen fields of nursing practice.

The annexes to these standards of proficiency are presented in two sections. The annexes provide a description of what registered nurses should be able to demonstrate they can do at the point of registration in order to provide safe nursing care. Annexe A specifies the communication and relationship management skills required, and Annexe B specifies the nursing procedures that registered nurses must demonstrate that they are able to perform safely. As with the knowledge proficiencies, the annexes also identify where more advanced skills are required by registered nurses, working in a particular field of nursing practice.

Platform 1
Being an accountable professional

Registered nurses act in the best interests of people, putting them first and providing nursing care that is person-centred, safe and compassionate. They act professionally at all times and use their knowledge and experience to make evidence-based decisions about care. They communicate effectively, are role models for others, and are accountable for their actions. Registered nurses continually reflect on their practice and keep abreast of new and emerging developments in nursing, health and care.

1. Outcomes:

The outcomes set out below reflect the proficiencies for accountable professional practice that must be applied across the standards of proficiency for registered nurses, as described in platforms 2-7, in all care settings and areas of practice.

At the point of registration, the registered nurse will be able to:

1.1 understand and act in accordance with the Code: *Professional standards of practice and behaviour for nurses, midwives and nursing associates*, and fulfil all registration requirements

1.2 understand and apply relevant legal, regulatory and governance requirements, policies, and ethical frameworks, including any mandatory reporting duties, to all areas of practice, differentiating where appropriate between the devolved legislatures of the United Kingdom

1.3 understand and apply the principles of courage, transparency and the professional duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes

1.4 demonstrate an understanding of, and the ability to challenge, discriminatory behaviour

1.5 understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to health

1.6 understand the professional responsibility to adopt a healthy lifestyle to maintain the level of personal fitness and wellbeing required to meet people's needs for mental and physical care

1.7 demonstrate an understanding of research methods, ethics and governance in order to critically analyse, safely use, share and apply research findings to promote and inform best nursing practice

1.8 demonstrate the knowledge, skills and ability to think critically when applying evidence and drawing on experience to make evidence informed decisions in all situations

1.9 understand the need to base all decisions regarding care and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence their decisions

1.10 demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences their judgments and decisions in routine, complex and challenging situations

1.11 communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges

1.12 demonstrate the skills and abilities required to support people at all stages of life who are emotionally or physically vulnerable

1.13 demonstrate the skills and abilities required to develop, manage and maintain appropriate relationships with people, their families, carers and colleagues

1.14 provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments

1.15 demonstrate the numeracy, literacy, digital and technological skills required to meet the needs of people in their care to ensure safe and effective nursing practice

1.16 demonstrate the ability to keep complete, clear, accurate and timely records

1.17 take responsibility for continuous self-reflection, seeking and responding to support and feedback to develop their professional knowledge and skills

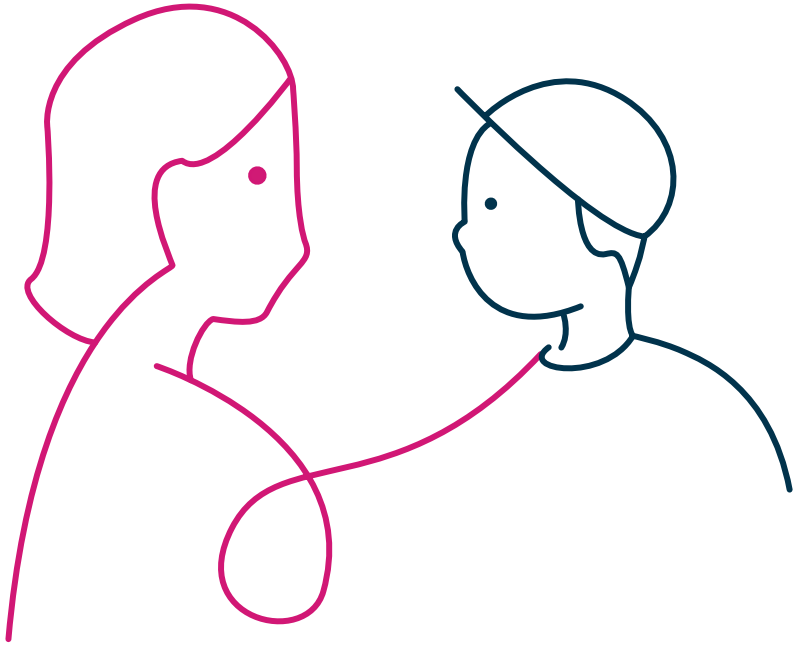
1.18 demonstrate the knowledge and confidence to contribute effectively and proactively in an interdisciplinary team

1.19 act as an ambassador, upholding the reputation of their profession and promoting public confidence in nursing, health and care services, and

1.20 safely demonstrate evidence-based practice in all skills and procedures stated in Annexes A and B.

Platform 2
Promoting health and preventing ill health

Registered nurses play a key role in improving and maintaining the mental, physical and behavioural health and well-being of people, families, communities and populations. They support and enable people at all stages of life and in all care settings to make informed choices about how to manage health challenges in order to maximise their quality of life and improve health outcomes. They are actively involved in the prevention of and protection against disease and ill health and engage in public health, community development and global health agendas, and in the reduction of health inequalities.



2. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in health promotion and protection and prevention of ill health.

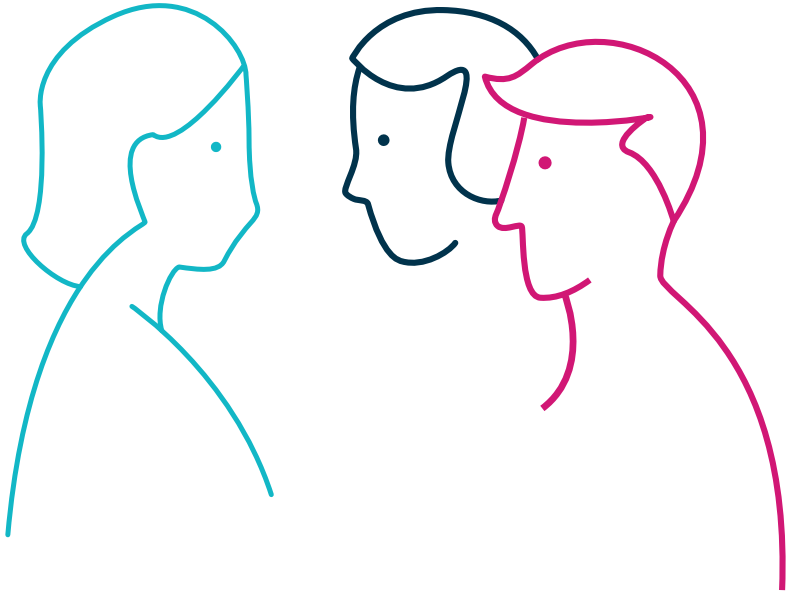
At the point of registration, the registered nurse will be able to:

2.1 understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health when engaging with people

2.2 demonstrate knowledge of epidemiology, demography, genomics and the wider determinants of health, illness and wellbeing and apply this to an understanding of global patterns of health and wellbeing outcomes

2.3 understand the factors that may lead to inequalities in health outcomes

2.4 identify and use all appropriate opportunities, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people's individual circumstances



2.5 promote and improve mental, physical, behavioural and other health related outcomes by understanding and explaining the principles, practice and evidence-base for health screening programmes

2.6 understand the importance of early years and childhood experiences and the possible impact on life choices, mental, physical and behavioural health and wellbeing

2.7 understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours and lifestyle choices to mental, physical and behavioural health outcomes

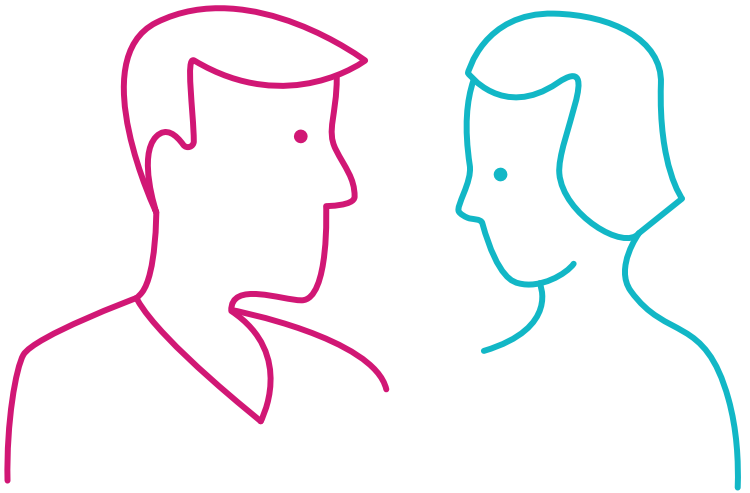
2.8 explain and demonstrate the use of up to date approaches to behaviour change to enable people to use their strengths and expertise and make informed choices when managing their own health and making lifestyle adjustments

2.9 use appropriate communication skills and strength based approaches to support and enable people to make informed choices about their care to manage health challenges in order to have satisfying and fulfilling lives within the limitations caused by reduced capability, ill health and disability

2.10 provide information in accessible ways to help people understand and make decisions about their health, life choices, illness and care

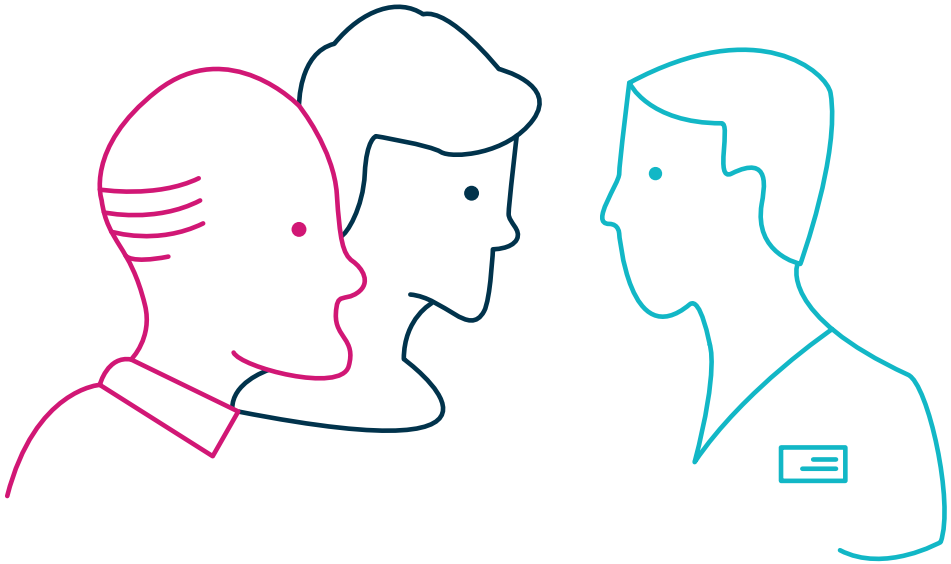
2.11 promote health and prevent ill health by understanding and explaining to people the principles of pathogenesis, immunology and the evidence-base for immunisation, vaccination and herd immunity, and

2.12 protect health through understanding and applying the principles of infection prevention and control, including communicable disease surveillance and antimicrobial stewardship and resistance.



Platform 3
Assessing needs and planning care

Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical, cognitive, behavioural, social and spiritual needs. They use information obtained during assessments to identify the priorities and requirements for person-centred and evidence-based nursing interventions and support. They work in partnership with people to develop person-centred care plans that take into account their circumstances, characteristics and preferences.



3. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in assessing and initiating person-centred plans of care.

At the point of registration, the registered nurse will be able to:

3.1 demonstrate and apply knowledge of human development from conception to death when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans

3.2 demonstrate and apply knowledge of body systems and homeostasis, human anatomy and physiology, biology, genomics, pharmacology and social and behavioural sciences when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans

3.3 demonstrate and apply knowledge of all commonly encountered mental, physical, behavioural and cognitive health conditions, medication usage and treatments when undertaking full and accurate assessments of nursing care needs and when developing, prioritising and reviewing person-centred care plans

3.4 understand and apply a person-centred approach to nursing care, demonstrating shared assessment, planning, decision making and goal setting when working with people, their families, communities and populations of all ages

3.5 demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person-centred evidence-based plans for nursing interventions with agreed goals

3.6 effectively assess a person's capacity to make decisions about their own care and to give or withhold consent

3.7 understand and apply the principles and processes for making reasonable adjustments

3.8 understand and apply the relevant laws about mental capacity for the country in which you are practising when making decisions in relation to people who do not have capacity

3.9 recognise and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are vulnerable

3.10 demonstrate the skills and abilities required to recognise and assess people who show signs of self-harm and/or suicidal ideation

3.11 undertake routine investigations, interpreting and sharing findings as appropriate

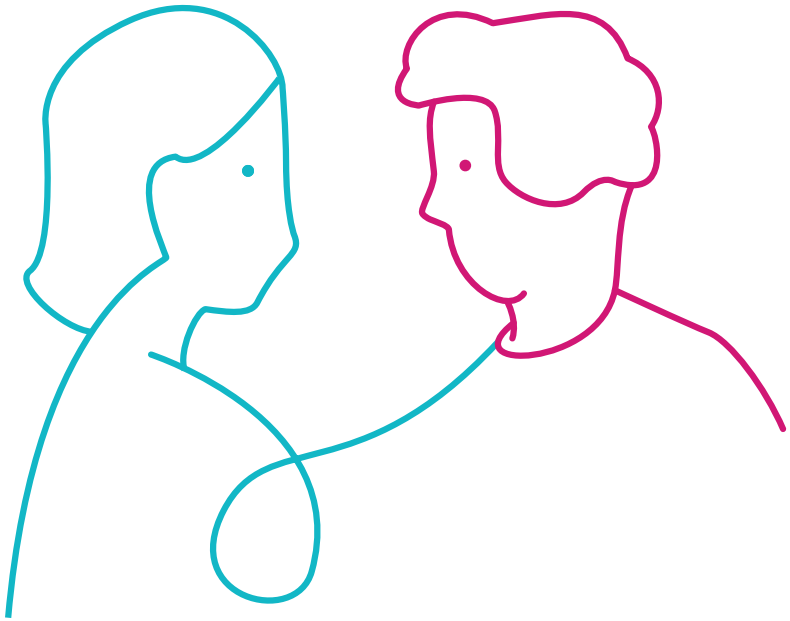
3.12 interpret results from routine investigations, taking prompt action when required by implementing appropriate interventions, requesting additional investigations or escalating to others

3.13 demonstrate an understanding of co-morbidities and the demands of meeting people's complex nursing and social care needs when prioritising care plans

3.14 identify and assess the needs of people and families for care at the end of life, including requirements for palliative care and decision making related to their treatment and care preferences

3.15 demonstrate the ability to work in partnership with people, families and carers to continuously monitor, evaluate and reassess the effectiveness of all agreed nursing care plans and care, sharing decision making and readjusting agreed goals, documenting progress and decisions made, and

3.16 demonstrate knowledge of when and how to refer people safely to other professionals or services for clinical intervention or support.



Platform 4 Providing and evaluating care

Registered nurses take the lead in providing evidence-based, compassionate and safe nursing interventions. They ensure that care they provide and delegate is person-centred and of a consistently high standard. They support people of all ages in a range of care settings. They work in partnership with people, families and carers to evaluate whether care is effective and the goals of care have been met in line with their wishes, preferences and desired outcomes.

4. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in providing and evaluating person-centred care.

At the point of registration, the registered nurse will be able to:

4.1 demonstrate and apply an understanding of what is important to people and how to use this knowledge to ensure their needs for safety, dignity, privacy, comfort and sleep can be met, acting as a role model for others in providing evidence based person-centred care

4.2 work in partnership with people to encourage shared decision making in order to support individuals, their families and carers to manage their own care when appropriate

4.3 demonstrate the knowledge, communication and relationship management skills required to provide people, families and carers with accurate information that meets their needs before, during and after a range of interventions

4.4 demonstrate the knowledge and skills required to support people with commonly encountered mental health, behavioural, cognitive and learning challenges, and act as a role model for others in providing high quality nursing interventions to meet people's needs

4.5 demonstrate the knowledge and skills required to support people with commonly encountered physical health conditions, their medication usage and treatments, and act as a role model for others in providing high quality nursing interventions when meeting people's needs

4.6 demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based nursing care to meet people's needs related to nutrition, hydration and bladder and bowel health

4.7 demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based, person-centred nursing care to meet people's needs related to mobility, hygiene, oral care, wound care and skin integrity

4.8 demonstrate the knowledge and skills required to identify and initiate appropriate interventions to support people with commonly encountered symptoms including anxiety, confusion, discomfort and pain

4.9 demonstrate the knowledge and skills required to prioritise what is important to people and their families when providing evidence-based person-centred nursing care at end of life including the care of people who are dying, families, the deceased and the bereaved

4.10 demonstrate the knowledge and ability to respond proactively and promptly to signs of deterioration or distress in mental, physical, cognitive and behavioural health and use this knowledge to make sound clinical decisions

4.11 demonstrate the knowledge and skills required to initiate and evaluate appropriate interventions to support people who show signs of self-harm and/or suicidal ideation

4.12 demonstrate the ability to manage commonly encountered devices and confidently carry out related nursing procedures to meet people's needs for evidence-based, person-centred care

4.13 demonstrate the knowledge, skills and confidence to provide first aid procedures and basic life support

4.14 understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies and demonstrate proficiency and accuracy when calculating dosages of prescribed medicines

4.15 demonstrate knowledge of pharmacology and the ability to recognise the effects of medicines, allergies, drug sensitivities, side effects, contraindications, incompatibilities, adverse reactions, prescribing errors and the impact of polypharmacy and over the counter medication usage

4.16 demonstrate knowledge of how prescriptions can be generated, the role of generic, unlicensed, and off-label prescribing and an understanding of the potential risks associated with these approaches to prescribing

4.17 apply knowledge of pharmacology to the care of people, demonstrating the ability to progress to a prescribing qualification following registration, and

4.18 demonstrate the ability to co-ordinate and undertake the processes and procedures involved in routine planning and management of safe discharge home or transfer of people between care settings.

Platform 5
Leading and managing nursing care and working in teams

Registered nurses provide leadership by acting as a role model for best practice in the delivery of nursing care. They are responsible for managing nursing care and are accountable for the appropriate delegation and supervision of care provided by others in the team including lay carers. They play an active and equal role in the interdisciplinary team, collaborating and communicating effectively with a range of colleagues.

5. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in leading and managing nursing care and working effectively as part of an interdisciplinary team.

At the point of registration, the registered nurse will be able to:

5.1 understand the principles of effective leadership, management, group and organisational dynamics and culture and apply these to team working and decision-making

5.2 understand and apply the principles of human factors, environmental factors and strength-based approaches when working in teams

5.3 understand the principles and application of processes for performance management and how these apply to the nursing team

5.4 demonstrate an understanding of the roles, responsibilities and scope of practice of all members of the nursing and interdisciplinary team and how to make best use of the contributions of others involved in providing care

5.5 safely and effectively lead and manage the nursing care of a group of people, demonstrating appropriate prioritisation, delegation and assignment of care responsibilities to others involved in providing care

5.6 exhibit leadership potential by demonstrating an ability to guide, support and motivate individuals and interact confidently with other members of the care team

5.7 demonstrate the ability to monitor and evaluate the quality of care delivered by others in the team and lay carers

5.8 support and supervise students in the delivery of nursing care, promoting reflection and providing constructive feedback, and evaluating and documenting their performance

5.9 demonstrate the ability to challenge and provide constructive feedback about care delivered by others in the team, and support them to identify and agree individual learning needs

5.10 contribute to supervision and team reflection activities to promote improvements in practice and services

5.11 effectively and responsibly use a range of digital technologies to access, input, share and apply information and data within teams and between agencies, and

5.12 understand the mechanisms that can be used to influence organisational change and public policy, demonstrating the development of political awareness and skills.

Platform 6
Improving safety and quality of care

Registered nurses make a key contribution to the continuous monitoring and quality improvement of care and treatment in order to enhance health outcomes and people's experience of nursing and related care. They assess risks to safety or experience and take appropriate action to manage those, putting the best interests, needs and preferences of people first.

6. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in contributing to risk monitoring and quality of care improvement agendas.

At the point of registration the registered nurse will be able to:

6.1 understand and apply the principles of health and safety legislation and regulations and maintain safe work and care environments

6.2 understand the relationship between safe staffing levels, appropriate skills mix, safety and quality of care, recognising risks to public protection and quality of care, escalating concerns appropriately

6.3 comply with local and national frameworks, legislation and regulations for assessing, managing and reporting risks, ensuring the appropriate action is taken

6.4 demonstrate an understanding of the principles of improvement methodologies, participate in all stages of audit activity and identify appropriate quality improvement strategies

6.5 demonstrate the ability to accurately undertake risk assessments in a range of care settings, using a range of contemporary assessment and improvement tools

6.6 identify the need to make improvements and proactively respond to potential hazards that may affect the safety of people

6.7 understand how the quality and effectiveness of nursing care can be evaluated in practice, and demonstrate how to use service delivery evaluation and audit findings to bring about continuous improvement

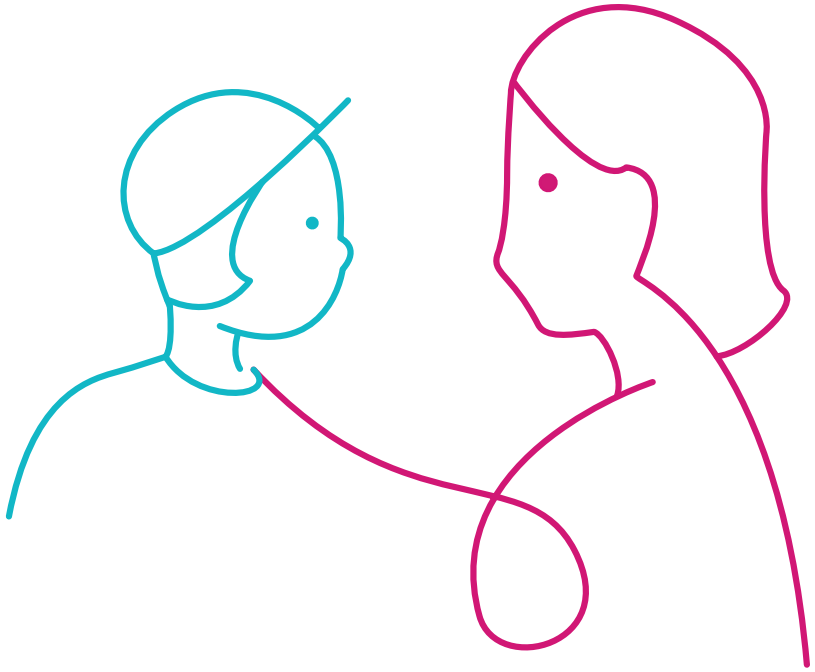
6.8 demonstrate an understanding of how to identify, report and critically reflect on near misses, critical incidents, major incidents and serious adverse events in order to learn from them and influence their future practice

6.9 work with people, their families, carers and colleagues to develop effective improvement strategies for quality and safety, sharing feedback and learning from positive outcomes and experiences, mistakes and adverse outcomes and experiences

6.10 apply an understanding of the differences between risk aversion and risk management and how to avoid compromising quality of care and health outcomes

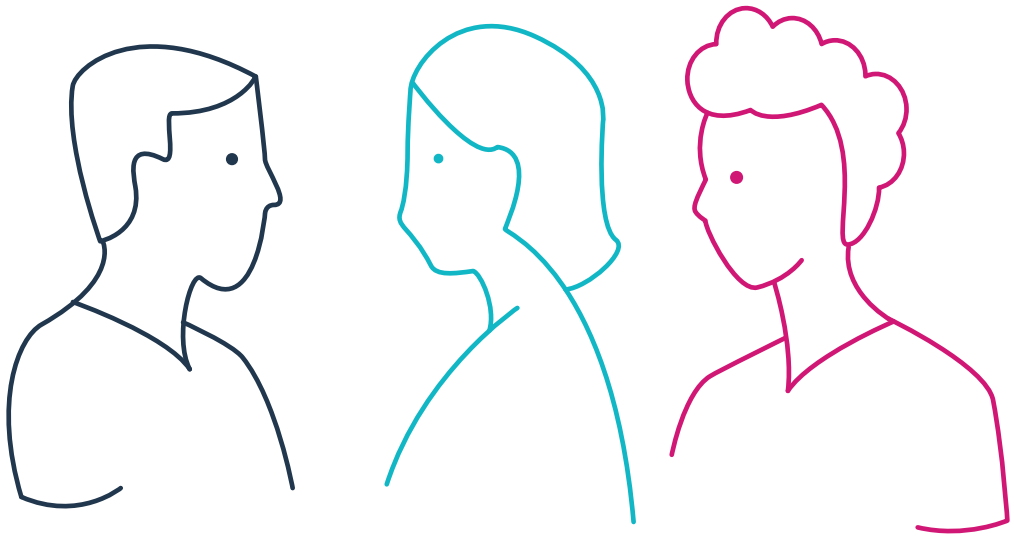
6.11 acknowledge the need to accept and manage uncertainty, and demonstrate an understanding of strategies that develop resilience in self and others, and

6.12 understand the role of registered nurses and other health and care professionals at different levels of experience and seniority when managing and prioritising actions and care in the event of a major incident.



Platform 7
Coordinating care

Registered nurses play a leadership role in coordinating and managing the complex nursing and integrated care needs of people at any stage of their lives, across a range of organisations and settings. They contribute to processes of organisational change through an awareness of local and national policies.



7. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in coordinating and leading and managing the complex needs of people across organisations and settings.

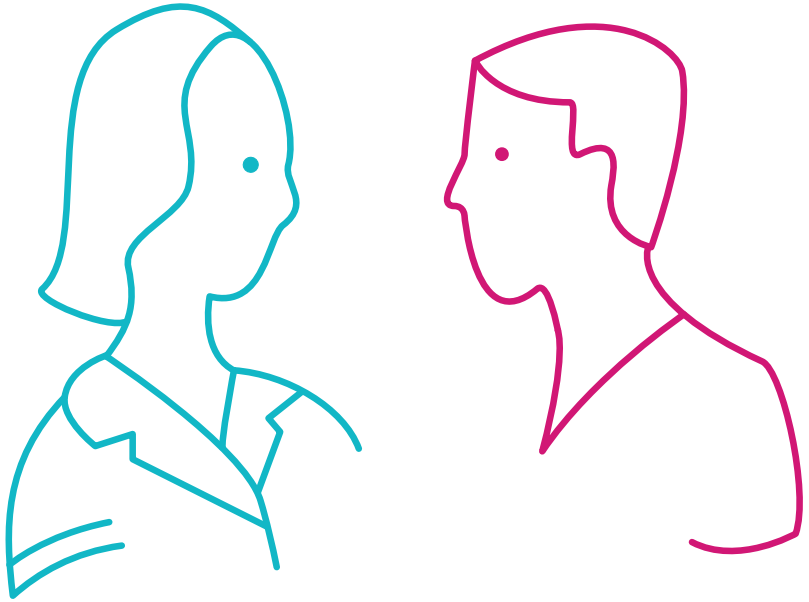
At the point of registration, the registered nurse will be able to:

7.1 understand and apply the principles of partnership, collaboration and interagency working across all relevant sectors

7.2 understand health legislation and current health and social care policies, and the mechanisms involved in influencing policy development and change, differentiating where appropriate between the devolved legislatures of the United Kingdom

7.3 understand the principles of health economics and their relevance to resource allocation in health and social care organisations and other agencies

7.4 identify the implications of current health policy and future policy changes for nursing and other professions and understand the impact of policy changes on the delivery and coordination of care



7.5 understand and recognise the need to respond to the challenges of providing safe, effective and person-centred nursing care for people who have co-morbidities and complex care needs

7.6 demonstrate an understanding of the complexities of providing mental, cognitive, behavioural and physical care services across a wide range of integrated care settings

7.7 understand how to monitor and evaluate the quality of people's experience of complex care

7.8 understand the principles and processes involved in supporting people and families with a range of care needs to maintain optimal independence and avoid unnecessary interventions and disruptions to their lives

7.9 facilitate equitable access to healthcare for people who are vulnerable or have a disability, demonstrate the ability to advocate on their behalf when required, and make necessary reasonable adjustments to the assessment, planning and delivery of their care

7.10 understand the principles and processes involved in planning and facilitating the safe discharge and transition of people between caseloads, settings and services

7.11 demonstrate the ability to identify and manage risks and take proactive measures to improve the quality of care and services when needed

7.12 demonstrate an understanding of the processes involved in developing a basic business case for additional care funding by applying knowledge of finance, resources and safe staffing levels, and

7.13 demonstrate an understanding of the importance of exercising political awareness throughout their career, to maximise the influence and effect of registered nursing on quality of care, patient safety and cost effectiveness.

Annexe A: Communication and relationship management skills

Introduction

The communication and relationship management skills that a newly registered nurse must be able to demonstrate in order to meet the proficiency outcomes outlined in the main body of this document are set out in this annexe.

Effective communication is central to the provision of safe and compassionate person-centred care. Registered nurses in all fields of nursing practice must be able to demonstrate the ability to communicate and manage relationships with people of all ages with a range of mental, physical, cognitive and behavioural health challenges.

This is because a diverse range of communication and relationship management skills is required to ensure that individuals, their families and carers are actively involved in and understand care decisions. These skills are vital when making accurate, culturally aware assessments of care needs and ensuring that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Where people have special communication needs or a disability, it is essential that reasonable adjustments are made in order to communicate, provide and share information in a manner that promotes optimum understanding and engagement and facilitates equal access to high quality care.

The communication and relationship management skills within this annexe are set out in four sections. For the reasons above, these requirements are relevant to all fields of nursing practice and apply to all care settings. It is expected that these skills would be assessed in a student's chosen field of practice.

Those skills outlined in **Annexe A, Section 3: Evidence-based, best practice communication skills and approaches for providing therapeutic interventions** also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field of practice. Registered nurses must be able to demonstrate these skills to an appropriate level for their intended field(s) of practice.

At the point of registration, the registered nurse will be able to safely demonstrate the following skills:

1. Underpinning communication skills for assessing, planning, providing and managing best practice, evidence-based nursing care

1.1 actively listen, recognise and respond to verbal and non-verbal cues

1.2 use prompts and positive verbal and non-verbal reinforcement

1.3 use appropriate non-verbal communication including touch, eye contact and personal space

1.4 make appropriate use of open and closed questioning

1.5 use caring conversation techniques

1.6 check understanding and use clarification techniques

1.7 be aware of own unconscious bias in communication encounters

1.8 write accurate, clear, legible records and documentation

1.9 confidently and clearly present and share verbal and written reports with individuals and groups

1.10 analyse and clearly record and share digital information and data

1.11 provide clear verbal, digital or written information and instructions when delegating or handing over responsibility for care

1.12 recognise the need for, and facilitate access to, translator services and material.

2. Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care

2.1 share information and check understanding about the causes, implications and treatment of a range of common health conditions including anxiety, depression, memory loss, diabetes, dementia, respiratory disease, cardiac disease, neurological disease, cancer, skin problems, immune deficiencies, psychosis, stroke and arthritis

2.2 use clear language and appropriate, written materials, making reasonable adjustments where appropriate in order to optimise people's understanding of what has caused their health condition and the implications of their care and treatment

2.3 recognise and accommodate sensory impairments during all communications

2.4 support and manage the use of personal communication aids

2.5 identify the need for and manage a range of alternative communication techniques

2.6 use repetition and positive reinforcement strategies

2.7 assess motivation and capacity for behaviour change and clearly explain cause and effect relationships related to common health risk behaviours including smoking, obesity, sexual practice, alcohol and substance use

2.8 provide information and explanation to people, families and carers and respond to questions about their treatment and care and possible ways of preventing ill health to enhance understanding

2.9 engage in difficult conversations, including breaking bad news and support people who are feeling emotionally or physically vulnerable or in distress, conveying compassion and sensitivity.

3. Evidence-based, best practice communication skills and approaches for providing therapeutic interventions

3.1 motivational interview techniques

3.2 solution focused therapies

3.3 reminiscence therapies

3.4 talking therapies

3.5 de-escalation strategies and techniques

3.6 cognitive behavioural therapy techniques

3.7 play therapy

3.8 distraction and diversion strategies

3.9 positive behaviour support approaches

4. Evidence-based, best practice communication skills and approaches for working with people in professional teams

4.1 Demonstrate effective supervision, teaching and performance appraisal through the use of:

4.1.1 clear instructions and explanations when supervising, teaching or appraising others

4.1.2 clear instructions and check understanding when delegating care responsibilities to others

4.1.3 unambiguous, constructive feedback about strengths and weaknesses and potential for improvement

4.1.4 encouragement to colleagues that helps them to reflect on their practice

4.1.5 unambiguous records of performance

4.2 Demonstrate effective person and team management through the use of:

4.2.1 strengths based approaches to developing teams and managing change

4.2.2 active listening when dealing with team members' concerns and anxieties

4.2.3 a calm presence when dealing with conflict

4.2.4 appropriate and effective confrontation strategies

4.2.5 de-escalation strategies and techniques when dealing with conflict

4.2.6 effective co-ordination and navigation skills through:

4.2.6.1 appropriate negotiation strategies

4.2.6.2 appropriate escalation procedures

4.2.6.3 appropriate approaches to advocacy.

Annexe B: Nursing procedures

Introduction

The nursing procedures that a newly registered nurse must be able to demonstrate in order to meet the proficiency outcomes, outlined in the main body of this document, are set out in this annexe.

The registered nurse must be able to undertake these procedures effectively in order to provide compassionate, evidence-based person-centred nursing care. A holistic approach to the care of people is essential and all nursing procedures should be carried out in a way which reflects cultural awareness and ensures that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Registered nurses in all fields of practice must demonstrate the ability to provide nursing intervention and support for people of all ages who require nursing procedures during the processes of assessment, diagnosis, care and treatment for mental, physical, cognitive and behavioural health challenges. Where people are disabled or have specific cognitive needs it is essential that reasonable adjustments are made to ensure that all procedures are undertaken safely.

The nursing procedures within this annexe are set out in two sections. These requirements are relevant to all fields of nursing practice although it is recognised that different care settings may require different approaches to the provision of care. It is expected that these procedures would be assessed in a student's chosen field of practice where practicable.

Those procedures outlined in **Annexe B, Part I: Procedures for assessing needs for person-centred care, sections 1 and 2** also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field(s) of practice. Registered nurses must therefore be able to demonstrate the ability to undertake these procedures at an appropriate level for their intended field(s) of practice.

At the point of registration, the registered nurse will be able to safely demonstrate the following procedures:

Part 1: Procedures for assessing people's needs for person-centred care

1. Use evidence-based, best practice approaches to take a history, observe, recognise and accurately assess people of all ages:

1.1 mental health and wellbeing status

1.1.1 signs of mental and emotional distress or vulnerability

1.1.2 cognitive health status and wellbeing

1.1.3 signs of cognitive distress and impairment

1.1.4 behavioural distress based needs

1.1.5 signs of mental and emotional distress including agitation, aggression and challenging behaviour

1.1.6 signs of self-harm and/or suicidal ideation

1.2 physical health and wellbeing

1.2.1 symptoms and signs of physical ill health

1.2.2 symptoms and signs of physical distress

1.2.3 symptoms and signs of deterioration and sepsis.

2. Use evidence-based, best practice approaches to undertake the following procedures:

2.1 take, record and interpret vital signs manually and via technological devices

2.2 undertake venepuncture and cannulation and blood sampling, interpreting normal and common abnormal blood profiles and venous blood gases

2.3 set up and manage routine electrocardiogram (ECG) investigations and interpret normal and commonly encountered abnormal traces

2.4 manage and monitor blood component transfusions

2.5 manage and interpret cardiac monitors, infusion pumps, blood glucose monitors and other monitoring devices

2.6 accurately measure weight and height, calculate body mass index and recognise healthy ranges and clinically significant low/high readings

2.7 undertake a whole body systems assessment including respiratory, circulatory, neurological, musculoskeletal, cardiovascular and skin status

2.8 undertake chest auscultation and interpret findings

2.9 collect and observe sputum, urine, stool and vomit specimens, undertaking routine analysis and interpreting findings

2.10 measure and interpret blood glucose levels

2.11 recognise and respond to signs of all forms of abuse

2.12 undertake, respond to and interpret neurological observations and assessments

2.13 identify and respond to signs of deterioration and sepsis

2.14 administer basic mental health first aid

2.15 administer basic physical first aid

2.16 recognise and manage seizures, choking and anaphylaxis, providing appropriate basic life support

2.17 recognise and respond to challenging behaviour, providing appropriate safe holding and restraint.

Part 2: Procedures for the planning, provision and management of person-centred nursing care

3. Use evidence-based, best practice approaches for meeting needs for care and support with rest, sleep, comfort and the maintenance of dignity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

3.1 observe and assess comfort and pain levels and rest and sleep patterns

3.2 use appropriate bed-making techniques including those required for people who are unconscious or who have limited mobility

3.3 use appropriate positioning and pressure-relieving techniques

3.4 take appropriate action to ensure privacy and dignity at all times

3.5 take appropriate action to reduce or minimise pain or discomfort

3.6 take appropriate action to reduce fatigue, minimise insomnia and support improved rest and sleep hygiene.

4. Use evidence-based, best practice approaches for meeting the needs for care and support with hygiene and the maintenance of skin integrity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

4.1 observe, assess and optimise skin and hygiene status and determine the need for support and intervention

4.2 use contemporary approaches to the assessment of skin integrity and use appropriate products to prevent or manage skin breakdown

4.3 assess needs for and provide appropriate assistance with washing, bathing, shaving and dressing

4.4 identify and manage skin irritations and rashes

4.5 assess needs for and provide appropriate oral, dental, eye and nail care and decide when an onward referral is needed

4.6 use aseptic techniques when undertaking wound care including dressings, pressure bandaging, suture removal, and vacuum closures

4.7 use aseptic techniques when managing wound and drainage processes

4.8 assess, respond and effectively manage pyrexia and hypothermia.

5. Use evidence-based, best practice approaches for meeting needs for care and support with nutrition and hydration, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

5.1 observe, assess and optimise nutrition and hydration status and determine the need for intervention and support

5.2 use contemporary nutritional assessment tools

5.3 assist with feeding and drinking and use appropriate feeding and drinking aids

5.4 record fluid intake and output and identify, respond to and manage dehydration or fluid retention

5.5 identify, respond to and manage nausea and vomiting

5.6 insert, manage and remove oral/nasal/gastric tubes

5.7 manage artificial nutrition and hydration using oral, enteral and parenteral routes

5.8 manage the administration of IV fluids

5.9 manage fluid and nutritional infusion pumps and devices.

6. Use evidence-based, best practice approaches for meeting needs for care and support with bladder and bowel health, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

6.1 observe and assess level of urinary and bowel continence to determine the need for support and intervention assisting with toileting, maintaining dignity and privacy and managing the use of appropriate aids

6.2 select and use appropriate continence products; insert, manage and remove catheters for all genders; and assist with self-catheterisation when required

6.3 manage bladder drainage

6.4 assess bladder and bowel patterns to identify and respond to constipation, diarrhoea and urinary and faecal retention

6.5 administer enemas and suppositories and undertake rectal examination and manual evacuation when appropriate

6.6 undertake stoma care identifying and using appropriate products and approaches.

7. Use evidence-based, best practice approaches for meeting needs for care and support with mobility and safety, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

7.1 observe and use evidence-based risk assessment tools to determine need for support and intervention to optimise mobility and safety, and to identify and manage risk of falls using best practice risk assessment approaches

7.2 use a range of contemporary moving and handling techniques and mobility aids

7.3 use appropriate moving and handling equipment to support people with impaired mobility

7.4 use appropriate safety techniques and devices.

8. Use evidence-based, best practice approaches for meeting needs for respiratory care and support, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

8.1 observe and assess the need for intervention and respond to restlessness, agitation and breathlessness using appropriate interventions

8.2 manage the administration of oxygen using a range of routes and best practice approaches

8.3 take and interpret peak flow and oximetry measurements

8.4 use appropriate nasal and oral suctioning techniques

8.5 manage inhalation, humidifier and nebuliser devices

8.6 manage airway and respiratory processes and equipment.

9. Use evidence-based, best practice approaches for meeting needs for care and support with the prevention and management of infection, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

9.1 observe, assess and respond rapidly to potential infection risks using best practice guidelines

9.2 use standard precautions protocols

9.3 use effective aseptic, non-touch techniques

9.4 use appropriate personal protection equipment

9.5 implement isolation procedures

9.6 use evidence-based hand hygiene techniques

9.7 safely decontaminate equipment and environment

9.8 safely use and dispose of waste, laundry and sharps

9.9 safely assess and manage invasive medical devices and lines.

10. Use evidence-based, best practice approaches for meeting needs for care and support at the end of life, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

10.1 observe, and assess the need for intervention for people, families and carers, identify, assess and respond appropriately to uncontrolled symptoms and signs of distress including pain, nausea, thirst, constipation, restlessness, agitation, anxiety and depression

10.2 manage and monitor effectiveness of symptom relief medication, infusion pumps and other devices

10.3 assess and review preferences and care priorities of the dying person and their family and carers

10.4 understand and apply organ and tissue donation protocols, advanced planning decisions, living wills and health and lasting powers of attorney for health

10.5 understand and apply DNACPR (do not attempt cardiopulmonary resuscitation) decisions and verification of expected death

10.6 provide care for the deceased person and the bereaved respecting cultural requirements and protocols.

11. Procedural competencies required for best practice, evidence-based medicines administration and optimisation

11.1 carry out initial and continued assessments of people receiving care and their ability to self-administer their own medications

11.2 recognise the various procedural routes under which medicines can be prescribed, supplied, dispensed and administered; and the laws, policies, regulations and guidance that underpin them

11.3 use the principles of safe remote prescribing and directions to administer medicines

11.4 undertake accurate drug calculations for a range of medications

11.5 undertake accurate checks, including transcription and titration, of any direction to supply or administer a medicinal product

11.6 exercise professional accountability in ensuring the safe administration of medicines to those receiving care

11.7 administer injections using intramuscular, subcutaneous, intradermal and intravenous routes and manage injection equipment

11.8 administer medications using a range of routes

11.9 administer and monitor medications using vascular access devices and enteral equipment

11.10 recognise and respond to adverse or abnormal reactions to medications

11.11 undertake safe storage, transportation and disposal of medicinal products.

Glossary

Abuse: is something that may harm another person, or endanger their life, or violate their rights. The person responsible for the abuse may be doing this on purpose or may not realise the harm that they are doing. The type of abuse may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

Cognitive: The mental processes of perception, memory, judgment, and reasoning.

Co-morbidities: the presence of one or more additional diseases or disorders that occur with a primary disease or disorder.

Demography: the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing structure of human populations.

Evidence-based person-centred care/nursing care: making sure that any care and treatment is given to people, by looking at what research has shown to be most effective. The judgment and experience of the nurse and the views of the person should also be taken into account when choosing which treatment is most likely to be successful for an individual.

Genomics: branch of molecular biology concerned with the structure, function, evolution, and mapping of genomes.

Health economics: a branch of economics concerned with issues related to efficiency, effectiveness, value and behaviour in the production and consumption of health and healthcare.

Health literacy: the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Human factors: environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety.

Interventions: any investigations, procedures, or treatments given to a person.

People: individuals or groups who receive services from nurses, midwives and nursing associates, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and other within and outside the learning environment.

Person-centred: an approach where the person is at the centre of the decision making processes and the design of their care needs, their nursing care and treatment plan.

Self-Reflection/Reflection: to carefully consider actions or decisions and learn from them.

Strength-based approaches: strength-based practice is a collaborative process between the person supported by services and those supporting them, working together to reach an outcome that draws on the person's strengths and assets.

Vulnerable people: those who at any age are at a higher risk of harm than others. Vulnerability might be in relation to a personal characteristic or a situation. The type of harm may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

The role of the Nursing and Midwifery Council

What we do

We regulate nurses and midwives in the UK, and nursing associates in England. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses, midwives and nursing associates can deliver high quality care throughout their careers.

We make sure nurses, midwives and nursing associates keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate professionals who fall short of our standards.

We maintain a register of nurses and midwives allowed to practise in the UK, and nursing associates allowed to practise in England.

These standards were approved by Council at their meeting on 28 March 2018.

A survey about nurses

Who we are

We are the Nursing and Midwifery Council.

We work with nurses and midwives in the UK.

We try to make sure they give all people the best care.

Nurses help people to stay healthy.

They help to care for people at home and in hospital.

Midwives care for women before, during and after they have a baby.

Nurses must have training so that they can do a good job of caring for you.

We decide what training nurses should have.

About this survey

We would like to know what training you think nurses should have.

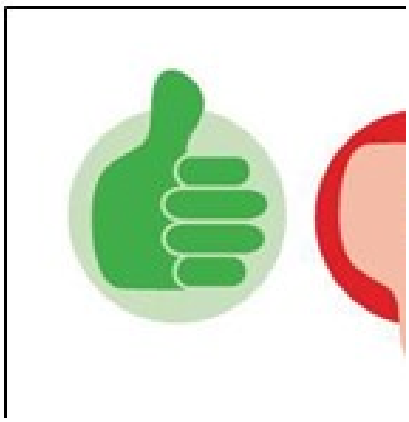
We would like to ask you some questions about nurses.

Please fill in this survey by Tuesday 12 September 2017.

Survey questions

1. What is a good nurse like?

(Free text box)



2. Do you agree with the following?

My nurse needs to include me in decisions about my care.

(Yes/No/Don't know)

My nurse should understand my feelings and my physical health needs.

(Yes/No/Don't know)

My nurse should be able to prescribe some medicines.

(Yes/No/Don't know)

My nurse should be able to care for me in my own home.

(Yes/No/Don't know)

My nurse should help me to make choices about my own health.

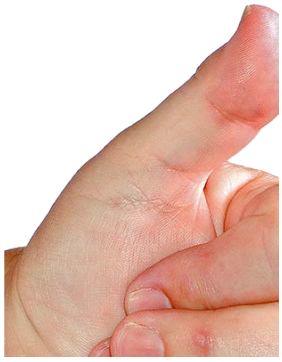
(Yes/No/Don't know)

3. What else should nurses be able to do for you to support your health?

   (Free text box)

4. What do you think nurses should be taught?

   (Free text box)



Thank you for answering these questions. Your views are very important to us.

We will look at the results of this survey and use them to think about what training nurses should have.

If you have any questions about this survey, or if you would like to know more about our work, please contact us at communications@nmc-uk.org.

Nursing & Midwifery Council

The Test of Competence 2021

Learning disabilities nursing blueprint

V 1.0

Introduction

We approve pre-registration nursing programmes in the United Kingdom.

Applicants to the **learning disability nursing** part of our register who do not hold an NMC-approved qualification will follow an alternate route to the register.

This route includes an evaluation of the qualification they hold. If their qualification is found not to be comparable to an NMC-approved qualification, the applicant will be required to complete a test of competence, or undertake an approved compensation measure if trained in the EEA but outside the UK.

This blueprint gives an overview of how each of the standards of proficiency for registered nurses and associated skills and procedures may be tested in the Test of Competence 2021 (ToC 21).

How to use this blueprint

The ToC 21 is made up of two parts: a multiple-choice computer based test (CBT) and a practical objective structured clinical examination (OSCE).

The blueprint shows how the standards of proficiency and associated skills and procedures for registered nurses may be tested in either the CBT, OSCE or both parts.

Applicants can use the blueprint to prepare for each part of the test.

The blueprint is mapped to the platforms in our Standards of proficiency for registered nurses (2018).

The seven platforms are:

1. Being an accountable professional
2. Promoting health and preventing ill health
3. Assessing needs and planning care
4. Providing and evaluating care
5. Leading and managing nursing care and working in teams
6. Improving safety and quality of care
7. Coordinating care

The communication and relationship management skills and nursing procedures identified in Annexe A and B are mapped in the blueprint to the seven platforms.

Proficiencies marked with **'PSP'** are patient safety proficiencies - these must be passed in the OSCE.

Platform 1: Being an accountable professional

Proficiency	May be tested by CBT	May be tested by OSCE
1.1 Understand and act in accordance with the Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, and fulfil all registration requirements (PSP)	✓	✓
1.2 Understand and apply relevant legal, regulatory and governance requirements, policies and ethical frameworks, including any mandatory reporting duties, to all areas of practice (PSP)	✓	✓
1.3 Understand and apply the principles of courage, transparency and the professional duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes (PSP)	✓	✓
1.4 Demonstrate an understanding of, and the ability to, challenge discriminatory behaviour	✓	
1.5 Understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or colleagues and the action required to minimise risks to health	✓	
1.6 Understand the professional responsibility to adopt a healthy lifestyle to maintain the level of personal fitness and wellbeing required to meet people's needs for mental and physical care	✓	
1.7 Demonstrate an understanding of research methods, ethics and governance in order to critically analyse, safely use, share and apply research findings to promote and inform best nursing practice	✓	
1.8 Demonstrate the knowledge, skills and ability to think critically when applying evidence and drawing on experience to make evidence informed decisions in all situations	✓	
1.9 Understand the need to base all decisions regarding care and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence their decisions	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
1.10 Demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences their judgments and decisions in routine, complex and challenging situations	✓	✓
1.11 Communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges (PSP) Annexe A 1. Underpinning communication skills for assessing, planning, providing and managing best practice, evidence-based nursing care 1.1 actively listen, recognise and respond to verbal and non-verbal cues 1.2 use prompts and positive verbal and non-verbal reinforcement 1.3 use appropriate non-verbal communication including touch, eye contact and personal space 1.4 make appropriate use of open and closed questioning 1.5 use caring conversation techniques 1.6 check understanding and use clarification techniques 1.7 be aware of own unconscious bias in communication encounters 1.12 recognise the need for, and facilitate access to, translator services and material.	✓	✓
1.12 Demonstrate the skills and abilities required to support people at all stages of life who are emotionally or physically vulnerable (PSP) Annexe A 2. Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care 2.1 share information and check understanding about the causes, implications	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
and treatment of a range of common health conditions including anxiety, depression, memory loss, diabetes, dementia, respiratory disease, cardiac disease, neurological disease, cancer, skin problems, immune deficiencies, psychosis, stroke and arthritis		
1.13 Demonstrate the skills and abilities required to develop, manage and maintain appropriate relationships with people, their families, carers and colleagues		✓
1.14 Provide and promote non-discriminatory, person centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments Annexe A 2. Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care 2.2 use clear language and appropriate, written materials, making reasonable adjustments where appropriate in order to optimise people's understanding of what has caused their health condition and the implications of their care and treatment	✓	✓
1.15 Demonstrate the numeracy, literacy, digital and technological skills required to meet the needs of people in their care to ensure safe and effective nursing practice (PSP) Annexe A 1. Underpinning communication skills for assessing, planning, providing and managing best practice, evidence-based nursing care 1.9 confidently and clearly present and share verbal and written reports with individuals		✓

Proficiency	May be tested by CBT	May be tested by OSCE
and groups 1.10 analyse and clearly record and share digital information and data 1.11 provide clear verbal, digital or written information and instructions when delegating or handing over responsibility for care		
1.16 Demonstrate the ability to keep complete, clear, accurate and timely records (PSP) Annexe A 1. Underpinning communication skills for assessing, planning, providing and managing best practice, evidence-based nursing care 1.8 write accurate, clear, legible records and documentation		✓
1.17 Take responsibility for continuous self-reflection, seeking and responding to support and feedback to develop their professional knowledge and skills	✓	
1.18 Demonstrate the knowledge and confidence to contribute effectively and proactively in an interdisciplinary team	✓	✓
1.19 Act as an ambassador, upholding the reputation of their profession and promoting public confidence in nursing, health and care services	✓	✓
1.20 Safely demonstrate evidence based practice in all skills and procedures stated in Annexes A and B. These have been mapped to the proficiencies and integrated across the platforms. See individual platforms for full details.	✓	✓

Platform 2: Promoting health and preventing ill health

Proficiency	May be tested by CBT	May be tested by OSCE
2.1 Understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health when engaging with people Annexe A 2. Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care 2.3 recognise and accommodate sensory impairments during all communications 2.4 support and manage the use of personal communication aids 2.5 identify the need for and manage a range of alternative communication techniques 2.6 use repetition and positive reinforcement strategies 2.8 provide information and explanation to people, families and carers and respond to questions about their treatment and care and possible ways of preventing ill health to enhance understanding 2.9 engage in difficult conversations, including breaking bad news and support people who are feeling emotionally or physically vulnerable or in distress, conveying compassion and sensitivity.	✓	✓
2.2 Demonstrate knowledge of epidemiology, demography, genomics and the wider determinants of health, illness and wellbeing and apply this to an understanding of global patterns of health and wellbeing outcomes	✓	

Proficiency	May be tested by CBT	May be tested by OSCE
2.3 Understand the factors that may lead to inequalities in health outcomes	✓	
2.4 Identify and use all appropriate opportunities, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people's individual circumstances	✓	✓
2.5 Promote and improve mental, physical, behavioural and other health related outcomes by understanding and explaining the principles, practice and evidence-base for health screening programmes	✓	
2.6 Understand the importance of early years and childhood experiences and the possible impact on life choices, mental, physical and behavioural health and wellbeing	✓	
2.7 Understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours and lifestyle choices to mental, physical and behavioural health outcomes	✓	
2.8 Explain and demonstrate the use of up to date approaches to behaviour change to enable people to use their strengths and expertise and make informed choices when managing their own health and making lifestyle adjustments Annexe A 2. Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care 2.7 assess motivation and capacity for behaviour change and clearly explain cause and effect relationships related to common health risk behaviours including	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
smoking, obesity, sexual practice, alcohol and substance use		
2.9 Use appropriate communication skills and strength based approaches to support and enable people to make informed choices about their care to manage health challenges in order to have satisfying and fulfilling lives within the limitations caused by reduced capability, ill health and disability	✓	✓
2.10 Provide information in accessible ways to help people understand and make decisions about their health, life choices, illness and care	✓	✓
2.11 Promote health and prevent ill health by understanding and explaining to people the principles of pathogenesis, immunology and the evidence-base for immunisation, vaccination and herd immunity	✓	
2.12 Protect health through understanding and applying the principles of infection prevention and control, including communicable disease surveillance and antimicrobial stewardship and resistance (PSP) Annexe B 4. Use evidence-based, best practice approaches for meeting the needs for care and support with hygiene and the maintenance of skin integrity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions 4.6 use aseptic techniques when undertaking wound care including dressings, pressure bandaging, suture removal and vacuum closures 4.7 use aseptic techniques when managing wound and drainage processes	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
Annexe B 9. Use evidence-based, best practice approaches for meeting needs for care and support with the prevention and management of infection, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions 9.1 observe, assess and respond rapidly to potential infection risks using best practice guidelines 9.2 use standard precautions protocols 9.3 use effective aseptic, non-touch techniques 9.4 use appropriate personal protection equipment 9.5 implement isolation procedures 9.6 use evidence-based hand hygiene techniques 9.7 safely decontaminate equipment and environment 9.8 safely use and dispose of waste, laundry and sharps 9.9 safely assess and manage invasive medical devices and lines.		

Platform 3: Assessing needs and planning care

Proficiency	May be tested by CBT	May be tested by OSCE
3.1 Demonstrate and apply knowledge of human development from conception to death when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans.	✓	✓
3.2 Demonstrate and apply knowledge of body systems and homeostasis, human anatomy and physiology, biology, genomics, pharmacology and social and behavioural sciences when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans Annexe B 4. Use evidence-based, best practice approaches for meeting the needs for care and support with hygiene and the maintenance of skin integrity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions 4.8 assess, respond effectively manage pyrexia and hypothermia	✓	✓
3.3 Demonstrate and apply knowledge of all commonly encountered mental, physical, behavioural and cognitive health conditions, medication usage and treatments when undertaking full and accurate assessments of nursing care needs and when developing, prioritising and reviewing person centred care plans (PSP) Annexe B 1. Use evidence-based, best practice approaches to take a history, observe, recognise and accurately assess people of	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
all ages: 1.1 mental health and wellbeing status 1.1.2 cognitive health status and wellbeing 1.1.3 signs of cognitive distress and impairment 1.1.4 behavioural distress based needs 1.1.5 signs of mental and emotional distress including agitation, aggression and challenging behaviour 1.2 physical health and wellbeing 1.2.1 symptoms and signs of physical ill health 1.2.2 symptoms and signs of physical distress Note: In addressing the above the candidate must ensure they are ready to demonstrate procedures at an appropriate level for the learning disabilities field of nursing practice when undertaking procedures for assessing needs for person centred care.		
3.4 Understand and apply a person-centred approach to nursing care, demonstrating shared assessment, planning, decision making and goal setting when working with people, their families, communities and populations of all ages	✓	✓
3.5 Demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person-centred evidence-based plans for nursing interventions with agreed goals		✓
3.6 Effectively assess a person's capacity to make decisions about their own care and to give or withhold consent (PSP)	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
3.7 Understand and apply the principles and processes for making reasonable adjustments Annexe A 2. Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care 2.3 recognise and accommodate sensory impairments during all communications 2.4 support and manage the use of personal communication aids 2.5 identify the need for and manage a range of alternative communication techniques		✓
3.8 Understand and apply the relevant laws about mental capacity for the country in which you are practising when making decisions in relation to people who do not have capacity	✓	✓
3.9 Recognise and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are vulnerable (PSP) Annexe B 1. Use evidence-based, best practice approaches to take a history, observe, recognise and accurately assess people of all ages: 1.1.1 signs of mental and emotional distress or vulnerability 2. Use evidence-based, best practice approaches to undertake the following procedures: 2.11 recognise and respond to signs of all forms of abuse	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
Note: In addressing the above the candidate must ensure they are ready to demonstrate procedures at an appropriate level for the learning disabilities field of nursing practice when undertaking procedures for assessing needs for person centred care.		
3.10 Demonstrate the skills and abilities required to recognise and assess people who show signs of self-harm and/or suicidal ideation (PSP) Annexe B 1. Use evidence-based, best practice approaches to take a history, observe, recognise and accurately assess people of all ages: 1.1.6 signs of self-harm and/or suicidal ideation Note: In addressing the above the candidate must ensure they are ready to demonstrate procedures at an appropriate level for the learning disabilities field of nursing practice when undertaking procedures for assessing needs for person centred care.	✓	✓
3.11 Undertake routine investigations, interpreting and sharing findings as appropriate	✓	✓
3.12 Interpret results from routine investigations, taking prompt action when required by implementing appropriate interventions, requesting additional investigations or escalating to others (PSP) Annexe B 1.Use evidence-based, best practice approaches to take a history, observe, recognise and accurately assess people of all ages: 1.2.3 symptoms and signs of deterioration	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
and sepsis. 2. Use evidence-based, best practice approaches to undertake the following procedures: 2.1 take, record and interpret vital signs manually and via technological devices 2.2 undertake venepuncture and cannulation and blood sampling, interpreting normal and common abnormal blood profiles and venous blood gases 2.3 set up and manage routine electrocardiogram (ECG) investigations and interpret normal and commonly encountered abnormal traces 2.4 manage and monitor blood component transfusions 2.5 manage and interpret cardiac monitors, infusion pumps, blood glucose monitors and other monitoring devices 2.6 accurately measure weight and height, calculate body mass index and recognise healthy ranges and clinically significant low/high readings 2.7 undertake a whole body systems assessment including respiratory, circulatory, neurological, musculoskeletal, cardiovascular and skin status 2.8 undertake chest auscultation and interpret findings 2.9 collect and observe sputum, urine, stool and vomit specimens, undertaking routine analysis and interpret 2.10 measure and interpret blood glucose levels 2.12 undertake, respond to and interpret neurological observations and		

Proficiency	May be tested by CBT	May be tested by OSCE
assessments 2.13 identify and respond to signs of deterioration and sepsis 2.17 recognise and respond to challenging behaviour, providing appropriate safe holding and restraint. Note: In addressing the above the candidate must ensure they are ready to demonstrate procedures at an appropriate level for the learning disabilities field of nursing practice when undertaking procedures for assessing needs for person centred care.		
3.13 Demonstrate an understanding of co-morbidities and the demands of meeting people's complex nursing and social care needs when prioritising care plans	✓	✓
3.14 Identify and assess the needs of people and families for care at the end of life, including requirements for palliative care and decision making related to their treatment and care preferences Annexe B 10. Use evidence-based, best practice approaches for meeting needs for care and support at the end of life, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions 10.1 observe, and assess the need for intervention for people, families and carers, identify, assess and respond appropriately to uncontrolled symptoms and signs of distress including pain, nausea, thirst, constipation, restlessness, agitation, anxiety and depression 10.3 assess and review preferences and care priorities of the dying person and	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
their family and carers		
3.15 Demonstrate the ability to work in partnership with people, families and carers to continuously monitor, evaluate and reassess the effectiveness of all agreed nursing care plans and care, sharing decision making and readjusting agreed goals, documenting progress and decisions made	✓	✓
3.16 Demonstrate knowledge of when and how to refer people safely to other professionals or services for clinical intervention or support	✓	

Platform 4: Providing and evaluating care

Proficiency	May be tested by CBT	May be tested by OSCE
4.1 Demonstrate and apply an understanding of what is important to people and how to use this knowledge to ensure their needs for safety, dignity, privacy, comfort and sleep can be met, acting as a role model for others in providing evidence based person-centred care (PSP) Annexe B 3. Use evidence-based, best practice approaches for meeting needs for care and support with rest, sleep, comfort and the maintenance of dignity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions 3.1 observe and assess comfort and pain levels and rest and sleep patterns 3.2 use appropriate bed-making techniques including those required for people who are unconscious or who have limited mobility 3.3 use appropriate positioning and pressure-relieving techniques 3.4 take appropriate action to ensure privacy and dignity at all times 3.5 take appropriate action to reduce or minimise pain or discomfort 3.6 take appropriate action to reduce fatigue, minimise insomnia and support improved rest and sleep hygiene	✓	✓
4.2 Work in partnership with people to encourage shared decision making in order to support individuals, their families and carers to manage their own care when appropriate		✓
4.3 Demonstrate the knowledge, communication and relationship management skills required to provide people, families and carers with accurate information that meets their needs before, during and after a range of interventions	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
Annexe A 3. Evidence-based, best practice communication skills and approaches for providing therapeutic interventions 3.1 motivational interview techniques 3.2 solution focused therapies 3.3 reminiscence therapies 3.4 talking therapies 3.5 de-escalation strategies and techniques 3.6 cognitive behavioural therapy techniques 3.7 play therapy 3.8 distraction and diversion strategies 3.9 positive behaviour support approaches Note: In addressing the above the candidate must ensure they are ready to demonstrate procedures at an appropriate level for the learning disabilities field of nursing practice when undertaking procedures for assessing needs for person centred care.		
4.4 Demonstrate the knowledge and skills required to support people with commonly encountered mental health, behavioural, cognitive and learning challenges, and act as a role model for others in providing high quality nursing interventions to meet people's needs (PSP)	✓	✓
4.5 Demonstrate the knowledge and skills required to support people with commonly encountered physical health conditions, their medication usage and treatments, and act as a role model for others in providing high quality nursing interventions when meeting people's needs	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
4.6 Demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based nursing care to meet people's needs related to nutrition, hydration and bladder and bowel health Annexe B 5. Use evidence-based, best practice approaches for meeting needs for care and support with nutrition and hydration, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions 5.1 observe, assess and optimise nutrition and hydration status and determine the need for intervention and support 5.2 use contemporary nutritional assessment tools 5.3 assist with feeding and drinking and use appropriate feeding and drinking aids 5.4 record fluid intake and output and identify, respond to and manage dehydration or fluid retention 5.5 identify, respond to and manage nausea and vomiting 5.6 insert, manage and remove oral/nasal/gastric tubes 5.7 manage artificial nutrition and hydration using oral, enteral and parenteral routes 5.8 manage the administration of IV fluids 5.9 manage fluid and nutritional infusion pumps and devices. 6. Use evidence-based, best practice approaches for meeting needs for care and support with bladder and bowel health, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions 6.1 observe and assess level of urinary and bowel continence to determine the need for support and intervention assisting with toileting, maintaining dignity and privacy	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
and managing the use of appropriate aids 6.2 select and use appropriate continence products; insert, manage and remove catheters for all genders; and assist with self-catheterisation when required 6.3 manage bladder drainage 6.4 assess bladder and bowel patterns to identify and respond to constipation, diarrhoea and urinary and faecal retention 6.5 administer enemas and suppositories and undertake rectal examination and manual evacuation when appropriate 6.6 undertake stoma care identifying and using appropriate products and approaches		
4.7 Demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based, person-centred nursing care to meet people's needs related to mobility, hygiene, oral care, wound care and skin integrity Annexe B 4. Use evidence-based, best practice approaches for meeting the needs for care and support with hygiene and the maintenance of skin integrity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions 4.1 observe, assess and optimise skin and hygiene status and determine the need for support and intervention 4.2 use contemporary approaches to the assessment of skin integrity and use appropriate products to prevent or manage skin breakdown 4.3 assess needs for and provide appropriate assistance with washing, bathing, shaving and dressing 4.4 identify and manage skin irritations and rashes 4.5 assess needs for and provide appropriate oral, dental, eye and nail care	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
and decide when an onward referral is needed Annexe B 7. Use evidence-based, best practice approaches for meeting needs for care and support with mobility and safety, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions 7.1 observe and use evidence-based risk assessment tools to determine need for support and intervention to optimise mobility and safety, and to identify and manage risk of falls using best practice risk assessment approaches 7.2 use a range of contemporary moving and handling techniques and mobility aids 7.3 use appropriate moving and handling equipment to support people with impaired mobility 7.4 use appropriate safety techniques and devices.		
4.8 Demonstrate the knowledge and skills required to identify and initiate appropriate interventions to support people with commonly encountered symptoms including anxiety, confusion, discomfort and pain	✓	✓
4.9 Demonstrate the knowledge and skills required to prioritise what is important to people and their families when providing evidence-based person-centred nursing care at end of life including the care of people who are dying, families, the deceased and the bereaved Annexe B 10. Use evidence-based, best practice approaches for meeting needs for care and support at the end of life, accurately assessing the person's capacity for independence and self care and initiating appropriate interventions 10.2 manage and monitor effectiveness of symptom relief medication, infusion pumps	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
and other devices 10.4 understand and apply organ and tissue donation protocols, advanced planning decisions, living wills and health and lasting powers of attorney for health 10.5 understand and apply DNACPR (do not attempt cardiopulmonary resuscitation) decisions and verification of expected death 10.6 provide care for the deceased person and the bereaved respecting cultural requirements and protocols		
4.10 Demonstrate the knowledge and ability to respond proactively and promptly to signs of deterioration or distress in mental, physical, cognitive and behavioural health and use this knowledge to make sound clinical decisions (PSP)	✓	✓
4.11 Demonstrate the knowledge and skills required to initiate and evaluate appropriate interventions to support people who show signs of self-harm and/or suicidal ideation (PSP)	✓	✓
4.12 Demonstrate the ability to manage commonly encountered devices and confidently carry out related nursing procedures to meet people's needs for evidence based, person-centred care Annexe B 8. Use evidence-based, best practice approaches for meeting needs for respiratory care and support, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions 8.1 observe and assess the need for intervention and respond to restlessness, agitation and breathlessness using appropriate interventions 8.2 manage the administration of oxygen using a range of routes and best practice	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
approaches 8.3 take and interpret peak flow and oximetry measurements 8.4 use appropriate nasal and oral suctioning techniques 8.5 manage inhalation, humidifier and nebuliser devices 8.6 manage airway and respiratory processes and equipment		
4.13 Demonstrate the knowledge, skills and confidence to provide first aid procedures and basic life support (PSP) Annexe B 2. Use evidence-based, best practice approaches to undertake the following procedures: 2.14 administer basic mental health first aid 2.15 administer basic physical first aid 2.16 recognise and manage seizures, choking and anaphylaxis, providing appropriate basic life support Note: In addressing the above the candidate must ensure they are ready to demonstrate procedures at an appropriate level for the learning disabilities field of nursing practice when undertaking procedures for assessing needs for person centred care.	✓	✓
4.14 Understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies and demonstrate proficiency and accuracy when calculating dosages of prescribed medicines (PSP) Annexe B	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
11. Procedural competencies required for best practice, evidence-based medicines administration and optimisation 11.1 carry out initial and continued assessments of people receiving care and their ability to self-administer their own medications 11.3 use the principles of safe remote prescribing and directions to administer medicines 11.4 undertake accurate drug calculations for a range of medications 11.5 undertake accurate checks, including transcription and titration, of any direction to supply or administer a medicinal product 11.6 exercise professional accountability in ensuring the safe administration of medicines to those receiving care 11.7 administer injections using intramuscular, subcutaneous, intradermal and intravenous routes and manage injection equipment 11.8 administer medications using a range of routes 11.9 administer and monitor medications using vascular access devices and enteral equipment 11.11 undertake safe storage, transportation and disposal of medicinal products		
4.15 Demonstrate knowledge of pharmacology and the ability to recognise the effects of medicines, allergies, drug sensitivities, side effects, contraindications, incompatibilities, adverse reactions, prescribing errors and the impact of polypharmacy and over the counter medication usage Annexe B 11. Procedural competencies required for best practice, evidence-based medicines administration and optimisation	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
11.10 recognise and respond to adverse or abnormal reactions to medications		
4.16 Demonstrate knowledge of how prescriptions can be generated, the role of generic, unlicensed, and off-label prescribing and an understanding of the potential risks associated with these approaches to prescribing Annexe B 11. Procedural competencies required for best practice, evidence-based medicines administration and optimisation 11.2 recognise the various procedural routes under which medicines can be prescribed, supplied, dispensed and administered; and the laws, policies, regulations and guidance that underpin them	✓	
4.17 Apply knowledge of pharmacology to the care of people, demonstrating the ability to progress to a prescribing qualification following registration	✓	
4.18 Demonstrate the ability to co-ordinate and undertake the processes and procedures involved in routine planning and management of safe discharge home or transfer of people between care settings (PSP)	✓	✓

Platform 5: Leading and managing nursing care and working in teams

Proficiency	May be tested by CBT	May be tested by OSCE
5.1 Understand the principles of effective leadership, management, group and organisational dynamics and culture and apply these to team working and decision-making	✓	
5.2 Understand and apply the principles of human factors, environmental factors and strength-based approaches when working in teams	✓	
5.3 Understand the principles and application of processes for performance management and how these apply to the nursing team Annexe A 4. Evidence-based, best practice communication skills and approaches for working with people in professional teams 4.1 Demonstrate effective supervision, teaching and performance appraisal through the use of: 4.1.1 clear instructions and explanations when supervising, teaching or appraising others 4.1.2 clear instructions and check understanding when delegating care responsibilities to others 4.1.3 unambiguous, constructive feedback about strengths and weaknesses and potential for improvement 4.1.4 encouragement to colleagues that helps them to reflect on their practice 4.1.5 unambiguous records of performance	✓	✓
5.4 Demonstrate an understanding of the roles, responsibilities and scope of practice of all members of the nursing and interdisciplinary team and how to make best use of the contributions of others involved in providing care	✓	

Proficiency	May be tested by CBT	May be tested by OSCE
5.5 Safely and effectively lead and manage the nursing care of a group of people, demonstrating appropriate prioritisation, delegation and assignment of care responsibilities to others involved in providing care	✓	✓
5.6 Exhibit leadership potential by demonstrating an ability to guide, support and motivate individuals and interact confidently with other members of the care team Annexe A 4. Evidence-based, best practice communication skills and approaches for working with people in professional teams 4.2 Demonstrate effective person and team management through the use of: 4.2.1 strengths based approaches to developing teams and managing change 4.2.2 active listening when dealing with team members' concerns and anxieties 4.2.3 a calm presence when dealing with conflict 4.2.4 appropriate and effective confrontation strategies 4.2.5 de-escalation strategies and techniques when dealing with conflict 4.2.6 effective co-ordination and navigation skills through: 4.2.6.1 appropriate negotiation strategies 4.2.6.2 appropriate escalation procedures 4.2.6.3 appropriate approaches to advocacy	✓	✓
5.7 Demonstrate the ability to monitor and evaluate the quality of care delivered by others in the team and lay carers	✓	
5.8 Support and supervise students in the delivery of nursing care, promoting reflection and providing constructive feedback, and	✓	

Proficiency	May be tested by CBT	May be tested by OSCE
evaluating and documenting their performance		
5.9 Demonstrate the ability to challenge and provide constructive feedback about care delivered by others in the team, and support them to identify and agree individual learning needs (see also 5.3)	✓	✓
5.10 Contribute to supervision and team reflection activities to promote improvements in practice and services	✓	
5.11 Effectively and responsibly use a range of digital technologies to access, input, share and apply information and data within teams and between agencies		✓
5.12 Understand the mechanisms that can be used to influence organisational change and public policy, demonstrating the development of political awareness and skills	✓	

Platform 6: Improving safety and quality of care

Proficiency	May be tested by CBT	May be tested by OSCE
6.1 Understand and apply the principles of health and safety legislation and regulations and maintain safe work and care environments (PSP)	✓	✓
6.2 Understand the relationship between safe staffing levels, appropriate skills mix, safety and quality of care, recognising risks to public protection and quality of care, escalating concerns appropriately	✓	
6.3 Comply with local and national frameworks, legislation and regulations for assessing, managing and reporting risks, ensuring the	✓	

Proficiency	May be tested by CBT	May be tested by OSCE
appropriate action is taken		
6.4 Demonstrate an understanding of the principles of improvement methodologies, participate in all stages of audit activity and identify appropriate quality improvement	✓	
6.5 Demonstrate the ability to accurately undertake risk assessments in a range of care settings, using a range of contemporary assessment and improvement tools (PSP)	✓	✓
6.6 Identify the need to make improvements and proactively respond to potential hazards that may affect the safety of people	✓	✓
6.7 Understand how the quality and effectiveness of nursing care can be evaluated in practice, and demonstrate how to use service delivery evaluation and audit findings to bring about continuous improvement	✓	✓
6.8 Demonstrate an understanding of how to identify, report and critically reflect on near misses, critical incidents, major incidents and serious adverse events in order to learn from them and influence their future practice	✓	
6.9 Work with people, their families, carers and colleagues to develop effective improvement strategies for quality and safety, sharing feedback and learning from positive outcomes and experiences, mistakes and adverse outcomes and experiences	✓	
6.10 Apply an understanding of the differences between risk aversion and risk management and how to avoid compromising quality of care and health outcomes	✓	✓
6.11 Acknowledge the need to accept and manage uncertainty, and demonstrate an understanding of strategies that develop resilience in self and others	✓	✓

Proficiency	May be tested by CBT	May be tested by OSCE
6.12 Understand the role of registered nurses and other health and care professionals at different levels of experience and seniority when managing and prioritising actions and care in the event of a major incident	✓	

Platform 7: Coordinating care

Proficiency	May be tested by CBT	May be tested by OSCE
7.1 Understand and apply the principles of partnership, collaboration and interagency working across all relevant sectors	✓	
7.2 Understand health legislation and current health and social care policies, and the mechanisms involved in influencing policy development and change, differentiating where appropriate between the devolved legislatures of the United Kingdom	✓	
7.3 Understand the principles of health economics and their relevance to resource allocation in health and social care organisations and other agencies	✓	
7.4 Identify the implications of current health policy and future policy changes for nursing and other professions and understand the impact of policy changes on the delivery and coordination of care	✓	
7.5 Understand and recognise the need to respond to the challenges of providing safe, effective and person-centred nursing care for people who have co-morbidities and complex care needs		✓
7.6 Demonstrate an understanding of the complexities of providing mental, cognitive, behavioural and physical care services across a wide range of integrated care settings	✓	✓
7.7 Understand how to monitor and evaluate the quality of people's experience of complex care	✓	✓
7.8 Understand the principles and processes involved in supporting people and families with a range of care needs to maintain optimal		✓

Proficiency	May be tested by CBT	May be tested by OSCE
independence and avoid unnecessary interventions and disruptions to their lives		
7.9 Facilitate equitable access to healthcare for people who are vulnerable or have a disability, demonstrate the ability to advocate on their behalf when required, and make necessary reasonable adjustments to the assessment, planning and delivery of their care (PSP)	✓	✓
7.10 Understand the principles and processes involved in planning and facilitating the safe discharge and transition of people between caseloads, settings and services	✓	✓
7.11 Demonstrate the ability to identify and manage risks and take proactive measures to improve the quality of care and services when needed (PSP)	✓	✓
7.12 Demonstrate an understanding of the processes involved in developing a basic business case for additional care funding by applying knowledge of finance, resources and safe staffing levels	✓	
7.13 Demonstrate an understanding of the importance of exercising political awareness throughout their career, to maximise the influence and effect of registered nursing on quality of care, patient safety and cost effectiveness	✓	

Published on: Monday 21 December 2020

Last updated: Monday 21 December 2020

Nursing & Midwifery Council

Test of Competence 2021: Reading List

Learning Disabilities Nursing

V.2 updated October 2023

Contents

Core Learning Disabilities Nursing Reading List

The following titles are essential reading for anyone entering the NMC Test of Competence:

- Dougherty, L., Hofland, J. and Grafton, H. (2020). *The Royal Marsden Manual of Clinical Nursing Procedures (Online Edition).* 10th edition. Hoboken, NJ: Wiley Blackwell.

- Nursing and Midwifery Council. (2020). *Standards of proficiency for registered nurses*. https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/

- Nursing and Midwifery Council. (2018). *The Code*: *Professional standards of practice and behaviour for nurses, midwives and nursing associates.* https://www.nmc.org.uk/standards/code/

- Nursing and Midwifery Council. (2020). *Test Specification for the Test of Competence.* https://www.nmc.org.uk/globalassets/sitedocuments/registration/toc-21/toc-21-test-specification---nursing.pdf

- Nursing and Midwifery Council. (2020). *The Test of Competence 2021: Learning disabilities nursing blueprint.* https://www.nmc.org.uk/globalassets/sitedocuments/registration/toc-21/toc-21-blueprint---learning-disabilities-nursing.pdf

- Resuscitation Council UK. (2021*). UK Statements and resources on COVID-19 (Coronavirus), CPR and Resuscitation.* https://www.resus.org.uk/covid-19-resources

- Resuscitation Council UK. (2021). 2021 *Resuscitation Guidelines.* 2021 Resuscitation Guidelines | Resuscitation Council UK

The following websites are essential reading for anyone entering the NMC Test of Competence:

- www.dh.gov.uk
- https://www.england.nhs.uk/
- https://www.nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/careers-and-recruitment/overseas-nurses.aspx
- https://gov.wales/overseas-trained-nurses-join-temporary-register
- https://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/uk-code-of-practice-for-international-recruitment/recruitment-agency-list/northern-ireland
- https://www.gov.uk/government/organisations/public-health-england
- https://www.nmc.org.uk/
- https://www.nice.org.uk/
- https://www.rcn.org.uk/covid-19
- https://www.rcn.org.uk/membership/international-nurse-membershttps://www.autistica.org.uk
- https://www.england.nhs.uk/learning-disabilities/
- https://www.mencap.org.uk/

Essential Reading for Learning Disabilities Nursing OSCEs

The following resources are the evidential base used for the assessment of the Test of Competence skills stations and should be referred to when preparing for your OSCE.

Professional Values

Free to access:

- Nursing and Midwifery Council. (2018). *The Code*: *Professional standards of practice and behaviour for nurses, midwives and nursing associates.* https://www.nmc.org.uk/standards/code/
- Royal College of Nursing. (2010). *Principles of nursing practice.* https://www.rcn.org.uk/professional-development/principles-of-nursing-practice

Available for purchase:

- Peate, I., Wilde, K. (2018). *Nursing Practice: Knowledge and Care*. 2nd edition. Oxford: Wiley-Blackwell. Unit 1 Part 2 – The Professional Nurse and Contemporary Healthcare.
- Baillie, L., Black, S. (2014). *Professional Values in Nursing*. 1st edition. Abingdon: Routledge Publishing.

Learning Disabilities Nursing Skills

Administration of Suppository

Free to access:

- Bladder and Bowel UK (2017). *Understanding constipation in people with learning difficulties – the importance of identification and treatment.* Retrieved November 2021. https://www.bbuk.org.uk/wp-content/uploads/2017/05/Understanding-constipation-in-people-with-learning-difficulties-for-review.pdf

De-Escalation

Online journal access required:

- Lowry, M. et al. (2016). Deescalating anger: A new model for practice. *Nursing Times* (online), 112(4), 4-7.

Available for purchase:

- Varcarolis, E. (2017). *Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care*. 3rd edition. Oxford: Elsevier.

Intramuscular injection

Online journal access required:

- Shepherd, E. (2018). Injection Technique 1: Administering drugs via the intramuscular route. *Nursing Times* (online), 114(8), 23-25.

Nutritional Assessment

Free to access:

- Public Health England (2016). *Constipation: making reasonable adjustments.* Retrieved November 2021. https://www.gov.uk/government/publications/constipation-and-people-with-learning-disabilities/constipation-making-reasonable-adjustments
- NHS (n.d.). *Managing weight with a learning disability.* Retrieved November 2021. https://www.nhs.uk/live-well/healthy-weight/managing-weight-with-a-learning-disability/

Pain assessment

Free to access:

- British pain society. (2019). *Outcome Measures*. Retrieved January 2021. https://www.britishpainsociety.org/static/uploads/resources/files/Outcome_Measures_January_2019.pdf

Online journal access required:

- Swift, A. (2015). Pain Management 3: The importance of assessing pain in adults. *Nursing Times* (online), 11(41),12-17.

Physiological observations

Free to access:

- Royal College of Physicians. (n.d.). E-learning tools. Retrieved January 2021. https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2
- Geeky Medics. (n.d.). *Measuring vital signs*. Retrieved January 2021. https://geekymedics.com/basic-observations-vital-signs-osce
- Mindham, J. and Espie, C.A. (2003). Glasgow Anxiety Scale for people with an intellectual Disability (GAS-ID): development and psychometric properties of a new measure for use with people with mild intellectual disabilities. *Journal of Intellectual Disability Research,* 47(1), 22-30. Retrieved January 2021. https://onlinelibrary.wiley.com/doi/epdf/10.1046/j.1365-2788.2003.00457.x

Supplementary Learning Disabilities Nursing Resource List

The following texts and websites contain useful background reading for those entering the NMC Test of Competence:

Free to access:

- Royal College of Nursing. (2021). *Library subject guides.* https://www.rcn.org.uk/library/subject-guides

- Royal College of Nursing. (2017). *Essential practice for infection prevention and control. Guidance for nursing staff.* London: RCN. https://www.rcn.org.uk/professional-development/publications/pub-005940

- Public Health England. (2020). *Donning and Doffing Personal protective equipment*. Retrieved January 2021. https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

- National Institute for Health and Care Excellence. (2014). *Infection control and prevention guidance*. Retrieved January 2021. https://www.nice.org.uk/guidance/qs61

Recommended reading which may be purchased:

- Barr, O. and Gates, B. (2018). O*xford Handbook of Learning and Intellectual Disability Nursing.* 2nd edition. Oxford: Oxford University Press.

- Gates, B., Fearns, D. and Welch, J. (2015). *Learning Disability Nursing at a Glance*. Chichester: Wiley Blackwell.

- Gates, B. and Mafuba, K. (2015). *Learning Disabilities Nursing: Modern Day Practice.* Abingdon: Routledge.

- Turnbull, J. (2004). *Learning Disability Nursing.* Chichester: Wiley Blackwell.

Nursing & Midwifery Council

Test of Competence 2021: Marking Criteria

Learning Disabilities Nursing

V 1.8

Table of contents

Important information

This document is intended to provide candidates with additional information to help them to prepare for the test of competence (Part 2). This document should be read in conjunction with the candidate information booklet, recommended/core reading, the mock OSCE and the Guidance on Taking Your OSCE.

As part of continuous improvement of the assessment and in response to changes in clinical best practice, the marking criteria for a specific OSCE station can be subject to change, so the information presented in this document should be treated as indicative. Candidates must be confident in performing the skills required by the NMC and should not attempt to memorise or rote learn the marking criteria as these are subject to periodic change.

OSCE assessment

Assessment process

Each station is marked against unique criteria matched to the skill being assessed. Within each station's marking grid, there are essential criteria that a candidate must meet in order to pass. These reflect the minimum acceptable standards of a pre-registration nurse entering the register.

For each station, a red flag can be applied if a candidate makes an action which could cause harm to a patient.

APIE stations

Assessment marking criteria: all APIEs

	Assessment criteria
1	Assesses the safety of the scene and privacy and dignity of the patient.
2	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following World Health Organisation (WHO) guidelines.
3	Introduces self to person.
4	Checks identity (ID) with person or carer (person's name is essential and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
5	Gains consent and explains reason for the assessment.
6	Uses SOLER throughout the assessment: • Sitting at a comfortable angle and distance • Open posture. arms and legs uncrossed • Leaning forward from time to time, looking genuinely interested, listening attentively • Effective eye contact, without staring • Remaining relatively relaxed.
7	Uses appropriate questioning skills (open questions).
8	Builds trust and rapport by demonstrating compassion, taking time, active listening, and taking an interest.
9	Uses brief verbal and non-verbal affirmations.
10	Uses reflection/paraphrasing to demonstrate concern.
11	Conducts an holistic assessment relevant to the patient's scenario.
12	Identifies and discusses any current risk factors, if present.
13	Accurately completes any assessment tools included and accurately calculates and records score, where appropriate.
14	Discusses the assessment findings with the person and closes the assessment appropriately.
15	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
16	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing

	associates’.

Planning marking criteria: all APIEs

Assessment criteria	
1	Clearly and legibly handwrites answers.
2	Identifies two relevant nursing problems/needs.
3	Identifies aims for both problems.
4	Sets appropriate evaluation date for both problems.
5	Ensures that nursing interventions are current/evidence-based/best practice.
6	Uses professional terminology in care planning.
7	Does not use abbreviations or acronyms.
8	Ensures strike-through errors retain legibility.
9	Accurately prints, signs and dates.
10	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Implementation marking criteria: all APIEs

Assessment criteria	
1	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
2	Introduces self to person.
3	Seeks consent from person or carer prior to administering medication.
4	Checks allergies on chart and confirms with the person in their care, also notes red ID wristband (where appropriate).
5	Before administering any prescribed drug (including oxygen), looks at the person's prescription chart and correctly verbalises ALL of the following checks: • person (checks ID with person: verbally, against wristband (where appropriate) and documentation) • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate).
6	Correctly checks ALL of the following*:* • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
7	Briefly acknowledges any possible contraindications and relevant medical information prior to administration (prompt permitted). (This may not be relevant in all scenarios.)
8	Provides a correct explanation of what each drug being administered is for to the person in their care (prompt permitted) and highlights any specific information regarding instruction for administration (e.g. on an empty stomach, take with food, take after food, specific timing etc. (This may not be relevant in all scenarios)).
9	Administers drugs due for administration correctly and safely.
10	Omits drugs not to be administered and provides a verbal rationale (ask candidate reason for non-administration if not verbalised).
11	Accurately documents drug administration and non-administration.
12	Accurately documents the details of person administering medication on page 2.
13	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Evaluation marking criteria: all APIEs

Assessment criteria	
Situation	
1a	Introduces self and the clinical setting.
1b	States the patient's name, hospital number and/or date of birth, and location.
1c	States the reason for the handover (where relevant).
Background	
2a	States date of admission/visit/reason for initial admission/referral to specialist team and diagnosis.
2b	Notes previous medical history and relevant medication/social history.
2c	Gives details of current events and detailing findings from assessment.
Assessment	
3a	States most recent observations, any results from assessments undertaken and what changes have occurred.
3b	Identifies main nursing needs.
3c	States nursing and medical interventions completed.
3d	States areas of concerns.
Recommendation	
4	States what is required of the person taking the handover and proposes a realistic plan of action.
Overall	
5	Verbal communication is clear and appropriate.
6	Systematic and structured approach taken to handover.
7	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Clinical skills stations

Administration of suppository marking criteria

	Assessment criteria
1	Introduces self, explains procedure and gains consent.
2	Ensures that a bedpan, commode or toilet is readily available.
3	Dons a disposable plastic apron and non-sterile gloves.
4	Verbalises that they would request/assist the person to lie on their left lateral side with knees flexed, feet level or slightly raised, buttocks near to the edge of the bed (the manikin should not be moved into position for health and safety reasons).
5	Places a disposable incontinence pad beneath the patient's hips and buttocks.
6	Before administering any prescribed drug (including oxygen), looks at the person's prescription chart and correctly verbalises ALL of the following checks: • person (checks ID with person: verbally, against wristband (where appropriate) and documentation) • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate) • allergies.
7	Correctly checks ALL of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
8	Prior to inserting the suppository, verbalises that they are observing the anal area for evidence of skin soreness, excoriation, swelling, haemorrhoids, rectal prolapse or infestation.
9	Places some lubricating jelly on a gauze square and lubricates the suppository. Separates the patient's buttocks and inserts the suppository using the correct end (referring to the manufacturer's instructions), advancing it approximately 2cm to 4cm. Repeats this procedure if additional suppositories are to be inserted.
10	Cleans any excess lubricating jelly from the patient's perineal and perianal areas using gauze squares after insertion of suppository.
11	Verbalises that they would advise the patient to remain lying down and retain the suppository for about 20 minutes or until they are no longer able to do so. Informs the patient that there may be some discharge as the medication melts in the rectum.
12	Verbalises that they would assist the patient into a comfortable position and offers a bedpan, commode or toilet facilities, as appropriate.
13	Maintains patient dignity: arranges the bedcovers to keep the patient covered as much as possible during the procedure and replaces patient's bedclothes and covers once the suppository has been inserted.
14	Disposes of waste appropriately and cleans any equipment used.
15	Cleans hands with alcohol hand rub, or washes with soap and water, and dries with paper

	towels following WHO guidelines – verbalisation accepted.
16	Dates and signs medicines administration record.
17	Reassures the person appropriately. Closes the interaction professionally and appropriately.
18	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

De-escalation marking criteria

Assessment criteria	
Identify the importance of the following in the written summary:	
1	Gains consent before entering the room.
2	Considers whether the physical environment is safe for self and person.
3	Introduces self to person.
4	Body language is non-threatening and relaxed.
5	Voice is calm, and tone and volume are low.
6	Speech is clear and kind.
7	Places self at person's eye level or below. Establishes eye contact while avoiding staring.
8	Allows the person time to share their concerns. Shows empathy.
9	Uses open-ended questions.
10	Uses active listening and acknowledges the person's concerns using reflective language and validation.
11	Offers answers to specific questions where able.
12	Repeats content of conversation as needed.
13	Uses distraction technique, using information of the person's interests.
14	Recaps areas discussed prior to ending the intervention.
15	Appropriately ends the intervention.
16	Writes clearly and legibly.

Intramuscular injection (IM) marking criteria

	Assessment criteria
1	Explains and discusses the procedure with the person.
2	Before administering any prescribed drug (including oxygen), looks at the person's prescription chart and correctly verbalises ALL of the following checks: • person (checks ID with person: verbally, against wristband (where appropriate) and documentation) • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate) • allergies.
3	Correctly checks **ALL** of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
4	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
5	Assembles equipment required and prepares medication.
6	Dons a disposable plastic apron. Closes the curtains/door and assists the person into the required position. Removes the appropriate garment to expose injection site.
7	Assesses the injection site for signs of inflammation, oedema, infection and skin lesions.
8	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines. Dons non-sterile gloves.
9	Cleans the injection site with a swab saturated with isopropyl alcohol 70% for 30 seconds and allows to dry for 30 seconds.
10	Stretches the skin around the injection site.
11	Inserts the needle at an angle of 90° into the skin until about 1cm of the needle is left showing.
12	Depresses the plunger at approximately 1ml every 10 seconds and injects the drug slowly. (ONLY if using dorsogluteal muscles: pulls back on the plunger to check for blood aspiration.)
13	Waits 10 seconds before withdrawing the needle.

14	Withdraws the needle rapidly. Applies gentle pressure to any bleeding point but does not massage the site.
15	Applies a small plaster over the puncture site.
16	Ensures that all sharps and non-sharp waste are disposed of safely (including scooping method of re-sheathing and transportation of sharps) and in accordance with locally approved procedures.
17	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
18	Dates and signs drug documentation.
19	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Nutritional assessment marking criteria

Assessment criteria	
1	Accurately calculates the body mass index (BMI) and the score in step 1 of the malnutrition universal screening tool (MUST).
2	Identifies the percentage of weight loss and accurately calculates the score in step 2 of the MUST.
3	Interprets the clinical information provided and accurately calculates the score in step 3 of the MUST.
4	Accurately calculates and documents an overall risk score and identifies the correct risk category.
5	Documents the date, time and signature, where required.
6	Verbally reports the findings to the examiner.
7	Verbally reports that the patient will need referring to a dietician or nutritional support team.
8	Verbally proposes a plan to improve nutritional intake.
9	Verbally proposes monitoring of the patient's nutritional status.
10	Verbally considers possible underlying causes and provides food choices.
11	Handwriting is clear and legible.
12	Ensures that strike-through errors retain legibility.
13	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Pain assessment marking criteria

Assessment criteria	
1	Introduces self and explains the assessment to be carried out and the rationale and importance of this.
2	Considers the following aspects of pain:
2a	P = provokes Where is the pain? (point to area) What causes the pain? What makes it better? What makes it worse?
2b	Q = quality What does the pain feel like? Is it dull, sharp, stabbing, burning, crushing, shooting, throbbing? Is the pain intense?
2c	R = radiating Where is it? Is it in one place? Does it move around? Did it start somewhere else?
2d	S = severity How bad is it? Uses the universal pain scale to ascertain severity.
2e	T = time When did the pain start? How long has it lasted? Is it constant? Does it come and go? Is it sudden or gradual?
3	Acknowledges that the patient is in discomfort, and offers to make them more comfortable by repositioning.
4	Asks patient whether they have had any analgesia, and states will arrange for suitable analgesia.
5	Identifies the need to communicate with multidisciplinary team/doctor.
6	Identifies the need for regular reassessment.
7	Indicates the need to document findings accurately and clearly in the patient notes/charts.
8	Reassures the patient.
9	Acts professionally throughout the procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Physiological observations marking criteria

	Assessment criteria
1	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
2	Introduces self to person.
3	Checks ID with person (person's name is essential and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
4	Gains consent and explains reason for the assessment.
5	Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
6	Accurately measures and documents the patient's vital signs on specific assessment tools.
7	Calculates National Early Warning Score (NEWS) accurately.
8	Accurately completes documentation: signs, and adds date and time on assessment chart.
9	Disposes of equipment appropriately – verbalisation accepted.
10	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
11	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Talking therapies marking criteria

	Assessment criteria
1	Introduces self.
2	Checks patient's ID by asking for name and date of birth.
3	Gains consent to continue the visit.
4	Body language is open and relaxed, personal space adequate, voice is calm, and speech is clear.
5	Discusses the reason for referral and the patient health questionnaire (PHQ9) assessment.
6	Listens to and acknowledges the person's feelings using reflective language and validation. Shows empathy, acknowledging person's feelings, compassion, and kindness.
7	Explains the benefits of talking therapy, for example: • having time to talk, cry, shout or just think • having someone to listen to how they feel can help • it can be easier talking to a stranger than to relatives or friends • assist to find own answers to problems • an opportunity to look at problems in a different way with someone who will respect you and your opinion in a non-judgmental manner. Overall aim: to help the person to feel better. Talking therapies won't make problems go away, but therapy may make it easier to cope with problems and feel happier.
8	Identifies and clearly explains the most relevant therapeutic interventions with the person. For example: • counselling • cognitive behavioural therapy (CBT) • psychotherapy • interpersonal therapy • mindfulness-based therapies.
9	Recommends a specific therapy, giving rationale for choice.
10	Recaps areas discussed prior to ending the visit.
11	Asks the person whether they have any questions, and correctly answers specific questions and provides information as required.
12	Appropriately concludes the visit.
13	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Professional values stations

Bullying marking criteria MAHI - STM - 212 - 533

Assessment criteria	
1	Recognises that any form of bullying and harassment is unacceptable and violates a person's human and legal rights.
2	Identifies that employers have a duty of care to provide a safe and healthy working environment for their staff, and that this is not achieved if a staff member is subjected to bullying.
3	Recognises the need to follow the actions set out in the local bullying and harassment policy.
4	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety, and promote professionalism and trust. Bullying is not a behaviour that protects others or promotes trust.
5	Encourages and supports Pat to report the incidents of harassment to the senior manager. Reports their own observations to the senior manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
6	Recognises that they may be asked by the senior manager to record a witness statement, documenting what was seen and what steps were taken to deal with the matter, including to whom the incident was reported. The witness statement must be signed and dated.
7	Recognises that Pat may need psychological support from the employee counselling service, and encourages her to use this resource.
8	Handwriting is clear and legible.

Concealment of bed status marking criteria MAHT STM 212 534

Assessment criteria	
1	Recognises that taking rest breaks using a bed intended for patients might result in a failure to provide necessary patient care and could place patient safety at risk.
2	Considers that the action taken to mislead the hospital site manager was dishonest and does not promote the fundamental tenets of truth and honesty.
3	Requests that the nurse in charge correctly inform the hospital site manager that the bed is empty. If this request is met with refusal, states that they would inform the site manager.
4	Acknowledges their professional duty to report to management any dishonest behaviour by a colleague that could result in the care of patients being compromised, and which could result in a notification to the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
5	Raises the concern with the manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
6	Recognises that they may be asked by the manager to record a witness statement, documenting what was seen and which steps were taken to deal with the matter, including to whom the incident was reported. The witness statement must be signed and dated.
7	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety, and promote professionalism and trust.
8	Handwriting is clear and legible.

Confidentiality marking criteria

Assessment criteria	
1	Outlines and provides reassurance to the patient of professional responsibility to respect the patient's right to privacy and confidentiality in all aspects of care, but outlines the need to act with honesty and integrity at all times (duty of candour).
2	Explores the patient's reasons for withholding diagnosis and prognosis from partner.
3	Offers support and time to facilitate discussion between patient and partner, respecting patient's decision, linked to duty of candour and confidentiality.
4	Documents the patient's wishes regarding the diagnosis and information sharing.
5	Acknowledges the partner's concern and feelings, acting with care and compassion, but explains the need to respect the patient's right to privacy and confidentiality in all aspects of care.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety and promote professionalism and trust.
7	Handwriting is clear and legible.

Drug error marking criteria

Assessment criteria	
1	Recognises the possible consequence of error and the importance of patient safety, and takes measures to reduce the effects of harm.
2	Checks the stability of the patient by taking observations, informs the nurse in charge and medical team of the event, and seeks advice.
3	Recognises the importance of disclosing the occurrence to the patient and apologises, reflecting duty of candour.
4	Documents events, actions and consequences in the patient's records, and completes an incident report.
5	Demonstrates the importance of reflection, explores the sequence of events and factors that may have influenced the occurrence, recognises the learning opportunity, and identifies the need to revisit drug administration procedure.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety and promote professionalism and trust.
7	Handwriting is clear and legible.

False representation marking criteria

Assessment criteria	
1	Recognises that false impersonation to provide a reference is an unlawful fraudulent action.
2	Acknowledges their professional duty to report the unlawful and dishonest behaviour of the nurse to the senior manager and the professional body, the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
3	Recognises that the action of falsely providing a reference could indirectly create a risk to the safety of patients in the care home.
4	Makes a clear written record of the occurrence, including the date and with whom the concern was raised.
5	Recognises that this action will need to be shared with police and will likely result in the need for a formal police statement.
6	Suspends the nurse in question from work, pending investigation, removing them from any forthcoming shifts from the roster, and identifying cover.
7	Identifies that the act of impersonating a ward manager breaches the fundamental tenets of truth and honesty set out in ‘The Code’ and does not promote professionalism and public trust.
8	Handwriting is clear and legible.

Falsifying Observations marking criteria

Assessment criteria	
1	Recognises that their colleague has deliberately misrepresented the care given by falsifying vital observations.
2	Identifies the need for immediate action to assess all patients' vital signs to ensure patient safety.
3	Documents events, actions and consequences in the patients' records, and completes an incident report.
4	Acknowledges their professional duty to report their colleague's dishonest behaviour to their manager, which may result in a notification to the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
5	Reports concerns to the manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
6	Recognises that the fundamental tenets of the nursing profession are truth and honesty, and that this behaviour does not promote the standards and values set out in 'The Code' of promoting professionalism and trust.
7	Handwriting is clear and legible.

Falsifying timesheets marking criteria

Assessment criteria	
1	Recognises that falsifying timesheets for personal financial gain is an unlawful fraudulent action.
2	Acknowledges their professional duty to report the nurse's unlawful and dishonest behaviours to their manager and the professional body, the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
3	Verbally reports concerns to the manager and the temporary staffing manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
4	Makes a clear written incident report of the occurrence, including the date and with whom the concern was raised.
5	Recognises that they may be asked to make a formal witness statement for the NHS fraud team and the police.
6	Recognises that the fundamental tenets of the nursing profession are truth and honesty, and that this behaviour does not promote the standards and values set out in ‘The Code’ for promoting professionalism and trust.
7	Handwriting is clear and legible.

Hospital food marking criteria

Assessment criteria	
1	Recognises that taking or consuming NHS or hospital property is prohibited and constitutes theft.
2	Acknowledges their professional duty to report their colleague's dishonest behaviour to their senior manager, which may result in notification to the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and may place their own registration at risk, reflecting the duty of candour.
3	Attempts to locate a replacement meal that the patient is happy with. If this is not possible, considers that it may compromise good nutritional care.
4	Raises concern with the senior manager at the earliest opportunity, verbally or in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
5	Recognises that they may be asked by a senior manager to record a witness statement, documenting what was seen and what steps were taken to deal with the matter, including to whom the incident was reported. The witness statement must be signed and dated.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety, and promote professionalism and trust.
7	Handwriting is clear and legible.

Impaired performance marking criteria

Assessment criteria	
1	Recognises that their colleague's social behaviour has created the potential for patient harm, as Dana is not able to practise safely and effectively.
2	Acknowledges the requirement to uphold the reputation of the profession and display behaviours that promote public trust.
3	Recognises the professional duty to report any concerns that may result in the care of patients being compromised, and that the failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
4	Raises the concern with a manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
5	Considers that their manager may ask them to record an incident report/witness statement, documenting what they have seen and which steps were taken to deal with the matter, including to whom the incident was reported. The witness statement must be signed and dated.
6	Takes into consideration their responsibility for the safety of their colleague, considering the effects of alcohol on their ability to work and drive home.
7	Considers that their colleague may need further support in dealing with an alcohol misuse problem.
8	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety and promote professionalism and trust.
9	Handwriting is clear and legible.

Laboratory results marking criteria

Assessment criteria	
1	Outlines their colleague’s professional responsibility to respect a patient's right to privacy and confidentiality in all aspects of care and the requirement to act with honesty and integrity at all times (the duty of candour).
2	Reassures the colleague that the paramedics would share any concerns about her neighbour's welfare with other healthcare professionals.
3	Recognises that accessing patient data without need or consent is a breach of the General Data Protection Regulation (GDPR), which may incur a financial penalty and also poses a question as to their colleague’s professional suitability.
4	Acknowledges the colleague’s concern and feelings, and that they are acting with care and compassion. However, explains the need to respect the patient’s right to privacy and confidentiality.
5	Acknowledges the need to keep to and uphold the standards and values set out in ‘The Code’: prioritise people, practise effectively, preserve safety, and promote professionalism and trust.
6	Handwriting is clear and legible.

Possible abuse marking criteria

Assessment criteria	
1	Acknowledges the need to escalate concern regarding safeguarding without patient consent, reflecting duty of candour.
2	Communicates with compassion and empathy in language appropriate to the patient.
3	Identifies the need to act without delay as there is a risk to patient safety, and raising concern at the first reasonable opportunity.
4	Raises concern with manager or local authority safeguarding lead in accordance with the safeguarding policy. Recognises the need to be clear, honest and objective about the reasons for concern.
5	Makes a clear written record of the concern (including a body map) and the steps taken to deal with the matter, including the date and with whom the concern was raised.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety and promote professionalism and trust.
7	Handwriting is clear and legible.

Professional confrontation marking criteria

Assessment criteria	
1	Recognises the importance of allowing the person to talk and vent frustration, showing an interest in what the person says. Identifies the crux of the problem as quickly as possible. Empathises with the person and offers assistance.
2	Recognises the importance of: • establishing rapport • using appropriate eye contact (not staring) • maintaining body language and open posture throughout. Identifies the need to remain calm, using appropriate tone and pace of voice (not mirroring anger).
3	Offers an explanation of the circumstance and offers an apology as early as possible, where appropriate.
4	Documents the incident. Offers to refer to senior staff member and/or the complaints procedure as a sign of respect and of taking the circumstance seriously.
5	Takes account of own personal safety and ensures that a witness is present.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety and promote professionalism and trust.
7	Handwriting is clear and legible.

Racism marking criteria MAHI - STM - 212 - 545

Assessment criteria	
1	Recognises that Piper is not adhering to the fundamental tenets of ‘The Code’ of promoting the health, wellbeing, rights, privacy and the dignity of individuals.
2	Recognises that the action of posting racially abusive comments demonstrates personal attitudinal views that deviate from the values of the nursing profession.
3	Acknowledges their professional duty to report Piper’s unlawful racist behaviour to their manager and professional body, the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
4	Identifies that, although there are no clinical concerns about Piper, patients may be put at risk because of the racist attitudes she holds.
5	Reports the post to the social media platform and ‘unfriends’ the colleague to dissociate from them.
6	Recognises that the employer may share the event with the police and so they may be required to make a formal statement.
7	Handwriting is clear and legible.

Social media marking criteria

Assessment criteria	
1	Recognises that sharing confidential information and posting pictures of patients and people receiving care without their consent is inappropriate.
2	Recognises the professional duty to report any concerns about the safety of people in their care or the public, and that failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
3	States that acknowledging someone else's post (sharing/reacting/commenting) can imply the endorsement or support of that point of view.
4	Raises the concern with a manager at the first reasonable opportunity, verbally or in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
5	Completes an incident report, recording the events, the steps taken to deal with the matter, including the date and with whom the concern was raised.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety and promote professionalism and trust.
7	Handwriting is clear and legible.

Witnessed abuse marking criteria

Assessment criteria	
1	Recognises that their colleague has used an unsafe and clinically inappropriate moving and handling technique to manoeuvre the patient up the bed.
2	Recognises that the patient may have suffered physical harm by being forcefully moved up the bed, undertakes a full assessment, and ensures that the patient is comfortable.
3	Identifies that the tone and delivery of their colleague's words were aggressive and inappropriate and caused the patient emotional distress. Communicates with compassion and empathy to reassure the patient.
4	Acknowledges their own professional duty to report the colleague's behaviours to their manager, which may result in notification to the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
5	Raises the concern with a manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
6	Documents what was seen and the steps taken to deal with the matter, including to whom the incident was reported. Identifies that the witness statement must be signed and dated.
7	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety, and promote professionalism and trust.
8	Handwriting is clear and legible.

Evidence-based practice stations

Ankle sprain marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs Xi that both paracetamol and ibuprofen are equally effective analgesics.
1c	Explains to Xi that some clinicians prefer to prescribe ibuprofen but there is no clear evidence that it is superior.
1d	Advises that the current available research suggests that paracetamol is an effective analgesia for pain resulting from soft-tissue injuries.
1e	Explains to Xi that, although ibuprofen is safe, it can have more adverse effects and be contraindicated in patients who have bronchospasm, cardiac and renal failure.
1f	Recognises that Xi is asthmatic and advises that paracetamol would be more suitable.

Autism Spectrum Disorder marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Explains to Charlie that healthcare professionals' poor knowledge and lack of understanding of autism spectrum disorder (ASD) are likely to be a barrier to those people who have autism accessing mental health support and treatment.
1c	Considers that healthcare professionals may need additional training to communicate with people who have autism.
1d	Explains that people who feel disregarded by healthcare professionals are less likely to seek further help.
1e	Informs Charlie that adults who have autism, previously diagnosed with Asperger Syndrome before 2013, are affected by a misperception that they have a learning disability, but this is not true. However, they may still have difficulties with understanding and processing information.
1f	Considers that mental health support and treatment may help Leslie's overall wellbeing and improve his self-harming behaviour.

Bedside handover marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusion, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs Tanveer that research has shown that adult patients and nurses both prefer handover at the bedside rather than elsewhere.
1c	Informs Tanveer that most patients find bedside handovers beneficial as they feel involved in their own care and it supports two-way communication.
1d	Advises Tanveer that patients prefer to have a family member/carer/friend present and to have two nurses rather than the nursing team present. However, having a family member/carer/friend present was not considered important by nurses.
1e	Explains to Tanveer that, while patients expressed a weak preference for having sensitive information handed over quietly at the bedside, nurses expressed a relatively strong preference for handing sensitive information over verbally away from the bedside.
1f	Advises Tanveer that developing the process and design of bedside handover can improve the implementation of this important patient-centred safety initiative in hospitals.

Cervical screening marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Explains to Roshni that the main cause of cervical cancer is human papillomavirus (HPV).
1c	Informs Roshni that it can take between 10 and 20 years for cervical cancer to develop from an HPV infection. Therefore, a woman's current sexual behaviour does not necessarily reflect her current risk.
1d	Explains that the peak age for developing cervical cancer is 30 to 45, but it can occur in anyone who has a cervix, irrespective of age.
1e	Discusses any concerns and/or fears about screening with Roshni.
1f	Advises Roshni that she should attend for screening every 3 years until she turns 49, when she should attend every 5 years. Women will be invited to attend after 65 only if they have previously received an abnormal result.

Cranberry juice and urinary-tract infections (UTIs) marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Explains to Freda that there is some research that shows that cranberry juice may prevent a UTI occurring in healthy individuals, if drunk regularly.
1c	Considers that cranberry juice may be less likely to induce nausea than other sugary drinks, when taken regularly.
1d	Informs Freda that there is no evidence available that cranberry juice may prevent UTIs in individuals who have high-risk conditions or those with indwelling catheters as people in these groups were not included in the study.
1e	Explains to Freda that there is no evidence available to suggest that cranberry juice can be used to treat a UTI in place of antibiotics.
1f	Informs Freda that it is necessary to note that the research was funded by a leading cranberry juice manufacturer, indicating a potential conflict of interest.

Dementia and music marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs Bindu's daughter that research trials have been conducted where music therapy has been introduced and that they have had some benefits for individuals who have dementia. The patients involved in the study had all had at least five music therapy sessions.
1c	Explains to Bindu's daughter that there is a lack of evidence that music therapy can improve symptoms of agitation.
1d	Explains that the current research available suggests some evidence to show that music therapy can positively improve depression, and this may provide a rationale for implementing music therapy.
1e	Informs Bindu's daughter that music therapy may have a positive effect on the overall quality of life of individuals who have dementia. However, this evidence is less reliable than the evidence on depression.
1f	Informs Bindu's daughter that there is no clear evidence on how long the effects created by music therapy remain after the activity stops.

Diabetes marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs the patient that they are less likely to suffer with hypoglycaemia as they are not prescribed insulin. However, hypoglycaemia remains a serious concern and there is a need to be vigilant, to monitor blood glucose levels and to recognise the signs and symptoms of hypoglycaemia.
1c	Advises the patient that hypoglycaemic episodes are often caused by diet-related factors, such as missing a meal or not eating enough carbohydrates. Emphasises the importance of eating regular meals and discusses the daily recommended amount of carbohydrates.
1d	Advises the patient to observe for excessive sweating, feeling faint, light-headed, blurred vision, new confusion and/or nausea, and to call 999 if any of these symptoms is experienced.
1e	Advises the patient to inform friends and family that, if the patient appears confused or loses consciousness, it may be a hypoglycaemic episode and to seek emergency medical help by calling 999.
1f	Informs the patient that an episode of acute illness may cause irregularities in blood glucose, and so blood sugars need to be monitored more frequently and any changes reported.

Female myocardial infarction (MI) marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Recognises that the importance of early and correct recognition of MI symptoms is vital in order to seek medical care promptly for a better outcome.
1c	Informs the patient that, as a female, she may or may not experience chest pain.
1d	Informs the patient that she may experience nausea and back, shoulder, throat/neck, cheek/teeth and arm pain.
1e	Emphasises to the patient that she should report any symptoms whether she considers them to be cardiac-related or not.
1f	Encourages the patient to call 999 immediately if she experiences any of the above symptoms.

Fever in children marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Explains to Selai that the fever is an important immune mechanism in fighting the underlying infection and that it is recommended to treat a fever only if it is causing the child distress.
1c	Considers that both paracetamol or ibuprofen can safely be used to treat the fever.
1d	Informs Selai that it is recommended that Ibuprofen is taken with food to reduce potential gastric side effects and they should encourage the child to eat something when taking ibuprofen. However explains that ibuprofen is safe to administer with or without food in the short term (up to 7 days).
1e	Considers whether the child has asthma, as both ibuprofen and paracetamol can exacerbate respiratory symptoms.
1f	Explains that healthcare professionals may perceive that ibuprofen has more adverse effects than paracetamol but that there is not the evidence to support this.

Pressure ulcer prevention marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs the patient that a specific foam preventative dressing applied to a person's sacrum has been shown to reduce pressure ulcer development by 10%. However, even with a dressing, a pressure ulcer may still develop, although it may occur later.
1c	Explains that a very rare side effect of the foam dressing is a mild skin irritation.
1d	Advises the patient that, being male, he may be at more risk of developing a pressure sore.
1e	Explains to the patient that regular skin inspections, regularly changing position, staying well hydrated, and maintaining a balanced diet will also help with the prevention of a pressure ulcer.
1f	Informs the patient that there is a foam dressing that may aid in the prevention of a pressure ulcer, and that this will be discussed further with the tissue viability team.

Restraint marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Explains to Bharva that compassionate communication may prevent the need to restrain patients.
1c	Considers that physical restraint may be necessary to promote the safety of staff and patients as a last resort after other options have been exhausted.
1d	Informs Bharva that physical restraint may promote fear in patients and distress among staff.
1e	Considers that physical restraint may be perceived as a demonstration of power that staff display over patients.
1f	Explains that the use of physical restraint may create a loss of trust and a breakdown in patient and staff relationships.

Saline versus Tap water marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs Fiona that trials comparing the occurrences of wound infections when cleaned with sterile saline or tap water have shown no difference between the two.
1c	Advises Fiona that there is a lack of available evidence on the effects of water or saline on wound healing.
1d	Makes Fiona aware that there are no differences in patient satisfaction in either group. However, there was a lack of robust evidence on the instances of pain experienced by patients, or on adverse events.
1e	Highlights to Fiona that there were no standard criteria for assessing wound infection across the trials, which limited the ability to pool the data across studies and limited the results.
1f	Explains to Fiona that tap water has been recommended as a cost-effective option for wound cleaning.

Smoking cessation marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs the patient that replacement therapies have not been found to achieve the same level of satisfaction as smoking. However, e-cigarettes have higher rates of satisfaction compared with nicotine replacement.
1c	Discusses with the patient that studies show that stopping smoking is more likely when using e-cigarettes than nicotine replacement.
1d	Advises the patient that e-cigarettes are more likely to cause throat and mouth irritation compared with nicotine replacement.
1e	Advises the patient that nicotine replacement therapies are more likely to cause nausea.
1f	Emphasises to the patient that, without face-to-face support, there is low efficacy for both treatments, and recommends using a smoking cessation support service, signposting the local service.
1g	Positively acknowledges the patient's consideration of giving up smoking by offering support and encouragement.

Use of honey dressing for venous leg ulcers marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs the patient that there is currently no conclusive evidence indicating that medical-grade honey improves outcomes for patients with chronic venous leg ulcers.
1c	Informs the patient that one large study found no reduction in size of ulcer or healing time with honey compared with standard treatment.
1d	Advises that, in the same study, patients reported an increased rate of pain.
1e	Advises that another study suggests that honey may have anti-microbial properties and may help patients with chronic venous leg ulcers who have a methicillin-resistant staphylococcus aureus (MRSA) infection. However, this was a very small study, and more research is required on the subject.
1f	Informs the patient that there is no evidence that medical-grade honey is cost-effective in the treatment of chronic venous leg ulcers.
1g	Recommends that, until further robust research is conducted and the efficacy of honey to treat chronic venous leg ulcers is established, the dressing of the wound should be based on current evidence-based trust protocol.

MAHI - STM - 212 - 563

Unit 109 Albert Mill
10 Hulme Hall Road
Castlefield
Manchester
M15 4LY

www.alphaplus.co.uk

+44 (0) 161 249 9249

Nursing & Midwifery Council

Test of Competence 2021: Mock OSCE

Learning Disabilities Nursing

V 1.6

Mock OSCE

Learning disabilities nursing

In your objective structured clinical examination (OSCE), four of the stations are linked together around a scenario: this is called the APIE, with one station for each of Assessment, Planning, Implementation and Evaluation, delivered in that sequence and with no stations in between.

Four of the six remaining stations will take the form of two sets of two linked stations, testing practical clinical skills. Each pairing of skills stations will last up to 20 minutes in total (including reading time), with no break between each paired skill.

There are also two new silent stations. In each OSCE, one station will specifically assess professional issues associated with professional accountability and related skills around communication (called the professional values and behaviours, or PV, station). One station will also specifically assess critical appraisal of research and evidence and associated decision-making (called the evidence-based practice station, or EBP).

We have developed this mock OSCE to provide an outline of the performance we expect and the criteria that the test of competence will assess. This mock OSCE contains an APIE, one pair of linked clinical skills, one PV and one EBP station.

The Nursing and Midwifery Council's code (2018) outlines professional standards of practice and behaviours, setting out the expected performance and standards that are assessed through the test of competence.

The code is structured around four themes: prioritise people, practise effectively, preserve safety and promote professionalism and trust. These statements are explained below as the expected performance and criteria. The criteria must be used to promote the standards of proficiency in respect of knowledge, skills and attitudes. They have been designed to be applied across all fields of nursing practice, irrespective of the clinical setting, and they should be applied to the care needs of all patients.

Please note: this is a mock OSCE example for education and training purposes only.

The marking criteria and expected performance apply only to this mock OSCE. They provide a guide to the level of performance we expect in relation to nursing care, knowledge and attitude. Other scenarios will have different assessment criteria appropriate to the scenario.

Evidence for the expected performance criteria can be found in the reading list and related publications on the learning platform.

Theme from the code	Expected performance	Criteria
Prioritise people	Treat people as individuals and uphold their dignity	Introduces self to the patient at every contact and upholds the patient's dignity and privacy.
	Listen to people and respond to their preferences and concerns	Actively listens to patients and provides clear information, behaving in a professional manner, respecting others and adopting non-discriminatory behaviour.
	Make sure that people's physical, social and psychological needs are responded to	Upholds respect by valuing the patient's opinions and being sensitive to feelings and/or appreciating any differences in culture.
	Act in the best interest of people at all times	Treats each patient as an individual, showing compassion and care during all interactions. Respects and upholds people's human rights.
	Respect people's right to privacy and confidentiality	Ensures that people are informed about their care and that information about them is shared appropriately, maintaining confidentiality.
Practise effectively	Always practise in line with the best available evidence	Provides skills, knowledge and attitude that is supported by an evidence base at all times.
	Communicate clearly	Communicates clearly and effectively to people in their care, colleagues and the public.
	Work co-operatively	Maintains effective and safe communication with people in their care, colleagues and the public.

	Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues	Supports others by providing accurate, honest and constructive verbal and written feedback.
	Keep clear and accurate records relevant to your practice	Provides clearly written feedback on all care given, and demonstrates accurate evidence-based verbal handover of care to others.
	Be accountable for your decisions to delegate tasks and duties to other people	Accountably delegates to competent others, ensuring patient safety at all times.
Preserve safety	Recognise and work within the limits of their competence	Accurately identifies, observes and assesses signs of normal or worsening physical and mental health in the person receiving care, requesting timely and appropriate assistance as required.
	Be open and candid about potential mistakes, preventing harm	Documents events formally and takes further action (escalates) if appropriate, so they can be dealt with quickly.
	Provide assistance in an emergency	Acts in an emergency within the limits of their knowledge and competence, seeking appropriate support as required.
	Act swiftly if there is a danger to others, maintaining safety	Delivers care according to national policies and procedures to prevent danger to others, and applies appropriate personal protective equipment (PPE) as indicated by the nursing procedure in accordance with the guidelines to prevent healthcare-associated infections.
	Raise concerns for those	Shares information if

	who are seen to be vulnerable or at risk of harm	someone is at risk of harm, in line with the laws relating to the disclosure of information.
	Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations	Checks prescriptions, patient identification and administers medicines safely, highlighting appropriately any areas of concern.
	Demonstrate awareness of any potential harm associated to their practice	Takes all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.
Promote professionalism and trust	Uphold the reputation of the profession at all times	Demonstrates and upholds the standards and values set out in the code.
	Fulfil the registration requirements	Demonstrates up-to-date knowledge, skills and competence to provide safe and effective care at all times.
	Provide leadership to make sure that people's wellbeing is protected and to improve their experiences of the health and care system	Identifies priorities, manages time and resources effectively, and deals with risk to make sure that the quality of care or service is maintained and improved, putting the needs of those receiving care or services first.

The mock APIE below is made up of four stations: assessment, planning, implementation and evaluation. Each station will last up to 20 minutes and is scenario-based. The instructions and available resources are provided for each station, along with the specific timing.

Scenario
Frankie Kapalis has a mild learning disability and Williams syndrome. However, Frankie can communicate verbally and is capable of independent self-care. They have lived in a supported living facility for the past 10 years. Two months ago, another resident at the complex, who Frankie was very friendly with, passed away suddenly. Since the loss of their friend, Frankie has become less talkative and increasingly reluctant to go to work or attend social group outings. Frankie has a loss of appetite and is no longer eating full meals. Frankie is becoming more resistant to eating meals,even with support from friends.

You will be asked to complete the following activities to provide high-quality, individualised nursing care for the patient, providing an assessment of needs that is based on the recovery model of care. All four of the stages in the nursing process will be continuous and will link with each other.

Station	**You will be given the following resources**
Assessment – **20 minutes** You will collect, organise and document information about the patient.	• Assessment overview and documentation (pages 10–14) • A Glasgow depression scale completed by the patient (pages 15–19) • A copy of the Hospital Communication Book, for reference (pages 20–43)
Planning – **14 minutes** You will complete the planning template, choosing two aspects of the patient's care needs and establishing how they will be met.	• A completed nursing care plan for two nursing care problems or needs (pages 44–47)
Implementation – 15 minutes You will administer and document medications while continuously assessing the individual's current health status.	• An overview and a medication administration record (MAR) (pages 48–51)
Evaluation – 8 minutes You will document the care that has been provided so that you can do a verbal handover to the nurse on the next shift (the examiner).	• Documents from the previous three stations • A blank situation, background, assessment and recommendation (SBAR) tool (pages 52–53)

On the following pages, we have outlined the expected standard of clinical performance and criteria. These marking matrices are there to guide you on the level of knowledge, skills and attitude we expect you to demonstrate at each station.

Assessment criteria
Assesses the safety of the scene and privacy and dignity of the patient.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following World Health Organisation (WHO) guidelines.
Introduces self to person.
Checks identity (ID) with person or carer (person's name is essential and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
Gains consent and explains reason for the assessment.
Uses SOLER throughout the assessment: • Sitting at a comfortable angle and distance • Open posture, with arms and legs uncrossed • Leaning forward from time to time, looking genuinely interested, listening attentively • Effective eye contact without staring • Remaining relatively relaxed.
Uses appropriate questioning skills (open questions).
Builds trust and rapport by demonstrating: compassion, taking time, active listening, taking interest.
Uses brief verbal and non-verbal affirmations.
Uses reflection/paraphrasing to demonstrate concern.
Conducts a holistic assessment relevant to the patient's scenario.
Identifies and discusses any current risk factors, if present.
Accurately completes any assessment tools included and accurately calculates and records score where appropriate.
Discusses the assessment findings with the person and closes the assessment appropriately.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Planning criteria
Clearly and legibly handwrites answers.
Identifies two relevant nursing problems/needs.
Identifies aims for both problems.
Sets appropriate evaluation date for both problems.
Ensures nursing interventions are current/evidence-based/best practice.
Uses professional terminology in care planning.
Does not use abbreviations or acronyms.
Ensures strike-through errors retain legibility.
Accurately prints, signs and dates (when required).
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Implementation criteria
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
Introduces self to person.
Seeks consent from person or carer prior to administering medication.
Checks allergies on chart and confirms with the person in their care, also notes red ID wristband (where appropriate).
Before administering any prescribed drug, looks at the person's prescription chart and correctly checks ALL of the following: Correct: • person (checks ID with person: verbally, against wristband (where appropriate) and documentation), • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate) • any allergies.
Correctly checks ALL of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed

with administration and should consult the prescriber.
Considers contraindication where relevant and medical information prior to administration (prompt permitted). (This may not be relevant in all scenarios.)
Provides a correct explanation of what each drug being administered is for to the person in their care (prompt permitted).
Administers drugs due for administration correctly and safely.
Omits drugs not to be administered and provides verbal rationale (ask candidate reason for non-administration if not verbalised).
Accurately documents drug administration and non-administration.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Evaluation criteria
Situation
Introduces self and the clinical setting.
States the patient's name, hospital number and/or DoB, and location.
States the reason for the handover (where relevant).
Background
States date of admission/visit/reason for initial admission/referral to specialist team and diagnosis.
Notes previous medical history and relevant medication/social history.
Gives details of current events and detailing findings from assessment.
Assessment
States most recent observations, any results from assessments undertaken and what changes have occurred.
Identifies main nursing needs.
States nursing and medical interventions completed.
States areas of concerns.
Recommendation
States what is required of the person taking the handover and proposes a realistic plan of action.
Overall
Verbal communication is clear and appropriate.
Systematic and structured approach taken to handover.

Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Assessment
Grief and bereavement

MAHI - STM - 212 - 574

Candidate briefing

You are a registered nurse for people who have learning disability working in a purpose-built residential facility supporting Frankie Kapalis. Frankie is a resident with a learning disability. Frankie may be experiencing issues of bereavement following the loss of their friend.

Please conduct a holistic assessment of the patient's physical, psychosocial, spiritual and sexual care needs.

Please proceed with your nursing assessment by calculating a pre-completed **Glasgow depression scale** score. The score must be **calculated** within this station. Please discuss the clinical response and outcome of the Glasgow depression scale with Frankie.

Complete your assessment using the headings in the table below.

You may focus on the following **TWO** care needs to help you to develop a care and support plan in the planning station.

- **Deteriorating mental and physical health**
- **Social needs**

This document must be completed using a GREEN PEN.

You have **20 minutes** to complete this station, including all the required documentation.

Assume that it is TODAY and that it is **10:00 hours.**

Assessment
Grief and bereavement

MAHI - STM - 212 - 575

Overview of recent history

Patient information
Name: Frankie Kapalis **Date of birth:** 01/01/1973 **Address:** Meadowlane Housing, 1 Sweet Street, Westshire, WW6 5PQ **GP**: Dr A. Beattie 1 Sugar Terrace, Westshire, WW6 5NP **Current location and time** Meadowlane Housing residential supported living, 10:00 hours. **Presenting complaint:** Two months ago, a resident in the complex passed away suddenly, and Frankie was very friendly with them. Since the loss of their friend, Frankie has become less talkative and increasingly reluctant to go to work or attend social group outings. Frankie has a loss of appetite and is no longer eating full meals. Frankie is becoming more resistant to eating meals, even with support from friends. **History of presenting complaint:** Frankie has lived in the supported living facility for the past 10 years. Frankie can communicate verbally and is capable of independent self-care. However, he has a mild learning disability and Williams syndrome. In the past, Frankie has had periods of depression and anxiety, which are common in people with Williams syndrome. Frankie has previously been treated with medication to manage depression and has had cognitive behavioural therapy. However, Frankie has not required any hospital admissions. Frankie requires a lot of support and supervision during these episodes. **Past medical history:** • Mild learning disability • Williams syndrome • Depression and anxiety • Insomnia • Hypertension **Social history:** • Single • Resident in the supported living home for the past 10 years, living and cooking with two flat mates. • Next of Kin is Frankie's mother, Elena Kapalis. Frankie's father is Christian Kapalis and there are two sisters; Chloe and Amelia. • Ethnic group: Greek • Next door neighbour is Sam who has a cocker spaniel dog called Buster. • Frankie attends a local college studying catering and has a part time job in a café. • Frankie likes to talk a lot and does not like it when someone interrupts. Frankie likes people to speak slowly. Sometimes, Frankie uses Makaton signs or cards when unable

to get the right words for the food they would like to eat.
- Does not smoke. Enjoys drinking cider from time to time.

Current medications:
- Lactulose 15 ml twice a day (as required)
- Zopiclone 3.75 mg once daily
- Ramipril 10 mg once daily

Allergies:
- Penicillin (reaction anaphylaxis).

Assessment
Grief and bereavement

MAHI - STM - 212 - 577

Candidate notes

This documentation is for your use and is not marked by the examiners.

Patient details: Name: Frankie Kapalis Address: Meadowlane Housing, 1 Sweet Street, Westshire, WW6 5PQ Date of birth: 01/01/1973
Deteriorating mental and physical health
Social needs
Health promotion
Sleeping

Nutrition and hydration
Elimination

GLASGOW DEPRESSION SCALE

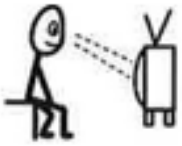
Client name: Frankie Kapalis Date: TODAY

Instructions to candidate:

This depression scale has been completed with Frankie. You are required to calculate the overall score and discuss the outcome with Frankie.

In the past week…		Prompts	No	Sometimes	Always
1.	 Have you felt sad?	*Have you felt upset?* *Have you felt miserable?* *Have you felt depressed?*	0	1	**2**
2.	 Have you been in a bad mood?	*Have you lost your temper?* *Have you felt as if you want to shout at people?*	0	1	**2**

In the past week…		Prompts	No	Sometimes	Always
3.	 Have you enjoyed doing things?	*Have you had fun?* *Have you enjoyed yourself?*	**2**	1	0
4.	 Have you enjoyed talking and being with people?	*Have you liked having people around you?* *Have you enjoyed other people's company?*	**2**	1	0
5.	 Have you had a bath/shower and changed your clothes?	*Have you taken care of the way you look?* *Have you looked after your appearance?*	2	**1**	0
6.	 Have you felt tired during the day?	*Have you gone to sleep during the day?* *Have you found it hard to stay awake during the day?*	0	1	**2**
7.	 Have you cried?		0	1	**2**

In the past week…	Prompts	No	Sometimes	Always
8.  Have you felt people don't like you?	*Have you felt others don't like you?*	**0**	1	2
9.  Have you been able to concentrate, such as watch TV?	*Have you been able to concentrate on things (like TV shows?)*	**2**	1	0
10.  Have you found it hard to choose things?	*Have you found it hard to decide what to wear, or to do?* *Have you found it hard to choose between two things?*	0	1	**2**
11.  Have you found it hard to sit still?	*Have you fidgeted when you are sitting down?* *Have you been moving around a lot, like you can't help it?*	0	**1**	2
12.  Have you eaten less? Have you eaten more?	*Do people say you should eat more or less? (positive response to eating too much or too little is scored)*	0	1	**2**

In the past week…		Prompts	No	Sometimes	Always
13.	 Have you found it hard to get a good night's sleep?	*Have you found it hard to fall asleep at night?* *Have you woken up in the middle of the night and found it hard to get back to sleep?* *Have you woken up too early in the morning?*	0	1	**2**
14.	 Have you wished you were dead?	*Have you wished you could die?* *Have you felt you do not want to go on living?*	0	**1**	2
15.	 Have you felt like everything is your fault?	*Have you felt as if people blame you for things?* *Have you felt that things happen because of you?*	0	**1**	2
16.	 Have you felt that people are looking at you?	*Have you worried about what other people think of you?*	0	**1**	2
17.	 Have you been upset if you say you have done something wrong?	*Do you feel sad if someone disagrees with you or argues with you?* *Do you feel like crying if someone disagrees with you or argues with you?*	0	**1**	2

In the past week…		Prompts	No	Sometimes	Always
18.	 Have you felt worried?	*Have you felt nervous?* *Have you felt tense/wound up/on edge?*	0	1	**2**
19.	 Have you thought that bad things will happen to you?	*Have you felt that nothing nice ever happens to you anymore?*	0	1	**2**
20.	 Have you felt happy when something good happens?	*If nothing good has happened in the past week, ask: if someone gave you a nice present, would that make you happy?*	**2**	1	0
		Total of each column			
		Overall score			
		Signature			
		Date			

SCORING INSTRUCTIONS:

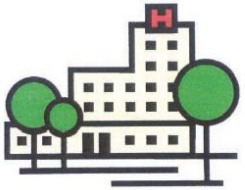
If you calculate a score of 13 or greater, please note that;

- A referral will be made for Frankie to have a consultation with the interdisciplinary team.

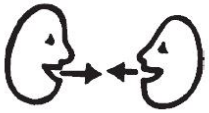
Cuthill, FM, Espie, CA, Cooper, S (2003), 'Development and Psychometric of the Glasgow Depression Scale for people with a Learning Disability', *The British Journal of Psychiatry* 182:347-353. Adapted by MK, GB, GW, DHCFT 2008.

Valuing People
Learning Disability Partnership Board in Surrey

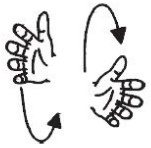
The Hospital Communication Book



Helping to make sure people who have difficulties understanding and /or communicating get an equal service in hospital



Talking clearly



Using Signing

Hearing loss

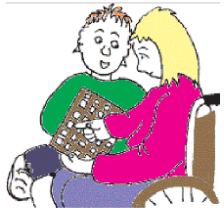
Visual Impairment

Using Pictures and Symbols

Developed on behalf of The Learning Disability Partnership Board in Surrey

Introduction and Contents

This communication book has been developed on behalf of The Learning Disability Partnership Board in Surrey.
The Partnership Board funded the Access To Acute Hospitals Project which aimed to help make sure that people with a learning disability had the right support when they used acute hospital services. The biggest barrier to people receiving the right support was found to be communication. This book aims to help hospital staff in 2 ways, and contains 2 sections.



- **Section 1** - To give acute hospital staff basic information about the communication needs people may have
- **Section 2** - To be a practical communication tool people can use to help communicate together.

Section 1 - Information Pages

These pages aim to explain some of the key communication issues for people with learning disabilities. Also to give you advice and practical tips on how to communicate clearly with people with learning disabilities, and other people who may have difficulties communicating.

Section 2 - The Picture, Symbol, Photo Toolkit

These are practical pages of pictures you can use to offer people choices, explain to people what is going to happen, and help them to communicate to you. Please read page 8 before using the pictures with people as this gives important advice on how to use them. Bear in mind not everyone will be able to recognise the meaning of all the pictures. They can help to back up what you are saying, and clue people in.

We are keen that you use this book in any way you feel can improve a person's experience whilst in hospital. You may find it useful to photocopy some of the pages to use separately. For example, the 'Nil by Mouth' page can be copied to be displayed above a person's bed.
To respect the copyright of Rebus, PCS, Makaton, Change Picturebank and Photosymbols graphics please do not reproduce these pages for any other purposes.

Many thanks to the Building Links Group from Bentley Day service for helping to choose the symbols used.

Communicating Clearly with Speech

We usually talk too fast

It takes more time for many people to process the words they hear.

This is true for many people with a learning disability.

And also true for all people when they are feeling anxious.

People don't understand all the words we use

Use everyday words wherever you can. Use short simple sentences. Have only one idea in a sentence.

You may have a much larger vocabulary than the person you are communicating with.

Use very Literal Language

When people are talking to us, we understand much of their meaning by their tone and body language.

Also, we often talk using abstract phrases rather than accurate words. Look at these phrases.

I'll give you a bell later

The doctor's doing her rounds

He can't see the wood for the trees

Some people will be less skilled at interpreting abstract language. They take a more literal meaning from words and can get confused.

Using gestures helps

Gestures and facial expressions give visual clues about the meaning of what you are saying, as well as slowing down the pace of your speech

Some people with a learning disability may only pick up key words in a sentence. This means they may only take in one, two, or three words of your sentence. **For example:**

Unfortunately, due to complications it's not possible for you to go **home** yet, we may know more **tomorrow**

home tomorrow

It's important to make sure the person has understood the main idea of your message

DON'T SHOUT - IT'S RUDE, AND DOESN'T HELP COMPREHENSION!

Supporting People with Visual Impairments

"In the UK 17,000 people with sight problems use a white cane. Another 5000 use guide dogs. There are many more who need help with their everyday living".

There are around 23,000 people in the UK who have a severe loss of both sight and hearing.

About 200,000 have less serious dual sensory loss.

Be aware how you explain things. We often talk in a very visual way. For example, when asked where the toilet is "the green door on the right" is not a helpful answer! If you are physically shown you can work the route out for yourself.

To make handwriting more legible, choose a dark felt-tip pen and write neatly using thicker strokes.
Be aware that some people have good vision in a limited area so would be ok with smaller print.

Avoid clutter! Try to minimise the risk of someone tripping over things.

It's important to take the time to tell people where the important things are like toilets, call buttons, and drinks.

People may need a bit of time before they are confident. It can help people to have a bed near a landmark in the room, say a bed at the end rather than in the middle.

Good lighting is important. A clip-on reading lamp may be useful for a person to have.

A magnifying glass may be useful to have around the ward for people who have a visual impairment to use to read.

Be aware that people have a variety of sight difficulties and a magnifier may not meet their needs.

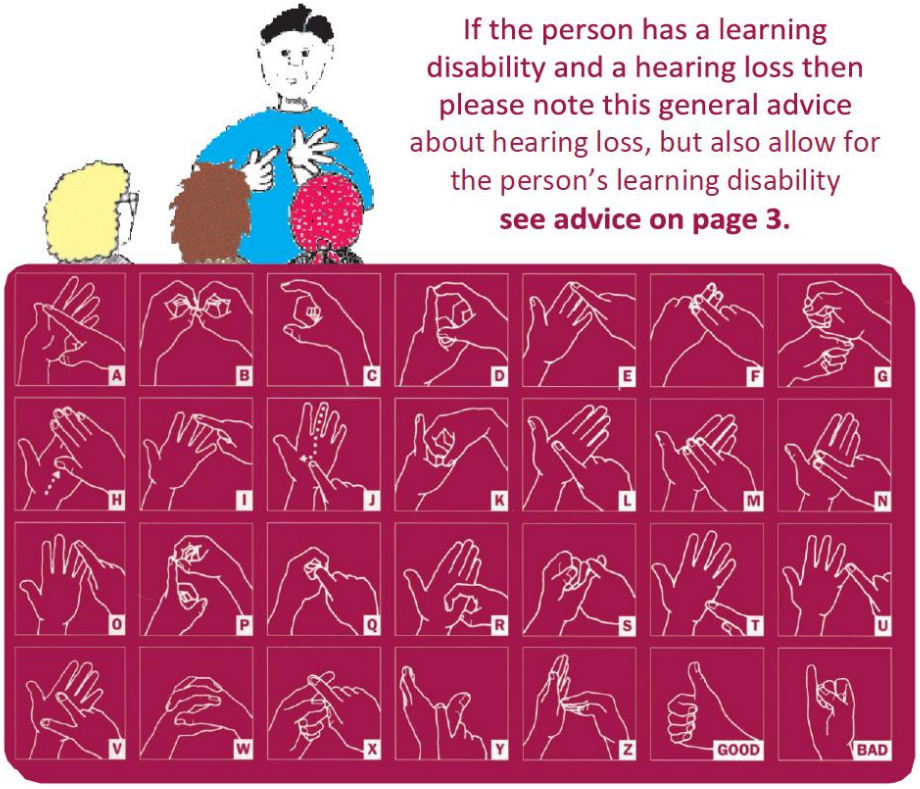
Encourage people to bring in their own magnifier.

Menus and food are a very common difficulty for people with sight problems in hospital
People will often have difficulty reading and ticking the menus as they are usually printed in very small writing. Read the menu out for someone or enlarge in on the photocopier if someone reads large print. **Meals may be left on a tray, on a table, which is out of reach near the end of the bed.** Someone who has a visual impairment may not see the meal and miss their food. It's important that staff take the time to describe to the person what is happening & where things are.

Supporting People with a Hearing Loss

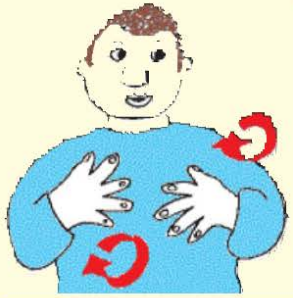
Firstly, establish how the deaf person communicates.
If they are asking you a question using their voice, it is safe to assume that they will be expecting to lip-read your reply.

- **Face the person directly**, if you look away the deaf person cannot see your lips.
- **Speak clearly at a normal pace.** Do not shout
- **Make sure you have good light on your face** so the person can see your features and read your lips easily.
- **Use whole sentences rather than one-word replies** - lip-reading is 70% guess work and many words look the same. Using sentences gives contextual clues.
- **Be patient**, if you are asked to repeat something try changing the sentence slightly, it may make it easier to understand.
- **Do not give up**, if you cannot make yourself understood then try writing it down or drawing what you mean.
- **If the person is a sign language user, they will probably still expect to have to try to lip-read your reply**. Very few hearing people sign, and deaf people are used to trying to communicate with hearing people.
- **Use gestures to help explain what you are saying**. Use gestures, point, mime to help explain what you are saying. E.g. Show a cup and ask what they want to drink. Mime driving a car to ask if you can give them a lift. Point to objects to give clues, or point to give directions. Show size and shape with your hands
- **Use facial expressions to help convey meaning**.
- **Fingerspelling -** Deaf people usually fingerspell names, places, and unusual words.



If the person has a learning disability and a hearing loss then please note this general advice about hearing loss, but also allow for the person's learning disability
see advice on page 3.

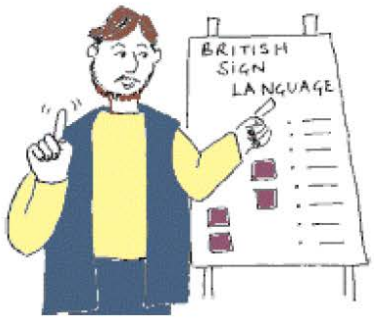
Using Signing to Support Speech



The main benefit of using signing with speech is that it makes communication visual.

People can see what you are saying as well as hearing it.

People then have more ways of understanding the message.



British Sign Language (BSL)

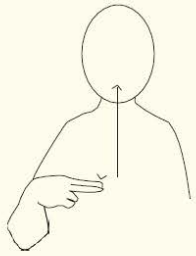
Is a full visual language used by many deaf people to communicate. Not everyone who signs uses the full BSL.

Some people use signs to support the words they are speaking. Many people who aquired a hearing loss later in life use signing in this way.

A deaf person may need the support of an interpretor. Contact your local Deaf Services Team

On the following page we have included diagrams of a few signs you may find useful on a hospital ward. These are signs for things not easily represented by a picture or symbol. It's best to use the symbols where you can.

Some signs have an arrow which shows you the direction to move your hand. The double headed arrow here means up and down.



A more specific action is explained in writing.

To explain that you are going for a drive you might say 'we are going in the car' as it keeps the language simple.

The limitation of signing is that, as with speech, when you stop signing the message is gone and relies on the person's memory.

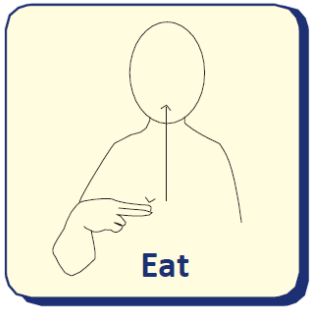
Makaton Signing

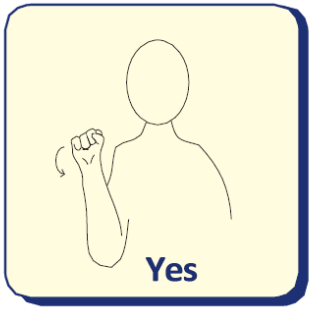
Makaton is a language programme integrating speech, manual signs, and graphic symbols. Many people with a learning disability use Makaton. Key words are signed.

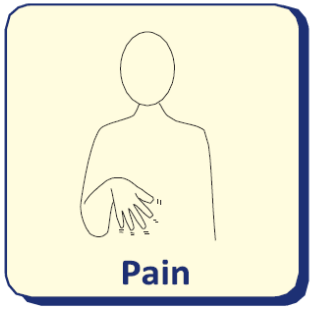
We are **going** to the **shop** in the **car**.

You only sign the bold words. Contact Makaton for advice on training. Their website is www.makaton.org

Some Useful Makaton Signs







Please Note : These signs are for illustration. People learn Makaton signing in groups supported by Makaton representatives. Please go to www.makaton.org.for more information.

Using Photos, Pictures, and Symbols

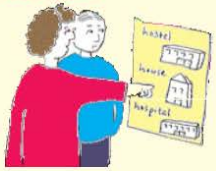
Photos, Pictures and symbols can help people to:

Understand Information
Many people with a learning disability do not read, and some people find it hard to understand when you explain things.

Pictures can help get your message across.

Tell you what they need
Some people with a learning disability do not communicate verbally. Some people 's speech can be hard to understand. **Pictures can help them get their message across**

Make choices
Many people find it hard to make choices in their head. Having pictures to look at helps.



One benefit of using pictures is that they are permanent. Once you stop speaking or signing you rely on the person's memory.

The symbols we have included on the next few pages may help you to communicate more clearly with a wide range of people.

car

Many people who have a learning disability will be familiar with some symbols

Symbols are simple line drawings that represent a word

headache

Note of Caution

A picture, photo, or symbol is only a 2-dimensional representation of an object or idea. Not all people with a learning disability will take a meaning from a picture, photo, or symbol.

Some people have a very profound disability and do not use pictures and symbols at all. Using an object, like a cup or a gown, can help to explain what you're saying.

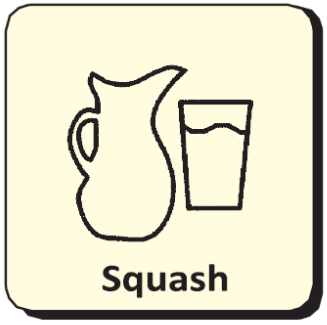
Many symbols look like what they represent - others are more abstract. If you can't easily tell what a symbol represents other people will struggle too, and will need help. Remember that many people won't be able to read the word underneath.

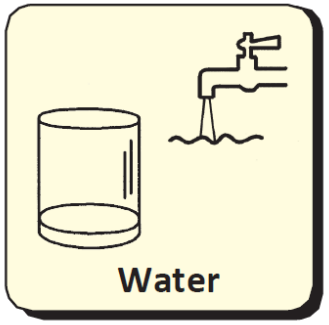
Some people will understand the symbol for car easily but may struggle with headache which is more abstract.

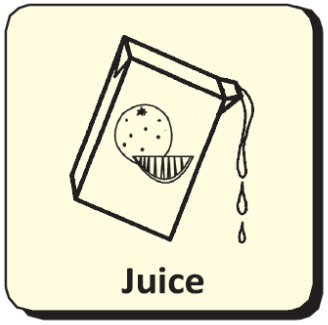
Symbols and Signing

Not everyone who uses signing will be familiar with symbols and not everyone who understands symbols will understand signing. Some people will use a mixture of both.

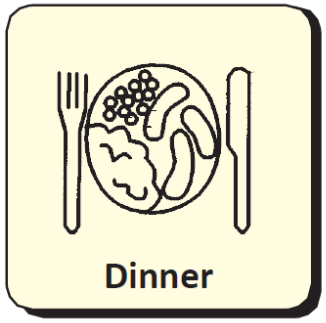
Symbols of Drinks

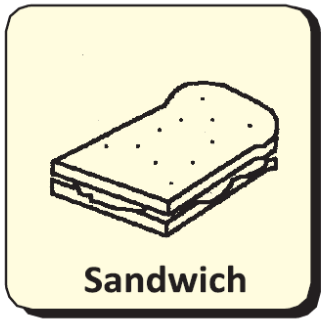


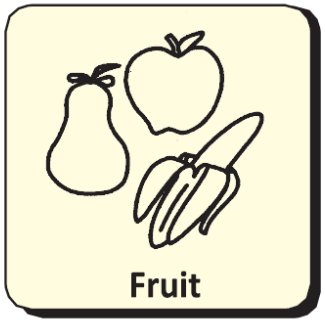


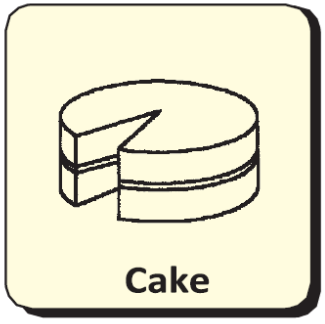


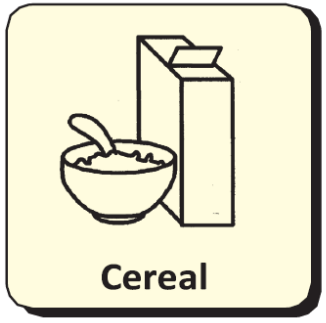
Symbols of Foods

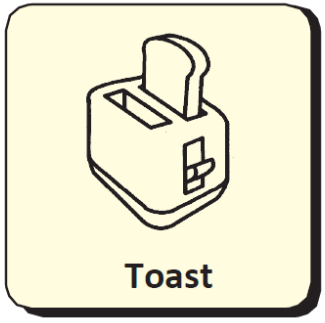


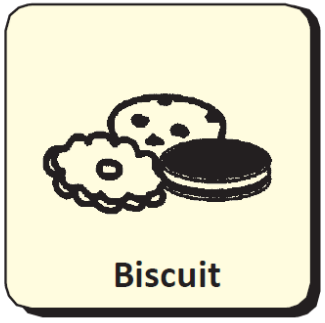


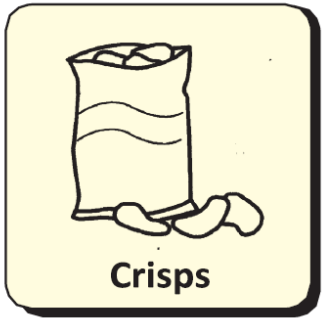




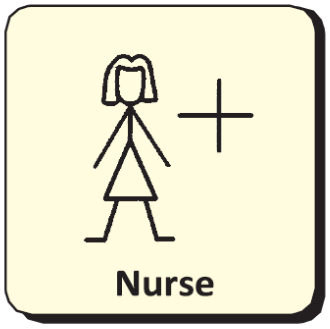


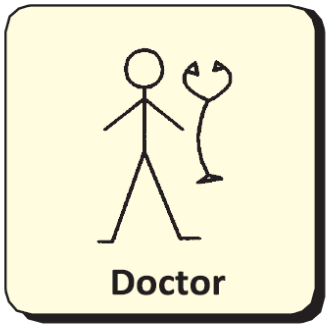


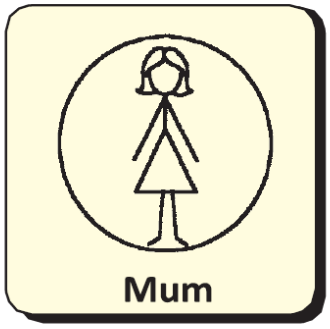


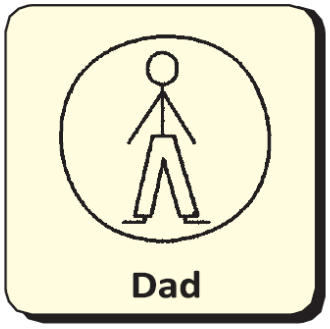


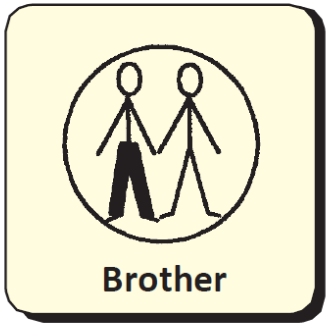
Symbols of People

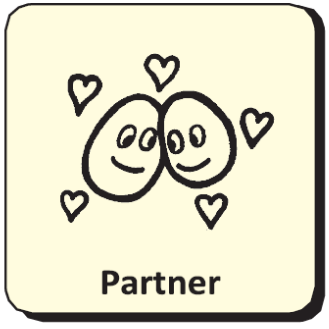


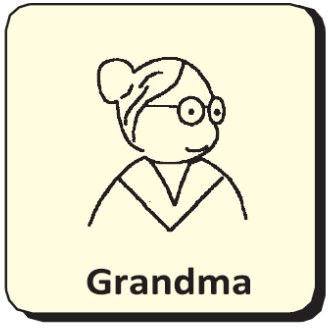


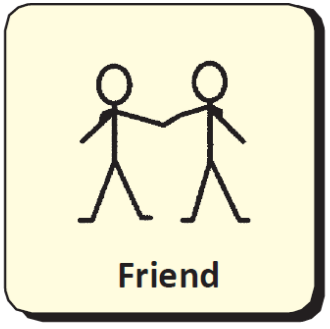








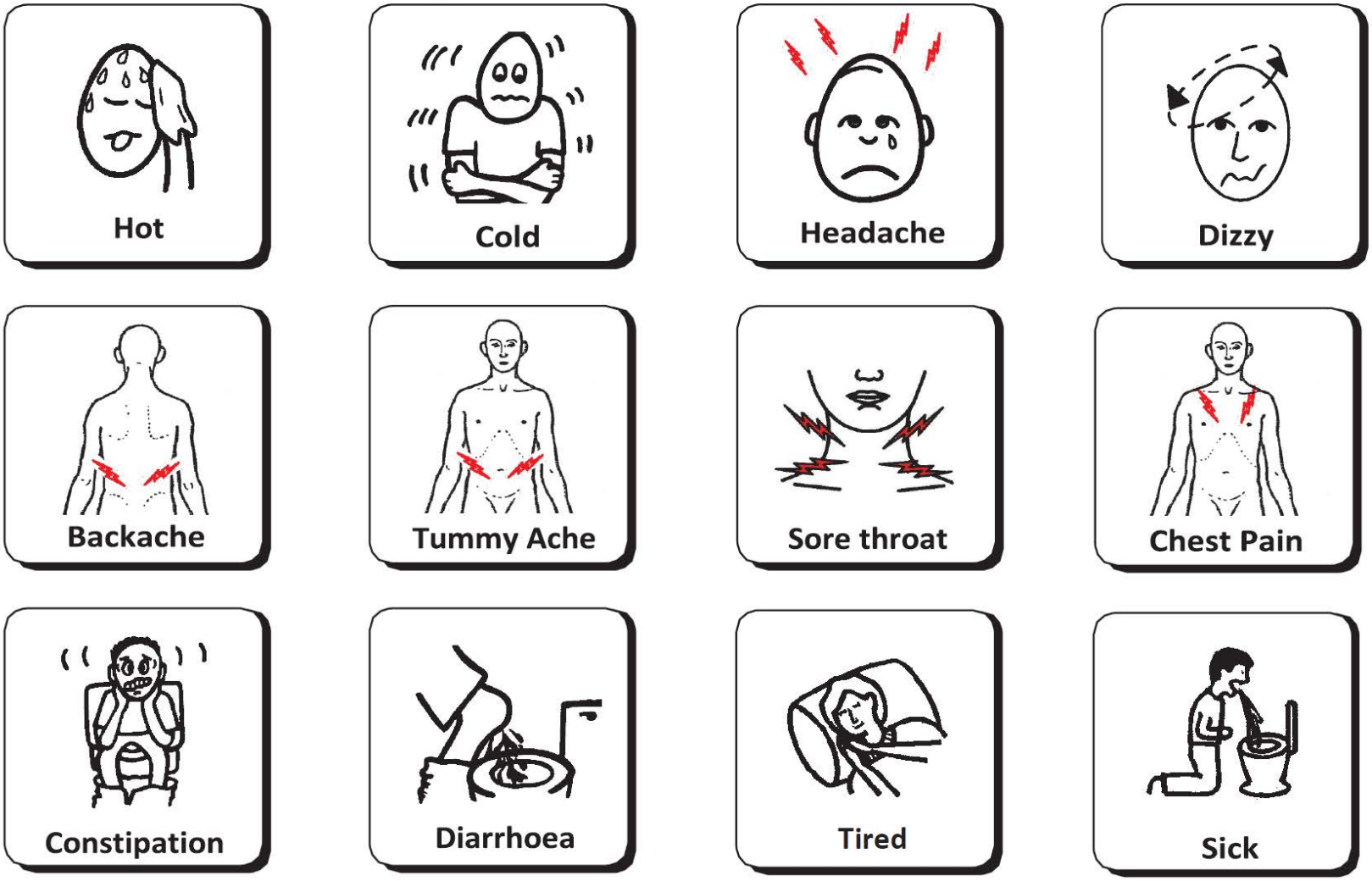




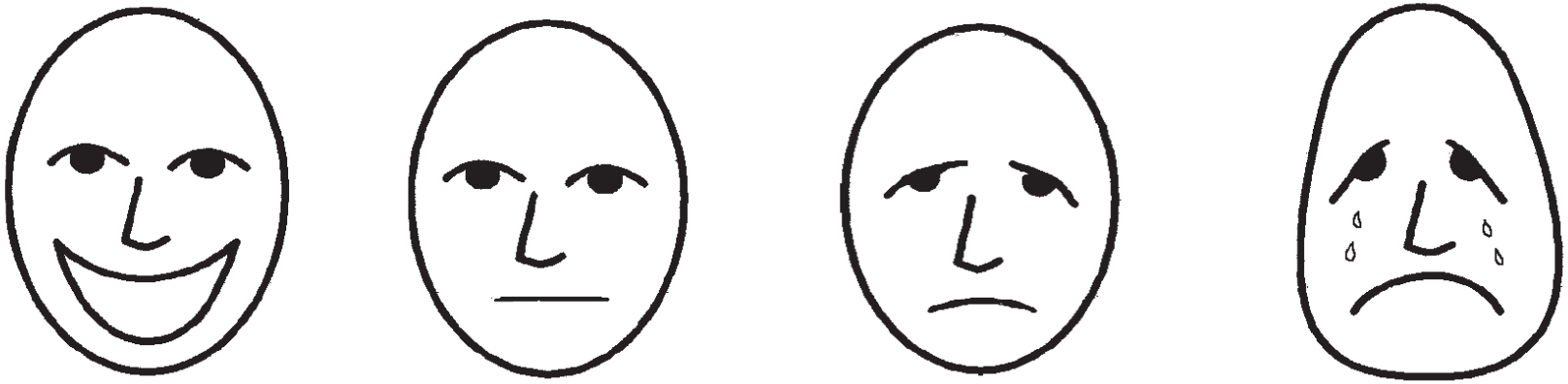
Symbols of Personal Things

Personal Care Symbols

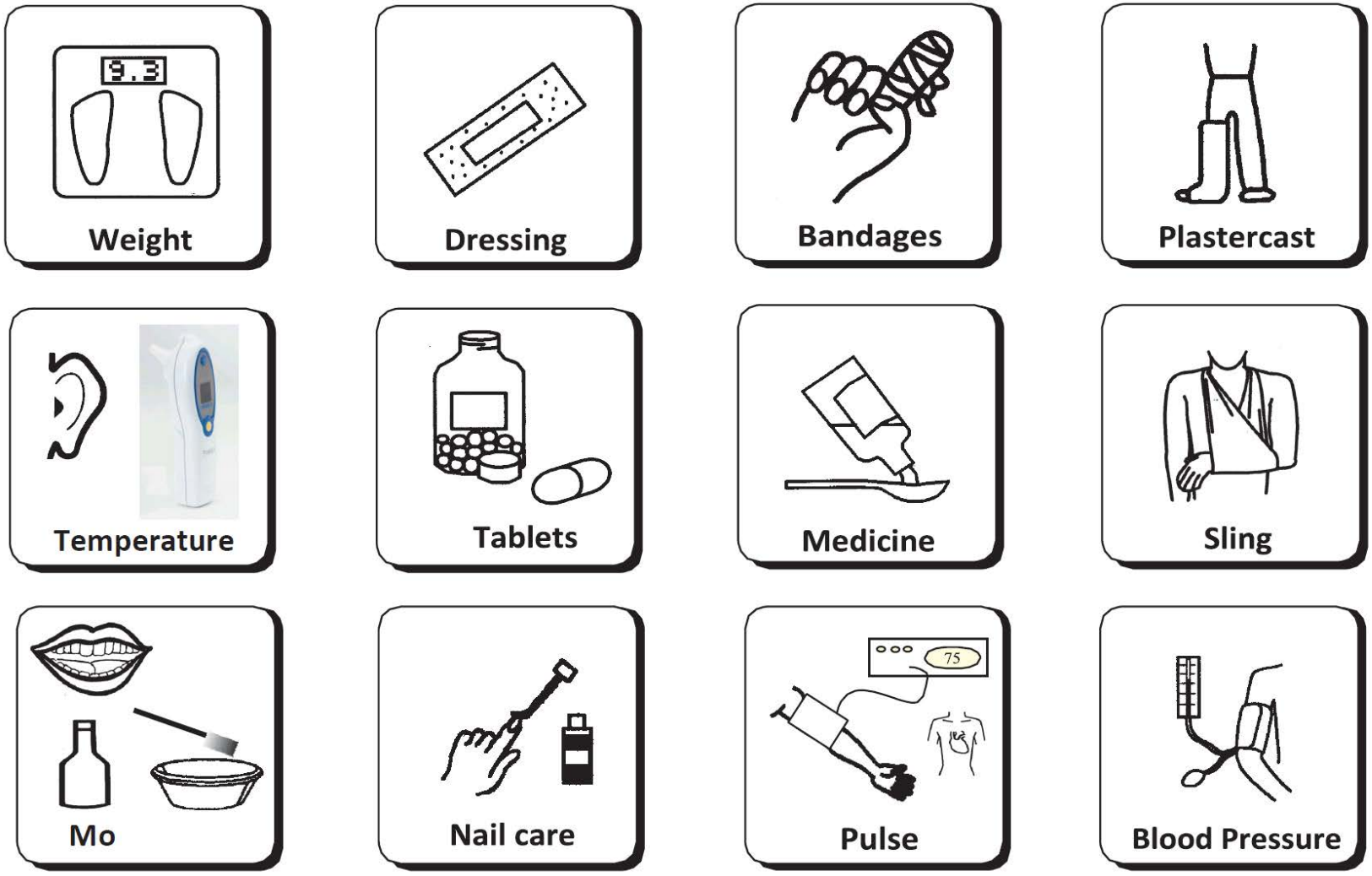
Symbols of Symptoms



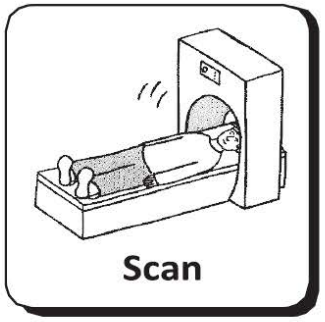
Degree of Pain

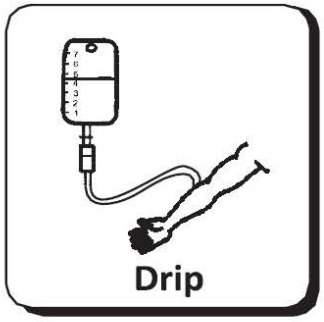


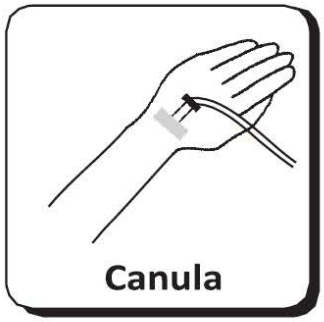
Symbols of Procedures

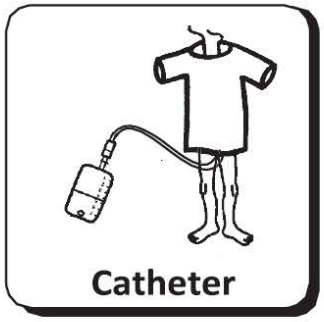


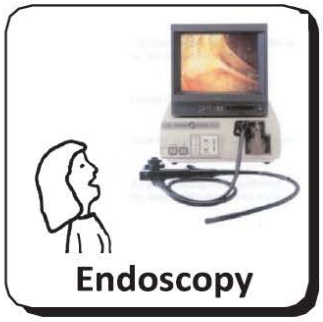
Symbols of Procedures

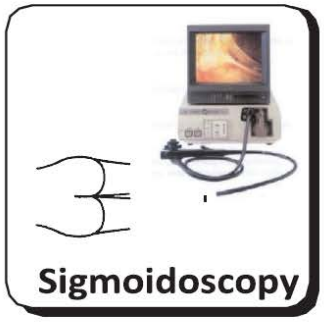


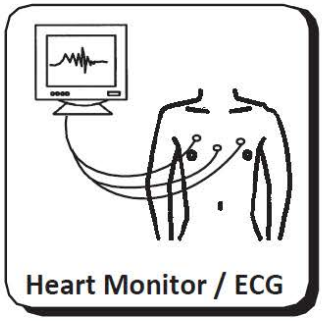


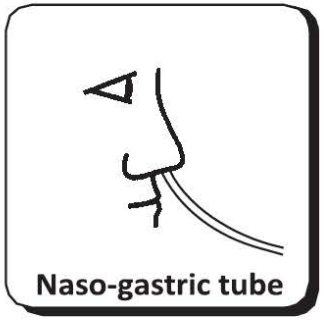


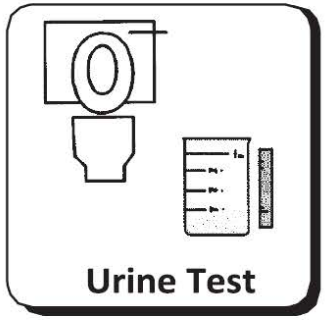




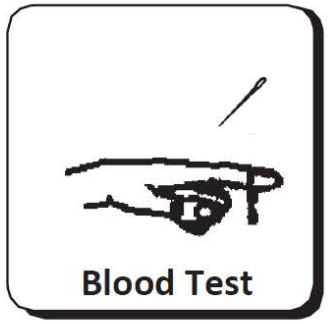


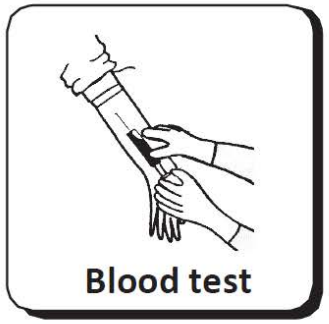


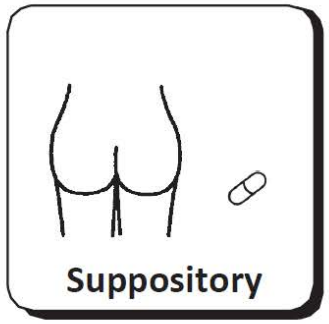


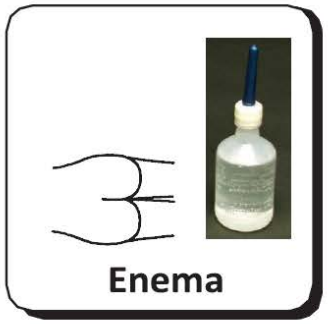


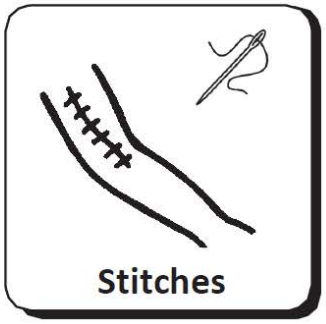
Symbols of Procedures

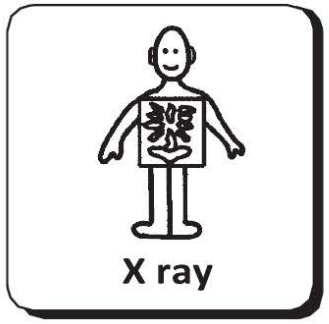


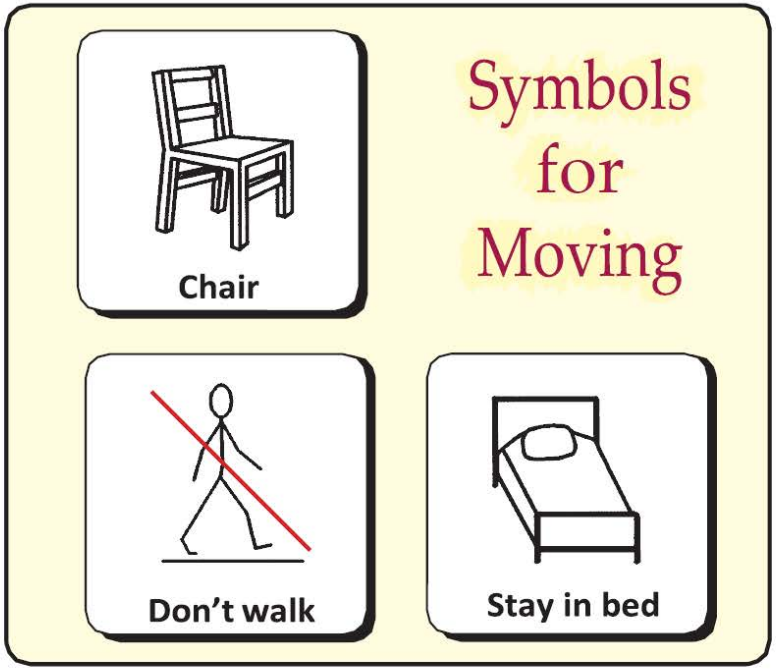


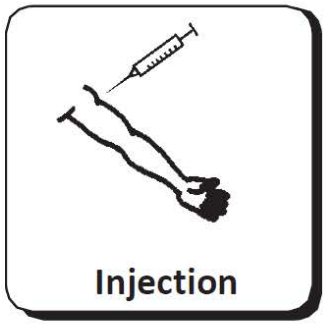


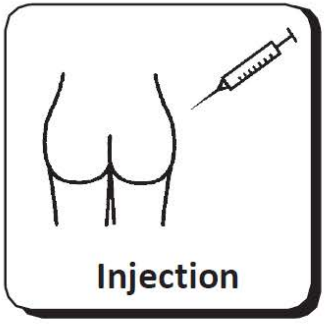




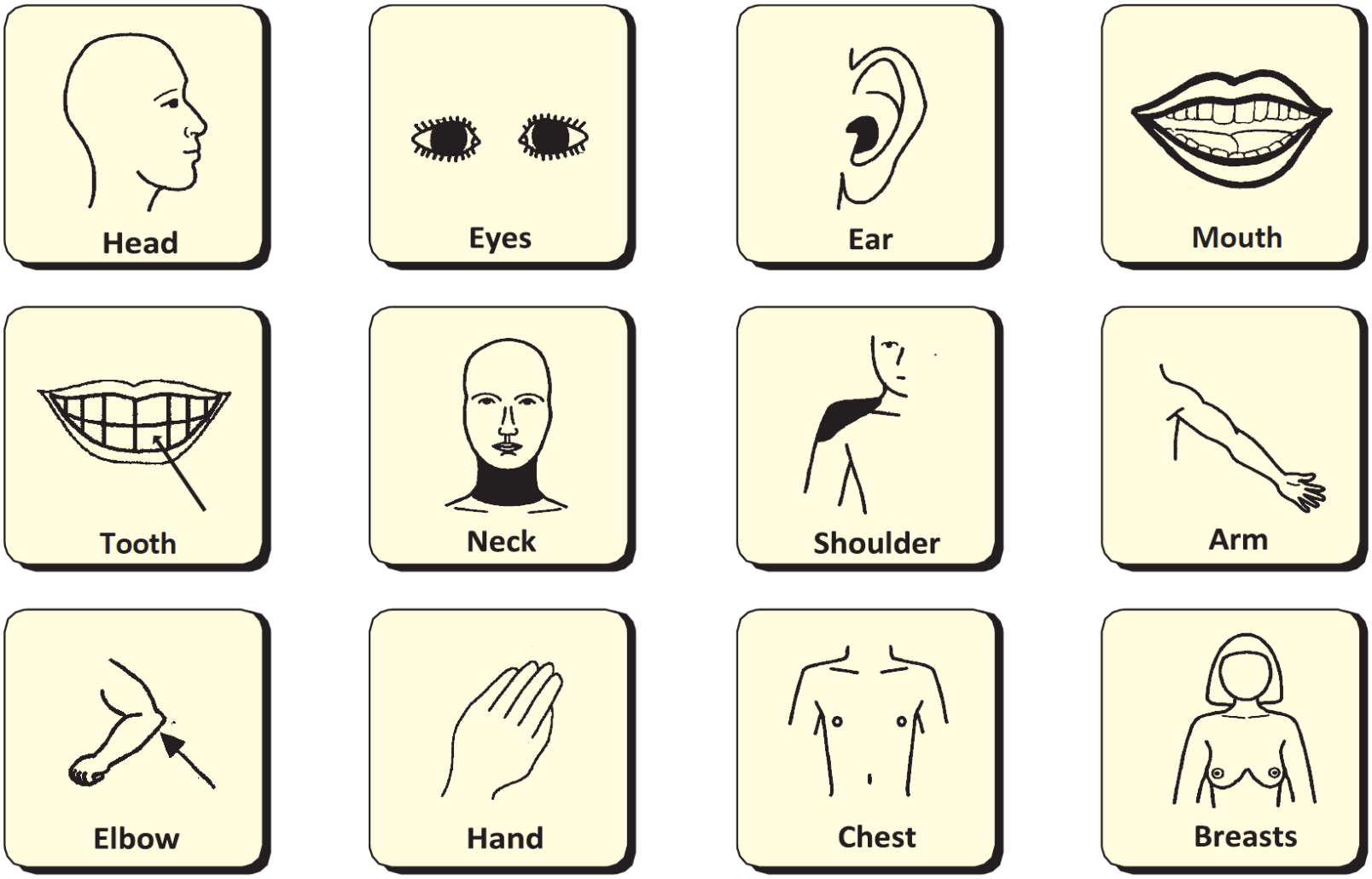




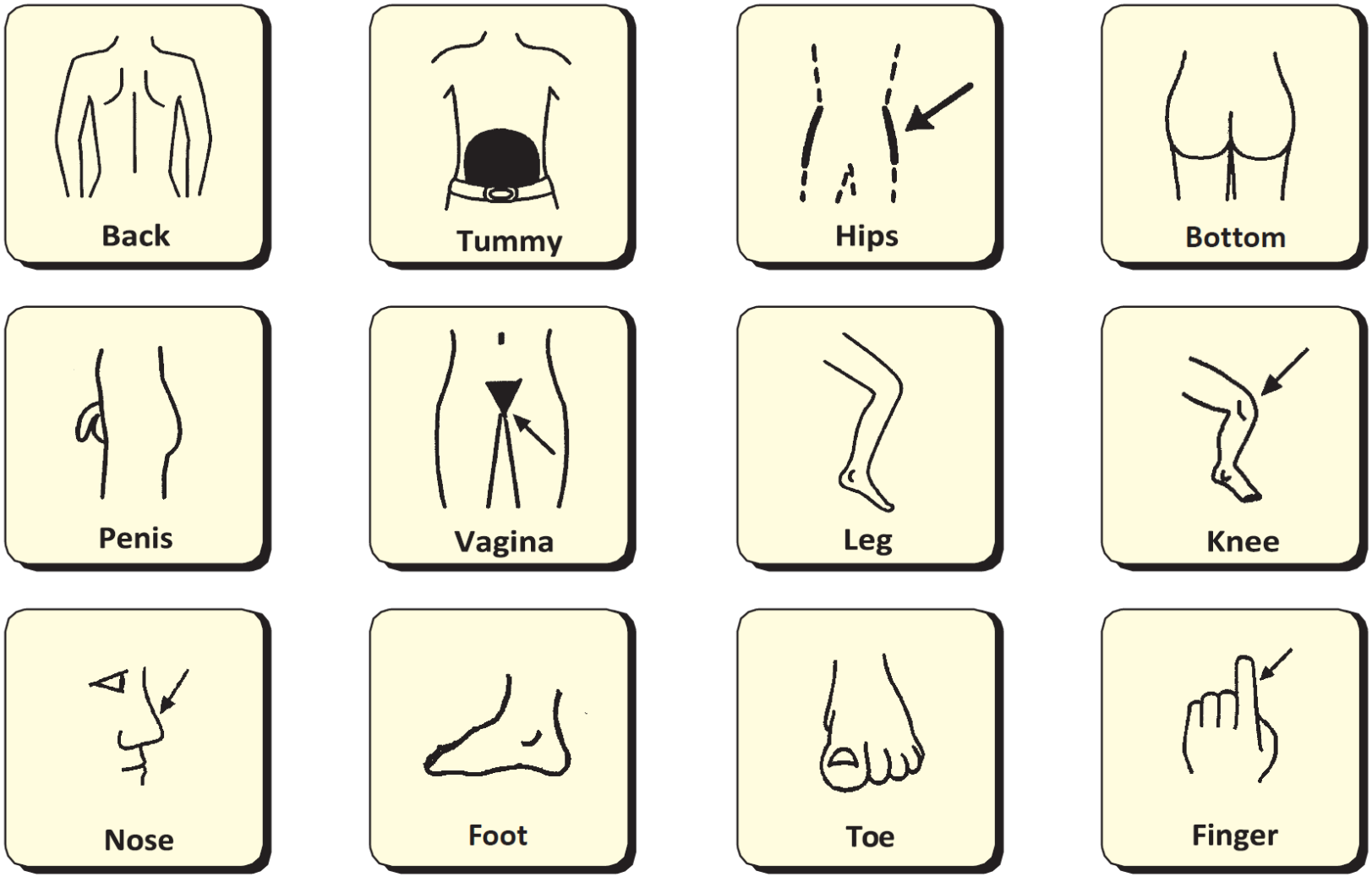




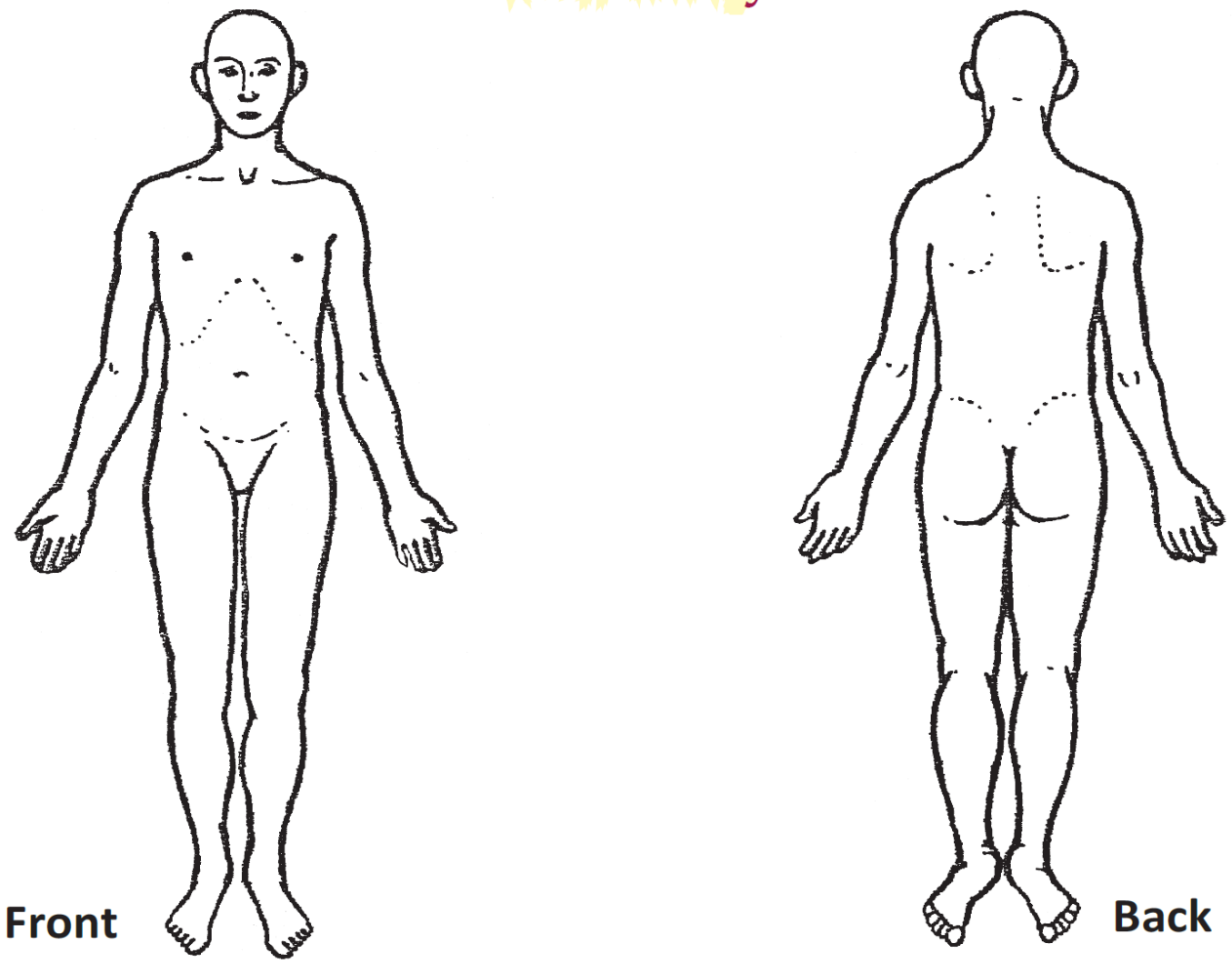
Body Parts


Head
Eyes
Ear
Mouth
Tooth
Neck
Shoulder
Arm
Elbow
Hand
Chest
Breasts

Body Parts

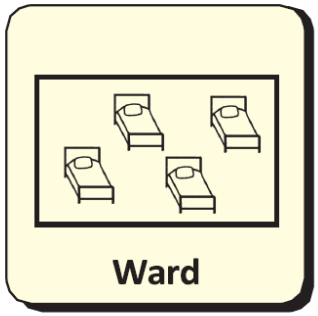

Back
Tummy
Hips
Bottom
Penis
Vagina
Leg
Knee
Nose
Foot
Toe
Finger

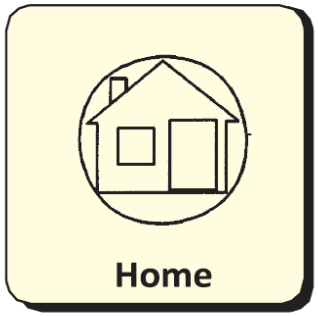
Full Body

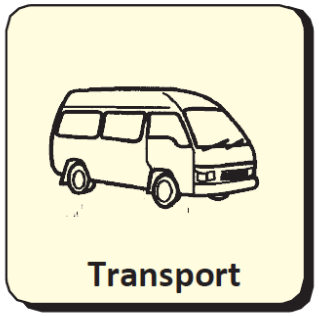


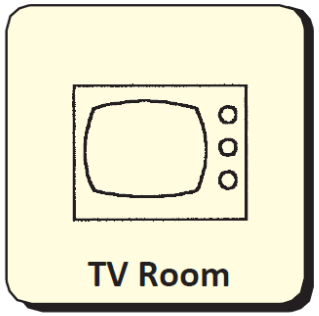
Nil By Mouth

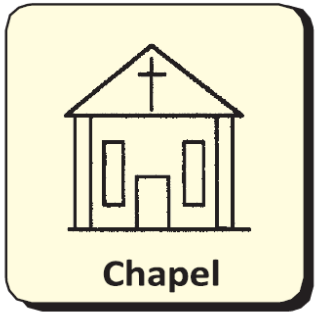
Symbols of Places

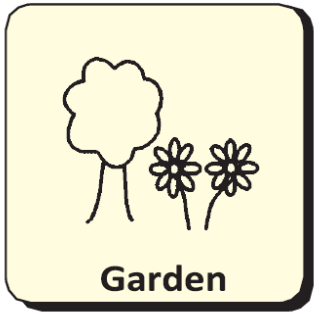




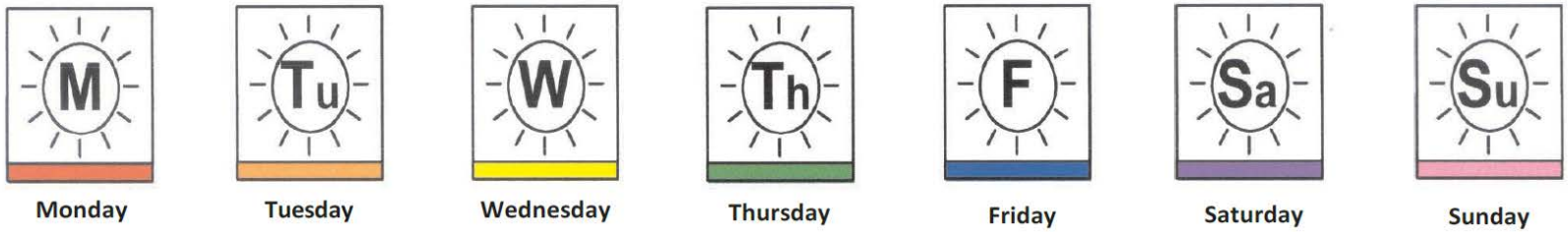


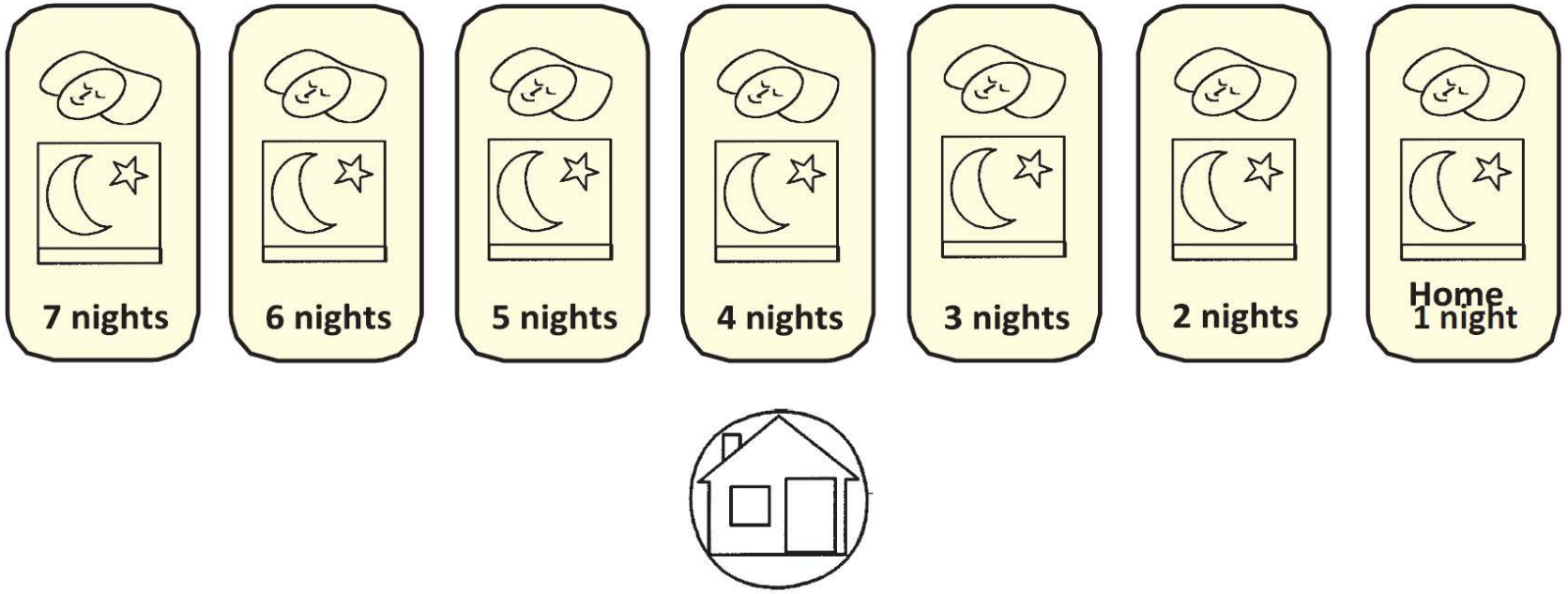






When do I go home?





Planning care
Grief and bereavement

MAHI - STM - 212 - 608

Candidate paperwork and briefing

Candidate's name: _____

This document must be completed using a BLACK PEN.

Scenario
Frankie has a mild learning disability and Williams syndrome. In the past, Frankie has had periods of depression and anxiety. Frankie can communicate easily and is capable of independent self-care. On occasions when Frankie finds communication difficult, they will use Makaton signs or cards to help the other person understand their needs. Frankie's support worker has reported to you that, over the past 2 months, Frankie has become less talkative and reluctant to go to work or to attend social group outings. Following completion of your assessment on Frankie using the Glasgow depression scale, it has been determined that Frankie is experiencing issues with grief and bereavement.

Based on your nursing assessment of Frankie, please produce an evidence-based person-centred care and support plan for <u>two relevant aspects</u> of nursing care needs, suitable for the next 48 hours.

This is a silent written station. Please ensure that you write legibly and clearly.

You have **14 minutes** to complete this station, including all the required documentation.

Complete **all** sections of the care plan.

Assume that it is TODAY and that it is **11:00.**

Planning care
Grief and bereavement

MAHI - STM - 212 - 609

Patient details: **Name:** Frankie Kapalis **Address:** Meadowlane Housing, 1 Sweet Street, Westshire, WW6 5PQ **Date of birth:** 01/01/1973
1) Problem/need
Aim(s) of care:
Re-evaluation timeframe:
Nursing interventions
NAME (Print):
Nurse signature: **Date:**

2) Problem/need
Aim(s) of care:
Re-evaluation timeframe:
Nursing interventions
NAME (Print):
Nurse signature: **Date:**

Planning care
Grief and bereavement

MAHI - STM - 212 - 611

This page is not a required element but is for use in case of error.
Problem/need
Aim(s) of care:
Re-evaluation timeframe:
Nursing interventions
NAME (Print):
Nurse signature: **Date:**

Implementing care
MAHI - STM - 212 - 612

Grief and bereavement

Candidate paperwork and briefing

Candidate name _____

This document must be completed using a BLACK PEN.

Scenario
For the past 2 months, Frankie has become gradually less talkative and more reluctant to go to work or to attend social group outings. Following completion of your assessment on Frankie using the Glasgow depression scale, it has been determined that Frankie is experiencing issues with grief and bereavement. As a result of this assessment, Frankie was referred for a consultation with the interdisciplinary team and, following the consultation, the general practitioner (GP) prescribed additional medications. **Please administer and document Frankie's 12:00 medications in a safe and professional manner.**

- Talk to the person.
- Please verbalise what you are doing and why to the examiner.
- Read out the chart and explain what you are checking/giving/not giving and why.
- Complete all the required drug administration checks.
- Complete the documentation and use the correct codes.
- The correct codes for non-administration are on the chart.
- Check and complete the last page of the chart.

You have **15 minutes** to complete this station, including all the required documentation.

Complete **all** sections of the document.

Assume that it is **TODAY** and that it is **12:00 hours.**

COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Kapalis **Forename(s):** Frankie **Date of birth:** 01/01/1973 **Hospital/NHS number:** 0004321	**Address:** Meadowlane Housing Sweet Street, Westshire WW6 5PQ
GP Name: Dr A Beattie	**Surgery address:** 1 Sugar Terrace, Westshire, WW6 5NP

Number of prescription records	**Chart** 1 ☑ 2 ☐ 3 ☐ **of** 1 ☑ 2 ☐ 3 ☐

Details of prescribers: must be completed by ALL prescribers			
NAME	**GMC/NMP Number**	**Signature**	**Contact details**
Dr Beattie	3214213	*Dr Beattie*	1 Sugar Terrace, Westshire

Details of person administering medication: must be completed by ALL administering medication			
NAME	**Initials**	**Signature**	**Base**

ALERTS: Allergies/sensitivities/adverse reaction					
Medicine(s)/Substance			**Effect(s)**		
PENICILLIN			ANAPHYLAXIS		
IF NO KNOWN ALLERGIES TICK BOX ☐					
Signature:	*Dr Beattie*	**Bleep Number:**	874	**Date:**	TODAY
Allergy status MUST be completed and SIGNED by a prescriber/pharmacist/nurse BEFORE any medicines are administered.					

Medication risk factors			
Pregnancy ☐	**Renal impairment ☐**	**Impaired oral access ☐**	**Diabetes ☐**
Other high-risk conditions ☐ – specify		**Patient self-medicating ☐**	

COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Kapalis **Forename(s):** Frankie **Date of birth:** 01/01/1973 **Hospital/NHS number:** 0004321	**Address:** Meadowlane Housing Sweet Street, Westshire WW6 5PQ
GP Name: Dr A Beattie	**Surgery address:** 1 Sugar Terrace, Westshire, WW6 5NP

Information for prescribers:	**Medicine non-administration/self-administration:**	
Write in BLOCK CAPITALS using black or blue ink.	If a dose is omitted for any reason, the nurse should enter the relevant code on the administration record and sign the entry.	
Sign and date and include bleep number.		
Record detail(s) of any allergies.	1. Medicine unavailable – INFORM DOCTOR OR PHARMACIST	2.Patient not present at time of administration
Sign and date allergies box. Tick box if no allergies know.	3.Self-administration	4.Unable to administer – INFORM DOCTOR (alternative route required?)
Different doses of the same medication must be prescribed on different lines.	5.Stat dose given	6.Prescription incorrect/unclear
Cancel by putting a line across the prescription and sign and date.	7.Patient refused	8. Nil by mouth (on doctor's instruction only)
Indicate the start and finish date.	9. Low pulse and/or low blood pressure	10. Other – state reason

COMMUNITY PATIENT-SPECIFIC DIRECTION

Check allergies/sensitivities and patient identity

Date	Drug	Dose	Route	Time	Frequency	End date	Prescriber name & date	Given by: Sign date & time	Pharmacy check
TODAY	LACTULOSE	15 ml	PO	12:00	BD		Dr Beattie TODAY		*K. Davis*
TODAY	LACTULOSE	15 ml	PO	22:00	BD		Dr Beattie TODAY		*K. Davis*
TODAY	RAMIPRIL	10 mg	PO	12:00	OD	+4 days	Dr Beattie TODAY		*K. Davis*
TODAY	FLUOXITINE	20 mg	PO	12:00	OD	+4 days	Dr Beattie TODAY		*K. Davis*
TODAY	ZOPICLONE	3.75 mg	PO	22:00	OD	+4 days	Dr Bothwell TODAY		*K. Davis*

MAHI - STM - 212 - 615

COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Kapalis **Forename(s):** Frankie **Date of birth:** 01/01/1973 **Hospital/NHS number:** 0004321	**Address:** Meadowlane Housing Sweet Street, Westshire WW6 5PQ
GP Name: Dr A Beattie	**Surgery address:** 1 Sugar Terrace, Westshire, WW6 5NP

OMITTED DOSES OF MEDICINE AND DELAYED DOSES								
Check allergies/sensitivities and patient identity								
Date	**Drug**	**Dose**	**Route**	**Instructions**	**Time given**	**Reason for omission or delay >2 hours**	**Signature**	**Pharmacy check**

Evaluating care Grief and bereavement

MAHI - STM - 212 - 616

Candidate paperwork and briefing

Candidate name: _____

- **This document must be completed using a BLUE PEN.**
- **At this station, you should have access to your assessment notes (but not the assessment overview), and the planning and implementation documentation. If not, please alert the examiner.**

Scenario
Frankie was referred for an assessment to you as a registered nurse for people who have learning disabilities working in a purpose-built residential facility. Following assessment, the GP prescribed additional medications for depression. Despite taking the prescribed medication, Frankie has not shown any sign of improvement and continues to deteriorate. Frankie is now being referred back to the GP.

Using the situation, background, assessment and recommendation (SBAR) tool, please make notes regarding your patient and use them to hand information over verbally to the GP (the examiner).

This is a verbally assessed station. You will have the opportunity to make notes to support your answer.

You have **8 minutes** in total to make notes on the SBAR form (this is not assessed) and to complete the verbal handover to the examiner. You will be informed when there are **2 minutes** remaining.

Assume that it is **TODAY** and that it is **14:00 hours**.

Evaluating care Grief and bereavement

MAHI - STM - 212 - 617

Candidate notes

This documentation is for your use and is not marked by the examiners.

Patient details: Name: Frankie Kapalis NHS number: 0004321 Address: Meadowlane Housing, 1 Sweet Street, Westshire, WW6 5PQ Date of birth: 01/01/1973
Situation:
Background:
Assessment:
Recommendation:

Mock clinical skills

The mock clinical skills assessment below is made up of two paired stations. The instructions and available resources are provided for each station, along with the specific timing.

Station	You will be given the following resources
Female urinary catheter insertion – 8 minutes You will insert the urinary catheter according to current evidence-based practice.	• Overview documentation (page 57)
Stoma bag change – 8 minutes You will change a stoma bag according to current evidence-based practice.	• Overview documentation (page 58)

On the following pages, we have outlined the expected standard of clinical performance and criteria. These marking matrices are there to guide you on the level of knowledge, skills and attitude we expect you to demonstrate at each station.

Marking criteria – Female urinary catheter insertion
Explains the procedure to the patient and gains consent.
Assembles equipment required and checks equipment is sterile. Takes the equipment to the person's bedside on trolley.
Ensures that the patient is in a supine position with knees bent, hips flexed and feet apart.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
Dons a disposable plastic apron.
Using an aseptic non-touch technique, opens the sterile pack and places the rest of the sterile equipment onto the sterile field.
Dons sterile gloves. Places a sterile towel under the patient's buttocks.
Uses non-dominant hand to separate labia and uses gauze swabs soaked in sodium chloride 0.9% to clean the urethral orifice using downward strokes, being careful not to touch surrounding skin.
Applies anaesthetic lubrication to the meatus and gently inserts nozzle of anaesthetic syringe into urethra, and then instils gel into the urethra.
Places the catheter, in the sterile receiver, between the patient's legs and attaches the drainage bag.
Uses dominant hand to introduce the tip of the catheter into the urethral orifice in an upward and backward direction. Advances the catheter until urine is draining and up to the bifurcation point (junction of the catheter/balloon inflation tubing).
Cautiously inflates the catheter balloon with prefilled syringe containing water for injection, noting any pain or discomfort.
Gently withdraws the catheter slightly, until resistance is felt.
Assists in cleaning the patient and disposing of equipment.
Supports the catheter using a specially designed support (such as Simpla G-Strap), ensuring that the catheter lumen is not occluded by the fixation device. Ensures drainage bag is supported and secure, with the drainage port away from the floor.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
States would document the reasons for catheterisation, time and date of catheterisation, catheter type, length and size, batch number and manufacturer.
States would measure and record urine output.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Marking criteria – Stoma bag change
Introduces self. Explains procedure to the person and gains consent.
Ensures that the patient is in a comfortable and suitable position where they are able to watch the procedure.
Checks all equipment required for the procedure, including expiry dates: new colostomy bag, a disposable bag, gauze, scissors and a receptacle.
Cleans hands with alcohol rub or washes with soap and water and dries with paper towels according to WHO guidelines.
Dons a disposable plastic apron and non-sterile gloves.
Places a small protective disposable pad below the stoma area to protect patient's clothes from accidental spillage.
Removes the stoma bag slowly using adhesive remover. Peels the adhesive off the skin while using the opposite hand to apply pressure on the surrounding skin.
Folds the removed stoma bag to prevent spillage before placing into a disposable bag.
Removes any visible faeces or mucus from the stoma with a piece of gauze soaked in warm tap water.
Examines the stoma site and peristomal skin for soreness, ulceration, signs of infection and other unusual signs such as unusual site colour (black or pale), foul odour or discharge.
Washes the skin around the stoma (peristomal area) with gauze soaked in warm tap water.
Gently dries the peristomal skin with dry gauze, ensuring that the area is thoroughly dry.
Measures the stoma site, cuts a hole in the adhesive flange of the new bag, aiming for 3mm larger than the site.
Applies the clean appliance, using the flat of hand to gently press to ensure it adheres in all areas.
Disposes of equipment including apron and gloves appropriately – verbalisation accepted.
Cleans hands with alcohol rub or washes with soap and water and dries with paper towels, according to WHO guidelines.
States would document the change of stoma bag in nursing notes and would report any abnormalities to the stoma nurse and/or surgical team.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Overview
Female urinary catheter insertion

Scenario
You are working on the surgical admissions unit. You are caring for Catherine Higgins, who has been diagnosed with obstruction of the bowel, and the doctor has requested the insertion of a urinary catheter for fluid monitoring. **Please insert the urinary catheter according to current evidence-based practice**. All identification checks have been completed and the patient has no known allergies. The trolley has been cleaned. The patient is lying in bed, with their lower clothing removed, is covered with a towel and has an absorbent pad underneath them.

All the equipment you need is provided.

You are not required to document anything during this skills station.

You have **8 minutes** to complete this station.

Overview
Stoma bag change

Scenario
You are working on a post-operative surgical ward. You are caring for Kendi Abara, who has undergone a right hemicolectomy and colostomy formation. They are 3 days post surgery, the one-piece stoma bag needs to be replaced, and Kendi is currently not well enough to do this themselves. **Please change the patient's stoma bag according to current evidence-based practice.** All identification checks have been completed, and the patient has no known allergies. The trolley has already been cleaned prior to the procedure.

Please change the patient's stoma bag and speak to your patient throughout the procedure.

All the equipment you need is provided.

You are not required to document anything during this skill station, but if necessary, verbalise to the examiner what would be documented or reported.

You have **8 minutes** to complete this station.

Assume that it is TODAY and that it is **12:00 hours**.

Mock silent stations

You will also be required to undertake two new silent stations. In each OSCE, one station will specifically assess professional issues associated with professional accountability and related skills around communication (called the professional values and behaviours station, or the PV station). One station will also specifically assess your critical appraisal of research and evidence and associated decision-making (called the evidence-based practice station, or EBP station).

The instructions and available resources are provided for each station, along with the specific timing.

Station	You will be given the following resources
Professional values and behaviours **Drug misuse – 10 minutes** You will read the scenario and summarise the actions that you would take, considering the professional, ethical and legal implications of this situation.	• Overview documentation (pages 61–62)
Evidence-based practice **Sleep in intensive care – 10 minutes** You will read the scenario and summary of the research, then write up how you would apply the findings to the scenario.	• Overview documentation (pages 63–64)

On the following pages, we have outlined the expected standards of clinical performance and criteria. These marking matrices are there to guide you on the level of knowledge, skills and attitude we expect you to demonstrate at each station.

Mock silent stations

Professional values & behaviours marking criteria – Drug misuse
Recognises that taking NHS/hospital property for personal use or gain, including medication, is prohibited.
Recognises professional duty to report any concerns that may result in compromising the safety of patients in their care or the public, and that failure to report concerns may bring their own fitness to practise into question and place own registration at risk.
Raises concern with manager at the earliest opportunity, verbally or in writing. Recognises the need to be clear, honest and objective about the reasons for concern, reflecting duty of candour.
Recognises that the manager may wish an incident report to be completed, recording the events, steps taken to deal with the matter including the date, and with whom the concern was raised.
Takes into consideration own responsibility for the safety of the colleague, and considers the effects of codeine on their ability to work and drive home.
Considers that the colleague may need a medical review for their headache or may need support in dealing with a substance misuse problem.
Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety and promote professionalism and trust.
Handwriting is clear and legible.

Evidence-based practice marking criteria – Sleep in intensive care
Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
Writes clearly and legibly.
Informs Mrs Green that it is very common for patients to experience sleep deprivation in the Intensive Care Unit (ICU).
Explains that the disturbances in sleep may continue for several months after discharge.
Explains that the nature of a patient's illness, previous sleep experience and severity of illness may influence sleep pattern.
Informs Mrs Green that noise, light, pain, anxiety, nursing interventions, diagnostic tests, medications and non-invasive ventilation may have impacted her sleep.
Discusses with Mrs Green any feelings of pain or anxiety that may have impacted her sleep. Invite Mrs Green back in 2 or 3 months' time for follow-up support.

Mock silent stations

Professional values and behaviours: Drug misuse

Overview

Scenario
You are just about to commence the lunchtime drug round. You enter the clinical room and one of your nursing colleagues is in the room already. You witness the nurse take a 30 milligram codeine phosphate tablet from the drug cupboard. She puts it in her mouth and swallows it in front of you. You ask if she is okay, and she tells you that she needs the tablet for a headache. As far as you are aware, this is an isolated incident.

Using your knowledge of NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates', consider the professional, ethical and legal implications of this situation.

Please summarise the actions you would take in a number of bullet points.

This is a silent written station. Please write clearly and legibly.

You have 10 minutes to complete this station.

Mock silent stations

Professional values and behaviours: Drug misuse

Candidate documentation

Candidate name:_____

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

Mock silent stations

Evidence-based practice: Sleep in intensive care

Overview

Read the scenario and the summary of the research below.

Please identify the main points from the summary and apply the findings to the scenario below.

This is a silent written station. Please write clearly and legibly.

You have 10 minutes to complete this task.

Scenario
You have been working on an Intensive Care Unit (ICU) for the past 6 months. Most of your patients are given medication to induce a coma while they receive care and treatment. As patients improve and are weaned off the sedation, you notice that it is common for patients to report that they have not slept for the whole time they have been on the unit. The patient you are looking after today, Mrs Green, reports this same lack of sleep. She asks if is this common and, if so, why it might be.
Article summary
A systematic review in a well-regarded peer-reviewed journal investigated the sleep disturbances in patients in intensive care units. The review found that: • Study A, a large-scale study, showed that 60% of patients discharged from ICU reported sleep disorders and deprivations. • Study B, a smaller study, found similar results, with 51% of patients experiencing dreams and nightmares, and 14% reporting nightmares negatively impacting their quality of life 6 months after discharge from ICU. The study recommended that patients return for a follow-up support appointment 2 to 3 months after leaving ICU. • Study C, a quantitative study, concluded that the inability to obtain physiological sleep depends on the patient's illness, previous sleep experience and the varying severity of their illness. • Patients in Study C reported a number of sleep-disturbing factors impacting their sleep, including: noise, light, pain, anxiety, nursing interventions, diagnostic tests, medications and non-invasive ventilation. The review concluded that sleep disorders in ICU were common and that there were multiple influencing factors causing sleep deprivation.

Mock silent stations

Evidence-based practice: Sleep in intensive care

Candidate documentation

Candidate name: _____

What is the relevance of the findings of this research for Mrs Green, and what advice would you give her?

Give your responses here as bullet points:

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

……

Unit 109 Albert Mill
10 Hulme Hall Road
Castlefield
Manchester
M15 4LY

www.alphaplus.co.uk

+44 (0) 161 249 9249

Exhibit 15

MAHI - STM - 212 - 630

Nursing & Midwifery Council

Return to practice standards

Published 20 May 2019
Updated December 2019

Return to practice standards

Our Registration and revalidation standards set out the minimum number of practice hours that a nurse, midwife or nursing associate must undertake to remain on, or rejoin, our register. People unable to meet these practice hours requirements who wish to remain on, or rejoin, our register must successfully complete an NMC approved return to practice programme ,or, pass the NMC test of competence.

1. Readmission standards[1]

In order to be eligible for readmission to the register you must have:

- completed 750 hours of practice in the previous five years, or
- completed 450 hours of practice in the previous three years, or
- completed the equivalent number of registered practice hours while registered with the relevant regulator overseas, or
- successfully completed a UK approved pre-registration qualification within five years, or
- successfully completed an NMC approved return to practice programme within five years, or
- passed the NMC test of competence within five years.

2. Revalidation standards

For those who have not completed minimum practice hours

If you have practised for fewer than the required number of hours in the three year period since your registration was last renewed (or you joined the register) then before the date of your application for renewal of registration you must:

- successfully complete an NMC approved return to practice programme, or
- pass the NMC test of competence.

[1] These standards are set under Article 19(3) of the Nursing and Midwifery Order 2001 (the Order) Rule 3(4) of the Education, Registration and Registration Appeals Rules 2004.

Practice hours

Registration	Minimum total practice hours required
Nurse	450
Midwife	450
Nurse and SCHPN (Nurse/SCPHN)	450
Midwife and SCHPN (Midwife/SCPHN)	450
Nurse and midwife (including Nurse/SCHPN and Midwife/SCHPN	900 (to include 450 hours for nursing, 450 hours for midwifery)
Nursing associate	450
Nursing associate and nurse*	900 (to include 450 hours for nursing, 450 hours for nursing)
Nursing associate and midwife*	900 (to include 450 hours for nursing associate and 450 hours for midwifery)

*Triple registration for nurse, midwife and nursing associate is also possible; this would require 1,350 practice hours.

The role of the Nursing and Midwifery Council

What we do

We're the independent regulator for nurses, midwives and nursing associates. We hold a register of around 700,000 nurses, midwives and nursing associates who can practise in the UK.

Better and safer care for people is at the heart of what we do, supporting the healthcare professionals on our register to deliver the highest standards of care.

We make sure nurses, midwives and nursing associates have the skills they need to care for people safely, with integrity, expertise, respect and compassion, from the moment they step into their first job.

Learning does not stop the day nurses, midwives and nursing associates qualify. To promote safety and public trust, we require professionals to demonstrate throughout their career that they are committed to learning and developing to keep their skills up to date and improve as practitioners.

We want to encourage openness and learning among healthcare professions to improve care and keep the public safe. On the occasions when something goes wrong and people are at risk, we can step in to investigate and take action, giving patients and families a voice as we do so.

These standards were approved by Council at their meeting on 27 March 2019.

Nursing & Midwifery Council

The Code

Professional standards of practice and behaviour for nurses, midwives and nursing associates

prioritise people

practise effectively

preserve safety

promote professionalism and trust

About us

The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, or a nursing associate in England. We take action if concerns are raised about whether a nurse, midwife or nursing associate is fit to practise.

It is against the law to claim to be, or to practise as, a nurse or midwife in the UK, or as a nursing associate in England, if you are not on the relevant part of our register.

It is also a criminal offence for anyone who, with intent to deceive, causes or permits someone else to falsely represent them as being on the register, or makes a false representation about them being on the NMC register.

Publication date: 29 January 2015 **Effective from:** 31 March 2015
Updated to reflect the regulation of nursing associates: 10 October 2018

A note on this version of the Code

All regulators review their Codes from time to time to make sure they continue to reflect public expectations. This new version of the Code is substantially similar to the 2015 version, but it has been updated to reflect our new responsibilities for the regulation of nursing associates. In joining the register, nursing associates will uphold the Code.

The current versions of our Code, standards and guidance can always be found on our website. Those on our register should make sure they are using the most up to date version of the Code.

For more information about the Code, please visit:
www.nmc.org.uk/code

Introduction

The Code contains the professional standards that registered nurses, midwives and nursing associates[1] must uphold. Nurses, midwives and nursing associates must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing[2] and midwifery practice in other roles, such as leadership, education, or research. The values and principles set out in the Code can be applied in a range of different practice settings, but they are not negotiable or discretionary.

Our role is to set the standards in the Code, but these are not just our standards. They are the standards that patients and members of the public tell us they expect from health professionals. They are the standards shown every day by those on our register.

When joining our register, and then renewing their registration, nurses, midwives and nursing associates commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. We can take action if those on our register fail to uphold the Code. In serious cases, this can include removing them from the register.

1 Anyone practising as a registered nurse or midwife in the UK, or a nursing associate in England, has to be registered with us. The nursing associate role is being used only in England.

2 We have used the word 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.

The Code sets out common standards of conduct and behaviour for those on our register. This provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care.

The professions we regulate have different knowledge and skills, set out in three distinct standards of proficiency. They can work in diverse contexts and have different levels of autonomy and responsibility. However, all of the professions we regulate exercise professional judgement and are accountable for their work.

Nurses, midwives and nursing associates uphold the Code within the limits of their competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the standards in the Code within the contribution they make to overall care. The professional commitment to work within one's competence is a key underpinning principle of the Code (see section 13) which, given the significance of its impact on public protection, should be upheld at all times.

In addition, nurses, midwives and nursing associates are expected to work within the limits of their competence, which may extend beyond the standards they demonstrated in order to join the register.

The Code should be useful for everyone who cares about good nursing and midwifery.

- Patients and service users, and those who care for them, can use it to provide feedback to nurses, midwives and nursing associates about the care they receive.
- Those on our register can use it to promote safe and effective practice in their place of work.
- Employer organisations should support their staff in upholding the standards in their professional Code as part of providing the quality and safety expected by service users and regulators.
- Educators can use the Code to help students understand what it means to be a registered professional and how keeping to the Code helps to achieve that.

For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing professionalism. Through revalidation, nurses, midwives and nursing associates provide evidence of their continued ability to practise safely and effectively. The Code is central to the revalidation process as a focus for professional reflection. This gives the Code significance in the professional life of those on our register, and raises its status and importance for employers.

The Code contains a series of statements that taken together signify what good practice by nurses, midwives and nursing associates looks like. It puts the interests of patients and service users first, is safe and effective, and promotes trust through professionalism.

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognise diversity and individual choice

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

1.5 respect and uphold people's human rights

The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.3 encourage and empower people to share in decisions about their treatment and care

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5 respect, support and document a person's right to accept or refuse care and treatment

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

4.2 make sure that you get properly informed consent and document it before carrying out any action

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

---

You can only make a 'conscientious objection' in limited circumstances. For more information, please visit our website at **www.nmc.org.uk/standards**

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care

5.3 respect that a person's right to privacy and confidentiality continues after they have died

5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

7.1 use terms that people in your care, colleagues and the public can understand

7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

7.5 be able to communicate clearly and effectively in English

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

10.5 take all steps to make sure that records are kept securely

10.6 collect, treat and store all data and research findings appropriately

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice

For more information, please visit our website at **www.nmc.org.uk/indemnity**

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.4 take account of your own personal safety as well as the safety of people in your care

13.5 complete the necessary training before carrying out a new role

---

The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

15.3 take account of your own safety, the safety of others and the availability of other options for providing care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

For more information, please visit our website at **www.nmc.org.uk/raisingconcerns.**

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship

Prescribing is not within the scope of practice of everyone on our register. Nursing associates don't prescribe, but they may supply, dispense and administer medicines. Nurses and midwives who have successfully completed a further qualification in prescribing and recorded it on our register are the only people on our register that can prescribe.

For more information, please visit our website at **www.nmc.org.uk/standards.**

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

---

Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive. You can find more information at **www.hse.gov.uk**

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.4 keep to the laws of the country in which you are practising

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

20.9 maintain the level of health you need to carry out your professional role

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

For more guidance on using social media and networking sites, please visit our website at **www.nmc.org.uk/standards**

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.1 refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment

21.2 never ask for or accept loans from anyone in your care or anyone close to them

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care

21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications

21.5 never use your status as a registered professional to promote causes that are not related to health

21.6 cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care

22 Fulfil all registration requirements

To achieve this, you must:

22.1 keep to any reasonable requests so we can oversee the registration process

22.2 keep to our prescribed hours of practice and carry out continuing professional development activities

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

For more information, please visit our website at **www.nmc.org.uk/standards.**

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise

23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body

23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment

---

When telling your employers, this includes telling (i) any person, body or organisation you are employed by, or intend to be employed by, as a nurse, midwife or nursing associate; and (ii) any person, body or organisation with whom you have an arrangement to provide services as a nurse, midwife or nursing associate.

23.5 give your NMC Pin when any reasonable request for it is made

For more information, please visit our website at **www.nmc.org.uk.**

24 Respond to any complaints made against you professionally

To achieve this, you must:

24.1 never allow someone's complaint to affect the care that is provided to them

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

Throughout their career, all our registrants will have opportunities to demonstrate leadership qualities, regardless of whether or not they occupy formal leadership positions.

nmc
Nursing & Midwifery Council

23 Portland Place,
London W1B 1PZ
+44 20 7637 7181
www.nmc.org.uk
@nmcnews
@nmcuk

REVALIDATION

How to revalidate with the NMC

Requirements for renewing your registration

CONTENTS

This updated document was **updated in May 2019**

WHAT DOES THIS DOCUMENT DO?

This document is for nurses, midwives and nursing associates who are registered with the NMC. It sets out how to renew your registration with the NMC through revalidation every three years.

The requirements for revalidation are either prescribed in the Nursing and Midwifery Order 2001 (the Order)[1] and the Education, Registration and Registration Appeals Rules (the Rules)[2], or are standards set by the NMC for revalidation and readmission.[3]

About the NMC

We're the independent regulator for nurses and midwives in the UK and nursing associates in England.

Better and safer care for people is at the heart of what we do, supporting the healthcare professionals on our register to deliver the highest standards of care.

How to use this document

This document gives an overview of the revalidation requirements which you will have to meet every three years in order to renew your registration. It also sets out how you should collect the required information and approach the process, including suggested templates which you can use as well as mandatory forms which you must complete as part of your revalidation application.

This document includes a checklist of the revalidation requirements and the supporting evidence for each requirement.

Each requirement is presented on pages 18-37 followed by information about:

- the purpose of the requirement
- how to meet the requirement
- the recommended or mandatory approach to collecting and recording the required information, and
- how to demonstrate to us that you have met the requirement in your online application.

You should read this document in conjunction with the Code[4] and other guidance on our website. We have published a range of resources that you might find helpful in preparing for revalidation, including completed templates and case studies. We have also provided information for confirmers, which you should ensure that your confirmer has read, as well as information for employers, which we recommend you encourage your employer (if applicable) to read.

Please note that you must still pay your annual registration fee every year to retain your registration with the NMC.

How the NMC will use your information

As part of the revalidation process you are required to submit information about yourself to the NMC. We will only process your personal data, as permitted by the Data Protection Act 2018 ('DPA').

Details of our data protection policy are included in our privacy notice at:
www.nmc.org.uk/privacy

We will use your personal data for the purposes of administering and assessing your revalidation application and any subsequent verification of that application. We may also use information obtained through the revalidation process for research, and for the purpose of maintaining and improving our internal systems and processes.

Your responsibility

You are responsible for your revalidation application. You need to sufficiently plan to ensure, to the best of your ability, that you will meet the requirements within your three year renewal period. If you require support from us to help you revalidate, please see our support to help you revalidate guidance sheet.

We expect you to complete your revalidation application on NMC online. This should not be delegated to someone else unless we have granted you an adjustment. You must provide accurate information in your online application.

You must adhere to the conditions we set out in this guidance and in the guidance we provide for confirmers and employers (if appropriate). Examples of these conditions include (but are not limited to) avoiding conflicts of interest and having your reflective discussion with a person on the NMC register.

If there are grounds for believing that you have not met these conditions, and/or that you have made a false declaration as part of your revalidation application, we will investigate and your registration could be at risk. Information supplied by you may be used to investigate any alleged breach of the Code and for the purpose of any subsequent fitness to practise proceedings.

Equality, diversity and inclusion

We value the diversity of the people on our register, and the wider community we serve. We are dedicated to ensuring revalidation is supportive and fair.

The Equality Act 2010 ('the Act') is legislation that applies in England, Wales and Scotland.[5] This Act protects people from discrimination, harassment or victimisation by specifying a number of 'protected characteristics':

- age
- gender reassignment
- being married or being in a civil partnership
- being pregnant or in the maternity period
- disability[6]
- race, including colour, nationality, ethnic or national origin
- religion, belief, or lack of religion or belief
- sex
- sexual orientation.

We expect all employers of nurses, midwives and nursing associates to meet their legal duty in the Equality Act 2010. We expect them to support you based on your individual needs and remove any unnecessary barriers to help you meet the revalidation requirements.

We cannot change the revalidation requirements as they are competence standards that demonstrate that you can practise safely and effectively. However, we can support you to renew your registration by providing adjustments that help you revalidate. For example, we can provide you with a short extension to your application date so you have more time to meet the revalidation requirements or give you a paper application form.

You can find further information on the support we offer on our website.

How to contact the NMC

For more information please see the revalidation section of the NMC website at: **www.nmc.org.uk**. If you are unable to find the information you need and you still require further help you can email us at: **revalidation.escalation@nmc-uk.org**.

If you wish to make a complaint or provide feedback about the standard of our service, please visit the 'Contact us' pages of our website at **www.nmc.org.uk/contact-us/complaints-about-us**.

WHAT IS REVALIDATION?

Revalidation

- is the process that allows you to maintain your registration with the NMC
- demonstrates your continued ability to practise safely and effectively, and
- is a continuous process that you will engage with throughout your career.

Revalidation is your responsibility. You are the owner of your own revalidation application. We recommend that you work towards meeting the revalidation requirements throughout the three year revalidation period so you are prepared when your application is due.

Revalidation is not

- an assessment of your fitness to practise
- a new way to raise fitness to practise concerns (any concerns about a nurse, midwife or nursing associate's practice should be raised through the existing fitness to practise process), nor
- an assessment against the requirements of your current/former employment.

Purpose of revalidation

- to raise awareness of the Code and professional standards expected of you
- to provide you with the opportunity to reflect on the role of the Code in your practice as a nurse, midwife or nursing associate and demonstrate that you are 'living' these standards
- to encourage you to stay up to date in your professional practice by developing new skills and understanding the changing needs of the public and fellow healthcare professionals
- to encourage a culture of sharing, reflection and improvement
- to encourage you to engage in professional networks and discussions about your practice, and
- to strengthen public confidence in the nursing and midwifery professions.

Revalidation and the Code

One of the main strengths of revalidation is that it reinforces the Code by asking you to use it as the reference point for all the requirements, including your written reflective accounts and reflective discussion.

This should highlight the Code's central role in the nursing and midwifery professions and encourage you to consider how it applies in your everyday practice.

The Code (paragraph 22) requires you to fulfil all registration requirements. To achieve this you must:

- meet any reasonable requests so we can oversee the registration process (22.1)
- keep to our prescribed hours of practice and carry out continuing professional development (CPD) activities (22.2), and
- keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance (22.3).

Revalidation and the standards of proficiency

One purpose of revalidation is to help you to maintain safe and effective practice. Revalidation does this by encouraging you to update your knowledge and develop new skills. The NMC publishes and regularly updates standards of proficiency for everyone on our register. These set out what we expect students to know, understand and be able to do to apply to join our register and to practise safely and effectively. It is important for you to become familiar with the most recent standards, identify which ones relate to your scope of practice and identify your training needs. This will help you to advance your practice and also means that you will be equipped to supervise and assess students if this is part of your role.

It is important that you speak to your employers about the types of continuous professional development that will help you achieve this.

Overall, revalidation should lead to improved practice and therefore public protection benefits.

CHECKLIST OF REQUIREMENTS AND SUPPORTING EVIDENCE

These are all of the requirements that you must meet in order to complete your revalidation and renew your registration every three years with the NMC.

Requirements	Supporting evidence
450 practice hours for each registration. **Dual registration (e.g. nurse and midwife) requires 900 practice hours[7]**	Maintain a record of practice hours you have completed, including: • dates of practice • the number of hours you undertook • name, address and postcode of the organisation • scope of practice (see tip box on page 22) • work setting (see tip box on page 22) • a description of the work you undertook, and • evidence of those practice hours should be recorded. See our practice hours requirements guidance sheet and suggested template at guidance and information.
35 hours of continuing professional development (of which 20 must be participatory)	Maintain accurate and verifiable records of your CPD activities, including: • the CPD method (examples of 'CPD method' are self-learning, online learning, course) • a brief description of the topic and how it relates to your scope of practice • dates the CPD activity was undertaken • the number of hours and participatory hours • identification of the part of the Code most relevant to the CPD, and • you should record evidence of the CPD activity. See our guidance sheet and suggested template at guidance and information
Five pieces of practice-related feedback	Notes on the content of the feedback and how you used it to improve your practice. This will be helpful for you to use when you are preparing your reflective accounts. Make sure your notes do not include any personal data (see the section on non-identifiable information on pages 15-17).

Requirements	Supporting evidence
Five written reflective accounts	Five written reflective accounts that explain what you learnt from your CPD activity and/or feedback and/or an event or experience in your practice, how you changed or improved your work as a result, and how this is relevant to the Code. You must use the NMC form on page 47 and make sure your accounts do not include any personal data (see the section on non-identifiable information).
Reflective discussion	A reflective discussion form which includes the name and NMC Pin of the NMC-registered nurse, midwife or nursing associate that you had the discussion with as well as the date you had the discussion. You must use the NMC form on page 48 and make sure the discussion summary section does not contain any personal data (see the section on non-identifiable information).
Health and character	You must make a declaration as to your health and character as part of your online revalidation application. You can find more information in our guidance on health and character.
Professional indemnity arrangement	Evidence to demonstrate that you have an appropriate indemnity arrangement in place. You must tell us whether your indemnity arrangement is through your employer, membership of a professional body or through a private insurance arrangement. If your indemnity arrangement is provided through membership of a professional body or a private insurance arrangement, you will need to record the name of the professional body or provider.
Confirmation	A confirmation form signed by your confirmer. You must use the NMC form on pages 49-51.

THE REVALIDATION PROCESS

During the three years since your last renewal/you joined the register

You need to meet a range of revalidation requirements to show that you are keeping your skills and knowledge up to date and maintaining safe and effective practice

See pages 18–37: for details of the requirements

In the 12 months before your renewal date

Once you have met the requirements, you will need to discuss your revalidation with a confirmer. As part of this confirmation discussion, you will demonstrate that you have complied with all of the revalidation requirements, except having a professional indemnity arrangement and meeting the requirements of health and character.

See pages 35–37: 'Confirmation'

At least 60 days before your revalidation application date

Every three years you will be asked to apply for revalidation using NMC Online. We will notify you at least 60 days before your application is due, either by email if you have set up an NMC Online account, or by letter sent to your registered address.

See pages 38–40: 'The application process'

In the 60 days before your revalidation application date

Once you receive your notification you will need to go online and complete the application form. As part of that application, you need to declare to the NMC that you have complied with the revalidation requirements.

See pages 38–40: 'The application process'

Following submission of your revalidation application

Each year we will select a sample of revalidation applications and ask those professionals to provide us with further information so we can verify the declarations they made as part of their revalidation application. If you are selected your registration will be held effective until the verification process is complete and you can continue to practise as normal during this time. Your registration will only renew if the verification is completed successfully.

See pages 41–42: 'Verification of your application'

HOW TO APPROACH REVALIDATION

Understand key terms

1. The registration process: Every three years from when you join (or re-join) the register you will need to renew your registration by revalidating. Every year you will also need to retain your registration by paying an annual registration fee. If you don't complete these processes on time your registration will expire.
2. Fee expiry date: The deadline for paying your annual registration fee in order to retain your registration.
3. Revalidation application date: The deadline for submitting your revalidation application. It is the first day of the month in which your registration expires, so if your renewal date is 30 April, your revalidation application date will be 1 April.
4. Renewal date: The date on which your registration will be renewed if you have successfully completed your revalidation application. It is the last day of the month in which your registration expires.

Keep a portfolio

5. We strongly recommend that you keep evidence that you have met the revalidation requirements in a portfolio. This does not necessarily need to be an e-portfolio; please see our guidance sheet on e-portfolios at **revalidation.nmc.org.uk/download-resources/guidance-and-information** for further information. We have provided forms you must use and templates you may like to use to record your evidence for each requirement; these are available at the end of this document and on our website at **revalidation.nmc.org.uk/download-resources/forms-and-templates,** where you will also find examples of completed forms and templates for you to refer to.
6. We expect any evidence to be kept in English, and nurses, midwives and nursing associates must submit their revalidation application, and any subsequent requested verification information in English.
7. The portfolio will be helpful for the discussion you have with your confirmer (see pages 35-37). You will also need to have this information available in case we request to see it to verify the declarations you made as part of your application (see pages 41-42).
8. You may already keep a professional portfolio. If so, you do not need to maintain a separate portfolio but you might like to add to it.

The NMC recognises the culture and linguistic needs of the Welsh speaking public (for further information please see **www.nmc.org.uk/about-us/our-equality-and-diversity-commitments/welsh-language-scheme**). We have published Welsh language versions of our guidance for nurses and midwives, confirmers and employers, as well as our templates and forms, on our website at **revalidation.nmc.org.uk/download-resources/guidance-and-information**.

9. You can use the checklist on page 9 to make sure that all of the information is in your portfolio before you have your confirmation discussion with your confirmer or submit your revalidation application.
10. We recommend that you keep your portfolio until after you complete your next revalidation. For example, if you revalidated in 2016, we suggest that you should keep your portfolio until after you have revalidated again in 2019.
11. Your portfolio must not record any information that might identify an individual, whether that individual is alive or deceased. This means that all information must be recorded in a way that no patient, service user, colleague or other individual can be identified from the information. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your portfolio does not contain any information that might identify an individual.
12. During your revalidation application we will not request that you upload your evidence or submit your portfolio to the NMC. However, each year we will select a sample of revalidation applications and request further information from you to verify your revalidation application via NMC online. In some cases, we may request further evidence, so it is important that you keep all of your revalidation evidence safe.

Conflicts of interest and perceptions of bias

13. A conflict of interest is a situation that has the potential to undermine the impartiality and objectivity of decision making within the revalidation process. Conflicts of interest can arise when an individual's judgement is influenced subjectively through association with colleagues out of loyalty to the relationship they have, rather than through an objective process.
14. Conflicts of interest can occur because of personal or commercial relationships.
15. You need to be mindful about any personal or commercial relationship between you, your confirmer and your reflective discussion partner. You may not choose a family member or person with whom you have a close personal relationship, such as a close friend to undertake either of these roles
16. You, your confirmer and reflective discussion partner will need to take responsibility for deciding whether there is any conflict of interest or perception of bias to ensure that the confirmation process and reflective discussion retains credibility and remains objective. If you think that there is a risk there might be a conflict of interest you should use a different person as your confirmer and reflective discussion partner.

Appraisals

17. Many nurses, midwives and nursing associates have an employer. It is important for their employers to be aware of the Code and the standards expected of people on our register in their professional practice. See our Employers guide to revalidation at **revalidation.nmc.org.uk/download-resources/guidance-and-information.**
18. Appraisals are a way for employers to assess the performance of their employees against the requirements of their role and identify areas for improvement and development.
19. The revalidation process is designed so that it can be undertaken as part of a regular appraisal. If you are an employee who does not have a regular appraisal you could consider asking your employer to arrange an appraisal for you in advance of your revalidation application date.

20. The confirmation discussion has a different purpose from an appraisal, as it is about demonstrating to an appropriate confirmer that you have met the revalidation requirements, not the requirements of your employment (please see the section on Confirmation on pages 35-37 for more details). However, it can be incorporated into an appraisal, and we recommend that, where possible, your confirmation discussion forms part of an annual appraisal, if you have one.
21. If your line manager is also registered with the NMC, you might like to have both your reflective discussion and your confirmation discussion as part of an annual appraisal, if you have one. You might find it helpful to have a discussion with your confirmer every year as part of an annual appraisal, so that you can keep them updated on your revalidation.
22. If you are not an employee, or if you are an employee who has been unable to arrange an appraisal in advance of your revalidation application date, you will still be able to renew your registration by meeting the revalidation requirements. You are not required to arrange for another person or organisation to conduct an appraisal for the purposes of revalidation, but you will still need to arrange a reflective discussion and confirmation discussion.

NON-IDENTIFIABLE INFORMATION

23. You are likely to process personal data as part of your day to day role. If you are employed, you are likely to be covered by your employer's registration under data protection legislation. If you are practising as an independent or self-employed nurse, midwife or nursing associate you are already likely to be registered under data protection legislation in your capacity.
24. This section sets out your obligations in relation to confidentiality and data protection in relation to meeting the revalidation requirements. It does not cover your existing obligations in relation to data protection legislation.

Personal data means data which identifies an individual.
Section 1(1) of the Data Protection Act 1998.

Your obligations in relation to confidentiality under the Code

25. The Code sets out the professional standards that you must uphold in order to be registered to practise in the UK. Standard 5 of the Code states:

Respect people's right to privacy and confidentiality

- As a nurse, midwife or nursing associate you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

- respect a person's right to privacy in all aspects of their care (5.1)
- make sure that people are informed about how and why information is used and shared by those who will be providing care (5.2)
- respect that a person's right to privacy and confidentiality continues after they have died (5.3)
- share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality, and (5.4)
- share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand. (5.5)

Making sure that your evidence does not include any personal information

26. In meeting the revalidation requirements and keeping your evidence, you must not record any information that might identify an individual, whether that individual is alive or deceased. This means that all information recorded must be recorded in a way that no patient, service user, colleague or other individual can be identified from the information.

27. For example, any notes or reflections must not include:

    - the name of any individual
    - the date of any incident or event referred to
    - the particular ward or place where the event occurred, or
    - descriptions of unique circumstances where an individual could be identified from the circumstances.

28. Any information extracted from employer data (such as complaints logs) must be extracted in a way that no information identifying an individual is obtained, used or recorded. For example, you must not forward work emails to your personal account, or download and take copies of employer records. You must seek consent to access or use your employer's information.

Example scenarios

29. You will already be aware of the importance of keeping personal information confidential, and not processing personal information outside of your employment or work settings. However, we have provided some simple examples below to demonstrate how an instance of feedback could be recorded in a way that no individual can be identified.

Scenario 1

In January 2015 Mrs Jones was in ward 8 with a broken hip. She made a complaint about lack of hydration. You want to use this feedback in one of your reflections as an example of where you put in place a new process to make sure all patients were offered water on a regular basis.

In your reflective account you could say: 'A patient with a serious injury made a complaint about lack of hydration.'

No dates, names or wards have been included in the record, and the type of injury has also been omitted, so Mrs Jones cannot be identified from this information. You can then explain what you did, what improvement you made and how this is related to the Code.

Scenario 2

In reviewing the complaints log held by the maternity unit where you work, you noticed a complaint made by Mrs Smith in relation to a lack of continuity of care and handover between midwives at the end of a shift on 12 January 2015. You were one of the midwives involved, along with your colleague Sarah. You discussed this with your colleagues and have made improvements in the way you handover at the end of shifts. You want to use this feedback in one of your reflections.

Before writing your reflective account, you need to check with your employer that you can use information from the complaints log. In your reflective account you could say: 'A complaint was received about the lack of continuity of care and handover between myself and a colleague at the end of a shift'.

No information identifying any individual, including both Mrs Smith and your colleague, has been included in this record. You can then explain what you did, what improvement you made and how this is related to the Code.

Storing your reflective accounts form, reflective discussion form and confirmation form

30. You are not required to submit your reflective accounts form, reflective discussion form and confirmation form to the NMC at any point in the revalidation application. There is no requirement to store them electronically or upload them into NMC Online as part of your application, or provide them if you are selected so we can verify your evidence.
31. Your 'reflective discussion form' and 'confirmation form' contain personal data about another person. This means that there are data protection implications for nurses, midwives and nursing associates completing these forms, when they are processing electronic records. There is not an exemption under Data Protection legislation which applies to personal data processed by our registrants, as part of the reflection and discussion elements of revalidation. However, the Information Commissioner's Office (ICO) have recognised that it would be highly disproportionate to expect our registrants to have to register with them as data controllers when processing electronic records, or to pay a fee. The ICO has confirmed that it does not plan to take any action against any of our registrants for failing to register with them.
32. You may choose to store your completed reflective discussion and confirmation forms in either paper or electronic format. You should still respect the fact that these forms contain personal data about your reflective discussion partner and confirmer. Please see our guidance sheet on e-portfolios for further information at guidance and information.

The Information Commissioner's Office has published a guide to data protection legislation at **ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/**

PRACTICE HOURS

The requirements

33. You must have practised as a registered nurse, midwife or nursing associate for a minimum number of hours over the three year period since your registration was last renewed or you joined the register.[8]

Registration	Minimum total practice hours required
Nurse	450 practice hours required
Midwife	450 practice hours required
Nursing associate	450 practice hours required
Nurse and SCPHN	450 practice hours required
Midwife and SCPHN	450 practice hours required
Nurse and midwife (including Nurse/SCPHN and Midwife/SCPHN)[9] Or Nursing associate and nurse	900 practice hours required (to include 450 hours for nursing, 450 hours for midwifery, 450 hours for nursing associate)

A specialist community public health nurse (SCPHN) means a registered nurse, midwife or nursing associate who is also registered in the Specialist Community Public Health Nurses' part of the register.

34. If you have practised for fewer than the required number of hours in the three year period since your registration was last renewed or you joined the register, then you must successfully complete an appropriate return to practice programme approved by the NMC before the date of your application for renewal of registration.[10]

35. Registered nurses, midwives or nursing associates who are admitted to another part of the register since their registration was last renewed or they joined the register only need to meet the practice hours requirement for their initial registration. They will need to meet the practice hours requirements for registration in both parts in subsequent three year renewal periods.[11]

The purpose of these requirements

36. The practice hours requirements are designed to help you to maintain safe and effective practice, and keep your skills up to date.

How to meet the requirements

37. You can only count practice hours that you undertook while you were registered with the NMC. You cannot count unregistered practice or hours completed when working in an entirely different regulated profession such as a paramedic or medical doctor.
38. Practice hours should reflect your current scope of practice. You must comply with The Code: professional standards of practice and behaviour for nurses, midwives and nursing associates at all times. This includes the duty to recognise and work within the limits of your competence.
39. You must meet your practice hours in a role where you rely on your skills, knowledge and experience of being a registered nurse, midwife or nursing associate.

    This includes:

    - practice as a nurse, midwife, SCPHN and nursing associate, in roles that are likely to require registration
    - practice in roles where your employment contract does not expressly require you to be registered with us but you rely on your skills, knowledge and experience of being a registered nurse, midwife or nursing associate. For example, this could include roles in public health or nursing, midwifery, management, commissioning, policy and education
40. The following activities cannot be counted towards the practice hours requirement: hours undertaken in a healthcare, nursing or midwifery assistant or support worker role cannot be counted towards practice hours as a registered nurse, midwife or nursing associate.
    - Hours completed when working in a separate regulated profession for example when working as a paramedic or medical doctor.
    - Nurses undertaking an 18-month midwifery programme cannot use their midwifery training hours in order to maintain their registration as a nurse. They will be able to use any practice hours undertaken as a nurse, either before or after their midwifery course, during the three-year period.
    - Hours undertaken in any healthcare, nursing or midwifery assistant or support worker roles cannot be counted towards practice hours.
41. If you are working overseas (or have worked overseas for part of your three year renewal period) as a nurse, midwife or nursing associate you can count these hours towards the practice hours requirements for revalidation. Where possible, you should always register with the appropriate regulator in the country in which you are practising.
42. If you have had a career break, you will still be able to meet the practice hours requirement if you have completed the required hours of registered practice during your three year renewal period.
43. We have produced a guidance sheet for people with multiple registrations and additional qualifications. Please see our guidance and information on our website.

Further information on working outside the UK and returning to practice can be found on our website **www.nmc.org.uk/registrations**

44. If you have not undertaken any type of work where you relied on your skills, knowledge or experience as a registered nurse, midwife or nursing associate, or if you are unable to meet the practice hours requirement, you have two options:
    - you can successfully complete an appropriate NMC-approved return to practice programme before the date of your revalidation application. These programmes are designed to allow you to renew your registration and return to practice after a break in practice. Further information about return to practice programmes is available on our website or
    - you can cancel your registration. You will continue to hold a nursing and/or midwifery qualification, but will not be registered with the NMC. You can apply for readmission to the register in future if you wish to practise as a registered nurse, midwife or nursing associate. Information on cancelling registration and seeking readmission to the register is available on our website.
45. If you do not renew your registration, you will lapse from the register. You will not be able to practise in the capacity of a registered nurse, midwife or nursing associate. You cannot rely on any hours of work you undertake when you were not registered with the NMC as part of any application for readmission to the register.

How to record practice hours

46. We strongly recommend that you maintain a record of practice hours you have completed.
47. This will form part of the discussion you have with your confirmer, and you will also need to have this information available in case we request to see it for verification of your application. We have provided a guidance sheet on practice hours and have a suggested template to help you record your practice hours. Your records should include:
    - dates of practice
    - the number of hours you undertook
    - name, address and postcode of the organisations
    - scope of practice
    - work setting
    - a description of the work you undertook, and
    - evidence of those practice hours, such as timesheets, job specifications and role profiles.
48. You do not necessarily need to record individual practice hours. You can describe your practice hours in terms of standard working days or weeks.

What you need to tell us in your online application

49. When you apply for revalidation, you need to declare that you have met the practice hours requirement during the three year period since your last registration renewal or initial registration. You only need to tell us about the most recent hours you have undertaken to meet the minimum requirement for your registration(s). If you are currently practising in more than one setting, provide details of your main setting first.
50. You will also be asked to enter the following details:
    - whether you are currently practising
    - if you are currently in practice, where you undertake that practice, including details of your scope of practice and work setting, and
    - if you are not currently in practice, where you undertook your most recent practice, including details of your scope of practice and work setting.
51. To help you prepare for your online application we have listed the scope of practice and work setting options in the tip box below. These were designed to capture the wide breadth of types of practice that people on our register can undertake, and as such they will not apply to all roles.
52. If you have completed a return to practice course or been admitted to another part of the register since you last renewed your registration or joined the register, your practice hours declaration will be as follows:
    - If you have recently completed an approved return to practice course since you last renewed your registration or joined the register, you will be able to meet the practice hours requirement for that registration.
    - If you have been admitted to another part of the register since you last renewed your registration or joined the register (for example you are a nurse who has undertaken training as a midwife and gained a second registration as a midwife), you only need to meet the practice hours requirement for your initial registration. Please note that next time you apply for revalidation, if you wish to renew your registration on both parts of the register and continue practising as both a nurse and a midwife, you will need to meet the practice hours requirements for both registrations.
    - For further information about multiple registrations and additional qualifications please see our guidance sheet at guidance and information.

Scope of practice

Direct clinical care or management: adult and general care nursing; children's and neo-natal nursing; mental health nursing; learning disabilities nursing; midwifery; health visiting; occupational health; school nursing; public health; other. Commissioning, Education, Policy, Quality assurance or inspection, Research, other.

Work setting

Ambulance service, Care home sector, Community setting (including district nursing and community psychiatric nursing), Consultancy, Cosmetic or aesthetic sector, Governing body or other leadership, GP practice or other primary care, Hospital or other secondary care, Inspectorate or regulator, Insurance or legal, Maternity unit or birth centre, Military, Occupational health, Police, Policy organisation, Prison, Private domestic setting, Public health organisation, School, Specialist or other tertiary care including hospice, Telephone or e-health advice, Trade union or professional body, University or other research facility, Voluntary or charity sector, other.

CONTINUING PROFESSIONAL DEVELOPMENT

The requirements

53. You must have undertaken 35 hours of continuing professional development (CPD) relevant to your scope of practice as a nurse, midwife or nursing associate, in the three year period since your registration was last renewed or you joined the register.[12]
54. Of those 35 hours of CPD, at least 20 must have included participatory learning.[13]
55. You must maintain accurate records of the CPD you have undertaken. These records must contain:
    - the CPD method
    - a description of the topic and how it related to your practice
    - the dates on which the activity was undertaken
    - the number of hours (including the number of participatory hours)
    - the identification of the part of the Code most relevant to the activity, and
    - evidence that you undertook the CPD activity.[14]

The purpose of these requirements

56. As a professional, you have a duty to keep your professional knowledge and skills up to date through a continuous process of learning and reflection.
57. The CPD requirements are designed to help you to maintain safe and effective practice, to improve practice or develop new skills where a gap has been identified and to respond to changes and advances in nursing and midwifery.
58. The participatory requirement also helps to challenge professional isolation by requiring learning through engagement and communication with others.

How to meet the requirements

59. CPD is a learning activity that you undertake separately from your normal practice. This is different from the everyday learning that all healthcare professionals will engage in as part of their ongoing practice.
60. Any learning activity you participate in should be relevant to your scope of practice as a nurse, a midwife or a nursing associate. When you plan, undertake and record your CPD you should focus on what you are learning, how it is linked to your scope of practice and how you can apply it to your practice.

61. We do not prescribe any particular type of CPD. We think that you are better placed to decide what learning activities are the most suitable and beneficial to your individual scope of practice. We have produced a guidance sheet that suggests some individual and participatory CPD activities that you can undertake, which includes many activities other than training courses (see guidance and information). It is not an exhaustive list and we have only provided it as an example.

62. We know that many organisations require their staff to undertake mandatory training. You should not include mandatory training that is not directly related to your practice (for example, fire training or health and safety training) as part of your 35 hours of CPD. However, if you undertake any mandatory training that is necessary to your scope of practice and professional development, for example, mandatory training on equality legislation if you are in a policy role, you could include that.

63. Participatory learning includes any learning activity in which you personally interact with other professionals, including professionals working outside healthcare. It can be an activity undertaken with one or more professionals or in a larger group setting. The group does not always need to be in a common physical environment, such as a study group or conference. It could be a group in a virtual environment (such as an online discussion group).

64. The NMC publishes and regularly updates standards of proficiency for everyone on our register. These set out what we expect students to know, understand and be able to apply to join our register and practise safely and effectively. When you are considering what CPD to undertake we recommend that you review the latest standards of proficiency for your part of the register and reflect on how your scope of practice relates to the standards and consider CPD activities that would help you to develop your skills. This is particularly important if you supervise and/or assess students as part of your role.

How to record CPD

65. You must maintain accurate records of your CPD activities, and we have provided a template to help you with this. This will form part of the discussion you have with your confirmer. You will need to have this information available in case we request to see it for verification of your application. Your records should include:
    - the CPD method
    - a brief description of the topic and how it relates to your practice
    - dates the CPD activity was undertaken
    - the number of hours and participatory hours
    - identification of the part of the Code most relevant to the CPD, and
    - evidence of the CPD activity.

What you need to tell us in your online application

66. You need to declare that you have met the CPD requirement.

PRACTICE-RELATED FEEDBACK

The requirement

67. You must have obtained five pieces of practice-related feedback in the three year period since your registration was last renewed or you joined the register.[15]

The purpose of this requirement

68. The practice-related feedback requirement is intended to encourage you to be more responsive to the needs of patients and service users and those who care for them. You need to seek feedback from people you work with and care for and importantly you need to use the feedback that you receive to assess and make improvements to you practice.

How to meet the requirement

69. We recommend that you try to obtain feedback from a variety of sources, for example:
    - feedback from patients, service users, carers or students as part of your day to day practice
    - feedback from colleagues such as nurses, midwives, nursing associates and other healthcare professionals
    - feedback from colleagues in management, on reception, in assistant positions, as well as fellow teachers, researchers, academics or policy colleagues
    - complaints
    - team performance reports
    - serious event reviews, and
    - feedback received through your annual appraisal.
70. Types of feedback:
    - feedback can be about your individual practice or about your team, ward, unit or organisation's practice (you should be clear about the impact the feedback had on your practice)
    - formal or informal
    - written or verbal, and
    - positive or constructive.

71. It's likely that you will already receive a range of feedback. In many organisations, feedback is already collected in a variety of ways. You must seek consent to access or use your employer's information. Any information must be extracted in a way that no information identifying an individual is obtained, used or recorded. For example, you must not forward work emails to your personal accounts, or download and take copies of employer records. See the section on non-identifiable information on pages 15-17 for more information.

72. Should you choose to solicit feedback directly from colleagues, patients or service users, you must make clear in your request that no information identifying individuals should be included in any feedback provided. You should also inform them how you intend to use their feedback, and reassure patients and service users that any feedback they give will not affect the care they receive.

How to record feedback

73. We recommend that you keep a note of the content of any feedback you obtain, including how you used it to improve your practice. This will be helpful for you to use when you are preparing your reflective accounts. We have provided a template to help you record your feedback.

74. You may choose to collect more feedback but to meet the revalidation requirement you only need to note the details of five pieces of feedback.

75. In any note you keep, you must not record any information that might identify an individual, whether that individual is alive or deceased. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

What you need to tell us in your online application

76. You need to declare that you have met the feedback requirement.

WRITTEN REFLECTIVE ACCOUNTS

The requirement

77. You must have prepared five written reflective accounts in the three year period since your registration was last renewed or you joined the register. Each reflective account must be recorded on the approved form and must refer to:
    - an instance of your CPD and/or
    - a piece of practice-related feedback you have received and/or
    - an event or experience in your own professional practice and how this relates to the Code.

The purpose of this requirement

78. We want you to engage in reflective practice so that you identify any changes or improvements you can make to your practice based on what you have learnt.

79. This requirement should also raise awareness of the Code and encourage you to consider the role of the Code in your practice and professional development.

How to meet the requirement

80. Each reflective account can be about an instance of your CPD, feedback, an event or experience in your practice as a nurse, midwife or nursing associate, or a combination of these. Both positive and negative experiences should be reflected on. Any experience, including a conversation with a colleague, a significant clinical or professional event, or a period of time can generate meaningful reflections, insights and learning. For example, you could create a reflective account on a particular topic which may have arisen through some feedback your team received following an event, such as consent and confidentiality and identify how that relates to the Code.

How to record your reflective accounts

81. We have provided a form that you must use to record your reflective accounts. You must explain what you learnt from the CPD activity, feedback, event or experience, how you changed or improved your practice as a result, and how this is relevant to the Code.
82. This form can be hand written, typed or, if necessary, dictated.
83. Your reflective accounts must not include any information that might identify an individual whether that individual is alive or deceased. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your reflective accounts do not contain any information that might identify an individual.
84. You do not need to submit a copy of the reflective accounts to the NMC for the purpose of revalidation. However, you should retain these as a record to inform your reflective discussion and to show your confirmer.

What you need to tell us in your online application

85. You need to declare that you have met the requirement for written reflective accounts.

REFLECTIVE DISCUSSION

The requirement

86. You must have had a reflective discussion with another NMC registrant, covering your five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code.[16]

87. You must ensure that the NMC registrant with whom you had your reflective discussion signs the approved form recording their name, NMC Pin, email, professional address and postcode, as well as the date you had the discussion.[17]

The purpose of this requirement

88. This requirement will encourage a culture of sharing, reflection and improvement. It does this by requiring you to discuss your professional development and improvement, and by ensuring that you do not practise in professional isolation.

How to meet the requirement

89. You must discuss your five written reflective accounts with another person on our register as part of a reflective discussion. In the discussion you and your reflective discussion partner will be linking your reflective accounts to the Code, so it is important that both of you are familiar with, and working to, the professional standards presented in the Code.

90. The reflective discussion partner:

- must be a nurse, midwife or nursing associate with an effective registration with the NMC, by which we mean they cannot be subject to any kind of suspension, removal or striking-off order at the time of having the discussion
- could be someone you frequently work with or someone from a professional network or learning group
- does not need to be someone you work with on a daily basis
- does not need to undertake the same type of practice as you, and
- does not need to be on the same part of the register as you (so a nurse can have a reflective discussion with a midwife and vice versa).

91. If you practise in a setting with few or no nurses, midwives or nursing associates, you can reach out to peers, who are registered with the NMC, from your wider professional or specialty network in order to have your reflective discussion.

92. It is for you to decide the most appropriate person for you to have this conversation with, including whether they are senior or junior to you.

93. If your confirmer is on our register, your reflective discussion can form part of the confirmation discussion. If your confirmer is not on our register, you will need to have your reflective discussion with an NMC-registered nurse, midwife or nursing associate before your confirmation discussion with your confirmer.

94. We expect the discussion to be a face-to-face conversation in an appropriate environment. If for some reason you cannot have a face-to-face discussion, then you could arrange a video conference.

95. During your discussion you should not discuss patients, service users or colleagues in a way that could identify them unless they expressly agree. For further information on reflective discussions please guidance and information.

How to record your reflective discussion

96. We have provided an NMC form that you must use to record your discussion. You must make sure that the nurse, midwife or nursing associate with whom you had your reflective discussion signs the form and records their name, NMC Pin, email, professional address including postcode, contact number and the date you had the discussion and a summary of the discussion.[18] You should keep the completed and signed form.

97. The discussion summary section of the form must not include any information that might identify an individual, whether that individual is alive or deceased. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

What you need to tell us in your online application

98. You need to declare that you have had a reflective discussion with another NMC-registered nurse, midwife or nursing associate.

99. You will also need to enter the name, NMC Pin, email, professional address including postcode and contact number of your reflective discussion partner, as well as the date you had the reflective discussion.

HEALTH AND CHARACTER

The requirements

100. You must provide a health and character declaration.[19]

101. You must declare if you have been convicted of any police charge, police caution, conviction or conditional discharge.[20]

102. You will be asked to declare if you have been subject to any adverse determination that your fitness to practise is impaired by a professional or regulatory body (including those responsible for regulating or licensing a health and social care profession).[21]

The purpose of these requirements

103. These requirements will help to satisfy the Registrar that you are capable of safe and effective practice.

How to meet the requirements

104. You will need to complete these declarations as part of your revalidation application.

105. When making these declarations please refer to our guidance on health and character for nurses, midwives and nursing associates.

106. Your character is important and is central to the Code because nurses, midwives and nursing associates must be honest and trustworthy. Your character is based on your conduct, behaviour and attitude. When declaring that you are of good character you should consider whether you have been involved in conduct which would breach the requirements of the Code. You can read the Code on our website: **www.nmc.org.uk/standards/code**. See our guidance on health and character for further information.

107. You will also be asked to declare if you have been subject to any determination by a professional or regulatory body (including those responsible for regulating or licensing a health or social care profession) to the effect your fitness to practise is impaired.[22]

108. In accordance with the Code, we expect you to declare any police charges, cautions, convictions and conditional discharges to the NMC immediately, not wait until revalidation. [23] A caution or conviction includes a caution or conviction you have received in the UK for a criminal offence, as well as a conviction received elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence.[24] Please do not notify the NMC of motoring offences unless it led to a disqualification of driving or offences that have previously been considered by the NMC. See our guidance on health and character for further information.

109. We need to know that people applying to renew their registration meet our requirements for health to ensure they can practise safely and effectively.

110. It's important to remember that when we talk about 'good health' we mean that you are capable of safe and effective practice as a nurse, midwife or nursing associate either with or without reasonable adjustments and adjustments which your employer has made.

111. Our focus is whether you have a health condition and/or disability which may affect your practice. This is because we need to be able to assess whether it may place at risk the safety of people in your care

112. It doesn't mean the absence of a health condition and/or disability. Many people with disabilities and health conditions are able to practise with or without adjustments put in place by their employer to support them.

113. It is up to you to decide whether your health allows you to be capable of safe and effective practice. If you are satisfied with your decision then you do not need to provide us with any further information apart from your declaration (see section below).

How to record health and character declarations

114. If your health and character enable you to practise safely and effectively in accordance with the Code, and you do not have any charges, cautions, convictions, conditional discharges or determinations to declare, you do not need to keep any information as part of this requirement. Your confirmer does not need to check that you have met this requirement.

115. If you do need to declare any charges, cautions, convictions, conditional discharges or determinations you will need to keep evidence of these to provide us with further information.

Paragraph 23.2 of the Code states that you must inform us and any employers you work for as soon as you can of any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction).

What you need to tell us in your online application

116. You need to declare that your health and character enable you to practise safely and effectively in accordance with the Code. See our guidance on health and character.

117. You will be asked to declare if you have a charge, caution, conviction or conditional discharge other than those which are protected. You do not have to tell us about protected cautions and convictions. These are minor offences that will not be disclosed on a Disclosure and Barring Service (DBS) check. Listed offences are never protected and must always be declared to us. See the full list from the DBS for England, Wales and Northern Ireland. In Scotland, the checking and barring service is operated by Disclosure Scotland.

PROFESSIONAL INDEMNITY ARRANGEMENT

The requirement

118. You must declare that you have, or will have when practising, appropriate cover under an indemnity arrangement.[25]

The purpose of this requirement

119. By law, you must have in place an appropriate indemnity arrangement in order to practise and provide care. While the arrangement does not need to be individually held by you, it is your responsibility to ensure that appropriate cover is in place.

How to meet the requirement

120. You will need to complete this declaration as part of your revalidation application.

121. Most employers provide appropriate indemnity cover for their employees. If you are employed you should check this with your employer(s). Further information is available from the NHS Employer's website.

122. Please refer to our information on professional indemnity arrangements when making this declaration This document defines 'appropriate cover' and sets out information for those who are employed, self-employed or undertake work in both employed and self-employed roles. It also sets out information for those who work in education, undertake voluntary work, or are having a break in their practice.

123. If it is discovered that you are practising as a nurse, midwife or nursing associate without an appropriate indemnity arrangement in place, you will be removed from the NMC register and unable to practise as a nurse, midwife or nursing associate.

How to record your professional indemnity arrangement

124. Your declaration will be made as part of your revalidation application.

125. We strongly recommend that you retain evidence that you have an appropriate arrangement in place.

126. If your arrangement is provided through membership of a professional body or a private insurance arrangement, your declaration should be based on having an indemnity arrangement in place which provides 'appropriate cover' in relation to your individual scope of practice, as explained on our website and in the professional indemnity arrangement guidance. Please note that you will need to justify decisions on cover you put in place or rely on, if we request you to do so. Your confirmer does not need to check that you have met this requirement.

127. Your confirmer does not need to check that you have met this requirement.

What you need to tell us in your online application

128. You need to inform the NMC whether your indemnity arrangement is through your employer, membership of a professional body, or a private insurance arrangement. Alternatively, you will be able to inform us that you are not practising at this time but that you intend to have appropriate cover in place before you practise.

129. You are required to have appropriate cover in place for all of your current practice settings. If you are currently practising in more than one setting, please tell us first about your arrangement in relation to your main practice setting. Please then add other arrangements to cover all your current practice settings.

130. If your indemnity arrangement is provided through membership of a professional body or a private insurance arrangement, you will be asked to provide the name of the professional body or provider.[26]

CONFIRMATION

The process

131. We will ask you for information for the purpose of verifying the declarations you have made in your application.[27]
132. This will be a declaration that you have demonstrated to an appropriate confirmer that you have complied with the revalidation requirements. We have provided a form for you to use to obtain this confirmation.
133. We will ask you to provide the name, NMC Pin or other professional identification number (where relevant), email, professional address and postcode of the confirmer.

The purpose of confirmation

134. Confirmation encompasses several benefits for you. It will provide assurance, increase support and engagement between you and your confirmer, and make you more accountable for your own practice and improvement. It should support you by increasing access to appraisals.
135. The interactive nature of the confirmation process should reduce professional isolation and encourage a culture of sharing, reflection and improvement.
136. Ultimately, the confirmation process is designed to increase professionalism by making nurses, midwives and nursing associates more accountable for their practice and improvement. This requirement also gives us an additional layer of assurance that nurses, midwives and nursing associates are complying with the revalidation requirements.
137. Confirmation is not a new way for employers to raise fitness to practise concerns. Confirmation is not about employers judging whether a nurse, midwife or nursing associate is fit to practise or an assessment against the requirements of their current or former employment. Raising a concern about a nurse, midwife or nursing associate's fitness to practise should be raised promptly through our fitness to practise procedures. Information on our website about our fitness to practise processes.

How to obtain confirmation

138. The confirmation process involves having a discussion about your revalidation with an appropriate confirmer. We recommend that you obtain confirmation through a face-to-face discussion or video conference.
139. As part of that discussion, you will demonstrate to that confirmer that you have complied with all of the revalidation requirements, except those related to a professional indemnity arrangement and health and character, as set out in this guidance.
140. We recommend that you obtain your confirmation during the final 12 months of the three year renewal period to ensure that it is recent. If you obtain confirmation earlier, we may ask you to explain why.

141. If your confirmer is a NMC-registered nurse, midwife or nursing associate, your reflective discussion can form part of the confirmation discussion. If your confirmer is not on the NMC register, you will need to have your reflective discussion with an NMC-registered nurse, midwife or nursing associate before you have your confirmation discussion with your confirmer.

142. We have provided further information about the role of confirmers in our guidance document Information for confirmers, which you should ensure your confirmer has read.

An appropriate confirmer

143. Your line manager is an appropriate confirmer, and we strongly recommend that you obtain confirmation from your line manager wherever possible. A line manager does not have to be an NMC-registered nurse, midwife or nursing associate. For example they could be a GP practice manager or care home manager at your place of work.

144. If you do not have a line manager, you will need to decide who is best placed to provide your confirmation. Wherever possible we recommend that your confirmer is an NMC-registered nurse, midwife or nursing associate. It is helpful if they have worked with you or have a similar scope of practice, but this is not essential.

145. If that is not possible, you can seek confirmation from another healthcare professional that you work with and who is regulated in the UK. For example, you could ask a doctor, dentist or a pharmacist. You will need to record their profession and professional Pin or registration number.

146. If you do not have a line manager, or access to someone on the NMC register or another healthcare professional, please check our online confirmation tool for further guidance as to who can act as a confirmer in this situation at **revalidation.nmc.org.uk/what-you-need-to-do/confirmation**.

147. If your confirmer is an NMC-registered nurse, nursing associate, midwife, they must have an effective registration with the NMC. We will not be able to verify your application if your confirmation was provided by a person who was subject to any kind of suspension, removal or striking-off order at the time of making the confirmation.

Obtaining confirmation if you work wholly overseas

148. If you work wholly overseas, you can seek confirmation from your line manager where you undertake your work.

149. If you do not have a line manager, you will need to decide who is best placed to provide your confirmation. Wherever possible we recommend that your confirmer is a nurse, midwife or nursing associate regulated where you practise, or another regulated healthcare professional. Our online confirmation tool provides further guidance as to who can act as a confirmer in this situation.

Obtaining confirmation if you have more than one line manager

150. If you have more than one employer or undertake more than one role, you only need to obtain one confirmation. You will need to decide which line manager is most appropriate to provide confirmation that you have met the revalidation requirements.

151. We recommend that you have your revalidation discussion and obtain confirmation through the line manager where you undertake the majority of your work. You may choose to have a revalidation discussion with each of your line managers, and bring the outputs of those discussions to the line manager you think is most appropriate to be your confirmer.

Confirmation and appraisals

152. The revalidation process is designed so that it can form part of an appraisal process, and where possible we recommend that you use your annual appraisal to have your revalidation discussion and obtain confirmation.

153. If your line manager is an NMC-registered nurse or midwife, you might like to have your reflective discussion at the same time as your confirmation discussion as part of your annual appraisal.

154. However, it is not a requirement of revalidation that you obtain your confirmation as part of an appraisal.

How to record confirmation

155. You must use the NMC form to record your confirmation. Your confirmer will need to complete and sign this form.

156. You should keep the completed and signed form.

What you need to tell us in your online application

157. You will be asked to enter the name, NMC Pin or other professional identification number (where relevant), email, professional address including postcode and contact number of your confirmer. If your confirmer is not your line manager or an individual on the NMC register, you will also need to provide details of their profession and regulation.

158. We will also ask you whether you have a regular appraisal and whether you have a line manager who is an NMC-registered nurse, midwife or nursing associate so that we understand what level of support was available to you in completing your revalidation application.

THE APPLICATION PROCESS

Before you apply

159. **Set up an NMC Online account.**
You will need to submit your application through NMC Online. You can also check your renewal date and revalidation application date on NMC Online. We have published a step-by-step guide to registering for NMC Online at **www.nmc.org.uk/registration/nmc-online**.

> Once you have set up your online account, you will receive all subsequent notifications by email. Please add the NMC as a safe sender and check your email (including any junk email folder) regularly during the revalidation process.

160. **Keep your contact details up to date so that we can notify you when your revalidation application is due.**
The most common reason for someone failing to revalidate is a failure to keep the NMC updated on your contact details.

161. **Make sure you know when your revalidation application is due.**
You must submit your application by the date we specify. You may affect our ability to process your revalidation application if you do not submit your application by this date, and the renewal of your registration may be at risk as a result.

162. **Make sure that you have all your supporting evidence to hand when you start your online application.**
Please contact the NMC well in advance of your revalidation application date if you require an adjustment for using NMC Online (see Support to help you revalidate section below).

The online application

163. Your online application opens 60 days before your revalidation application date.

164. During this 60 day period you will need to log into your application via NMC Online and address each of the requirements.

165. Do not submit your application until you have met all the revalidation requirements.

Contacting your employer or any other relevant third party

166. As part of your application process we may need to contact your employer or any other relevant third party who can verify the information that you have provided in your application.[28]

167. In your online application you will be asked to provide consent for this purpose.

Equality and diversity information

168. As part of the online application process you will be asked to supply some equality and diversity information. We use this data to monitor our services so that we can support you and make sure we are treating everyone in a fair and equal way. The questions have been designed to gather data about our service users in relation to the characteristics protected by the law under the Equality Act 2010.

169. We will keep the information from this questionnaire confidential and store it in line with the Data Protection Act 2018 and the NMC's Data Protection Policy. By submitting this sensitive personal information to us, you explicitly consent to the collection and processing of your sensitive personal information in accordance with the NMC's Data Protection Policy.

170. Providing this information is optional and will not affect your revalidation application or registration renewal. If you would prefer not to disclose this information you can select the 'prefer not to say' option for any or all of the questions.

Details of our Data Protection Policy are included in our privacy notice at **www.nmc.org.uk/privacy.**

Paying your fee

171. Alongside your revalidation application you need to pay your annual registration fee every year to maintain your registration with the NMC. Your registration will not be renewed until we have received your payment.

172. Please refer to our guidance on paying your fees at **www.nmc.org.uk/registration/staying-on-the-register/paying-your-fee**. This sets out the different ways that you can pay, including by direct debit and by debit or credit card, as well as how to pay your fee in four quarterly instalments.

173. As a registered UK tax payer you can claim tax relief on the NMC registration fees. HM Revenue and Customs (HMRC) allows individuals to claim tax relief on professional subscriptions or fees which have to be paid in order to carry out a job. The registration fee you pay to us is included in this category. Please refer to our guidance on how to claim tax relief on your fee at **www.nmc.org.uk/registration/staying-on-the-register/tax-relief**.

After you have completed your application

174. After you have completed your online application you will be offered the option of printing a paper copy of your application for your records.

175. Once your application has been successfully processed and your payment has been received we will send you an email confirming that your registration has been renewed.

176. We advise you to search the register on our website at to double check your status.

Support to help you revalidate

177. We understand that there may be circumstances that make it more difficult for you to meet the revalidation requirements. This may be as a result of a disability, an illness, pregnancy, a maternity period or any other life event that impacts on your ability to meet the revalidation requirements.

178. We can support you to meet the revalidation requirements in several ways, for example by:

- helping you to use NMC Online, or
- providing a short extension to your application date.[29]

For further information on the support we can offer and how to apply for this support please see our support to help you revalidate guidance sheet.

VERIFICATION OF YOUR APPLICATION

179. Each year we will select a sample of revalidation applications and request further information so we can verify the information provided.[30] Such a request does not necessarily mean that there are any concerns about your application and you can continue to practise while we review the information that you provide.

180. We will contact you by email within 24 hours of you submitting your revalidation application if you have been selected to provide further information and where possible we will notify you immediately after you have submitted your application through NMC online. Please make sure to check your email during this time, including junk email folders.

181. If you are selected to provide further information, you will need to complete an online form where you will be asked to provide further information. We may also request further evidence. We will ask you to provide this information within 21 days of receiving your notice that you have been selected for verification.

182. Your registration will not lapse during the verification process, even if the process extends past your renewal date. We will hold your registration effective until the verification process is complete, and you can continue to practise as normal during this time.

183. The table below sets out the information that you will need to provide if you are selected to provide further information. You should already have this information so you should not need to seek any additional information.

184. We will contact your confirmer to request further information using the email address you provided in your application. Please contact us if your confirmer requires adjustments in the way we contact them. Please ensure that your confirmer is aware that if they do not respond to our request for verification they may put your registration at risk. We may also contact your employer and reflective discussion partner.

185. If we identify that you have not met the revalidation requirements, or you have submitted fraudulent information, your registration might be at risk. Please note that if you do not engage fully with the verification process your registration could lapse and you would have to apply for readmission.

186. The verification process will be completed within three months of your renewal date.

Verification information

Practice hours

You will need to provide the following information, starting with your most recent practice until you demonstrate the minimum number of practice hours during the three year revalidation period:

- dates of practice
- the number of hours you undertook
- name, address and postcode of the organisations
- scope of practice and work setting (see tip box on page 22)
- a description of the work you undertook, and
- if practising overseas, whether you are registered with the appropriate regulating body.

We may contact your employer for further information, and you may also be asked to provide further evidence of practice hours and how this relied on your knowledge, skills and experience as a nurse, midwife or nursing associate.

If you are using a completed return to practice course for your practice hours requirement, or you have been admitted to another part of the register since you last renewed your registration or joined the register, please see our guidance sheet on return to practice and new registration at **revalidation.nmc.org.uk/download-resources/guidance-and-information** for further information.

Continuing professional development

You will need to provide the following information:

- the CPD method
- a brief description of the topic and how it relates to your practice
- the dates the CPD activity was undertaken
- the number of hours and participatory hours, and
- identification of the part of the Code most relevant to the CPD.

You may also be asked to provide evidence of the CPD activity.

Reflective discussion

We will not ask you to upload a copy of the signed reflective discussion form; however, we may contact your reflective discussion partner about your discussion.

Professional indemnity arrangement

You are required to have appropriate cover in place for all of your current practice settings. If your arrangement is provided through membership of a professional body or a private insurance arrangement you will be asked to confirm a) that you have read and understood our information on professional indemnity arrangements; b) that you have in place an indemnity arrangement which provides "appropriate cover" in relation to your individual scope of practice, as explained in our guidance, Professional indemnity arrangements; and c) that you understand that you will need to justify decisions on cover you put in place or rely on, if we request you to do so. If you are currently practising in more than one setting, please tell us first about your arrangement in relation to your main practice setting, followed by any other arrangements to cover all your current practice settings.

Confirmation

We will not ask you to upload a copy of the signed confirmation form; however, we will contact your confirmer using the contact details you provided to us in your initial application so please ensure these are accurate. Please ensure that your confirmer is aware that if they do not respond to our request for verification they may put your registration at risk.

REVALIDATION AND NMC FITNESS TO PRACTISE PROCESSES

187. If an employer, a nurse, midwife or nursing associate, or any other individual becomes aware of a serious concern about the fitness to practise of a nurse, midwife or nursing associate they should raise it promptly through our fitness to practise procedures. All nurses, midwives and nursing associates have a professional duty to raise a concern about the practice of a person on our register either through their employer or directly with us.

188. Revalidation does not create a new way of raising a fitness to practise concern about a nurse , midwife or nursing associate. You should not wait until a nurse, midwife or nursing associate's renewal is due before raising a concern.

For more information on how to raise a fitness to practice concern see www.nmc.org.uk/concerns-nurses-midwives/concerns-complaints-and-referrals/

189. The confirmation stage of revalidation is not for the confirmer to make a judgment as to whether a nurse, midwife or nursing associate is fit to practise but rather to confirm that they have met the revalidation requirements.

190. If you are subject to an NMC investigation, condition(s) of practice order or a caution, you are still required to apply to renew your registration as long as you fulfil all the requirements for renewal. However, You will remain subject to NMC fitness to practise processes and the outcome of those processes.

191. If you have been struck off the register, you are not able to revalidate because you are no longer on the register. You will need to apply for restoration to the register.

For more information on restoration please see www.nmc.org.uk/concerns-nurses-midwives/information-under-investigation/restoration

192. If you are suspended from the register, you are not able to revalidate during your suspension. At the end of your suspension, if your registration is effective, you will need to comply with the revalidation requirements at the time that your registration is due to be renewed. If your registration is not effective following the end of your period of suspension, you will need to follow the readmission process.

CANCELLING YOUR REGISTRATION

193. You may not want to retain one or all your registrations with us.

- For example you may wish to cancel all of your registrations with us if you have moved abroad, have retired from practice, changed career or wish to take a break from practice due to your current health.
- Alternatively you may wish to cancel one of your registrations if you wish to continue practising in one but not the other. For example if you are registered as both a nurse and a midwife but only wish to continue practising as a midwife you may want to cancel your nursing registration.

Please note that if you are receiving pay as a nurse, midwife or nursing associate whilst on maternity leave, sick leave or annual leave you may need to maintain your registration with us throughout this period in order to receive it. Please speak to your employer about this.

194. If you want to cancel your registration at the time of your revalidation application, you can do this online through the online revalidation application.

195. If you want to cancel your registration when you are not due to revalidate, you must submit an 'application to lapse your registration' form.

196. You will need to provide your NMC Pin, full name, contact address, the reason for cancelling and a declaration stating that you are not aware of any matter which could give rise or has given rise to a fitness to practise allegation being made against you.

Information on cancelling your NMC registration is available on our website at **www.nmc.org.uk/registration/leaving-the-register/cancelling-registration/**

197. You will not be able to practise or present yourself as a registered nurse or midwife in the UK or nursing associate in England if you are no longer registered with the NMC. It is a criminal offence if with intent to deceive (whether expressly or by implication), you falsely represent yourself as being on the register, or on part of it, possess qualifications in nursing or midwifery or to use a title to which you are not entitled.[31]

198. If you choose to cancel your registration, and later wish to resume practising as a nurse or midwife in the UK, please refer to our guidance on readmission to the register at **www.nmc.org.uk/registration/returning-to-the-register**.

199. If you apply for readmission within six months of lapsing your registration when your revalidation was due, you will have to meet some of the revalidation requirements in addition to the usual readmission requirements, unless you are able to demonstrate that exceptional circumstances apply. These additional revalidation requirements are:
    - 20 of your 35 CPD hours must be participatory
    - Five pieces of practice related-feedback
    - Five written reflective accounts
    - Reflective discussion
200. For further details of the revalidation readmission requirements and process please see **www.nmc.org.uk/registration/returning-to-the-register/readmission-register/details-of-the-requirements**.

Failure to revalidate and appeals

201. If you cannot meet the revalidation requirements, you can cancel your registration with us. By cancelling your revalidation and providing us with a reason for doing so, you are showing insight and it demonstrates to us that you are managing your situation in a responsible way. You will continue to hold a nursing, midwifery or nursing associate qualification, but will not be a registered nurse, midwife or nursing associate. When you are ready to practise again, you can apply for readmission. Information on cancelling registration and seeking readmission to the register is available on our website at **www.nmc.org.uk/registration**.
202. If you do not cancel your registration, but you fail to submit your revalidation application before the end of your three year renewal period, your registration will lapse (automatically expire). You will need to apply for readmission if you want to come back on to the register.
203. If your application for revalidation is refused because a decision is made that you have not met the revalidation requirements, you may appeal this decision within 28 days of the date on your decision letter.[32]
204. A notice of appeal should be sent to **registrationinvestigations@nmc-uk.org** made in writing and include:
    - your name, address and NMC Pin
    - the date, nature and other relevant details of the decision against which the appeal is brought
    - a concise statement of the grounds of the appeal
    - the name and address of your representative (if any) and a statement as to whether the NMC should correspond with that representative concerning the appeal instead of you
    - a statement that the notice is a notice of appeal
    - a signature by or on behalf of you, and
    - a copy of any documents that you propose to rely on for the purposes of your appeal.[33]

    Please contact us if you require support or assistance in completing this notice.
205. You do not have the right of appeal if you fail to pay the registration fee or submit a revalidation application form within the required timescale and your application to renew your registration is refused as a result.[34]
206. If your registration is not renewed because you cancelled your registration, did not complete your revalidation application, did not submit your application in time or your application for revalidation is refused, you will not be able to practise as a registered nurse, midwife or nursing associate. It is a criminal offence if you knowingly falsely represent yourself as being on the register, or on part of it or you use a title to which you are not entitled.

REFLECTIVE ACCOUNTS FORM

You **must** and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user, colleague or other individuals. Please refer to our guidance on preserving anonymity in the section on non-identifiable information in *How to revalidate with the NMC*.

Reflective account:

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

How did you change or improve your practice as a result?

How is this relevant to the Code?

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

REFLECTIVE DISCUSSION FORM

You **must** use this form to record your reflective discussion with another NMC-registered nurse, midwife or nursing associate about your five written reflective accounts. During your discussion you should not discuss patients, service users, colleagues in a way that could identify them unless they expressly agree, and in the discussion summary section below make sure you do not include any information that might identify an individual. Please refer to the section on non-identifiable information in *How to revalidate with the NMC* for further information. For more information about reflective discussion, please refer to our guidance sheet on reflective practice for revalidation.

To be completed by the nurse, midwife or nursing associate:

Name:	
NMC Pin:	

To be completed by the nurse, midwife or nursing associate with whom you had the discussion:

Name:	
NMC Pin:	
Email address:	
Professional address including postcode:	
Contact number:	
Date of discussion:	
Short summary of discussion:	
I have discussed five written reflective accounts with the named nurse, midwife or nursing associate as part of a reflective discussion. I agree to be contacted by the NMC to provide further information if necessary for verification purposes.	Signature: Date:

CONFIRMATION FORM

You **must** use this form to record your confirmation.

To be completed by the nurse, midwife or nursing associate:

Name:	
NMC Pin:	
Date of last renewal of registration or joined the register:	

I have received confirmation from (select applicable):

- ☐ A line manager who is also an NMC-registered nurse, midwife or nursing associate
- ☐ A line manager who is not an NMC-registered nurse, midwife nursing associate
- ☐ Another NMC-registered nurse, midwife or nursing associate
- ☐ A regulated healthcare professional
- ☐ An overseas regulated healthcare professional
- ☐ Other professional in accordance with the NMC's online confirmation tool

To be completed by the confirmer:

Name:	
Title:	
Email address:	
Professional address including postcode:	
Contact number:	
Date of confirmation discussion:	

If you are an NMC-registered nurse, midwife or nursing associate please provide:

NMC Pin:

If you are a regulated healthcare professional please provide:

Profession:
Registration number for regulatory body:

If you are an overseas regulated healthcare professional please provide:

Country of practice:
Profession:
Registration number for regulatory body:

If you are another professional please provide:

Name of regulating body:
Registration number for regulatory body:

Confirmation checklist of revalidation requirements

Practice hours

☐ You have seen written evidence that satisfies you that the nurse, midwife or nursing associate has practised the minimum number of hours required for their registration

Continuing professional development

☐ You have seen written evidence that satisfies you that the nurse, midwife or nursing associate has undertaken 35 hours of CPD relevant to their practice as a nurse, midwife or nursing associate

☐ You have seen evidence that at least 20 of the 35 hours include participatory learning relevant to their practice as a nurse, midwife or nursing associate.

☐ You have seen accurate records of the CPD undertaken.

Practice-related feedback

☐ You are satisfied that the nurse, midwife or nursing associate has obtained five pieces of practice-related feedback.

Written reflective accounts

☐ You have seen five written reflective accounts on the nurse, midwife or nursing associate's CPD and/or practice-related feedback and/or an event or experience in their practice and how this relates to the Code, recorded on the NMC form.

Reflective discussion

☐ You have seen a completed and signed form showing that the nurse, midwife or nursing associate has discussed their reflective accounts with another NMC-registered individual(or you are an NMC-registered individual who has discussed these with the nurse, midwife or nursing associate yourself).

I confirm that I have read *Information for confirmers*, and that the above named NMC-registered nurse, midwife or nursing associate has demonstrated to me that they have met all of the NMC revalidation requirements listed above during the three years since their registration was last renewed or they joined the register as set out in *Information for confirmers*.

I agree to be contacted by the NMC to provide further information if necessary for verification purposes. I am aware that if I do not respond to a request for verification information I may put the nurse, midwife or nursing associate's registration application at risk.

Signature:

Date:

PRACTICE HOURS LOG TEMPLATE

Guide to completing practice hours log

To record your hours of practice as a registered nurse, midwife and nursing associate, please fill in a page for each of your periods of practice. Please enter your most recent practice first and then any other practice until you reach 450 hours. You can only count practice hours during the three year period since your last registration renewal or initial registration. You do not necessarily need to record individual practice hours. You can describe your practice hours in terms of standard working days or weeks. For example if you work full time, please just make one entry of hours. If you have worked in a range of settings please set these out individually. You may need to print additional pages to add more periods of practice. If you are both a nurse and a midwife or a nursing associate and nurse you will need to provide information to cover 450 hours of practice for each of these registrations.[33]

Work setting

- Ambulance service
- Care home sector
- Community setting (including district nursing and community psychiatric nursing)
- Consultancy
- Cosmetic or aesthetic sector
- Governing body or other leadership
- GP practice or other primary care
- Hospital or other secondary care
- Inspectorate or regulator
- Insurance or legal
- Maternity unit or birth centre
- Military
- Occupational health
- Police
- Policy organisation
- Prison
- Private domestic setting
- Public health organisation
- School
- Specialist or other tertiary care including hospice
- Telephone or e-health advice
- Trade union or professional body
- University or other research facility
- Voluntary or charity sector
- Other

Scope of practice

- Direct clinical care or management
- Commissioning
- Education
- Policy
- Quality assurance or inspection
- Research
- Other

Registration

- Nurse
- Midwife
- Nurse/SCPHN
- Midwife/SCPHN
- Nurse and Midwife (including Nurse/SCHPN and Midwife/SCPHN) Nurse and nursing associate (including Nurse/SCPHN

Dates	Name and address of organisation	Your work setting (choose from list above)	Your scope of practice (choose from list above)	Number of hours	Your registration (choose from list above)	Brief description of your work

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

LOG TEMPLATE

Guide to completing CPD record log

Examples of learning method

- Online learning
- Course attendance
- Independent learning

What was the topic?

Please give a brief outline of the key points of the learning activity, how it is linked to your scope of practice, what you learnt, and how you have applied what you learnt to your practice.

Link to Code

Please identify the part or parts of the Code relevant to the CPD

- Prioritise people
- Practise effectively
- Preserve safety
- Promote professionalism and trust

Please provide the following information for each learning activity, until you reach 35 hours of CPD (of which 20 hours must be participatory).
For examples of the types of CPD activities you could undertake, and the types of evidence you could retain, please refer to our guidance sheet at **www.revalidation.nmc.org.uk/download-resources/guidance-and-information**.

Dates	Method Please describe the methods you used for the activity.	Topic(s)	Link to Code	Number of hours	Number of participatory hours
				Total	Total

MAHI - STM - 212 - 713

FEEDBACK LOG TEMPLATE

Guide to completing a feedback log

Examples of sources of feedback

- Patients or service users
- Colleagues – nurses, midwives, nursing associates other healthcare professionals
- Students
- Annual appraisal
- Team performance reports
- Serious event reviews

Examples of types of feedback

- Verbal
- Letter or card
- Survey
- Report

Please provide the following information for each of your five pieces of feedback. You should not record any information that might identify an individual, whether that individual is alive or deceased. The section on non-identifiable information in How to revalidate with the NMC provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

You might want to think about how your feedback relates to the Code, and how it could be used in your reflective accounts.

Date	**Source of feedback** Where did this feedback come from?	**Type of feedback** How was the feedback received?	**Content of feedback** What was the feedback about and how has it influenced your practice?

ENDNOTES

1 SI 2002/253 as amended.

2 SI 2004/1767 as amended.

3 The standards for revalidation are made under Article 19(1) of the NMC Order 2001.

4 The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, NMC, 2018.

5 The Equality Act 2010 does not apply to Northern Ireland. Where the legislation is spread across several pieces of legislation, with some differences. For example Section 75 of the Northern Ireland Act 1998 also includes consideration of 'political opinion' as a protected characteristic.

6 Disability' is defined in the Act as a physical or mental impairment that has a substantial or long-term negative effect on a person's ability to do normal daily activities.

7 Triple registration for nurse, midwife and nursing associate is also possible; this would require 1,350 practice hours.

8 Article 10(2)(c) of the Order, Rule 13(1)(b)(ii) of the Rules.

9 Triple registration for nurse, midwife and nursing associate is also possible; this would require 1,350 practice hours.

10 Standards set under Article 19(3) of the Order.

11 Standards set under Article 19(3) of the Order.

12 Standards set under Article 19(1) of the Order.

13 Standards set under Article 19(1) of the Order.

14 Standards set under Article 19(1) of the Order and under rule 13(1)(b)(i) of the Rules.

15 Standards set under Article 19(1) of the Order.

16 Standards set under Article 19(1) of the Order.

17 Standards set under Article 19(1) of the Order.

18 Rule 13(1)(b)(i).

19 Rule 13(1)(a) of the Rules.

20 Rule 13(1)(a) and paragraph 2 of Schedule 4 of the Rules.

21 Rule 13(1)(a) and Rules 6(6)(d) and 6(6)(e).

22 Rule 6(6)(c).

23 Rule 6(6)(c).

24 Rule 6(6)(c) of the Rules.

25 Article 10(2)(aa) of the Order and Rule 13(1)(aa) of the Rules.

26 Paragraph 1(h)(ii) of Schedule 4 of the Rules.

27 Rule 13(1)(d) of the Rules.

28 We cannot extend any application beyond three months. Rule 14(5) of the Rules.

29 Rule 13(1)(d).

30 Article 44 of the Nursing and Midwifery Order 2001.

31 Article 37(1)(a) of the Order.

32 Article 37(1)(a) of the NMC Order 2001 and the Rules 19, 20 and 21 of the Registration Rules.

33 Article 37(2) of the Order.

34 Article 44 of the Nursing and Midwifery Order 2001.

23 Portland Place, London W1B 1PZ
T +44 20 7333 9333
www.nmc.org.uk

The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland

NMC Nursing & Midwifery Council

nmc Insights

Spotlight on Nursing and Midwifery

Report 2023

Nursing & Midwifery Council

Contents

Sharing insights, improving care

Foreword

We're delighted that we are publishing our first edition of *Spotlight on Nursing and Midwifery*. We want the Nursing and Midwifery Council to be informed by evidence in everything we do and to improve learning and practice in our professions by sharing what we know.

The 788,638 nurses, midwives and nursing associates on our register make a positive difference to people's lives and set out to give safe, effective and kind care. They are under increasing pressure, from challenges such as heavy workloads and staffing shortages. Our insights into the learning and practice of the professionals on our register help us to regulate well, and work with others to create circumstances in which the public can experience care that is safe, effective and kind.

The insights contained in this report were commissioned for a range of purposes, but in bringing them together we are able to share a powerful story about contemporary nursing and midwifery – one that we can build on each year.

The insights in this first report are useful to those implementing the proposals contained in each of the UK's workforce plans: the NHS Long Term Workforce Plan in England, the National Workforce Strategy for Health and Social Care in Scotland, the Welsh Government's National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges, or A Vision for Nursing and Midwifery in Northern Ireland: 2023 – 2028.

There are some clear findings in this first edition.

Racism is affecting the quality of care and retention

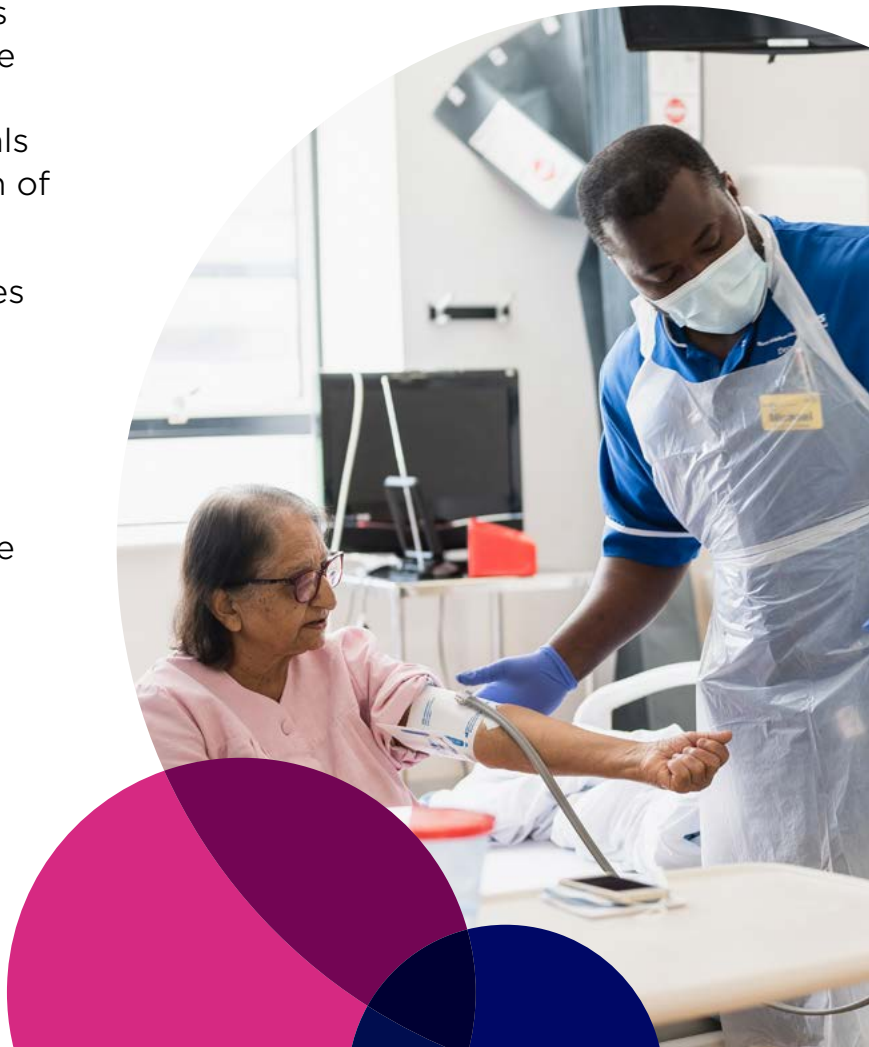
Our recently published registration data report demonstrated the increasing diversity of the nursing and midwifery professionals on our register, due to remarkable growth in new registrations from internationally educated professionals and increasing diversity in domestic entrants.

And yet we know from the NHS Workforce Race Equality Standard in England, academic research, and our own insights, that racism and discrimination are common experiences for Black and minority ethnic professionals, and that the health and care sector is failing to provide a just, inclusive environment in which all Black and minority ethnic nurses, midwives and nursing associates can thrive and progress. Inevitably, this is detrimental both for professionals themselves and for the provision of care to people using services.

Our research into the experiences of internationally educated professionals who have recently joined the register has revealed the impact of the abuse and discrimination that they receive from both colleagues and people for whom they care.

We will be redoubling our efforts to tackle this serious problem, by increasing our engagement with this group and relaying what we hear from them to employers. Alongside this, as part of our Ambitious for Change programme of research, we are addressing employers' disproportionate referrals of Black and/or male professionals, and will continue to audit fitness to practise cases containing allegations relating to racism or discrimination. We will be sharing these findings too.

Employers and leaders across health and social care must keep striving to foster inclusive cultures, free of the bias that profoundly affects people from Black and ethnic minority communities.



Poorly supported new entrants lack confidence in their ability to practise safely and are more likely to leave

Our research into the experiences of nursing and midwifery professionals new to our register shows that where professionals lack the right support at the outset of their practice, consequences can be significant. It can affect their confidence, their sense of being able to practise safely and whether they intend to stay in their profession.

Making the transition from student or overseas nurse, midwife or nursing associate to registered professional can be challenging, and a good quality preceptorship (structured support for nurses, midwives and nursing associates in their first role) can help new professionals to feel more confident in their ability to provide good quality care.

The human and financial costs of early leaving are high. Professionals on our register invest time and money in pursuing their chosen careers; there are costs to the overseas recruitment of internationally educated professionals; and the sooner people leave the register after joining, the greater the loss in years of service they might have given. This affects the quality and safety of the care we receive, and staff shortages have contributed to the lowest levels of satisfaction with the NHS since 1997.

In 2022, we published our Principles for Preceptorship. We are clear that the main aim of preceptorship is to welcome and integrate new professionals into their team and place of work, help them grow in confidence, and begin their lifelong journey as an accountable, independent, knowledgeable and skilled practitioner. As a professional regulator, we can advise employers on good practice, but we can't require compliance with it. We are looking at what else we can do with our partners to ensure that new entrants to our register are supported to thrive in their chosen careers.

Poor communication is affecting experiences of care

We receive concerns about a tiny minority of the people on our register each year. We can investigate these and take action if needed to protect the public. Professionals on our register have to meet our standards of proficiency and uphold our Code: **Professional standards of practice and behaviour for nurses, midwives and nursing associates**.

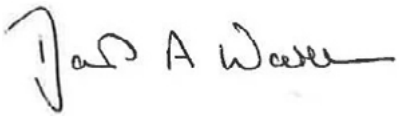
In response to the high level of concern about maternity safety, we undertook a detailed look at some of our midwifery referrals, as well as consolidating our learning from inquiries and reviews into maternity services. We found many common themes. These include midwives not always speaking up when they see something that isn't right, and not communicating well enough with colleagues or people in their care.

All midwives join our register with the knowledge and skills to provide high standards of care. And from day one they commit to practising in line with our Code, which is clear about their responsibility to raise concerns and to communicate well.

But well-evidenced cultural problems in health and care can hold professionals back from the guiding principles of their Code. It's vital that managers and leaders do more to foster cultures in which every midwife feels confident about speaking up, and in which there is better teamwork that supports more consistent communication with women and families.

We hope you will find this *Spotlight on Nursing and Midwifery* an interesting and useful read, and a stimulus for further action. We are looking forward to further debate and collaboration with the wider community of interest in our insight work.

Andrea Sutcliffe, Chief Executive and Registrar



Sir David Warren, Council Chair

Introduction

Welcome to the first of our annual insight publications. As the independent regulator for nursing and midwifery, the Nursing and Midwifery Council's vision is safe, effective and kind nursing and midwifery practice that improves everyone's health and wellbeing. We promote and uphold the highest professional standards to protect the public and inspire confidence in the professions. In the course of our work as a regulator, we generate and review a variety of data and research. We hope that these insights can also help enhance support for good practice and positively influence the environments in which our professionals learn and work.

About this publication

In common with many regulators, we are on a journey to turn the information we capture from our regulatory processes into insights that have a wider benefit in our sector. Aligned with our remit to regulate, support and influence, we aim to understand where we can have the best impact on learning and practice across our professions for the benefit of those receiving care – from workforce planning to educational improvement, and the leadership of positive cultures in health and care.

We are increasingly using the perspectives of our professionals, the people they care for, their employers and their educators, to strengthen how we regulate – for example, when we update our standards or change requirements for education providers.

Spotlight on Nursing and Midwifery weaves together learning from a range of work. As *Spotlight* becomes an established vehicle for insights, we will commission work that explores priority themes. Your ideas and expertise will help shape our future directions.

We use a simple insight framework to determine the sorts of data and insights we need to play our role effectively:

- Understanding the impact of our regulatory approaches
- Understanding our professions - their learning and their practice
- Identifying and acting on risk
- Influencing the context for learning and practice

Please contact us via **research@nmc-uk.org** if you:

- would like to share relevant research
- are interested in discussing shared interests in research
- have feedback about our data and research work.

Reading this report

Spotlight on Nursing and Midwifery is divided into three sections:

1. **Becoming a registered professional**. This section looks at trends in the nurses, midwives and nursing associates joining our register. It also explores people's motivations for joining the profession, their experiences of education and training and how it prepared them for practice and any variation between those educated in the UK and overseas.
2. **Practising in the UK**. This section looks at the experiences of early career UK and internationally educated professionals practising in the UK, their career intentions and reasons why they choose to leave our register.
3. **Maternity care**. Sharing findings from public inquiries and insights from our fitness to practise cases, this section looks at people's experiences of maternity services across the UK.

Context

For the past year, health has been ranked second only to the economy among issues of greatest importance to the public.[1] At the same time, in England, Scotland and Wales, public satisfaction with the NHS is at its lowest recorded level since 1997. Staff shortages are a key reason for this dissatisfaction.[2]

Meanwhile, nurses remain the most trusted profession in the UK (and have done since 2016), although since 2021 this trust has fallen.[3] Diversity has increased but, alongside that, abuse and discrimination have risen – affecting staff morale and the care people receive.

Staffing levels

Having the right number and skill mix of nursing and midwifery staff impacts the quality and safety of people's care[4-9] and their experience.[10] Figures show there are significant nursing and midwifery vacancies across the four countries of the UK.[11-14] Staff shortages have led to increasing reliance on the recruitment of internationally educated health and care professionals.[15-18]

However, nurses and midwives represent more than 50 percent of the current global shortage in health and care workers,[19, 20] and additional demand is also being driven by active recruitment by other countries, including Germany, France, China and India.[21]

Recruitment of international professionals

While the number of professionals on our register has increased overall, we have seen a significant shift in where new professionals are coming from. Internationally educated professionals now account for one in five of the professionals on our register. This group accounts for more than two-thirds of the increase in our register between September 2019 and March 2023.[22, 23]

Internationally educated professionals working in the UK make a vital and welcome contribution to people's health and wellbeing. We have previously signalled international recruitment risks: around sustainability of supply, ethical recruitment, and the treatment of internationally educated professionals.

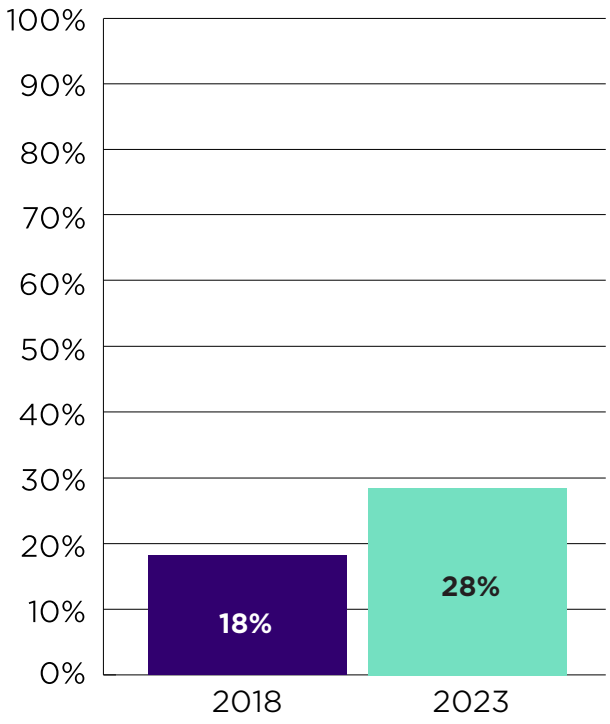
There is additional pressure, given that active recruitment is not permitted from 'red list' countries,[24] even though four of these – Nigeria, Ghana, Zimbabwe and Zambia – were in the 20 most common countries for the training of professionals joining our register in 2022–2023.

Diversity

Our register is becoming more ethnically diverse, as a result of increases in the numbers of internationally educated professionals joining and the growing ethnic diversity of UK educated professionals.[25]

However, we know that Black and minority ethnic staff are more likely to experience abuse and discrimination, whether from managers, colleagues, members of the public or people who use services.[26-31] This has a detrimental impact on care delivery and attitudes towards continuing to practise in the UK.[32-37]

Figure 1: Percentage of the register identifying as Black or minority ethnic in 2018 compared to 2023



Becoming a registered professional

For people to receive safe, effective and kind care, we need the right number and skill mix of professionals within our health and social care system.

Increasing the supply of overseas nurses, midwives and nursing associates is - at least in the short term - being used to address workforce shortages. However, stronger global competition for trained workers, and a reliance on recruitment from India and the Philippines, calls into question how sustainable these increases are for the UK over the medium- to long-term.

Irrespective of where they were educated, newly registered professionals we heard from were positive about the education they received and felt well-prepared for practising in the UK upon completion. However, those educated in the UK highlighted gaps in their education including some perceived limitations of simulated learning, lack of guidance in caring for people with particular diversity characteristics and mixed experiences of learning in practice settings.

Nearly all of the internationally educated professionals we spoke to had previous experience working as a nurse, midwife or nursing associate before coming to the UK. Experiences of applying for and finding work in the UK tended to be mixed, with those who had used a recruiter or agency reporting better experiences in comparison to those who applied directly.

We found that professionals' early experiences shape their subsequent satisfaction, confidence, and ability to care for diverse groups and address health inequalities. Professionals with positive early experiences were more likely to report being happy and confident in their role, while those with more negative experiences were more likely to be unhappy in their role and underconfident in their ability to meet the demands of it.

Understanding the experiences of new professionals

Research shows that experiences as a student can affect professionals' later confidence, competence and retention rates.[38-42] To help us understand the experiences of professionals who have recently joined our register, we surveyed a sample of people who had been educated internationally and undertook qualitative research with those educated both in the UK and internationally (see supplementary publication: Spotlight on Nursing and Midwifery: Underpinning research).

Our qualitative research identified three groups of newly registered professionals:

1. Professionals happy and confident in their role
2. Professionals in need of support
3. Professionals unhappy and underconfident.

Our early career professionals

1. **Happy and confident**. *Professionals satisfied with their role who feel they can fulfil their responsibilities.*
   UK educated professionals are more likely to sit in this group than those educated internationally, as are professionals currently working in Scotland, Wales and Northern Ireland.
2. **Happy but in need of support**. *Professionals who enjoy their work but face significant challenges: high pressure, staffing shortages and continued backlogs from Covid-19.*
   This was the biggest group and is predominantly made up of nursing associates and nurses currently practising in England.
3. **Unhappy and underconfident**. *Professionals unhappy in their role and underconfident about their ability to meet demands.*
   This is a minority of newly registered professionals but is more prevalent among midwives and internationally educated professionals.

Insights into the supply of UK educated professionals

Overall, the number of people studying to become a registered nurse or midwife in the UK, or nursing associate in England, has been rising at around one percent a year, with some differences in rates across professions and UK nations.

Table 1: Students on NMC-approved pre-registration programmes, by profession and country 2021–2022

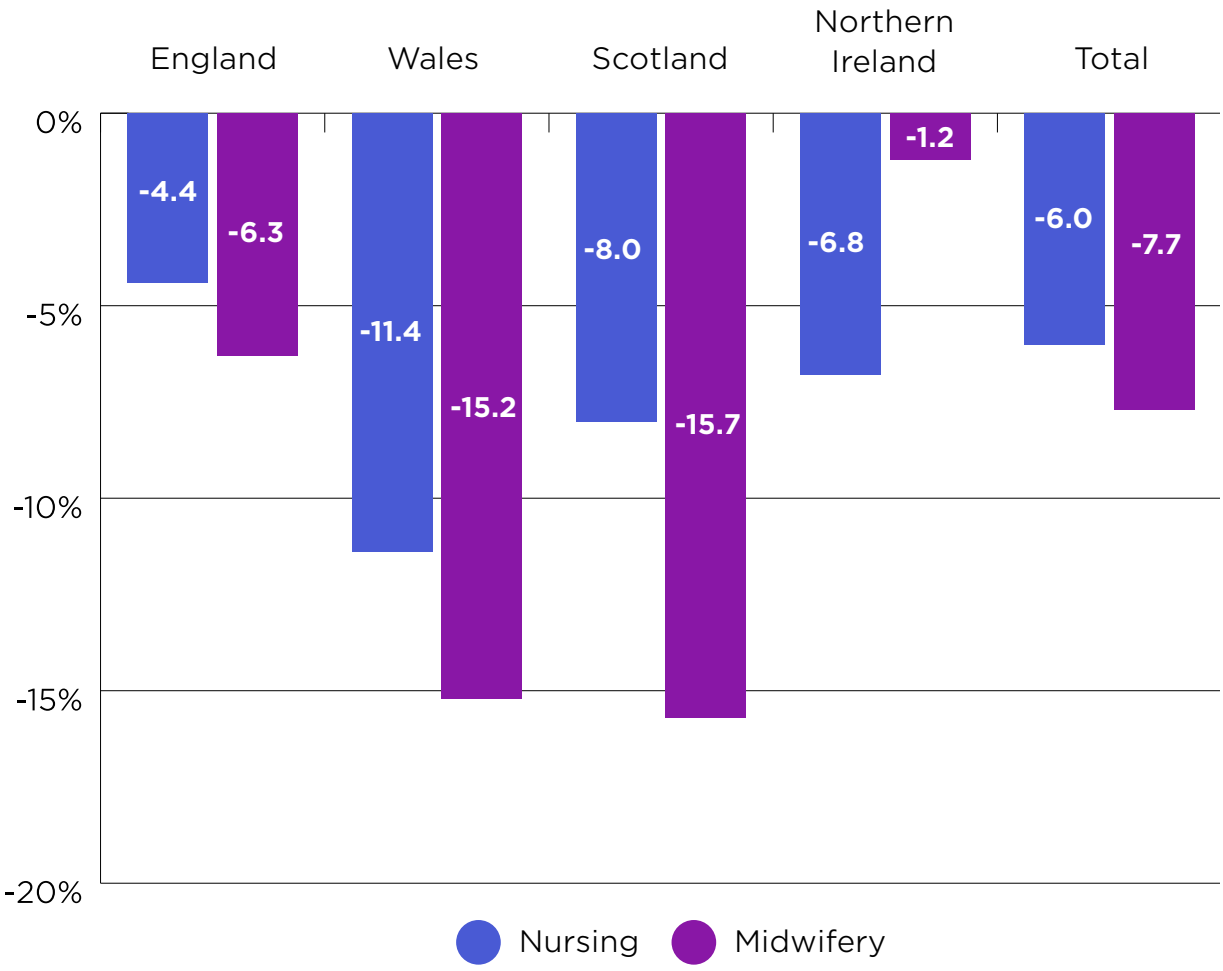
	Nursing	Midwifery	Nursing Associate	Total
England	62,509	8,694	7,495	78,698
Scotland	10,473	637	-	11,110
Wales	3,975	386	-	4,361
Northern Ireland	2,547	238	-	2,785

Applications

The UK's ability to increase workforce numbers by expanding the supply of domestically educated professionals is at risk from falls in the number of people applying to study nursing and midwifery. Securing the right amount and quality of placement capacity will be an additional challenge.[43]

Early data on applicants for 2023 show continued falls in applicant numbers.[44]

Figure 2: Percentage decrease in applications to study nursing and midwifery in 2022 compared to 2021 by UK country[45]



Attrition from pre-registration programmes

Our qualitative research with UK educated professionals revealed that most were inspired to pursue a career in our professions by personal experiences of receiving or observing care, or knowing someone on our register. Many midwives cited their own experience of childbirth as a motivator. More broadly, the key motivations for entering the professions are the attractions of caregiving, wanting to 'do good' in the world and a desire to build a strong, esteemed career.

The RePair (Reducing Pre-registration Attrition and Improving Retention) project reported that in England between 2009–2010 and 2014–2015, the average attrition rate for first year students ranged from 6.2 percent for midwifery students to 8.9 percent for learning disabilities nursing students.[46]

Data from the Higher Education Statistics Authority (HESA) 2014-2015 and 2016-2017, shows that male students, students from mixed ethnic backgrounds, and disabled students, were more likely to drop out from nursing and midwifery pre-registration courses.[26]

"Before...I worked as a home carer...in the community supporting people so they could remain independent in their homes. I really enjoyed knowing I made a difference to people's lives and that is what motivated me to get a job within the NHS as I felt I had the ability to help people on a bigger scale."

UK educated nursing associate, England

Experiences of education and training

Overall, we found UK educated newly registered professionals were positive about their education and training, with the majority feeling adequately prepared upon qualification. They were positive about the length of courses, the balance between theory and practice, the exposure to a broad range of topics, and the varied settings and specialisms of placement types. However, some participants identified gaps in the education they had received.

These included:

- **Access to and quality of simulation**
  Simulation is a teaching method that allows students to practise their skills in an artificial representation of a real-world practice scenario. It supports students to develop their knowledge, behaviours and skills in a safe, supportive environment.

  Most professionals felt that simulation was helpful for practising clinical skills and building confidence in a less pressured environment. Some felt it delivered limited impact compared to real clinical experience.

"I brought this up during my studies and discussed that while religion, beliefs and spirituality was touched on, there were next to no knowledge and learning around LGBTQIA healthcare needs or the needs of different abilities such as blind or deaf patients."

UK educated nurse, Scotland

- **Teaching on health inequalities**
  Professionals said they were made aware of disparities in health outcomes between different groups (for example, by ethnicity) or the need for specialist care for some people (for example, LGBTQ+ people, or disabled people), but felt they were not then given adequate guidance on implications for their practice and how they could better support these groups.

- **Practice placements**
  Nursing and midwifery students are required to undertake placements in different practice settings to give them opportunities to demonstrate their proficiencies. Placements give students opportunities to practice their skills under supervision. However, finding sufficient and varied placements for students can be difficult when health and social care services are under pressure. The Covid-19 pandemic meant placement sufficiency and quality were particularly acute for those on pre-registration programmes during this time - an issue that would have impacted the newly registered professionals we spoke to in our research.

  Experiences of placements were variable, with most newly registered professionals experiencing a 'mixed bag' throughout their education.

- **Oversight of practice placements**. Newly registered professionals highlighted some examples of poor planning and oversight of placements. For example, placements not corresponding with theoretical learning, practical arrangements not being communicated to students and, in some cases, students being deployed inappropriately as substitutes for qualified professionals.
- **Breadth of experience on placements**. Some newly registered midwives felt they did not get the full breadth of experience they needed on placements, and as a result felt underprepared and overwhelmed when faced with certain situations in their practice (for example, emergencies).
- **Support within placements**. Some professionals spoke about a lack of support from employers, other professionals, or universities, which translated into hostile or unwelcoming working environments.

  Our research found that those newly registered professionals who emphasised feeling alone and undervalued during their placements (particularly in their final placement), were more likely to be 'unhappy and underconfident' about their role and their ability to do well in it.

"There was a constant repetition of placement areas for me and many of my cohort. The placement team seemed unable to ensure a broad and balanced experience for students and were unwilling to look into this despite repeated requests from students and their personal tutors."

UK educated nurse, Wales

On the other hand, where placements worked well, the outcome was more positive. Most of the UK educated, newly registered professionals that we spoke to had got their first job at the same place where they did their final placement, which made the process of finding a job straightforward and helped with their transition to becoming a qualified professional.

Insights into recruitment of internationally educated professionals

Since 2017-2018 there have been increases in the number of internationally educated professionals joining our register to cope with rising demand for health and care services in the UK. This means that professionals educated outside of the UK and the EU/EEA make up a bigger proportion of joiners than they did in 2017–2018, while those educated in the UK and EU/EEA comprise a smaller proportion.[47] Two-thirds of the internationally educated professionals joining our register were educated in India and the Philippines (the top two training countries for internationally educated professionals joining our register since April 2017).

A recent Ipsos Mori poll of members of the public on attitudes to immigration showed support for increased immigration for these roles. More than half the public want more doctors and nurses from overseas; and 44 percent want more care workers. Fewer than one in five support reducing immigration to any of these roles.[48]

Workforce location in the UK

Most internationally educated professionals who have joined our register live in England, with fewer than one in ten in Scotland, Northern Ireland and Wales. This is in contrast to the nearly one in four UK educated professionals who have joined, who live outside of England. There is little in our data to suggest that internationally educated professionals move within the UK once they arrive, with most remaining registered at an address in the country they arrived in for at least five years.

Duration on our register

Internationally educated professionals spend less time on our register compared to those educated in the UK. Between April 2017 and September 2022:

- just under a third of internationally educated professionals spent 5–10 years on our register before leaving (28.9 percent or 6,582 people). In comparison, just over a third of UK educated professionals spent 30–40 years on our register before leaving (36 percent), with nearly a quarter (23 percent) spending 40-50 years.

Motivations

The internationally educated professionals we heard from wanted to become a nurse, midwife or nursing associate for many of the same reasons highlighted by those educated in the UK. They also spoke about wanting to come and work in the UK because of the prospect of better working opportunities and conditions, quality of life (such as free healthcare and a better education for children), the chance to earn a better salary and the desire to work in the NHS as an advanced healthcare system. This reflects findings from wider research.[21, 28, 49, 50]

Obtaining work

Nearly all internationally educated professionals had previous experience working as a nurse, midwife or nursing associate before coming to the UK (96 percent or 1,451 people). Most (92 percent or 1,387 people) felt either "very well" or "well" prepared by their education and training for working in the UK. Just under one in ten (9 percent or 128 people) said that they felt unprepared or very unprepared.

Most respondents told us they came to the UK with a job already lined up (85 percent or 1,277 people). Of the rest, just under half contacted a recruiter (49 percent or 734 people), one third conducted their own job search (30 percent or 457 people), a little over one in ten were contacted directly by a recruitment agency (12 percent or 186 people), and just under one in ten found their job through a friend or family member already in the UK (8 percent or 125 people).

The experiences of applying for and finding work in the UK tended to be mixed. In our qualitative research, most of those who used a recruiter or agency reported better experiences in comparison to those who applied directly.

Those who received support from their employer or agency (such as with arranging tests, getting financial support and receiving guidance), describe relatively positive experiences, and a sense that the process was easier, shorter and simpler than originally anticipated.

For those with no or limited support, there were less positive experiences. These included not receiving feedback when rejected from jobs, not being made aware of support available from their employer to prepare for moving to and working in the UK (such as financial support with health tests or support with visa applications), and reports that some employers were not familiar with overseas recruitment processes.

"I found it frustrating to a degree, because there were documents and details that they requested that I was struggling to obtain – for instance, proof of address when first relocating – and which ultimately extended the hiring process. I also found that if something was incorrect or couldn't be accepted, I wouldn't be notified... Only when I called them was I told they needed further clarification or certification... While I understand the strict nature of a hiring process, overall I found it very tiresome."

Internationally educated nurse, England

Using insights

We will use these insights for our next refresh of the pre-registration standards, and to focus our monitoring of approved education institutions. They will also be material to our work on the framework we set for pre-registration programmes in nursing, in particular, the extent and nature of practice learning.

We encourage educators to reflect on preparing their students for practice in a diverse society, and understanding the specific health needs of different groups. We will use our education quality assurance process to focus on these issues.

Early experiences while studying or applying to practise as a nurse, midwife or nursing associate in the UK shape professionals' later satisfaction, confidence and ability to care. We all need to think more holistically about the continuum from previous practice or learning to becoming a registered professional in the UK and early career support. More specifically, what each new professional needs to consolidate and embed their learning and previous experience so that they are confident in their practice and provide good care.

Practising in the UK

As we saw in the previous chapter, people are motivated to become a nurse, midwife or nursing associate because they want to do good, help others and make a difference in people's lives.

Most domestically educated new nurses are happy and confident in their roles. They cite a sense of pride in what they are doing, supportive colleagues, the opportunity to learn and expand their knowledge, enjoyment of the responsibilities they hold and variety of experiences they can undertake.

Internationally educated professionals and domestically educated midwives are less positive. They are less likely to feel satisfied by their role and are struggling to meet the demands of their profession. Negative experiences during their education and training and/or in practice mean they are now disillusioned and feel underprepared and underconfident in their ability to practise safely.

It's clear that all groups of professionals are facing serious challenges which are impacting their ability to provide safe, effective and kind care. Some are particularly experienced by minority groups – such as racism and discrimination. Others are experienced only by those early in their career – such as inconsistencies in the management of their transition period during their first role (preceptorship).

These challenges are affecting how happy and confident newly registered professionals feel and how long they intend to stay practising in the UK. They are also having a big impact on the people being cared for. Organisational factors, such as discrimination, racism and negative workplace cultures have a significant influence on professionals' abilities to act appropriately and provide care that is safe, effective and kind.[33-36, 51-57]

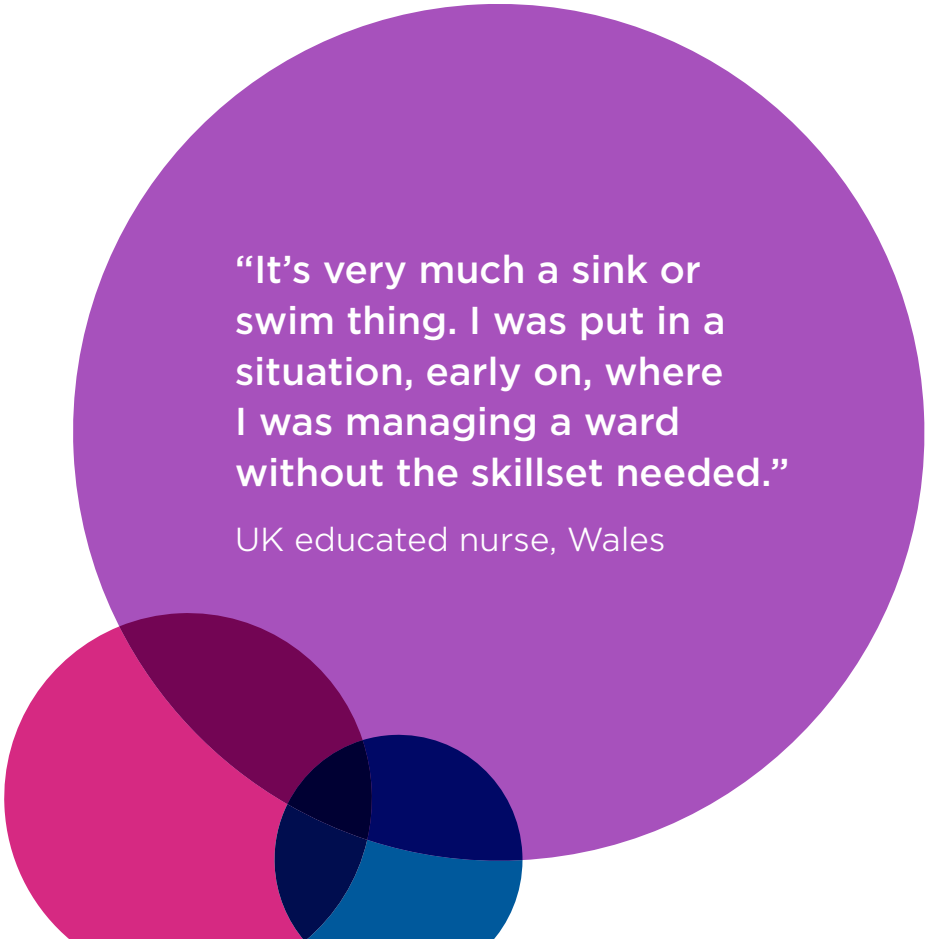
In the following section, we share factors that have affected the successful transition of these new professionals into practice, and the things that can affect their ability to provide safe, effective and kind care, as well as influencing their attitude to staying in their profession.

Staffing levels and workload

All new entrants to our register have had experience of health and care settings - as students, on practice placements, and in the case of most internationally educated new joiners, substantive practice as a nurse, midwife or nursing associate in another country.

Despite this, many new entrants felt shocked and overwhelmed by the demands of practice as a newly registered professional. This included feeling 'tired', 'overwhelmed' and 'burnt out', from taking on more responsibility earlier than they had anticipated. Some also felt that this went beyond 'the shock of the new' and constituted inappropriate deployment.

Newly registered professionals described feeling pressured to undertake tasks that they felt they were either unprepared for or were inadequately supervised, because of staffing shortages. Midwives were particularly likely to share experiences of these challenges.



Internationally educated professionals' views on workload and staffing

- Nearly two-thirds found staffing levels in the UK worse or much worse than expected (61 percent or 903 people), with fewer than one in six finding them better or much better (15 percent or 227 people).
- Nearly half of respondents said that they found the workload in the UK worse or much worse than they expected (45 percent or 664 people), with only a fifth finding it better or much better (20 percent or 299 people).
- Staffing levels and workload were more likely to be seen as reasons not to recommend working in the UK (59 percent or 836 people and 55 percent or 776 people respectively).

(From our survey of 1,512 internationally educated professionals)

Workplace culture

In our qualitative research with 72 newly registered professionals, we heard more about the pressures of staff shortages being exacerbated by poor workplace and management cultures. Some newly registered professionals told us of bullying, hostility, or being sidelined by other staff. This left them feeling underconfident, upset and isolated, with little awareness or understanding of any resources they could access or who they could turn to for help.

Key issues included:

- unrealistic expectations from managers that they could fulfil duties outside of their scheduled hours or experience
- an emphasis on getting on with the job at the expense of personal wellbeing (such as continuing to work a shift after a distressing experience)
- an unwillingness to speak up, due to their inexperience and a perception that their employers would not take their concerns or emotional welfare into consideration.

"There are often deaths and you just have to carry on. You can't just leave your shift if someone dies. We try and do debriefs, but there's just no time, especially if you're on nights."

UK educated nurse, England

"There seems to be service-wide burnout going on at the moment. It has a massive knock-on effect, almost a toxic effect where, if I go looking for support, other people go 'well I never got that when I qualified, I got chucked straight in'."

UK educated nurse, Scotland

Pay

A third challenge highlighted was pay. Professionals told us they do not feel their current pay adequately reflects the level of responsibility they hold and the value they bring. This feeling of being underpaid and undervalued is exacerbated by working long hours, often without a break.

"Financial instability, increased costs of housing, rent and bills, which are not proportional to the salary. Not even able to afford a car, difficult to travel with kids during this winter."

Internationally educated nurse, England

Internationally educated professionals' views on pay

- Internationally educated professionals were especially likely to cite low pay as a downside of working in the UK – reflecting findings from wider research.[58] Many anticipated being able to use higher UK wages to save money but feel the high cost of living here means they are unable to do so.
- Pay was cited as the reason why four in ten respondents would not recommend practising in the UK to other internationally educated professionals (40 percent or 605 people) and over half cited the cost of food and bills as a reason not to recommend working in the UK (56 percent or 847 people).
- Pay and benefits have been cited as reasons for leaving our register by internationally educated professionals since 2017. Nearly one in four (23 percent or 50 people) said that pay and benefits were reasons for them leaving with 7 percent (15 people) saying they were the main reason why they left. For younger professionals this is linked to the cost-of-living crisis, with just over a fifth of those aged 21–40 (22 percent or 127 people) saying that the cost-of-living influenced their decision to leave our register earlier than planned.[59]

Racism and discrimination

Newly registered professionals also told us about experiences of abuse and discrimination from colleagues, members of the public and people who use services. Abuse from members of the public and people who use services tended to involve explicitly racist language, while discrimination from colleagues often involved having their authority undermined and skills and experience being undervalued. This reflects findings from wider research, including our own Ambitious for change work.[27-29] Internationally educated professionals, in particular, cited racism and discrimination as a major challenge they had not anticipated prior to arriving in the UK.

These findings echo the feedback we heard about racism and discrimination from the 86 internationally educated professionals who attended our pilot Welcome to the UK workshops. These attendees:

- raised concerns that included not feeling respected or treated the same as local colleagues; feeling as though their previous experience was not understood or valued; experiencing poor culture, gossiping, and being talked about behind their backs, and not feeling able to trust colleagues to be supportive and keep things confidential
- described crying at the end of shifts, losing weight, being resigned to "that just being how things are here", feeling "traumatised", feeling misled during the recruitment process, and experiencing explicitly racist and derogatory comments.

This feedback resonates with the findings of our own wider research and that of others.

"It is difficult to give the best of yourself if you are looked down upon or treated unfairly and differently from other people."

Internationally educated nurse, Scotland

"The major challenge I face in my workplace is racism by the patients, but I pay deaf ears to it and do my work as it pleases my conscience."

Internationally educated nurse, England

Experiences of preceptorship

Preceptorship is a period of structured transition to guide and support new professionals to become autonomous registrants in order to develop their practice further. Our Principles of Preceptorship state that preceptorship should welcome and integrate the newly registered nurse, midwife or nursing associate into the team and place of work, help them grow in confidence, and begin their lifelong journey as an accountable, independent, knowledgeable and skilled practitioner.

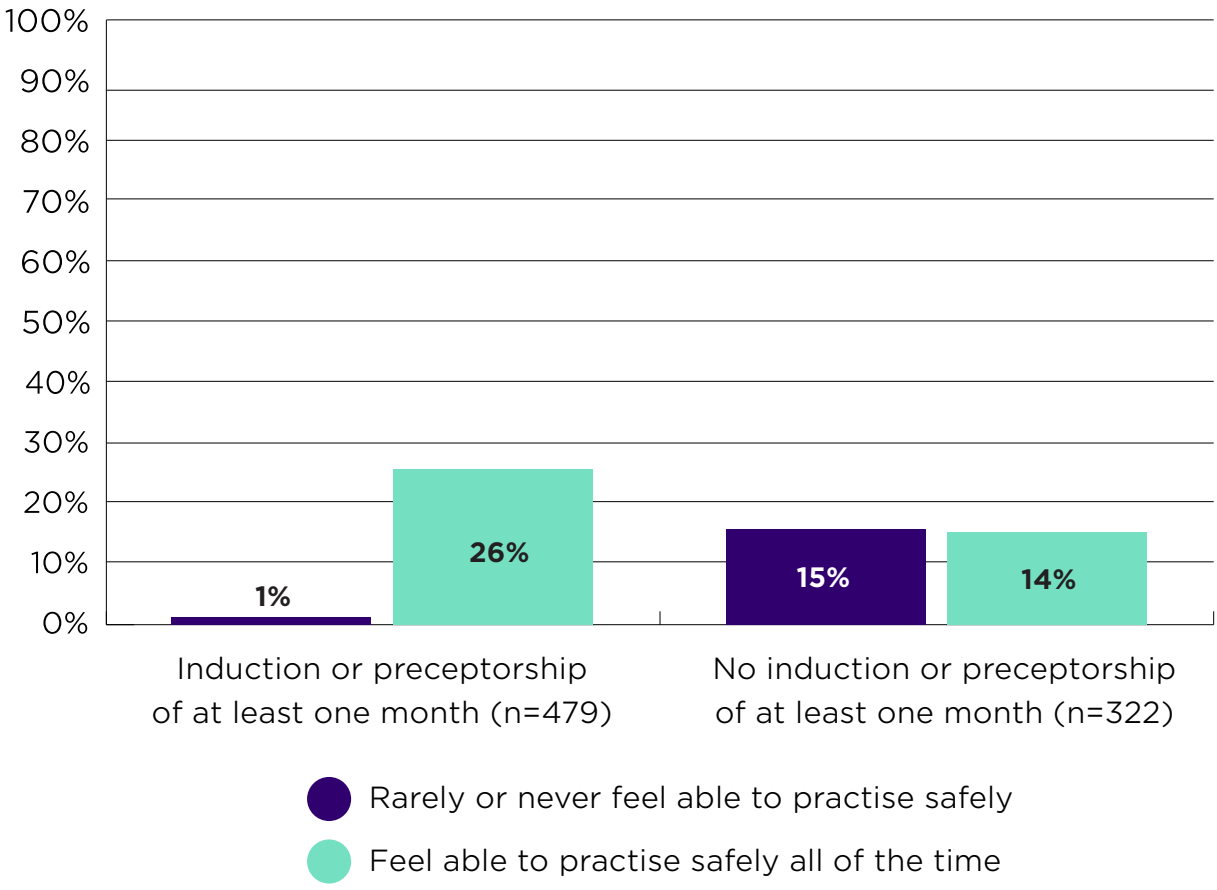
Research suggests that effective preceptorship can help to improve new professionals' sense of confidence and competence.[60-63] Of the newly registered professionals that took part in our qualitative research, around three quarters had experience of preceptorship and felt it could be extremely helpful. But only a minority (more likely to be nurses or nursing associates than midwives) felt highly satisfied with their experience, and there was a feeling that its potential was not always being met.

Participants felt that the length, supervision and organisation of preceptorships were inconsistent across employment settings. This reflects the findings of wider research, which has identified significant variation in the amount, type and quality of preceptorship programmes.[63, 64] We found that newly registered professionals in Scotland and Wales were slightly more positive, reporting that national frameworks and guidelines on preceptorship are laid out to support newly qualified professionals. However, professionals' experiences of preceptorship support and supervision in England were widely varied.

One in six of the internationally educated professionals that responded to our survey had not received a preceptorship. Preceptorship of less than one month was not uncommon; half had an induction shorter than one month and just under one in ten had no induction at all. Despite this, internationally educated professionals participating in our qualitative research were less likely to report negative experiences than those educated in the UK. Overall, those who did not receive a preceptorship generally felt it would have been helpful, particularly in helping them to understand UK ways of working better and build their confidence and competence about practising in another country.

We found a statistically significant link between survey respondents receiving little or no preceptorship and having feelings of being unable to practise safely (see Figure 2), and of questioning whether they intended to remain practising in the UK. Those who had not received an induction or preceptorship of at least a month were nearly twice as likely to tell us they intended to leave UK practice in the next three years, compared to those who had (15 percent and 8 percent, respectively).

Figure 3: The influence of induction and preceptorship on internationally educated professionals' perceptions of their ability to practise safely[65]



Understanding the challenges for newly registered professionals

To better understand some of the challenges faced by newly registered professionals, we looked at the fitness to practise cases we received between April 2017 and March 2022 that involved professionals in their first three years of joining our register.

Referrals received for newly registered professionals account for only a small proportion of referrals (just over one in ten – 11.5 percent or 1,925 people). Early career referrals were more common from employers than from members of the public.

In general, newly registered professionals are referred for much the same reasons as other professionals, with allegations about patient care and prescribing and medicines-management the most common. However, more newly registered professionals were referred for competence-related reasons (just under three percent) compared to those who have been on our register for longer (0.7 percent).

We took a closer look at allegations associated with 88 of these fitness to practise cases (see supplementary publication: ***Spotlight on Nursing and Midwifery: Underpinning research***). Associated allegations suggest that calculating dosages for prescribed medicines in real-life settings (as opposed to doing so in test or training environments) may be an issue for some newly registered professionals. Although a small, non-representative sample, this may offer insight into a need for better induction and supervision in this area of practice.

The higher prevalence of competence issues may help to explain some of the differences in outcomes we found for newly registered professionals in the fitness to practise cases we received between April 2017 and March 2022.

Findings from fitness to practise cases

- Cases involving newly registered professionals were more likely to receive Conditions of Practice Orders and Striking Off Orders at adjudication stage.
- Cases that involved allegations about employment and contractual issues received the highest proportion of sanctions – with most applied where professionals did not complete training or abide by remedial measures.
- Cases that involved allegations about communication issues were more likely to result in newly registered professionals being struck off, compared to those on our register for longer.
  - Most of these cases involved EU/EEA educated professionals and were received in 2017 and 2018, so may be linked to changes in how English language competence was assessed for EU/EEA educated professionals.
  - From 18 January 2016, EU/EEA educated professionals wanting to join our register were required to prove that they had the necessary knowledge of English to practise safely and effectively in the UK.
  - Legislation introduced at this time gave us a new basis for investigating professionals' fitness to practise. It related to patient safety concerns over professionals' ability to communicate effectively in English.

(Relating to newly registered professionals April 2017–March 2022)

Retaining new entrants

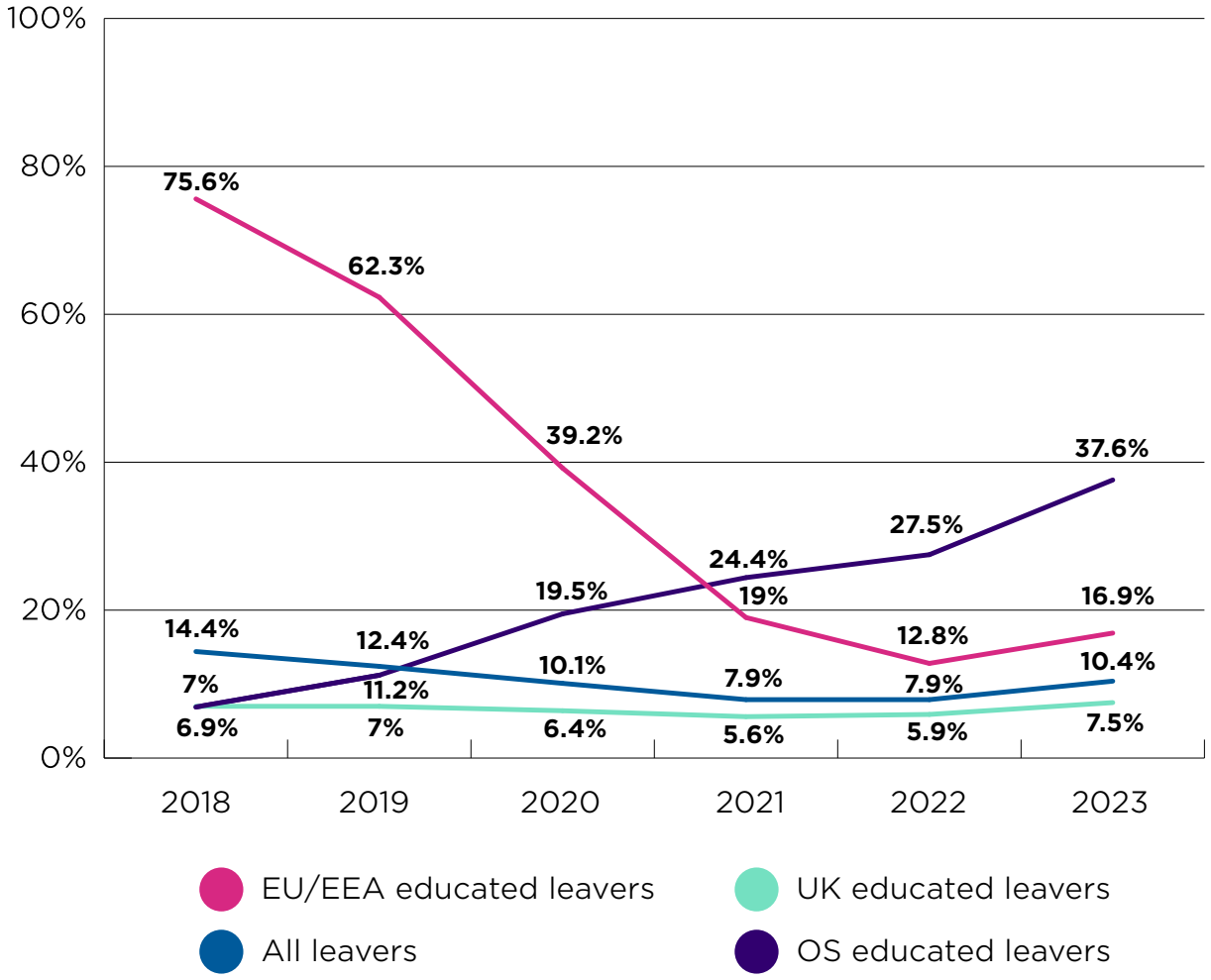
Overall, the number of professionals leaving within the first five years of registration has fallen since March 2018. Of those leaving in that timeframe, the greatest number are internationally educated professionals, and we have seen an ongoing increase in the proportion of these professionals leaving each year.

However, when we asked this group about career intentions, more than half of survey respondents said they saw their long-term future in UK health and care, with a third looking to stay indefinitely (33 percent or 506 people) and a fifth looking to stay more than five years (21 percent or 313 people).

Findings related to newly registered professionals leaving the register

In line with all professionals leaving the register, more than half of those leaving within the first five years had done so earlier than planned. However, the newly registered professionals leaving were more likely to mention staffing, pay and burnout as reasons for doing so than those who had been on our register for longer. And it is clear that the cost-of-living crisis has had a particular impact on this group: a quarter (25 percent) of newly registered professionals said they had left earlier than planned because of it. For comparison, this was cited as the reason for leaving earlier than planned by 13 percent of those with 5–20 years of being on the register, and three percent of those with more than 20 years on the register.

Figure 4: Proportion of leavers in the first five years of registration by region of training March 2018 to March 2023



Future career intentions

- The majority of newly registered professionals shared their intent to spend a good period of time in the profession. They shared a range of future career goals, including progressing in their current position up the bands; moving into a different field of specialism; and completing further education (including Master's degrees and PhDs).
- The minority of newly registered professionals who said they were planning on leaving, spoke about moving into research roles and travelling and practising abroad.
- In contrast to other leavers, newly registered professionals were in fact the group most likely to say they expect to return to a career as a nurse, midwife or nursing associate.
- Compared to those who have been on our register for longer, newly registered professionals are significantly more likely to be leaving the register because they are leaving the UK. This is probably because these leavers are predominantly internationally educated. (As a whole, just over one in ten professionals (14.2 percent or 216 people) said they intended to leave the UK in the next five years.)

(From our in-depth qualitative research with 72 newly registered professionals and our annual leavers' survey)

Using insights

There is more to be done to ensure that people joining our register can thrive in our professions. Effective preceptorship and support for newly registered nurses, midwives and nursing associates is essential. It is clear from our research that there is undue variation in preceptorship, and that poor preceptorship negatively affects psychological safety and contributes to early leaving. We will work with providers and system regulators to encourage high quality early career support, which should be viewed as a vital and essential investment.

The increasing diversity of our professions, and population, make a positive and inclusive culture in health and care more important than ever. Yet, excessive workloads, staffing shortages, racism and discrimination are impacting on internationally educated professionals and their ability to provide safe, effective and kind care. Without urgent action from leaders and employers, more professionals will leave earlier than planned, risking the substantial investment that has been made in overseas recruitment in recent years and further exacerbating existing staffing shortages.

Providers who rely on the contribution of internationally-educated professionals will want to reflect on what we have learned about their formative experiences in the UK. We know there is some excellent practice in welcoming and inducting nurses, midwives and nursing associates who come to the UK, which suggests that with the right commitment and resource, this can be done well. Our findings point to the importance of setting expectations among wider staff about welcome and support, and reacting swiftly and effectively if colleagues encounter poor attitudes, from any quarter.

Maternity care

Pregnancy and childbirth are generally safe in the UK and usually happy, positive experiences for women and families, but when things go wrong, the consequences can be devastating. Evidence demonstrates that there are some stark inequalities of outcome affecting poorer women, and Black and minority ethnic women.

Only a tiny minority of all the professionals on our register are referred to us each year. The number of referrals we have received about midwives annually since 2017-2018 has equated to less than one percent of all the midwives on our register.

We've found some common themes in the maternity concerns that have been raised with us. Some relate to the specific competencies and skills of midwives – such as how well they monitor babies' heart rates and mothers' contractions (cardiotocography), and how they speak up and escalate concerns about these. Others relate to how well staff work together, and how well they communicate with women and families. These factors affect all areas of health and social care and are not specific to maternity or midwifery. They increase the chances of things going wrong in people's care and, in severe cases, of death or serious illness or injury.

What's clear from our case audit, wider research, and inquiries is that often the actions of individual professionals are shaped by the culture and environment in which they work – with bullying, excessive workloads, burnout and unsupportive management being contributory factors in major failings of care across different sectors. This is particularly concerning in the light of what we heard from newly registered midwives. Many told us that since starting to practise they do not feel confident or able to ask for help from colleagues, and are disillusioned with high levels of pressure and negative working cultures.

In this section, we share insights about issues affecting maternity care in the UK. These are drawn from different sources, including external literature and the further research we have done into issues affecting maternity care.

Inequality of outcomes in pregnancy and childbirth

Research shows that pregnancy and childbirth remain very safe in the UK, across a range of measures.[66] However, there are persistent inequalities in safety outcomes for women of different ethnic backgrounds, ages and socio-economic circumstances.[67-69]

For most women, pregnancy and childbirth are positive experiences, as reported in studies in England,[70] Scotland,[71] Wales,[72] and Northern Ireland.[73] However, as with maternal outcomes, there is variation amongst women of different groups.[70, 74-77]

Inappropriate or delayed response to people's condition

We are responsible for investigating fitness to practise concerns raised with us and acting on them, where necessary, to protect the public. The most common allegations associated with fitness to practise referrals relate to patient care. Within this, the two most common issues raised in all referrals are to do with diagnosis, observation and assessment, and delayed response to negative signs, deterioration or incidents.

Delays in escalating care have been shown to increase the risk of stillbirth, neonatal death and severe brain injury in babies and occurred in more than a third of reports relating to maternity care throughout the UK in 2018.[78, 79]

The failure to act effectively when faced with emergency situations – in particular, failure to escalate concerning deceleration in a baby's heart rate or the inability to recognise and/or interpret other abnormal cardiotocography readings – was a recurring theme in the maternity cases we looked at.

Cardiotocography (a 'CTG') can be used to monitor a baby's heart rate and a mother's contractions during pregnancy. It is used both antenatally and during labour, to monitor the baby for any signs of distress.

We found examples where midwives had not adhered to guidelines set out by the National Institute for Health and Care Excellence (NICE) on monitoring babies' heart rates[80] and failed to recognise risks to both mothers' and babies' heart rates. These concerns led to a failure in speeding up the delivery of the baby, which sometimes resulted in serious harm. Issues relating to CTGs being incorrectly classified, and delays in acting upon clearly abnormal CTG readings, have also been identified as factors leading to major failings of care in maternity services.[51, 81, 82]

As well as failures by midwives to escalate concerns, we found recurring examples of poor communication between colleagues and difficulties with inter-professional working. Where concerns were escalated, they were not always acted upon appropriately or escalated to the appropriate level (for example by obstetricians-in-training to consultants). These themes are also identified in other inquiries into maternity care:

"Fundamentally, there were poor relationships both within and between professional groups. There were factions and divisions within midwifery. There was poor working in obstetrics, with a division between consultants and junior staff that left unsupported staff to deal with complex situations beyond their experience. The failure of obstetric staff and midwives to trust and, in some cases, respect each other added a further significant threat to patient safety."

Kirkup B (2022) Reading the Signals': Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation. HMSO, London

"The failure to follow guidelines, combined with delays in escalation and a lack of collaborative working across disciplines, 'resulted in the many poor outcomes experienced by mothers or their babies, such as sepsis, hypoxic ischaemic encephalopathy and, unfortunately, death'."

'Ockenden Report Final (2022) Findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust. HC 1219'

Not listening to women's concerns

Fitness to practise referrals that we receive from members of the public and people who use services often involve allegations about professionals' poor communication. Allegations of this nature feature more frequently in referrals from members of the public than from other sources, such as employers. Within this, people frequently cite professionals' unfriendly, uncaring or rude manner. In our review of maternity cases between 2017 and 2020, we also found a recurring theme around professionals' lack of empathy and compassion when communicating with members of the public and people who use services.

A review of complaints about UK healthcare found that poor communication from health and care professionals, and a perceived lack of respect, dignity or care, comprise nearly a third of complaints.[83] The failure to listen to concerns, and to prioritise the voices of people who use services as partners in care, has been highlighted as a recurring theme in successive public inquiries into failings of care in different settings.[51, 84-89]

Effective communication, support and compassion from maternity care staff can help a woman during labour and birth to feel in control, feel her wishes are respected, and contribute to a positive birth experience.[90, 91] Receiving kind, respectful and responsive care matters to women during childbirth,[92] yet women across the UK continue to report not being treated with kindness and understanding or having their concerns listened to.[68, 70, 93, 94]

"I know I haven't had a baby before, but this is my body and I know what's going on and this doesn't feel right, this doesn't feel safe. I was expecting to be in pain, I'm not stupid, but this feels unsafe, this amount of pain; and being told, 'you've never had a baby before, I don't know what you expected'..."

"I just wish so hard that when I went and said she was not moving the way she should be, that if they'd listened to me seriously..."

Kirkup B (2022) Reading the Signals': Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation. HMSO, London

"There was one point in my labour, right near the end, where I remember looking at [my partner] and saying, I'm going to be a Black statistic. I was so scared, and the epidural hadn't come, so I felt like people weren't listening to me. It had been days..."

Birthrights (2022) Systemic racism, not broken bodies, An inquiry into racial injustice and human rights in UK maternity care

The ability to recognise significant changes in people's condition was highlighted in the inquiry into failings at the East Kent NHS Trust in England, which emphasised how not listening to women nor taking their concerns seriously resulted in "a failure to recognise warning signs or a deteriorating situation".[53]

Our Standards of Proficiency for Midwives set out the midwife's duty to 'develop and maintain trusting, respectful, kind and compassionate person-centred relationships with women, their partners and families, and with colleagues'. This was strongly supported by feedback from members of the public on the draft Standards.[95]

All midwives, regardless of level of experience, are subject to our standards and have to revalidate against them. We need all leaders in maternity services to commit to support midwives to develop their practice in line with these standards.

Organisational factors

The public know that individual professionals alone cannot deliver a person-centred service (describing it as 'personalised, empathetic and seamless'[96]). They feel that organisational culture and ethos, systems and processes, and staffing and resourcing levels, all have an impact on individuals' ability to provide person-centred care.[96]

High profile inquiries and wider research have shown the influence of organisational culture on individual behaviour.[51-54, 97] For example, a recent review looking at compassion in healthcare, found that poor organisational culture, exacerbated by excessive workloads and inadequate staffing, unsupportive management and a lack of unity within teams, are some of the most common barriers to professionals providing compassionate care.[55] Other research highlights a link between these types of organisational factors and staff burnout, compassion fatigue and difficult professional relationships.[56, 98-103]

The system regulator in England, the Care Quality Commission (CQC), has established criteria for assessing whether an organisational culture is inadequate. These red flags include: low levels of staff satisfaction; staff who do not feel respected, valued, supported or appreciated; poor collaboration or cooperation; high levels of bullying, harassment, discrimination or violence, and not treating staff with respect when they raise concerns.

In this context, findings from the most recent responses to the NHS staff survey in England are particularly concerning. Compared to 2017, fewer midwives felt that their organisation acted on concerns raised by members of the public and people who use services, or that they would be happy with the standard of care provided by their organisation if a friend or relative needed treatment.[104, 105]

This is also reflected in what we heard from newly registered midwives, who were more likely to sit in the 'unhappy and underconfident' group of respondents. We heard how some midwives felt prepared upon qualifying but have now become disillusioned by high levels of pressure or negative working cultures. Their lack of confidence is exacerbated by a perceived lack of support from senior staff, feelings of being unwelcome, unappreciated and unable to ask for help when they need it. As a result, they doubt their ability to carry out their responsibilities, reporting burnout and dissatisfaction.

"I'm not sure I can imagine another five years in the NHS as a midwife, at the moment. I would love to be in a position where I love my job and I am fully satisfied, but the current system and staffing crisis is not making the future look reassuring in my career."

UK educated midwife, England

Looking at the context of fitness to practise referrals

In 2021, we introduced a new approach to taking account of context whenever concerns are raised with us about the practice of somebody on our register. We know that sometimes concerns that appear to be the result of poor individual practice are caused by system pressures or other factors. We need to hold professionals on our register to account when their actions fall below our standards, and we need to identify where an event has arisen because of wider factors that contribute to poor outomes for women and babies. Only then can we identify what needs to happen to keep people safe in the future – even if we're not the ones who can take that action.

Our approach to exploring the context of allegations involves looking at the following areas:

- **The individual nurse, midwife or nursing associate**. We want to know whether there were any specific factors that may have impacted the nurse, midwife or nursing associate and how these may have affected them.
- **The working environment and culture**. Contextual factors or the working environment can prevent nurses, midwives and nursing associates from delivering safe care. We need to understand what the environment was like and whether it was a contributing factor to an incident.
- **Learning, insight and any steps the nurse, midwife or nursing associate has taken to strengthen their practice**. This will help us understand how the nurse, midwife or nursing associate has responded and how this may affect our assessment of the likelihood of something happening again. We also want to hear from the employer about what they have done to resolve any issues within a workplace. This will help us think about whether we need to take wider regulatory action, such as making a referral to another regulator.

In the maternity cases we analysed, we found examples of organisational factors at play, including examples of the red flags outlined by the CQC. (This reflects what is known from the wider literature about factors that affect the quality and safety of maternity care). These related to the following areas:

- workload and staffing
- organisational culture
- training and support
- relationships with others
- issues with the physical environment that professionals were working in.

We also found examples of mitigating personal factors, such as the impact of a professional's difficult family situation.

"I believe there was an element of racism in there and also there was an element of scapegoating and closing ranks."

Professional's statement, Shrewsbury and Telford NHS Trust

"I was upset by my colleagues, worried about my family and stressed."

Professional's statement, East Kent NHS Trust

Using insights

We will continue to grow our understanding of the factors that undermine good standards of midwifery practice. Our analysis suggests that our standards broadly cover the right terrain, but they are not always upheld in practice.

There are some stark findings about the problems in maternity care and midwifery practice. It is clear that organisational factors get in the way of professionals providing the kind of care that women have a right to expect. We need employers to support midwives to develop their practice in line with our standards and to address the organisational factors that we know inhibit good practice. We need system regulators and leaders to recognise the significant risks to public safety from employers not enabling midwives to practise in line with our standards and to use the levers open to them to help address these issues.

We will also continue to talk to providers of maternity services about what they can do to promote positive and open culture, and how we can support their efforts.

What next?

In conclusion, we hope that insights from our regulatory work can lead to understanding and improvement across learning and practice in our professions.

Our insights can impact the professionals we regulate and the people they care for. Our commitment is to use them to improve our work, and to share them with national partners and local leaders in education institutions and health and care providers who are well placed to take steps to improve the environment for learning and care delivery in our professions.

We continually strive to support the professionals on our register to deliver safe, effective and kind care for people. We hope the insights outlined in this report will inspire discussion among our wider community and with us – and in doing so, lead to further beneficial actions and outcomes in the months ahead.

You will see us making a few changes to how we share our research and analysis in future. In addition to *Spotlight on Nursing and Midwifery*, you will see us extending our regular data reports.

This year we have published a report on **revalidation**, alongside our well-established report on **registration**. We will be adding to this series. We are developing a new insight hub on our website, where you will be able to find these resources and more, over time. As with *Spotlight on Nursing and Midwifery*, we'll start with what we can do now and build on that, benefitting from others' feedback and suggestions.

Working together

We want to strengthen and deepen our relationships with the data and research community of interest – which will include people in academia, think tanks, government and national bodies, and other regulators. One of our NMC values is 'collaboration', and we want to hear about research relevant to our work and to support studies that ultimately improve care.

Please register your interest with us via **research@nmc-uk.org**

References

1 YouGov (2023) The most important issues facing the country

2 NatCen (2022) British Social Attitudes 39 | NHS and social care

3 Ipsos Mori (2022) Ipsos Veracity Index 2022: Trust in Professions survey

4 Dall'Ora C; Saville C; Rubbo Bl Turner L; Jones J; Griffiths P (2022) Nurse staffing levels and patient outcomes: A systematic review of longitudinal studies. International Journal of Nursing Studies 134. DOI https://doi.org/10.1016/j.ijnurstu.2022.104311

5 Sworn K and Booth A (2020) A systematic review of the impact of 'missed care' in primary, community and nursing home settings, Journal of Nursing Management, 28(8): 1805–1829.

6 Twigg D; Kutzer Y; Jacob E and Seaman K (2019) A quantitative systematic review of the association between nurse skill mix and nursing-sensitive patient outcomes in the acute care setting, Journal of Advanced Nursing, 75(12): 3404–3423

7 Driscoll A, Grant M, Carroll D, Dalton S, Deaton C, Jones I, Lehwaldt D, McKee G, Munyombwe T & Astin F (2018) The effect of nurse-to-patient ratios on nurse-sensitive patient outcomes in acute specialist units: a systematic review and meta-analysis. European Journal of Cardiovascular Nursing; 17: 6–22.

8 Leary A, Punshon G. (2019) Determining acute nurse staffing: a hermeneutic review of an evolving science. BMJ Open 9: e025654. doi:10.1136/bmjopen-2018-025654

9 Griffiths P, Ball J, Murrells T, Jones S & Rafferty AM (2016) Registered nurse, healthcare support worker, medical staffing levels and mortality in English hospital trusts: a cross-sectional study. BMJ Open; 6: e008751. Doi: 10.1136/bmjopen-2015-008751

10 NIHR (2019) Themed review: Staffing on wards. NIHR Dissemination Centre Doi 10.3310/themedreview-03553

11 NHS Digital (2023) NHS Vacancy Statistics, England, April 2015 - December 2022, Experimental Statistics

[12] NHS Education for Scotland (2023) NHS Scotland Workforce. Latest statistics as at 31 March 2022.

[13] Department of Health (2023) Northern Ireland health and social care (HSC) workforce vacancies December 2022: HSC Vacancies Actively Being Recruited at 31 December 2022

[14] RCN Wales (2022) Nursing in Numbers

[15] NHS England (2021) 2021/22 priorities and operational planning guidance

[16] Scottish Government (2022) National Workforce Strategy for Health and Social Care in Scotland

[17] Health Education and Improvement Wales, and Social Care Wales (2022) A Healthier Wales: Our Workforce Strategy for Health and Social Care

[18] Department of Health Northern Ireland (2022) Health and Social Care Workforce Strategy 2026 – Delivering for our People. Second Action Plan (2022-23 to 2024-25)

[19] WHO (2020) State of the world's nursing 2020: investing in education, jobs and leadership

[20] WHO (2021) The State of the World's Midwifery 2021

[21] Nuffield Trust (2021) Recruitment of nurses from overseas: Exploring the factors affecting levels of international recruitment

[22] NMC (2023) Registration data 2023

[23] Nuffield Trust (2023) Reliance on international nurse recruitment during a workforce crisis

[24] The Department of Health and Social Care (DHSC) has a recently updated Code of practice for the international recruitment of health and social care personnel in England. The Code prohibits active recruitment from 'red list' countries designated by the World Health Organisation. The Code does not prevent individual health workers from 'red list' countries from seeking employment independently, but employers should not be actively recruiting from those countries.

[25] NMC (2023) Equality, diversity and inclusion data tables 2022-2023

[26] NMC (2020) Ambitious for Change: Research into NMC processes and people's protected characteristics

[27] Bond S, Merriman C, Walthall H (2020) The experiences of international nurses and midwives transitioning to work in the UK: A qualitative synthesis of the literature from 2010 to 2019. International Journal of Nursing Studies, Volume 110 https://doi.org/10.1016/j.ijnurstu.2020.103693

[28] Garside J, Newton D, Pressley C, Mejia-Olivares C & Stephenson J (2023) International nurses and their initial integration into NHS England's healthcare workforce: a population analysis. University of Huddersfield

[29] Smith, H, Woodward-Kron R & Ewers M (2022) Nurse Migration in Australia, Germany, and the UK: A Rapid Evidence Assessment of Empirical Research Involving Migrant Nurses. Policy, Politics, & Nursing Practice 2022, Vol. 23(3) 175–194. Doi: 10.1177/15271544221102964

[30] NHS (2023) NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts

[31] NMC (2022) Ambitious for Change: Phase two report

[32] Zabin L; Abu Zaitoun R; Sweity E & de Tantillo L (2023) The relationship between job stress and patient safety culture among nurses: a systematic review. BMC Nursing 22, 39. https://doi.org/10.1186/s12912-023-01198-9

[33] Kritsotakis G; Gkorezis P; Andreadaki E; Theodoropoulou M; Grigoriou G; Alvizou A; Kostagiolas P & Ratsika N (2021) Nursing practice environment and employee silence about patient safety: the mediating role of professional discrimination experienced by nurses. Journal of Advanced Nursing 78, 2: 434-45. doi:10.1111/jan.14994

[34] Dawson J (2009) Does the experience of staff in NHS link to patient experience of care? Institute for Health Services Effectiveness, Aston Business School

[35] Alingh C, van Wijngaarden J, van de Voorde K, Paauwe J & Huijsman R (2019) Speaking up about patient safety concerns: the influence of safety management approaches and climate on nurses' willingness to speak up. BMJ Quality and Safety 28: 39–48. http://dx.doi.org/10.1136/bmjqs-2017-007163).

[36] Guo L; Ryan B; Leditschke I; Haines K; Cook K; Eriksson L; Olusanya O; Selak T; Shekar K; Ramanan M (2022) Impact of unacceptable behaviour between healthcare workers on clinical performance and patient outcomes: a systematic review. BMJ Quality and Safety 31: 679-687. http://dx.doi.org/10.1136/bmjqs-2021-014157 "

[37] NHS Race and Health Observatory (2022) Ethnic Inequalities in Healthcare: A Rapid Evidence Review

[38] Inocian E, Hill M, Felicilda-Reynaldo R, Kelly S, Paragas E & Turk M (2022) Factors in the clinical learning environment that influence caring behaviours of undergraduate nursing students: An integrative review. Nurse education in practice 63(103391)

[39] Green, S., & Baird, K., 2009. An exploratory, comparative study investigating attrition and retention of student midwives. Midwifery, 25, 79-87. doi:10.1016/j.midw.2007.09.002.

[40] Wier J & Lake K (2022) Making the transition: A focus group study which explores third year student and newly qualified midwives' perceptions and experiences of becoming a registrant midwife. Midwifery 111(103377)

[41] Kumaran S & Carney M (2014) Role transition from student nurse to staff nurse: Facilitating the transition period. Nurse education in practice 14(6): 605-611

[42] Maben J, Latter S & Macleod Clark J (2007) The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study. Nursing inquiry 14(2): 99-113

[43] House of Commons Library (2023) The NHS workforce in England. Number 9731

[44] UCAS (2023) 2023 cycle applicant figures – 25 January deadline

[45] UCAS (2023) UCAS Undergraduate End of Cycle Data Resources 2022

[46] HEE (2018) RePAIR: Reducing Pre-registration Attrition and Improving Retention

[47] NMC (2023) Registration data tables 2022-23

[48] Ipsos Mori (2022) Attitudes towards immigration. Survey conducted in collaboration with British Future

[49] Smith D & Gillin N (2021) Filipino nurse migration to the UK: Understanding migration choices from an ontological security-seeking perspective. Social Science & Medicine, 276 https://doi.org/10.1016/j.socscimed.2021.113881

[50] Dlamini S, Masuku S, Mhlanga S & Siphepho J (2022) Perceptions of Emaswati Nurses Working in The United Kingdom (UK) About International Migration: Experiences and Plans. Journal of Nursing & Healthcare 7(1): 01-13

[51] Dr Bill Kirkup CBE (2015) The Report of the Morecambe Bay Investigation

[52] Ockenden Report Final (2022) Findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust. HC 1219'

[53] Kirkup, B. (2022), 'Reading the Signals': Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation. HMSO, London

[54] House of Commons Health and Social Care Committee (2021) The safety of maternity services in England. HC 19

[55] Malenfant S, Jaggi P, Hayden K & Sinclair S. (2022) Compassion in healthcare: an updated scoping review of the literature. BMC Palliative Care 21, 80.

[56] Sinclair S, Norris J, McConnell S. et al. (2016) Compassion: a scoping review of the healthcare literature. BMC Palliative Care 15, 6.

[57] Johnson J, Cameron L, Mitchinson L, Parmar M, Opio-Te G, Louch G, & Grange A. (2019). An investigation into the relationships between bullying, discrimination, burnout and patient safety in nurses and midwives: is burnout a mediator?. Journal of research in nursing, 24(8), 604–619

[58] Pressley C, Newton D, Garside J, Simkhada P & Simkhada B (2022) Global migration and factors that support acculturation and retention of international nurses: A systematic review. International Journal of Nursing Studies Advances, Volume 4. https://doi.org/10.1016/j.ijnsa.2022.100083

[59] NMC (2023) Leavers survey 2023

[60] Irwin, C., Bliss, J., Poole, K (2018) Does preceptorship improve confidence and competence in Newly Qualified Nurses: A systematic literature review. Nurse Education Today, 60: 35-46

[61] Logina, A. and Traynor, M (2019) The relationship between effective transition models and the optimal management of patient care. British Journal of Nursing 28(3): 168-172

[62] Edward K-L, Ousey K, Playle J & Giandinoto J-A (2017) Are new nurses work ready – the impact of preceptorship. An integrative systematic review. Journal of Professional nursing 33(5): 326-333

[63] O'Driscoll M, Allan H & Traynor M (2022) 'Preceptorship: what works?': an integrative literature review. Middlesex University

[64] Scholes, J., Petty, N., McIntosh, T., Green, A., Flegg, M. (2017) Managing support for newly qualified practitioners: lessons learnt from one health care region in the UK. Journal of Nursing Management 25, 102-109.

[65] Findings are statistically significant at a 95 percent confidence level

[66] WHO (2023) Trends in maternal mortality 2000 to 2020. Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division

[67] Knight M, Bunch K, Patel R, Shakespeare J, Kotnis R, Kenyon S & Kurinczuk J (2022) Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. Maternal, Newborn and Infant Clinical Outcome Review Programme, MBRRACE UK

[68] Fair F, Furness A, Higginbottom G, Oddie S & Soltani H (2023) Review of neonatal assessment and practice in Black, Asian and minority ethnic newborns. NHS Race and Health Observatory

[69] Birthrights (2022) Systemic racism, not broken bodies, An inquiry into racial injustice and human rights in UK maternity care

[70] Care Quality Commission (2023) NHS Patient Survey Programme: Independent analysis for England published: January 2023

[71] Black M, Farre A, Gray N, Kynn M, Gavine A & Symon A (2022) Perinatal in Scotland: exploring the impact of changes in maternity services on women and staff. Public Health Scotland

[72] Health Inspectorate Wales (2020) National Review: Maternity Services Phase One. National review of the quality and safety of maternity services

[73] Alderice F, Hamilton K, McNeill J, Lynn F, Curran & Redshaw M (2016) Birth NI: A Survey of Women's Experience of Maternity Care in Northern Ireland. School of Nursing and Midwifery, Queen's University Belfast

[74] MacLellan J, Collins S, Myatt M, Pope C, Knighton W & Rai T (2022) Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis. Journal of Advanced Nursing 78: 2175-2190. DOI: 10.1111/jan.15233

[75] Peter M & Wheeler R (2022) The Black Maternity Experiences Survey: A nationwide survey of Black Women's experiences of maternity services in the United Kingdom. Five X More

[76] Cheyne H, Elders A, Hill D, Milburn E (2019) Is maternity care in Scotland equitable? Results of a national maternity care survey. BMJ Open 9(e023282). doi:10.1136/bmjopen-2018-023282

[77] Higginbottom G, Evans C, Morhan M; Bharj K, Eldridge J, Hussain B (2019) Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review. BMJ Open 9(12): e02948. DOI: 10.1136/bmjopen-2019-029478

[78] The Royal College of Obstetricians and Gynaecologists (2021) Each baby counts. 2020 final progress report

[79] Healthcare Safety Investigation Branch (2020) Delays in intrapartum intervention once fetal compromise is suspected

[80] NICE (2022) Fetal monitoring in labour. NICE guideline [NG229]

[81] Dr Bill Kirkup CBE (2020) The Life and Death of Elizabeth Dixon: A Catalyst for Change

[82] Ockenden Report Final (2022) Findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust. HC 1219

[83] Reader T, Gillespie A & Roberts J (2014) Patient complaints in healthcare systems: a systematic review and coding taxonomy. BMJ Quality & Safety; 23: 678-689.

[84] Robert Francis QC (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

[85] Department of Health (2012) Transforming care: A national response to Winterbourne View Hospital

[86] Baroness Cumberledge (2020) First Do No Harm: The report of the Independent Medicines and Medical Devices Safety Review

[87] Right Revered Graham James (2020) Report of the Independent Inquiry into the Issues raised by Paterson

[88] David Strang CBE (2020) Trust and Respect: Final Report of the Independent Inquiry into Mental Health Services in Tayside

[89] The Muckamore Abbey Hospital Review Team (2020) A review of leadership and governance at Muckamore Abbey Hospital

[90] NICE (2021) Antenatal care. NICE guideline [NG201]

[91] World Health Organisation (2016) Standards for improving quality of maternal and newborn care in health facilities

[92] Downe S, Finlayson K, Oladapo O, Bonet M, Gülmezoglu A (2018) What matters to women during childbirth: A systematic qualitative review. PLoS ONE 13(4): e0194906

[93] Jefferson A (2023) What does the NHS Maternity Survey 2022 tell us about maternity services since the pandemic? Ipsos Mori

[94] John J, Curry G, Cunningham-Burley S (2021). Exploring ethnic minority women's experiences of maternity care during the SARS-CoV-2 pandemic: a qualitative study, BMJ Open ;11: e050666. Doi: 10.1136/bmjopen-2021-050666.

[95] NMC (2019) Future midwife: Consultation response document

[96] Traverse (2023) Understanding 'Person-Centred' Regulation

[97] Pezaro, S., Clyne, W., Turner, A., Fulton, E. A., & Gerada, C. (2016). 'Midwives Overboard!' Inside their hearts are breaking, their makeup may be flaking but their smile still stays on. Women and birth: journal of the Australian College of Midwives, 29(3), e59–e66

[98] Liberati, E.G., Tarrant, C., Willars, J., Draycott, T., Winter, C., Chew, S. and M. Dixon-Woods (2019) 'How to be a very safe maternity unit: An ethnographic study', Social Science & Medicine, 223: 64-72

[99] Johnson J, Cameron L, Mitchinson L, Parmar M, Opio-Te G, Louch G, & Grange A. (2019). An investigation into the relationships between bullying, discrimination, burnout and patient safety in nurses and midwives: is burnout a mediator?. Journal of research in nursing, 24(8), 604–619

[100] Hunter, B., Fenwick, J., Sidebotham, M., & Henley, J. (2019). Midwives in the United Kingdom: Levels of burnout, depression, anxiety and stress and associated predictors. Midwifery, 79, 102526

[101] Leinweber, J. and Rowe, HJ (2010) 'The costs of 'being with the woman': secondary traumatic stress in midwifery'. Midwifery, 26 (1), pp. 76-87

[102] Hunter B. (2004). Conflicting ideologies as a source of emotion work in midwifery. Midwifery, 20(3), 261–272

[103] Smith A., & Dixon A. (2008) Health Care Professionals' Views About Safety in Maternity Services. London, Kings Fund

[104] Rolewicz L (2022) How serious is the fall in job satisfaction among midwives? Nuffield Trust

[105] Royal College of Midwives (2022) NHS staff survey 2022: RCM staff briefing

What we do

Our vision is safe, effective and kind nursing and midwifery practice that improves everyone's health and wellbeing. As the independent regulator of more than 788,000 nursing and midwifery professionals, we have an important role to play in making this a reality.

Our core role is to **regulate**. First, we promote high education and professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects a tiny minority of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.

To regulate well, we **support** our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to **influence** health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

Nursing & Midwifery Council

23 Portland Place,
London W1B 1PZ
+44 20 7637 7181
www.nmc.org.uk
@nmcnews @nmcuk

Nursing & Midwifery Council

Standards for education and training

Part 3:

Standards for prescribing programmes

Original publication **17 May 2018**
Newly published **25 April 2023**

Contents

These updated standards were approved by Council at their meeting on 25 January 2023.

About our standards

Our standards for education and training include the Standards framework for nursing[1] and midwifery education, Standards for student supervision and assessment, and programme standards specific to each approved programme.

Our standards for education and training are set out in three parts:

Part 1: Standards framework for nursing and midwifery education

Part 2: Standards for student supervision and assessment

Part 3: Programme standards:

- Standards for pre-registration nursing programmes
- Standards for pre-registration midwifery programmes
- Standards for pre-registration nursing associate programmes
- Standards for prescribing programmes
- Standards for post-registration programmes: programmes leading to specialist community public health nurse qualifications and programmes leading to community nursing specialist practice qualifications
- Standards for return to practice programmes

Supporting information for our Standards for student supervision and assessment is on our website.

These standards help nursing and midwifery **students** achieve NMC proficiencies and programme outcomes. All nursing and midwifery professionals must practise in line with the requirements of the Code, the professional standards of practice, values and behaviours that nurses, midwives and nursing associates are expected to uphold.

1 We have used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession in England with their own part of our register, but they are part of the nursing team.

Introduction

Our Standards for prescribing programmes sets out the legal requirements, entry requirements, availability of recognition of prior learning, requirements for supervision and assessment and information on the award for all NMC approved prescribing programmes.

Student nurse and midwife prescribers in the UK must successfully complete an NMC approved post-registration prescribing programme in order to meet the standards of proficiency necessary for an annotation to be made against an entry on the NMC register as a nurse or midwife prescriber.

Public safety is central to our standards. Students will be in contact with people throughout their education and it's important that they learn in a safe and effective way.

These programme standards should be read with the NMC's Standards framework for nursing and midwifery education and Standards for student supervision and assessment, both of which apply to all NMC approved programmes. NMC Approved Education Institutions (AEIs) intending to deliver our prescribing programmes must comply with all these standards to run an approved programme.

Education providers structure their educational programmes to comply with our programme standards. They also design their curricula around the published proficiencies for a particular programme and students are assessed against these proficiencies to make sure they are capable of providing safe, effective and kind care that improves health and wellbeing.

Proficiencies are the knowledge, skills and behaviours that nurses and midwives need in order to practise. We publish standards of proficiency for the nursing and midwifery professions as well as proficiencies for NMC approved post-registration qualifications.

Our standards for education and training highlight the need for programmes to adopt an inclusive approach to recruitment, selection and progression, ensuring admissions and all other academic processes are open, fair, transparent and demonstrate an understanding of and take measures to address underrepresentation.

Through our quality assurance processes we check that education programmes meet all of our standards regarding the structure and delivery of educational programmes, that the programme outcomes relate to the expected proficiencies for particular qualifications and that AEIs and practice learning partners are managing risks effectively. Using internal and external intelligence we monitor risks to quality in education and training; this intelligence gathering includes analysis of system regulator reports.

We believe that involving people who use services and members of the public in the planning and delivery of curricula will promote public confidence in the education of nursing and midwifery professionals. We expect the use of supportive evidence and engagement from people who have experienced care.

Before any programme can be run, we make sure it meets our standards. We do this through an approvals process, in accordance with our quality assurance framework.

AEIs, their practice learning partners, and employers all have ownership and accountability for the development, delivery and management of nurse and midwife prescriber programmes, including curricula and assessment, in line with our standards.

Legislative framework

Article 19(6) of the Nursing and Midwifery Order 2001 ('the Order') allows the NMC to establish standards for education and training that lead to additional qualifications which may be recorded on the NMC register. The Standards for prescribing programmes are made under this provision.

The Royal Pharmaceutical Society Competency Framework

As part of our commitment to inter-professional learning and in recognition of the emphasis now being placed on adopting interdisciplinary approaches to prescribing proficiency, we have decided that in future all NMC approved prescribing programmes must deliver outcomes which meet the Royal Pharmaceutical Society's (RPS) **Competency Framework for all Prescribers**[2].

For all categories of prescriber, the RPS Competency Framework applies in full and demonstration of all those competencies contained within it must be achieved in order to be awarded prescriber status.

They must also be maintained thereafter throughout subsequent prescribing practice. The category of award determines the **formulary** a qualified prescriber may prescribe from.

2 This and subsequent references in these standards to the RPS Competency Framework apply to the version of that document that was in place when these standards came into effect and to any subsequent revisions to it or any documents that replace it.

Titles, qualifications and formularies

The following three titles apply to registered nurses, midwives and specialist community public health nurses (SCPHNs) who are able to prescribe.

1. Community practitioner nurse or midwife prescriber

This refers to a registered nurse (level 1), midwife or SCPHN who has an annotation next to their name on our register confirming that they are qualified to prescribe drugs, medicines and appliances from the Nurse Prescribers' Formulary for Community Practitioners[3] in the current edition of the British National Formulary[4].

To obtain community practitioner nurse or midwife prescriber status, a registered nurse, midwife or SCPHN must successfully complete either:

1.1 A community practitioner nurse prescribing course as part of an existing approved SCPHN or district nursing specialist practitioner qualification (SPQ) education programme. This is sometimes known as a 'V100 course' from the code that is used to enter the annotation onto the NMC register indicating that a registrant has successfully completed a prescribing course as part of a SCPHN or district nursing SPQ programme and can prescribe from the limited community formulary; or

1.2 A stand-alone prescribing course for nurse or midwives who have not undertaken the community practitioner nurse (V100) qualification as part of an integrated programme of education, for example as part of a specialist practice qualification in district nursing or a SCPHN health visiting programme but who wish to be able to prescribe from the Nurse Prescribers' Formulary for Community Practitioners in the current edition of the British National Formulary. This is sometimes known as a 'V150 course' from the code that is used to enter the annotation onto the NMC register indicating that a nurse or midwife (who is not a SCPHN and has not completed an SPQ as, for example, a district nurse that includes a prescribing qualification) has successfully completed an approved NMC prescribing programme and can prescribe from the limited community formulary.

3 Nurse Prescribers' Formulary

4 British National Formulary

2. Nurse or midwife independent prescriber

This refers to a registered nurse (level 1), midwife or SCPHN who has an annotation next to their name on our register confirming that they may prescribe any medicine for any medical condition within their competence (with the exception of certain controlled drugs).

3. Supplementary prescriber

This refers to a registered nurse (level 1), midwife or SCPHN who has an annotation next to their name on our register confirming that they are able to work in partnership with an independent prescriber (such as a doctor or dentist) to implement an agreed patient/client-specific clinical management plan with the patient/client's agreement.

To obtain independent/supplementary prescriber status, a registered nurse, midwife or SCPHN must successfully complete an independent/supplementary prescriber preparation programme. This is sometimes known as a 'V300 course', from the code that is used to enter the annotation onto the NMC register indicating that a nurse or midwife has successfully completed an NMC approved prescribing programme that gives them independent/supplementary prescriber status, allowing them to prescribe any drugs (except certain controlled drugs) appropriate to their scope of practice.

Stand-alone extended formulary prescriber status was previously available by way of successfully completing the now discontinued V200 prescribing programme, before supplementary prescribing was introduced in 2003.

The above titles are set out in law[5] and in NMC legislation[6].

5 Human Medicines Regulations SI 2012/1916, regulations 214(3)(c), 214(3)(d) and 214(4).

6 The Nurses and Midwives (Parts of and Entries in the Register) Order of Council 2004 ("the Parts and Entries Order") SI 2004/1765, Article 7(2).

The student journey

Standards for prescribing programmes follow the student prescriber's journey and are grouped under the following five headings:

1. Selection, admission and progression

Standards about an applicant's suitability and continued participation in a prescribing programme

2. Curriculum

Standards for the content, delivery and evaluation of prescribing programmes

3. Practice learning

Standards specific to learning for student prescribers that takes place in practice settings

4. Supervision and assessment

Standards for safe and effective supervision and assessment for prescribing programmes

5. Qualification to be awarded

Standards which state the award and information for annotation onto the NMC register

1 Selection, admission and progression

Approved education institutions together with practice learning partners must:

1.1 ensure that the applicant is a registered nurse (level 1), a registered midwife or a SCPHN before being considered as eligible to apply for entry onto an NMC approved prescribing programme

1.2 provide opportunities that enable all nurse (level 1), midwife or SCPHN registrants (including NHS, self-employed or non-NHS employed registrants) to apply for entry onto an NMC approved prescribing programme

1.3 confirm that the necessary governance structures are in place (including clinical support, access to protected learning time and employer support where appropriate) to enable students to undertake, and be adequately supported throughout, the programme

1.4 consider recognition of prior learning that is capable of being mapped to the RPS Competency Framework for all Prescribers

1.5 confirm on entry that any applicant selected to undertake a prescribing programme has the competence, experience and academic ability to study at the level required for that programme

1.6 confirm that the applicant is capable of safe and effective practice at a level of proficiency appropriate to the programme to be undertaken and their intended area of prescribing practice in the following areas:

1.6.1 Clinical/health assessment

1.6.2 Diagnostics/care management

1.6.3 Planning and evaluation of care, and

1.7 ensure that applicants for V300 supplementary/independent prescribing programmes have been registered with the NMC for a minimum of one year prior to application for entry onto the programme.

2 Curriculum

Approved educations institutions, together with practice learning partners, must:

2.1 ensure that programmes comply with the NMC **Standards framework for nursing and midwifery education**

2.2 ensure that all prescribing programmes are designed to fully deliver the competencies set out in the RPS Competency Framework for all Prescribers, as necessary for safe and effective prescribing practice

2.3 state the learning and teaching strategies that will be used to support achievement of those competencies

2.4 develop programme outcomes that inform learning in relation to the formulary relevant to the individual's intended scope of prescribing practice:

- **2.4.1** stating the general and professional content necessary to meet the programme outcomes
- **2.4.2** stating the prescribing specific content necessary to meet the programme outcomes
- **2.4.3** confirming that the programme outcomes can be applied to all parts of the NMC register: the four fields of nursing practice (adult, mental health, learning disabilities and children's nursing); midwifery; and specialist community public health nursing;

2.5 ensure that the curriculum provides a balance of theory and practice learning, using a range of learning and teaching strategies

2.6 ensure technology and **simulation** opportunities are used effectively and proportionately across the curriculum to support supervision, learning and assessment, and

2.7 ensure that programmes delivered in Wales comply with any legislation which supports the use of the Welsh language.

3 Practice learning

Approved education institutions must:

3.1 ensure that suitable and effective arrangements and governance for practice learning are in place for all applicants including arrangements specifically tailored to those applicants who are self-employed.

Approved education institutions, together with practice learning partners, must:

3.2 ensure that practice learning complies with the NMC **Standards for student supervision and assessment**, and

3.3 ensure that students work in partnership with the education provider and their practice learning partners to arrange supervision and assessment that complies with the NMC **Standards for student supervision and assessment**.

4 Supervision and assessment

Approved education institutions, together with practice learning partners, must:

4.1 ensure that support, supervision, learning and assessment provided complies with the NMC **Standards framework for nursing and midwifery education**

4.2 ensure that support, supervision, learning and assessment provided complies with the NMC **Standards for student supervision and assessment**

4.3 appoint a programme leader in accordance with the requirements of the NMC **Standards framework for nursing and midwifery education**. The programme leader of a prescribing programme may be any registered healthcare professional with appropriate knowledge, skills and experience

4.4 ensure the programme leader works in conjunction with the Lead Midwife for Education (LME) and the practice assessor to ensure adequate support for any midwives undertaking prescribing programmes

4.5 ensure the student is assigned to a practice assessor who is a registered healthcare professional and an experienced prescriber with suitable equivalent qualifications for the programme the student is undertaking

4.5.1 In exceptional circumstances, the same person may fulfil the role of practice supervisor and practice assessor for that part of the programme where the prescribing student is undergoing training in a practice learning setting. In such instances, the student, practice supervisor/assessor and the AEI will need to evidence why it was necessary for the practice supervisor and assessor roles to be carried out by the same person

4.6 ensure the student is assigned to an academic assessor who is a registered healthcare professional with suitable equivalent qualifications for the programme the student is undertaking

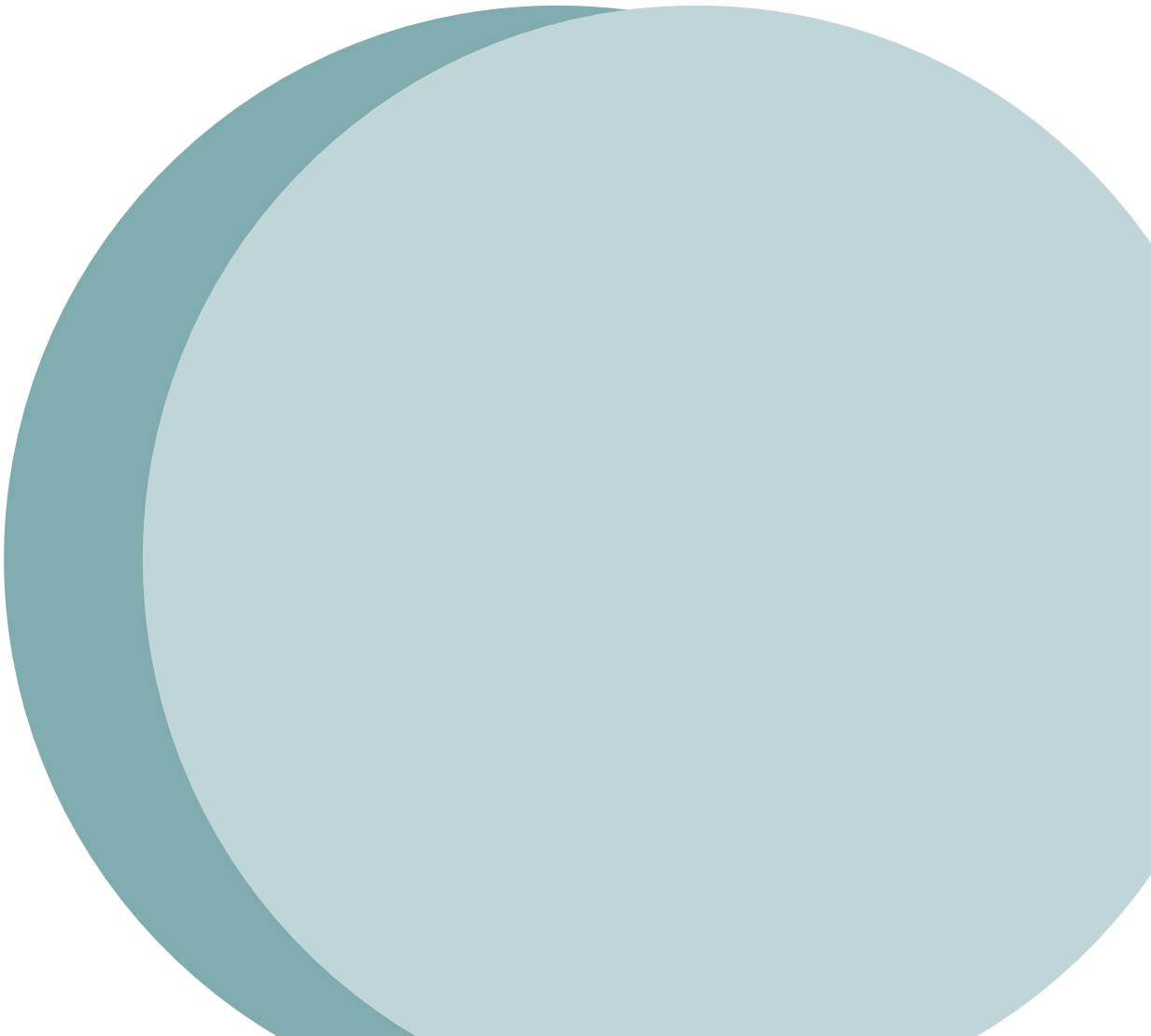
4.7 provide constructive feedback to students throughout the programme to support their development as necessary for meeting the RPS competencies and programme outcomes

4.8 assess the student's suitability for award based on the successful completion of a period of practice based learning relevant to their field of prescribing practice

4.9 ensure that all programme learning outcomes are met, addressing all areas necessary to meet the RPS competencies. This includes all students:

4.9.1 successfully passing a **pharmacology** exam (the pharmacology exam must be passed with a minimum score of 80 percent), and

4.9.2 successfully passing a numeracy assessment related to prescribing and calculation of medicines (the numeracy assessment must be passed with a score of 100 percent).



5 Qualification to be awarded

Approved Education Institutions, together with practice learning partners, must:

5.1 following successful completion of an NMC approved programme of preparation, confirm that the registered nurse (level 1), midwife or SCPHN is eligible to be recorded as a prescriber, in either or both categories of:

5.1.1 a community practitioner nurse or midwife prescriber (V100/V150), or

5.1.2 a nurse or midwife independent/supplementary prescriber (V300)

5.2 ensure that participation in and successful completion of an NMC approved prescribing programme leads to accreditation at a level equivalent to a bachelor's degree[7] as a minimum award

5.3 inform the student that the award must be registered with us within five years of successfully completing the programme and if they fail to do so they will have to retake and successfully complete the programme in order to qualify and register their award as a prescriber[8], and

5.4 inform the student that they may only prescribe once their prescribing qualification has been annotated on the NMC register and they may only prescribe from the formulary they are qualified to prescribe from and within their competence and scope of practice.

7 Level 6 in England, Wales and Northern Ireland and Level 9 in Scotland.

8 The requirement to undertake the qualification again is a standard made by Council under its powers contained at Article 19(3) of the Nursing and Midwifery Order (2001 as amended)

Glossary

Approved Education Institutions (AEIs): the status awarded by the NMC to an institution, or part of an institution, or combination of institutions that work in partnership with practice placement and work placed learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

Educators: in the context of the NMC standards for education and training, educators are those who deliver, support, supervise and assess theory, practice and/or work placed learning.

Formulary: an official list giving details of prescribable medicines. The main function of a nursing and midwifery prescription formulary is to specify those particular medications that are approved to be prescribed by nurses and midwives, depending on the level of qualification they have obtained.

Nurse and midwife prescribers: the collective title for those nurses and midwives who have successfully completed an NMC approved prescribing programme and had that qualification added as an annotation to their entry on the NMC register.

Pharmacology: the study of medicinal drugs and their effect on the body. This includes both pharmacokinetics (the effect of the body on drugs) and pharmacodynamics (the effect of drugs on the body).

Practice learning partners: organisations that provide practice learning necessary for supporting pre-registration and post-registration students in meeting proficiencies and programme outcomes.

Quality assurance: NMC processes for making sure all AEIs and their approved education programmes comply with our standards.

Recognition of prior learning: a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes and requirements; this means it includes both theory and practice achievement.

Simulation: an educational method which uses a variety of modalities to support students in developing their knowledge, behaviours and skills, with the opportunity for repetition, feedback, evaluation and reflection to achieve their programme outcomes and be confirmed as capable of safe and effective practice.

Student: any individual enrolled onto an NMC approved programme at pre-registration or post-registration level, whether full-time or less than full-time.

What we do

Our vision is safe, effective and kind nursing and midwifery practice that improves everyone's health and wellbeing. As the independent regulator of more than 771,000 nursing and midwifery professionals, we have an important role to play in making this a reality

Our core role is to **regulate**. First, we promote high education and professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects a tiny minority of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.

To regulate well, we **support** our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to **influence** health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

Nursing & Midwifery Council

23 Portland Place,
London W1B 1PZ
+44 20 7637 7181
www.nmc.org.uk
@nmcnews @nmcuk

Nursing & Midwifery Council

Standards of proficiency for specialist community public health nurses

Published 7 July 2022

Contents

Introduction

What we do

The Nursing and Midwifery Council (the 'NMC') is required to set standards of proficiency, education and training for nursing and midwifery professionals seeking to join our registers for the first time. As part of this we review our standards regularly to ensure they continue to protect the public, are fit for purpose, and are necessary for safe, effective and kind care. When we review any of our standards, including standards of proficiency for specialist community public health nurses (SCPHN) we take into account new evidence, the changes taking place in society and changes in health and care.

Education and training beyond initial registration

We recognise that in today's health and care services, the roles of nurses, midwives and nursing associates are changing and expanding, requiring higher levels of autonomy, knowledge and skill in order to achieve their full potential and to contribute to the delivery of services for the benefit of the people they serve. Everyone on our register undertakes additional education and training after their initial professional registration to develop further knowledge and skills, but not all of this ongoing education is or needs to be regulated.

We take a proportionate approach to the regulation of post-registration qualifications. We reserve regulation for those areas where ensuring consistency of standards of proficiency, and standards for education and training, is needed to achieve a higher level of quality and safety in order to mitigate risk and to reassure the public. One of the means we have of recognising post-registration qualifications is through setting standards of proficiency for specialist community public health nurses (SCPHN).

The role of the specialist community public health nurse in the 21st century

SCPHN professionals are in the frontline of public health. They are culturally competent, autonomous practitioners who are committed to improving people's health and wellbeing. They understand the wider determinants of health and seek to address health inequalities across the diverse communities and populations they serve.

All SCPHNs work in partnership with people to prevent ill health, protect health and promote wellbeing. Using a formidable evidence base they will lead, influence and collaborate with other agencies, organisations and professionals to improve and embed sustainable changes to the overall health and wellbeing of people at home, within communities, in schools and in the workplace. SCPHNs play a key role in the safeguarding of those people who are most vulnerable in society, and are ambitious for the public health of the communities they serve. They actively pursue sustainable development goals that promote everyone's right to a healthy life.

SCPHN health visitors (HV) are uniquely placed to reach every child in their own home, and be connected to their whole family and community. They build trusting relationships with children, carers and families, to positively influence their future health outcomes. They identify their health needs and strengths and deliver timely, effective, evidence-based interventions in partnership with them. They provide a universal service that ensures support for children and families is personalised, effective, timely and proportionate. The needs and the welfare of the child are at all times central to their work.

Health visitors use their professional autonomy to adapt and tailor their response to the health and wellbeing needs of individuals, families and communities within diverse and changing contexts. They are sensitive to different cultural perspectives and use in-depth knowledge of local communities to develop strong community relationships and to connect families with the community resources that best meet their needs.

Health visitors are advocates for fairness, equity and social justice and will challenge discriminatory practices and behaviours. They understand the impact of the wider determinants of health and are committed to addressing health inequalities through prevention and early intervention, and the promotion and improvement of health.

They lead services that are person-centred and evidence driven, with creativity and resourcefulness, and evaluate the impact of their interventions to continuously improve the quality of care and outcomes for children and families. They maximise the positive impact of health visiting services by working within a collaborative system, planning and coordinating care and maintaining continuity across different services and agencies. They embrace and champion new technologies and are skilled in leading changes in service delivery.

SCPHN school nurses (SN) are autonomous practitioners who uphold the rights of school-aged children and young people at all times. Working collaboratively across health, education and other agencies, and as an integral part of a broader public health service, school nurses advocate for optimum health for all school-aged children and young people, seeking to ensure that services are fair, inclusive, equitable, anti-discriminatory and positively influence health and wellbeing.

Using a variety of advanced communication skills, school nurses build mutually trusting relationships with school-aged children and young people, and parents, carers and families. Importantly, school nurses actively listen to school-aged children and young people, taking account of what matters to them and always putting the needs, welfare and safety of school-aged children and young people first.

School nurses provide culturally appropriate support and early interventions which aim to promote positive choices and reduce risk-taking behaviours. They focus on and support the holistic needs of school-aged children and young people. They understand the wider determinants of health and are committed to addressing health inequalities across the life course, through health education, health promotion and evidence-based age and maturity appropriate interventions.

They know their community and its assets and lead services that are person-centred and evidence driven to ensure positive health outcomes for school-aged children and young people. They collaborate and work effectively with teams and other professionals across a range of sectors and agencies.

SCPHN occupational health nurses (OHN) lead and work in a range of work environments and sectors. They lead services to enhance the health and wellbeing of people in their workplaces and beyond. Working autonomously, they promote and protect the health of the workforce, ensuring a healthy balance between work and wellbeing. As a distinct group of public health professionals, they help to prevent work-related ill health and disease by advising on the creation of workplaces that are safe, efficient and inclusive.

Occupational health nurses collaborate with other professionals, sector experts, employers and employees to lead workplace health initiatives that are responsive to the needs of individuals and organisations. They are able to use and analyse data effectively combining their specialist nursing skills with broader understanding and experience of the distinct sector they work in to embed health initiatives in the wider organisational planning for the benefit of people and communities and in addressing inequalities.

Applying their professional judgement and business acumen, occupational health nurses create innovative strategies for inclusive workplaces that enable people of varied abilities to be productively employed.

They champion the need for workplace health and wellbeing strategies that recognise the impact of health on work and the value of work to health. Recognising the value of a diverse working population, occupational health nurses embed person-centred approaches to health that address the needs of a varied workforce.

They are change agents who influence at strategic and sector level, thinking globally but acting locally, to create a healthy workforce for the present and the future.

SCPHN public health nurses (PHN) are specialists in public health who do not have a predetermined field of SCPHN practice. They may work in roles across a wide range of sectors and settings, applying their specialist public health knowledge and skills to the people, communities and populations they serve.

They take a life course and whole population approach to make a valuable contribution to the wider society's health and wellbeing and in addressing health inequalities. They advocate for people fostering therapeutic relationships that build confidence and trust. They may provide public health information, support and provide timely interventions to people. Equally they may offer public health advice and support to voluntary or third sector organisations within the wider community.

They proactively collaborate with interdisciplinary and interagency teams and services to ensure that people who require wider public health support, care and interventions have fair and equitable access to public health resources, that promote their health and wellbeing, prevent ill health and protect those who are vulnerable.

How to read these standards

The proficiencies in this document specify the knowledge, skills and behaviours that registered nurses and midwives go on to achieve to support and care for people, communities and populations across the life course in specialist community public health nursing roles. They reflect what the public can expect SCPHN health visitors, school nurses, occupational health nurses and SCPHN public health nurses to know and be able to do in order to lead, collaborate, promote, protect and prevent ill health across the life course.

- **Core standards of proficiency** that apply to all fields of SCPHN practice: **HV**, **SN**, **OHN** and **PHN**, and are grouped under six spheres of influence, and;

These core standards of proficiency apply to:

Core	=	HV	SN	OHN	PHN
Core		Health Visitor	School Nurse	Occupational Health Nurse	Public Health Nurse

- **Field specific standards of proficiency** that apply to each of the following fields of SCPHN practice: **HV**, **SN** and **OHN**, and are grouped under four of the six spheres of influence.

These field-specific standards of proficiency apply to:

HV	SN	OHN
Health Visitor	School Nurse	Occupational Health Nurse

These proficiencies will provide new post-graduate specialist community public health nurses entering the profession with the knowledge, skills and behaviours they need at the point of registration. SCPHN health visitors, school nurses, occupational health nurses and SCPHN PHNs will build on these proficiencies as they gain experience and fulfil their professional responsibility. They will demonstrate their commitment to develop as a SCPHN practitioner and to build a career pathway, engaging in ongoing education and professional development opportunities necessary for revalidation.

The six spheres of influence	Specialist Community Public Health Nursing core standards of proficiencies for HV, SN, OHN and PHN	Core and Field Specific Proficiencies
	Core = HV SN OHN PHN	
Sphere A	Autonomous specialist community public health nursing practice	Core only
Sphere B	Transforming specialist community public health nursing practice: evidence, research, evaluation and translation	Core only
Sphere C	Promoting human rights and addressing inequalities: assessment, surveillance and intervention	Core + HV or SN or OHN
Sphere D	Population health: enabling, supporting and improving health outcomes of people across the life course	Core + HV or SN or OHN
Sphere E	Advancing public health services and promoting healthy places, environments and cultures	Core + HV or SN or OHN
Sphere F	Leading and collaborating: from investment to action and dissemination	Core + HV or SN or OHN

The nature of regulatory standards

Regulatory standards are intended to be high level and outcome-focused. They are translated by education institutions and their practice placement partners into more detailed curricula and programme learning outcomes.

These core and field specific standards of proficiency apply to all NMC registered SCPHN HVs, SNs and OHNs. The core standards of proficiency also apply to all NMC registered SCPHN PHNs. They should be read alongside Realising professionalism: Standards for education and training, which set out our expectations regarding provision of all pre-registration and post-registration NMC approved nursing and midwifery education programmes.

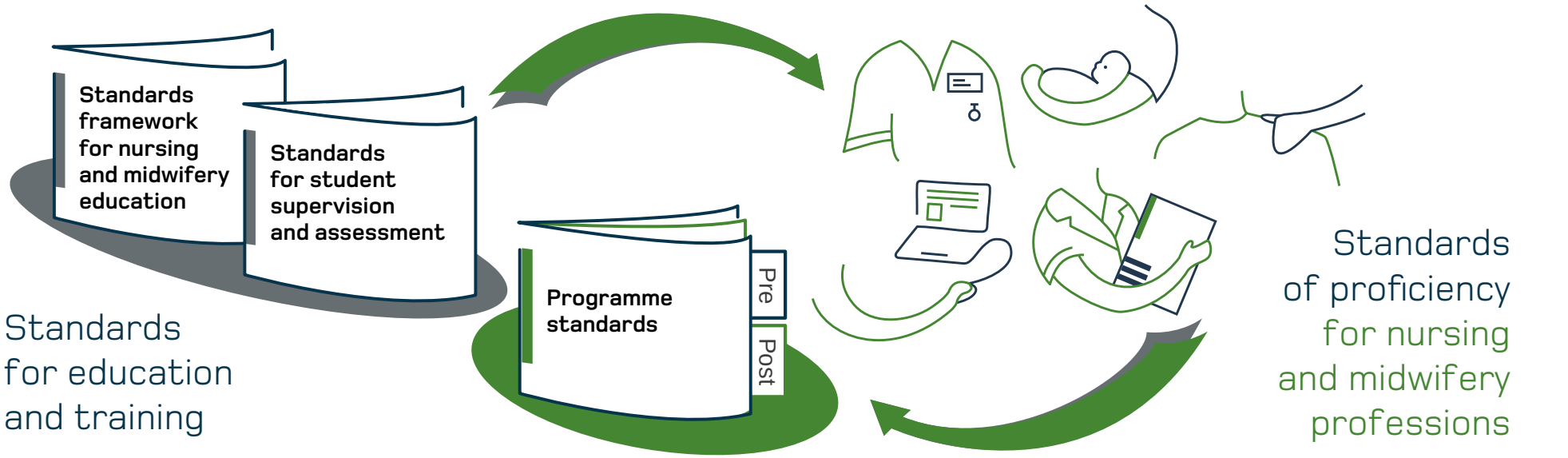
These standards apply to all approved education providers and are set out in three parts:

Part 1: Standards framework for nursing and midwifery education

Part 2: Standards for student supervision and assessment

Part 3: Programme standards, which are the standards specific for each pre-registration or post-registration programme.

Education institutions must comply with our standards to be approved to run any NMC approved programmes. Together these standards aim to provide approved education institutions (AEIs) and their practice learning partners with the flexibility to develop innovative approaches to education for SCPHN health visitors, school nurses, occupational health nurses and SCPHN public health nurses while being accountable for the local provision and management of approved post-registration SCPHN programmes in line with our standards. This is shown in the diagram below.



Legislative framework

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order') requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The standards for nursing and midwifery education providers are established under the provision of Article 15(1) of the Order.

Article 5(2) of the Nursing and Midwifery Order 2001 requires the NMC to establish standards of proficiency necessary to be admitted to each part of the register and for safe and effective practice under that part of the register. The standards of proficiency have been established under this provision.

As SCPHN standards of proficiency are post-registration standards, individuals can only enter the SCPHN part of the register if they are a registered level one nurse or midwife and have successfully met all the requirements of their NMC approved SCPHN programme. Only those on our register can use the protected title of specialist community public health nurse.

Core

Sphere of influence A: Autonomous specialist community public health nursing practice

SCPHN Health visitors, school nurses, occupational health nurses and SCPHN public health nurses understand that health and access to health support is a fundamental human right. They use their professional autonomy to adapt and tailor their response to the health and wellbeing needs of people, communities and populations within diverse and changing contexts at home, in school, in the workplace and in communities. They are sensitive to different cultural perspectives and advocate for and protect those people, communities and populations who are most vulnerable. They are innovative, creative, promote health literacy and maximise the use of new technologies in their day to day practice.

Sphere A: Outcomes

At the point of registration, the registered SCPHN HV, SN, OHN and SCPHN PHN will be able to:

A.1 demonstrate the ability to practice with a high level of autonomy, entrepreneurship and innovation as a specialist community public health nurse

A.2 be an effective ambassador, role model and compassionate leader, and a positive influence on the profession

A.3 use an expanded knowledge of the links between global and national socio-economic and political strategies and policies and public health to drive and influence their own field of SCPHN practice

A.4 select and apply relevant legal, regulatory and governance requirements, policies and ethical frameworks to their specialist community public health practice, differentiating between the devolved legislatures of the UK

A.5 lead on the application of legislation, guidance and advice regarding sustainable development goals, including environmental factors and other pollutants that affect the health and wellbeing of people now and in the future

A.6 influence and promote health as a fundamental human right and as a shared value through engagement, inclusion and participation

A.7 make professional judgements and decisions, and work in complex, unfamiliar and unpredictable environments, proactively identifying actions and solutions to problems that may have many interacting factors

A.8 lead and promote public health provision that is person-centred, anti-discriminatory, culturally competent and inclusive

A.9 demonstrate critical awareness of stigma and the potential for bias, taking action where necessary to educate others and resolve issues arising from both

A.10 recognise the need for and lead on action to provide reasonable adjustments for people, groups and communities, influencing public health policy change and best practice

A.11 demonstrate the advanced numeracy, literacy, digital and technological skills required to meet the needs of people, communities and the wider population, to ensure safe and effective specialist public health nursing practice.

Core

Sphere of influence B: Transforming specialist community public health nursing practice: evidence, research, evaluation and translation

SCPHN Health visitors, school nurses, occupational health nurses and SCPHN public health nurses locate, critique, use, generate and apply evidence, data and information that seeks to promote health and prevent ill health and disability from life choices, environmental factors, non-communicable diseases, trauma or other health conditions. They evaluate public health interventions to better understand what works and what may need to change and why. They propose new and innovative ideas and concepts to inform and improve the health and wellbeing of people across the life course and apply an evidence-based approach to optimise public health programmes and interventions.

Sphere B: Outcomes

Core

At the point of registration, the registered SCPHN HV, SN, OHN and SCPHN PHN will be able to:

B.1 assess the impact and benefits of local and national health and other policies on the health and wellbeing of people, communities and populations

B.2 identify, evaluate and proficiently use multiple sources of evidence and research relevant to people, communities and populations to inform specialist community public health nursing practice

B.3 identify gaps in research, evidence and policy that impact on public health nursing practice and influence how to address these

B.4 utilise and effectively participate in new areas of research across interdisciplinary and interagency teams related to public health priorities and interventions

B.5 use reliable data, statistics and informatics to lead on and support policies and programmes that improve the health outcomes of people, communities and populations

B.6 identify where insufficient information and data is available to inform public health priorities and national intervention strategies and how this may be addressed by refining data sets or in recognising the need for further study

B.7 critically appraise epidemiological research and demonstrate its use in evidence-based specialist public health nursing practice

B.8 synthesise and apply knowledge from research, evaluation, audit and global innovation that leads to improvements in the health of people, communities and populations and addresses health inequalities

B.9 apply the evidence base theory and principles of public health and nursing practice to support innovative approaches to influence people's motivation, choices and behaviours

B.10 critically appraise the evidence that informs new innovations in public health programmes, including genomics, and evaluate early success measures and impact on population health outcomes

B.11 share outcomes and lessons learned from audit, research and evaluation in specialist public health nursing practice locally and nationally and across sectors through professional and peer reviewed processes

Sphere of influence C: Promoting human rights and addressing inequalities: assessment, surveillance and intervention

Health visitors are ideally placed to identify, highlight and address health inequalities due to their unique reach into every family. They actively seek to uphold the human rights of all of those they engage with while recognising that all families are unique and have individual needs. They advocate on behalf of those who are vulnerable or unable to speak up for themselves.

School nurses are in a unique position to advocate for the rights of all school-aged children and young people, including those who may be vulnerable but not visible to other services or agencies. They seek to address health inequalities in school-aged children and young people, and their families. They consider the impact of the home dynamic and complex family situations on school-aged children and young people, and the impact of their educational experiences on their health, wellbeing and future life prospects.

Occupational health nurses use their specialist knowledge to recognise the value of work to health and wellbeing, and the impact of health on work. Using their knowledge and experience of wider socio-economic influences on health and work, they create services and plan interventions that contribute to addressing inequalities by increasing accessibility to and an improved experience of work for all.

Sphere C: Outcomes

Core

At the point of registration, the registered SCPHN HV, SN, OHN and SCPHN PHN will be able to:

C.1 critically analyse the factors that may lead to inequalities in health outcomes and health inequity and take appropriate action to mitigate their impact on people, communities and populations

C.2 demonstrate compassionate leadership in applying human rights, equality, diversity and inclusion, to improve the health and wellbeing of people, communities and populations

C.3 appreciate the legal, ethical, moral and spiritual needs and challenges that may be faced when promoting population health, helping to mitigate barriers that enable people and families to live to their full potential

C.4 assess the impact of complexity and comorbidity and their impact on people, communities and populations, in order to share knowledge and lead on person-centred public health approaches

C.5 develop, promote and support opportunities to educate individuals on the risks to themselves and others of the abuse of tobacco, alcohol and other substances and potentially addictive behaviours

C.6 conduct, interpret and evaluate health assessment and screening, surveillance and profiling checks and interventions, and immunisation and vaccination programmes for people, communities and populations

C.7 ensure equitable and accessible services for all through improved health literacy communication and networking

C.8 consult with, listen to and support people, communities and populations when assessing, planning and co-producing public health interventions

C.9 use models, evidence and concepts to plan, conduct and evaluate population level interventions to address specific public health issues

C.10 apply understanding of determinants of health to develop culturally responsive and inclusive public health interventions with people, communities and populations

C.11 lead on identifying vulnerable people, families, communities and populations and take action to support, safeguard and protect them, and coordinate timely care and other responsive support when needed.

Sphere C: Outcomes – Health Visitor

HV

At the point of registration, the SCPHN health visitor will be able to:

C.HV1 critically analyse and apply evidence-based knowledge of the determinants of health, intergenerational cycles of deprivation and health inequalities that affect the mental, physical, cognitive, behavioural, social, and spiritual health and wellbeing of children, parents, carers and families

C.HV2 provide support to parents, carers and families in understanding what is needed to secure healthy development and wellbeing of infants and children

C.HV3 continually assess and skilfully adapt to different environments and complex situations in order to identify and advocate for those families most at risk, while at all times safeguarding the welfare of the child and others at risk

C.HV4 play a significant role in promoting mental health for parents, families, infants and children during the perinatal period and in the assessment and early identification of perinatal mental ill health

C.HV5 provide care and support to infants, children, parents and families where appropriate and facilitate access to specialist mental health services according to the level of need

C.HV6 promote infant mental health and early identification of infant distress, providing support to families to enable them to prioritise and respond to their infant's needs

C.HV7 initiate appropriate evidence-based person-centred interventions to promote healthy relationships and minimise risks of domestic violence, child maltreatment and other forms of abuse within the family and the developmental impact of parental conflict on children

C.HV8 use their professional judgement to observe, recognise and respond to signs of abuse and neglect across the life course, recognising that individual safeguarding needs will differ.

Sphere C: Outcomes – School Nurse

SN

At the point of registration, the SCPHN school nurse will be able to:

C.SN1 proactively promote, support and improve the health and wellbeing of school-aged children and young people, recognising the rights of the child at all times

C.SN2 evaluate the relationship between school, life, mental and physical health and ill health and lead on proactive approaches to promote and protect health and wellbeing of school-aged children and young people in and outside of school

C.SN3 lead evidence-based interventions that are holistic, inclusive and responsive to the needs of school-aged children and young people

C.SN4 evaluate the impact of intergenerational cycles of dependency and adversity on school-aged children and young people, and how protective factors, early help, and interventions improve health outcomes

C.SN5 apply an evidence-based approach to identify vulnerability and inequality within the school-aged population, identifying those needing support and those at risk

C.SN6 safeguard and prioritise support for school-aged children and young people most at risk, escalating concerns and provide specialist expertise for safeguarding and child protection pathways

C.SN7 use specialist evidence-based knowledge of capacity, consent, and confidentiality to safely manage challenges and potential conflicts when applying safeguarding and child protection pathways to individual school-aged children and young people

C.SN8 assess the risk for vulnerability in school-aged children and young people and families that are impacted by changes to their circumstances, to maximise access and support from relevant services

C.SN9 foster positive relationships and facilitate inclusion, recognising the potential impact of stigma, bias and assumptions that people may make about school-aged children and young people

C.SN10 demonstrate knowledge and understanding of the factors that influence identity and support school-aged children and young people to develop their identity.

Sphere C: Outcomes – Occupational Health Nurse

OHN

At the point of registration, the SCPHN occupational health nurse will be able to:

C.OHN1 synthesise their specialist knowledge and experience to appraise the impact of socio-economic and political issues on work and health to implement occupational health interventions

C.OHN2 critically examine the relationship between worklessness and health and their association with health inequalities that affect people, families and communities

C.OHN3 lead an occupational health service that is open, holistic, inclusive and responsive to wider socio-economic and health concerns including but not limited to safeguarding and abuse within and outside the workplace

C.OHN4 evaluate the relationship between work, life, mental and physical health and ill health to lead on proactive organisational approaches to promote and protect health and wellbeing within and outside the workplace

C.OHN5 apply their specialist professional knowledge and judgement to identify individuals who may be vulnerable or at risk of direct and indirect abuse or harm within or outside the workplace, appropriately escalating and referring to other professionals and agencies

C.OHN6 lead the development, delivery and evaluation of inclusive, multifunctional occupational health services that meet the diverse needs of employees and organisations, adopting a life course approach

C.OHN7 apply specialist knowledge and skills to identify emerging health issues, and signpost to available support for access to health and care services and other agencies to balance individual health and wellbeing with employment obligations.

Sphere of influence D: Population health: enabling, supporting and improving health outcomes of people across the life course

Health visitors take the lead role in ensuring that the health of children, parents, carers, families, communities and populations is maintained, improved and protected in order to create the best foundation for their long term sustainable health and wellbeing. They proactively develop open and meaningful dialogue with families to develop trusting relationships and use their advanced assessment and communication skills to identify and assess need and prioritise support based on risk.

School nurses understand the impact of socio-economic factors on school-aged children's and young people's long term health and wellbeing. They proactively develop open and meaningful conversations with school-aged children, young people and families and use their knowledge to make appropriate interventions to support and empower school-aged children and young people in their life choices to prevent ill health, manage emerging risks and improve ongoing health and life outcomes.

Occupational health nurses use their specialist knowledge and professional judgement to develop inclusive workplace strategies that enable people of all abilities to remain healthy, and productively in work. They design occupational health services that add value to employees, employers and organisations.

Sphere D: Outcomes

Core

At the point of registration, the registered SCPHN HV, SN, OHN and SCPHN PHN will be able to:

D.1 recognise, critically evaluate and monitor trends in global and national strategies and programmes for preventative interventions and promotion of health to inform specialist public health practice locally, nationally and globally

D.2 recognise and accommodate any future developments in the application of genomics into their SCPHN practice to support prevention and early intervention in the health of the population across the life course

D.3 appreciate and use community assets and resources to support positive health and wellbeing of people, communities and populations

D.4 in partnership with people, adopt a life course approach when assessing the public health needs of people, communities and populations

D.5 empower people, communities and populations to connect effectively with local initiatives, support networks, community assets, programmes and resources that support their health and wellbeing

D.6 apply specialist knowledge of social prescribing to support individual, community and population health outcomes

D.7 critically apply knowledge of behavioural, psychological and social sciences to the health of people across the life course, and to communities and populations, to enhance collaborative, strength-based therapeutic relationships

D.8 appreciate the importance of medicines management with respect to administration, optimisation and reconciliation, and the positive impact of correct medicines management on people's current and future health outcome

D.9 assess the health status and health literacy of populations across the life course and their related determinants of health

D.10 use culturally appropriate, evidence-based approaches to assess, support and monitor the health and wellbeing of people, and appropriately refer to specialist services if necessary

D.11 critically apply knowledge of populations, places, communities and determinants of health to inform key areas of specialist public health practice

D.12 in partnership with communities, develop and implement plans for local communities and populations to positively affect public health outcomes

D.13 lead on and contribute to policy and reporting into environmental, social-structural factors, and individual behaviours that impact on the health of people across the life course

D.14 use data and observation to evaluate the effectiveness and acceptability of services that seek to improve health outcomes of their intended users, and be able to identify trends or a need for improvement.

Sphere D: Outcomes – Health Visitor

HV

At the point of registration, the SCPHN health visitor will be able to:

D.HV1 demonstrate specialist knowledge and understanding of infant and child anatomy, physiology, genetics, genomics and development when undertaking programmed health assessment and development reviews

D.HV2 apply specialist knowledge and use validated tools to deliver holistic health assessments and programmed health and development reviews, working in partnership with parents and families to promote health and identify emergent and existing concerns including vulnerability and inequality, and facilitate and prioritise support and/or early intervention for the child and family as appropriate

D.HV3 assess for early signs of atypical patterns of development, or significant anomalies that may result in disability or emotional, physical or developmental health needs or risks, and deliver evidence-based anticipatory guidance or targeted intervention tailored to individual and family circumstances and needs

D.HV4 apply advanced level communication and interpersonal skills to establish trusting relationships which are respectful of families' capabilities, priorities and values

D.HV5 work in partnership with families to continually assess, and appraise the impact of known strengths, changing circumstances and relationships on child and family health and wellbeing and adapt support accordingly, acknowledging the needs of the family as a whole and prioritising support on the basis of immediate and continuing risk and need

D.HV6 work in partnership with families to promote, educate and support sensitive, responsive relationships between parents and their children through the application of specialist knowledge of early emotional development, theories and models of attachment and the impacts of positive and enduring parental-child relationships

D.HV7 evaluate the effects of trauma on child development and how they adjust to those effects, and work in partnership with children and families who are affected by trauma to strengthen their resilience

D.HV8 critically apply specialist knowledge of the anatomy, neurodevelopment, physiology and epigenetics relevant to infant nutrition, including the implications of infant feeding, weaning and early food behaviour for optimum child and maternal health, child physical and socio-emotional development and future behaviour patterns

D.HV9 using a strength-based approach support children and families to identify risks to healthy weight in childhood, promoting family nutrition and supporting them to make optimum and available choices, referring to other services according to need and risk

D.HV10 work in partnership with families to support positive, nurturing child and family relationships, and in promoting the benefits for children learning life skills in the home environment

D.HV11 support parents and families who receive a life changing or life limiting diagnosis during pregnancy and in the early years, and in partnership with them use a strength-based and empowering approach to respond to their needs, which may be complex

D.HV12 use specialist knowledge to facilitate access to a range of appropriate and effective available resources to support children, parents and families with additional needs due to mental and/or physical ill health, learning disabilities or physical disability, and/or those living with multiple, complex, long term conditions

D.HV13 support children, parents and families to develop motivation and self-advocacy when raising awareness of opportunities for local grants, financial support and other local community assets and services

D.HV14 advise parents, carers and families on symptom identification and relief, enabling them to manage minor illnesses and injuries safely and effectively, and in knowing when to seek support for further treatment where necessary

D.HV15 provide evidence-based support and advice on child, adolescent and adult sexual and reproductive health and contraception

D.HV16 provide, evidence-based support to bereaved parents, children and families in the event of miscarriage, stillbirth or parental death and refer to additional support as appropriate.

Sphere D: Outcomes – School Nurse

SN

At the point of registration, the SCPHN school nurse will be able to:

D.SN1 apply specialist knowledge of the healthy development of school-aged children and young people and use of validated tools to deliver holistic health assessments and programmed development reviews that aim to improve individual, community and population health outcomes

D.SN2 critically analyse and apply specialist knowledge of the biopsychosocial, moral and spiritual development of school-aged children and young people at all key phases in the life course

D.SN3 evaluate how age and biopsychosocial development influence communication skills in the school-aged population, using advanced communication techniques to facilitate positive, trusting relationships with school-aged children and young people, parents, carers and families

D.SN4 evaluate how biopsychosocial influences in adolescent years impact on behaviour, life skills and transition to adulthood, recognising adolescence as a distinct stage of the life course

D.SN5 assess the impact of key transition periods and events for school-aged children and young people including starting and leaving school, change of care provider, illness and bereavement, and apply appropriate intervention to support their development of self-managing behaviours

D.SN6 use a range of evidence-based interventions to support young people's safe transition to adulthood

D.SN7 optimise positive behaviours in parents, carers, families and peers and, through evidence-based interventions, promote trust and self-efficacy to improve health and wellbeing for school-aged children and young people

D.SN8 support school-aged children and young people, parents and families to develop motivation and self-advocacy when raising awareness of opportunities for local grants, financial support and other local community assets and services

D.SN9 use evidence-based observations, assessment and apply professional judgement when taking action to prevent and minimise the risk of adverse childhood experiences and build on protective factors to support and guide school-aged children and young people, parents and carers

D.SN10 demonstrate knowledge and understanding of school-aged children and young people's emotional literacy, cognitive ability, wellbeing and resilience skills when observing, assessing and making decisions on the appropriate intervention

D.SN11 use professional judgement to assess for early signs of low mood and anxiety in school-aged children and young people, and provide early interventions to support emotional and mental health and wellbeing

D.SN12 evaluate how evidence-based interventions help school-aged children and young people consider the impacts of and risks associated with specific behaviour choices related to social media, alcohol/substances, violence, exploitation and gang culture

D.SN13 evaluate the effects of trauma on children and young people's development and adjustment and use culturally appropriate, evidence-based, trauma-informed approaches to assess, support and monitor, using professional judgement when making decisions to refer to specialist services.

Sphere D: Outcomes – Occupational Health Nurse

OHN

At the point of registration, the SCPHN occupational health nurse will be able to:

D.OHN1 use evidence to justify the impact and value of occupational health services for employees, organisations and the wider population

D.OHN2 apply specialist knowledge to interpret, inform and provide impartial advice on health and safety legislation and case law

D.OHN3 critically analyse and apply the principles of occupational hygiene, engineering controls and ergonomics when advising on the creation and maintenance of healthy work environments

D.OHN4 evaluate how disease, illness and impairment act as barriers to gaining, sustaining and returning to work and the impact of this on people and all areas of life

D.OHN5 influence and provide impartial advice on the design of inclusive, adaptive and supportive workplaces

D.OHN6 develop inclusive strategies that enable innovative, person-centred approaches for employees who may need adaptations and adjustments to their work due to health and wellbeing reasons

D.OHN7 develop evidence-informed strategies to support and enable employees with multiple or long term conditions to have sustainable, productive and fulfilling work

D.OHN8 provide specialist, personalised occupational health advice on work adjustments to employees and employers which considers the impact of diagnoses, therapies, interventions, medications and treatments

D.OHN9 apply specialist knowledge and skills to contribute to organisational disaster planning and preparedness to support business continuity and in optimising the ongoing safety and health of people.

Sphere of influence E: Advancing public health services and promoting healthy places, environments and cultures

Health visitors actively seek out opportunities to promote and improve health visiting services and the quality of care that is provided to children, parents, carers and families by their services. They promote healthy environments, attitudes and cultures for infants and children that acknowledge and respect the uniquely individual nature of each home setting and family unit.

School nurses actively promote the value of school nursing services when working collaboratively with educators, local authorities, voluntary sector organisations, the youth justice sector and their local community. They encourage the development of healthy environments and cultures and evaluate the impact of these on the health and wellbeing of school-aged children and young people.

Occupational health nurses put health and wellbeing at the core of job design and workplace strategies. With their specialist input they help to embed employee health and wellbeing initiatives within the business planning cycle, leading on ambitious strategies that are also environmentally sound. They harness new and emerging technologies which enables participation in work for all people in society.

Sphere E: Outcomes

Core

At the point of registration, the registered SCPHN HV, SN, OHN and SCPHN PHN will be able to:

E.1 critically appraise and apply strategies and initiatives that improve home, community and workplace cultures and environments to enhance the health and wellbeing of people and communities in the places they live, learn and work

E.2 critically appraise the use of new and assistive technologies that support and influence people's choices for their own health and wellbeing, and assist with access to services

E.3 demonstrate professional business and financial acumen when developing and presenting business cases to create investment for change and value for money

E.4 tailor nationwide programmes or commission new services that promote healthy cultures, environments and behaviours for local implementation and evaluate their effectiveness

E.5 lead and support a culture of learning and continuous professional development for colleagues, and with interdisciplinary and interagency teams

E.6 recognise individual abilities and learning needs when applying the standards of education and training for pre- and post-registration nursing, midwifery and nursing associate students, in order to educate, supervise and assess effectively

E.7 promote and lead effective public health workplace cultures that benefit people, communities and populations

E.8 advance public health through identifying sustainable development goals and prepare to take action on risks to the environment and its impact on the health and wellbeing of people

E.9 share information regarding communicable diseases and approaches necessary for communicable disease surveillance, infection prevention and control, including immunisation and vaccination programmes

E.10 know how to assess and manage major incidents and outbreaks including contamination and communicable disease across local or wider boundaries

E.11 know how to identify, critically analyse and manage new and enduring hazards and risks to health at local, national and global levels

E.12 plan for emergencies and pandemic threats to population health taking account of the direct and wider risk, impacts and hierarchy of controls on health and wellbeing and service provision.

Sphere E: Outcomes – Health Visitor

HV

At the point of registration, the SCPHN health visitor will be able to:

E.HV1 work in partnership with parents and carers to promote child safety, reduce risk behaviours and enhance awareness of the differentials of risk in relation to the child's age, stage of development and home environment

E.HV2 respect parents' and carers' need for autonomy and control with sensitivity to a wide range of attitudes, values, beliefs, expectations, faiths, cultures and approaches to parenting, using a transparent approach whilst simultaneously safeguarding the welfare of the children at all times

E.HV3 demonstrate sensitivity and respect for privacy in assessing whether the child or family's home situation and environment is appropriate for facilitating and encouraging open discussion and disclosure of personal issues

E.HV4 evaluate community health needs and assets, and advance practice through community profiling, the synthesis and application of data and information, use of informatics, and other techniques

E.HV5 develop sustainable and innovative health visiting strategies that contribute to place-based complex interventions and improve public health outcomes for children and families, reporting outcomes and areas for improvement in line with local and national governance and audit requirements.

Sphere E: Outcomes – School Nurse

SN

At the point of registration, the SCPHN school nurse will be able to:

E.SN1 use community and population profiling to identify and assess health and wellbeing needs and priorities for school-aged children and young people

E.SN2 lead, support and advocate for collaborative cultural and community developments that improve health and wellbeing in the school-aged population

E.SN3 lead, co-design, provide and evaluate local health education, health promotion and safety campaigns aligned to key public health priorities for school-aged children and young people

E.SN4 recognise the impact of the school environment, its culture and relationships that school-aged children and young people form and their effect on their health, wellbeing and achievement

E.SN5 raise awareness of the impact of socio-economic disadvantage including digital poverty, and work with others to facilitate policy changes that support school-aged children and young people to achieve their potential

E.SN6 evaluate lived experiences which may impact on school-aged children and young people's behaviour, health and wellbeing, ensuring that their needs, rights and safety remain paramount and central to all planning interventions

E.SN7 respect parents' and carers' need for autonomy and control with sensitivity to a wide range of attitudes, values, beliefs, expectations, faiths, cultures and approaches to parenting, using a transparent approach whilst simultaneously safeguarding the welfare of school-aged children and young people at all times

Sphere E: Outcomes – Occupational Health Nurse

OHN

At the point of registration, the SCPHN occupational health nurse will be able to:

E.OHN1 develop sustainable, data-driven occupational health strategies with short, medium and long term aims to improve employee health and wellbeing, embedded as part of the business improvement cycle

E.OHN2 focus on inclusion and innovation in job design to lead, improve and innovate ways to address health hazards by elimination, mitigation and control

E.OHN3 lead on the organisational response to safe, appropriate and economically viable approaches to waste management for food, hazardous chemicals, biological and clinical waste, taking into consideration infection control measures and the impact of environmental pollution on health and wellbeing

E.OHN4 recognise and act on the importance of the environmental impact of work processes and products, and collaborate on reducing and controlling emissions and other pollutants that may impact on safety, health and wellbeing and the environment

E.OHN5 critically examine and apply the hierarchy of control to manage risks to health, safety and wellbeing in the workplace

E.OHN6 anticipate and appraise the impact of new and emerging technology to improve workability now and in the future

E.OHN7 facilitate workplace adjustments that enable wider participation of people in work, effectively using assistive technologies

E.OHN8 evaluate the impact of job redesign and the potential need for skills development and/or redeployment on the health and wellbeing of people

E.OHN9 critically examine the effect of worklessness on the health and wellbeing of people, families and communities

E.OHN10 critically appraise and use assistive technologies, recognising their potentially varied impact on individual people's work and health.

Sphere of influence F: Leading and collaborating: from investment to action and dissemination

Health visitors take the leading role in providing, managing and coordinating care. They promote collaborative working, through leading and working within interdisciplinary and interagency teams and ensuring smooth transition between services, and also by working in partnership with families, communities and populations.

School nurses lead, manage and coordinate school nursing services and individual caseloads. They collaborate with interdisciplinary and interagency teams and services to ensure that public health programmes are embedded in schools and within the local community. School nurses lead safe and effective universal services, early help interventions and provide targeted interventions to school-aged children and young people when needed.

Occupational health nurses are leaders of services, with the ability to influence strategic planning and policy making. They bring their unique specialist nursing knowledge and skills, combining them with the business acumen required to plan the resources for occupational interventions that are tailored to the specific requirements of the employees and organisations they work with.

Sphere F: Outcomes

Core

At the point of registration, the registered SCPHN HV, SN, OHN and SCPHN PHN will be able to:

F.1 lead public health services that promote and improve the health and wellbeing of people, communities and populations

F.2 lead teams that are effective in delivering public health services, both on their own and in collaboration with others

F.3 assess service requirements influencing and leading on policy development and strategic planning to address population health needs incorporating approaches for prevention and risk management

F.4 monitor and report on the outcomes of strategy and policy implementation and make recommendations for improvement including changes to commissioning

F.5 evaluate the efficacy of service provision by triangulating information obtained from audit, continuous improvement activity, governance, risk management and performance monitoring

F.6 compassionately lead and support a culture of critical reflection and continuous professional development that promotes team and interdisciplinary learning

F.7 build alliances and partnerships that support equality, diversity and inclusion, collaboration and sharing of new ideas and innovations and be able to agree shared goals and priorities

F.8 use a range of advanced communication skills with people, communities, peers and interdisciplinary and interagency colleagues, including use of digital and other modalities to support communication in virtual and remote environments

F.9 communicate simple and complex public health information in a variety of formats, tailored for different community and population audiences

F.10 use a range of techniques to influence, challenge, and persuade peers and senior stakeholders in relation to public health strategies and policies that affect people, communities and populations.

Sphere F: Outcomes – Health Visitor

HV

At the point of registration, the SCPHN health visitor will be able to:

F.HV1 lead creative, flexible approaches to engage parents and carers in child health promotion programmes, providing advice and support to enable co-design and collective decision making

F.HV2 lead discussions and collaborate on the development of services for children with high impact health and care needs and ensure workforce readiness for implementation

F.HV3 involve, escalate, report and make decisions with interdisciplinary and interagency teams on the immediate and continuing risk of domestic violence, child maltreatment and other forms of abuse to the safety of infants, children and families and collaborate on all necessary actions

F.HV4 lead interdisciplinary and interagency discussions and make decisions regarding the referral, transfer, support and management of children and families where there are complex mental or physical health needs and/or concerns

F.HV5 work in partnership with midwives and other interdisciplinary and interagency teams and services during the antenatal period and first days of the infant's life to ensure consistency and continuity of care for infants, parents and carers, and a smooth transition between midwifery and health visiting services

F.HV6 work in partnership with school nurses to ensure the transition of support for the child and family from the health visitor to the school nursing service is positive, seamless and effective.

Sphere F: Outcomes – School Nurse

SN

At the point of registration, the SCPHN school nurse will be able to:

F.SN1 synthesise data, information and intelligence related to home, school and community environments, and apply professional judgement to determine how this intelligence can be widely reported to positively influence policy and strategy to improve health and wellbeing

F.SN2 evaluate existing services to identify gaps in available support for school-aged children and young people and develop strategies to maximise support and access to relevant services according to age and maturity

F.SN3 advocate for school-aged children and young people in public health services, ensuring their voice is heard, supporting co-production, co-design and development at universal, targeted and specialist service levels

F.SN4 design and lead the delivery and evaluation of evidence-based school nursing services, educational campaigns and co-produced interventions aligned to regional and national public health initiatives to protect and promote the health and wellbeing of school-aged children and young people

F.SN5 use specialist public health knowledge, skills and evidence when influencing and advocating and making decisions for the safety and wellbeing of school-aged children and young people at interagency meetings and hearings

F.SN6 capture the lived experience and lived existence of school-aged children and young people and evaluate how this and other sources of evidence influences and informs current and future specialist practice, policy decisions and school nursing service design

F.SN7 lead and promote visibility of school nursing services and ensure accessibility through engagement with school-aged children and young people, parents, carers, families, school staff, other professionals and voluntary sector organisations

F.SN8 use specialist skills and knowledge to design school nursing services which recognise and respect children and young people's privacy and dignity

F.SN9 critically analyse the opportunities, benefits and risks for school nursing services when communicating with school-aged children and young people face to face and via social media and virtual platforms

F.SN10 work in partnership with relevant professionals and services to ensure the transition of support for school-aged children and young people to adult services mitigates risks and is positive, seamless and effective.

Sphere F: Outcomes – Occupational Health Nurse

OHN

At the point of registration, the SCPHN occupational health nurse will be able to:

F.OHN1 triangulate and appraise organisational and workforce profiling data to secure resources for the development and delivery of occupational and employee health, safety and wellbeing

F.OHN2 create systems to allow data collection, information retrieval and dissemination protocols for enhancing occupational health nursing practice

F.OHN3 develop and manage a safe and effective occupational health nursing service, which promotes innovative, evidence-informed workplace protocols and strategies

F.OHN4 influence organisational policy and strategy for employee health and wellbeing which embraces and reflects national and international public health agendas and strategies

F.OHN5 critically apply business acumen to develop, promote and report on evidence-based occupational health and wellbeing initiatives that take account of economic and non-economic resources

F.OHN6 evaluate, synthesise and communicate data and information to quantify and qualify the positive impact of occupational health interventions on workplace and business targets and outcomes.

Glossary

The words in the glossary have been included to explain their specific meaning in the context of these regulatory standards. The meaning might expand on or be slightly more nuanced than the dictionary meaning of some of these words.

Biopsychosocial: a model that assumes that biological, psychological and social factors must be considered to understand disease, illness and health

Community assets: resources that can be used to contribute to developing and improving local health and wellbeing. It may include people and their knowledge, skill, networks and relationships, physical structures, local services, businesses, charities and funds

Co-design: a partnership of representative people or groups of people who come together to design care pathways, develop new pathways and revise existing services models

Co-produce: a partnership approach which brings people together to find shared solutions and involves partnering with people from the start to the end of any initiative or change that affects them

Cultural competence: knowledge, skills and attitudes needed to support and provide health and care services to people that are respectful, responsive and honours the culturally based needs of diverse populations

Determinants of health: includes the social and economic environment, the physical environment and the person's individual characteristics and behaviours

Hierarchy of controls: a step-by-step approach to eliminating or reducing risks, ranking risk controls from the highest level of protection and reliability through to the lowest and least reliable protection

Holistic assessment: collection, analysis and sorting of multiple sources of observation and information about a person or people to inform interventions to improve health. The focus is on the whole person, not just a potential or actual illness

Person-centred: an approach where the person is at the centre of the decision making processes and the design of their health and care needs, their public health nursing care and treatment plan.
In the context of public health this can also apply to public health services

Place-based interventions: service providers, communities and civic partners working together in a specific location to improve health and care for the populations they serve

Protective factors: individual or environmental characteristics, conditions, or behaviours that reduce the effects of stressful life events. These factors also increase people's resilience and ability to avoid risks, and support wellbeing

Self-efficacy: belief in one's own capability to organise and take action which could influence the adoption and maintenance of health-promoting behaviour

Back to text

Shared value: awareness of behaviours and attitudes to health and recognition that individuals, families, workplace, communities and populations have a role in improving health for all

Social-structural factors: the social environment, physical environment, health services, and structural and societal factors that can influence health

Sustainable development goals: development of institutions, infrastructure and services to end poverty and protect the environment, aims which go beyond health and wellbeing as set out by the United Nations https://www.un.org/sustainabledevelopment/sustainable-development-goals/

Workability: consideration of people's health and their ability to work

Worklessness: having no paid work or employment, may be extended to people who are unable to work or be employed as a result of disability, carer responsibilities, students and pensioners

Back to text

The role of the Nursing and Midwifery Council

What we do

Our vision is safe, effective and kind nursing and midwifery that improves everyone's health and wellbeing. As the independent regulator of more than 758,000 nursing and midwifery professionals, we have an important role to play in making this a reality.

Our core role is to **regulate**. First, we promote high professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects less than one percent of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.

To regulate well, we **support** our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to **influence** health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

23 Portland Place, London W1B 1PZ

T +44 20 7333 9333

nmc.org.uk

@nmcnews

@nmcuk

Nursing & Midwifery Council

The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Registered charity in England and Wales (1091434) and in Scotland (SC038362)

These standards were approved by Council at their meeting on 26 May 2022.

Nursing & Midwifery Council

Standards of proficiency for community nursing specialist practice qualifications

Published 7 July 2022

MAHI - STM - 212 - 834

Contents

Introduction

What we do

The Nursing and Midwifery Council (the 'NMC') is required to set standards of proficiency, education and training for nursing and midwifery professionals seeking to join our registers for the first time. As part of this we review our standards regularly to ensure they continue to protect the public, are fit for purpose, and are necessary for safe, effective and kind care. When we review any of our standards, including standards that lead to annotation, we take into account new evidence, the changes taking place in society and changes in health and care.

Education and training beyond initial registration

We recognise that in today's health and care services, the roles of nurses, midwives and nursing associates are changing and expanding, requiring higher levels of clinical autonomy, knowledge and skill in order to achieve their full potential and to contribute to the delivery of services for the benefit of the people they serve. Everyone on our register undertakes additional education and training after their initial professional registration to develop further knowledge and skills, but not all of this ongoing education is, or needs to be, regulated.

We take a proportionate approach to the regulation of post-registration qualifications. We reserve regulation for those areas where ensuring consistency of standards of proficiency, and standards for education and training, is needed to achieve a higher level of quality and safety in order to mitigate risk and to reassure the public. One of the means that we have of recognising post-registration qualifications is through setting standards for specialist practice qualifications (SPQs).

Specialist practice qualifications are annotations to our register. They indicate that a registered nurse has successfully undertaken an NMC approved SPQ programme that meets our standards in a particular area of practice. To undertake a specialist practice qualification, you must be a first level registered nurse.

Community nursing in the 21st century

In the 21st century, support and care of people of all ages is increasingly being delivered in the community, in people's homes and in settings close to their homes. These settings include care homes, hospices, general practice, residential and educational settings, and prisons and offender health settings. As a result, new models of community care are emerging, new nursing roles have been developed and there are likely to be more in the future. The limited number of community nursing SPQs that we currently have – community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing and general practice nursing – no longer represent the totality of specialist nursing practice in the community.

Holding a community nursing specialist practice qualification is not a requirement to work in the community or to care for any individual client group. For the majority of nursing roles, a combination of the standards of professional behaviour and conduct enshrined in the Code, and the requirement to meet the knowledge and skills specified in the pre-registration nursing standards of proficiency, along with subsequent and ongoing revalidation, is sufficient for effective regulation. In order to take a proportionate approach, we need to consider which roles and activities justify regulation at a post-registration level.

About these standards

This document contains our new outcome-focused specialist community nursing standards of proficiency for registered nurses. These proficiencies reflect the specialist knowledge, skills and attributes required by nurses working in the community in any roles which involve more autonomous decision making, in situations that require registered nurses to manage greater clinical complexity and risk, both in terms of the people they care for, the caseloads they manage and the services they work within, which in turn may be integrated with other agencies, professionals and disciplines.

In our 2020-2025 strategy we have made a commitment to explore whether the regulation of advanced practice is needed. These new specialist community nursing qualifications incorporate standards of proficiency that will support registered nurses working in the community to advance their clinical, managerial, research and educative practice. This will enable greater clinical autonomy, independent decision making and leadership in complex and high-risk situations for the benefit of people and services.

It is likely that more community nursing roles will be developed in the future that also demand higher levels of clinical autonomy. These standards therefore serve to build on current good practice and intend to promote learning and create ambition and opportunity for other registered nurses who work in the community. This is why we have introduced a new SPQ for other fields of community nursing practice.

The nature of regulatory standards

Regulatory standards are intended to be high level and outcome-focused. They are translated by education institutions and their practice placement partners into more detailed curricula and programme learning outcomes. These standards apply to all fields of community nursing practice, however the evidence base and their application in different fields of community nursing will differ. These standards should therefore be read alongside *Realising professionalism: Standards for education and training*, which sets out our expectations regarding provision of all pre-registration and post-registration NMC approved nursing and midwifery education programmes. These standards apply to all approved education providers and are set out in three parts:

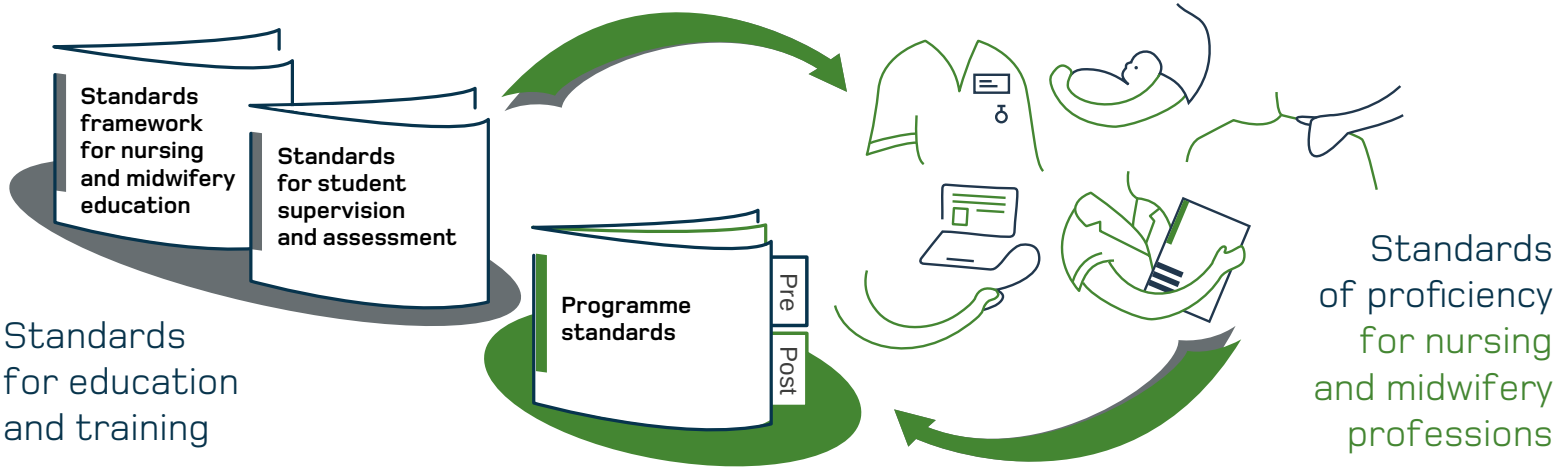
- Part 1: Standards framework for nursing and midwifery education
- Part 2: Standards for student supervision and assessment
- Part 3: Programme standards, which are the standards specific for each pre-registration or post-registration programme.

The relationship between the different sets of standards is shown in the diagram on this page.

Educational institutions must meet our programme standards in order to be approved to deliver a programme which leads to one of the SPQs: community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing or specialist community nursing.

The rationale for the new community nursing SPQ annotation which does not specify a particular field of community nursing role is that it can be applied to registered nurses who work in different community roles, including potential new roles that are emerging in the community, which require professionals to have the knowledge and skills that are specified in these standards in order to practise with higher levels of clinical autonomy and provide a better service for the people in their care.

Together these standards aim to provide approved education institutions (AEIs) and their practice learning partners with the flexibility to develop innovative approaches to education, helping registered nurses to achieve a community nursing SPQ qualification, while also being accountable for the local provision and management of approved post-registration community nursing SPQ programmes in line with our standards.



Structure of these standards

The approach to the standards of proficiency aligns with that of Future nurse, our new standards for registered nurses, published in 2018.

The standards are organised under seven headings, and were designed to ensure that across all fields of nursing practice, registered nurses are able to meet the person-centred, holistic care needs of the people they encounter in their practice who may have a range of mental, physical, cognitive, behavioural, social or spiritual needs. This ambition also applies to specialist community nursing to meet the diverse needs of people of all ages, in their home, in settings close to home and in the community.

Professionals on our register already possess the knowledge and skills required to be registered as a nurse. These specialist community nursing standards of proficiency state the additional knowledge and skills required for community nursing SPQs.

These proficiencies will provide new post-graduate community nurses with SPQs entering the profession with the knowledge, skills and behaviours they need when they record their qualification on the register. Community nurses with a SPQ will build on these proficiencies as they gain experience and fulfil their professional responsibility. They will demonstrate their commitment to develop as a specialist community practitioner and to build a career pathway, engaging in ongoing education and professional development opportunities necessary for revalidation.

The seven platforms are:

Platform 1: Being an accountable, autonomous professional and partner in care

Platform 2: Promoting health and wellbeing and preventing ill health

Platform 3: Assessing people's abilities and needs, and planning care

Platform 4: Providing and evaluating evidence-based care

Platform 5: Leading, supporting and managing teams

Platform 6: Leading improvements in safety and quality of care

Platform 7: Care coordination and system leadership

Taken together these proficiencies, developed in an appropriately structured educational programme, will provide nurses undertaking community nursing SPQs with the knowledge, skills and behaviours they need to work within their intended field of community nursing practice.

Legislative framework

Article 19(6) of the Nursing and Midwifery Order 2001 ('the Order') allows the NMC to establish standards of education and training for any additional qualifications that may be recorded on the register. Articles 15(3) to (9) and articles 16 to 18 of the Order will apply in respect of those standards as if they were standards established under article 15(1)(a). This means the NMC may establish standards of education and training and may approve a course of education or qualification in relation to SPQs.

Platform 1: Being an accountable, autonomous professional and partner in care

All registered nurses with a community nursing specialist practice qualification are required to work autonomously in people's homes, close to home or in the community, with people of all ages. They work in interdisciplinary and interagency environments, and they work with, and delegate to, diverse interdisciplinary and interagency teams involved in providing care. These teams include registered professionals, other colleagues who are not on a professional register, carers, family members, volunteers and others working in third sector organisations.

They often work in unpredictable, unconventional and complex settings, with consequently higher risks. They work independently, and require specialist knowledge and skill, in order to work effectively as an autonomous, accountable professional.

Many community nurses specialise in caring for a particular client group or are specialists in a particular field of practice. They apply their specialist community knowledge and skill in the context of their intended field of practice and the setting they practise in. As registered nurses, they abide by the Code, and meet all of the Standards of proficiency for registered nurses relevant to their field of specialist community nursing practice.

Platform 1: Outcomes

Registered nurses with this qualification in their intended field of practice, will be able to:

1.1 practise autonomously, proactively and innovatively, demonstrating self-awareness, emotional intelligence and openness

1.2 lead and manage a service, with the ability to effectively admit, discharge and refer people to other professionals, services and agencies as appropriate

1.3 deliver specialist person-centred care in complex, challenging and unpredictable circumstances

1.4 account for their decisions, actions and omissions when working with complexity, risk, unpredictability and when all of the information required might not be available

1.5 critically understand and apply relevant legal, regulatory and governance requirements, policies, and professional and ethical frameworks, differentiating where appropriate between the devolved legislatures of the United Kingdom

1.6 lead and promote care provision that is person-centred, anti-discriminatory, culturally competent and inclusive

1.7 demonstrate critical awareness of stigma and the potential for bias, taking action to resolve any inequity arising from either, and educate others where necessary

1.8 recognise the need for, and lead on action to provide, reasonable adjustments for people, groups and communities, influencing health policy and promoting best practice

1.9 demonstrate the principles of courage, transparency and the professional duty of candour, taking responsibility to address poor practice wherever it is encountered

1.10 critically reflect and recognise when their personal values and beliefs might impact on their behaviour and practice

1.11 assess the opportunities, risk and demands of specialist community nursing practice, and take action to maintain their own mental and physical health and wellbeing

1.12 apply the numeracy, literacy, digital and technological skills required to deliver safe and effective specialist practice that meets the needs of people, their families and carers

1.13 be an effective ambassador and role model, and a positive influence on the profession.

Platform 2: Promoting health and wellbeing and preventing ill health

Registered nurses with a community nursing specialist practice qualification are pivotal to health protection and the promotion of health and wellbeing. They play a central role in co-designing the provision of care that supports and improves mental, physical and behavioural health and wellbeing with the people, families, communities and populations that they serve.

They engage effectively, working with people of all ages at home, close to home or in the community, and support them to make their own choices and decisions that can improve their health and care. They promote health and reduce health inequalities, actively promoting participation in local and national public health programmes and interventions. Using their knowledge of community assets, community nurses with a specialist qualification build on their day-to-day interactions to support people to make positive changes to their mental and physical health and wellbeing.

Platform 2: Outcomes

Registered nurses with this qualification in their intended field of practice, will be able to:

2.1 apply specialist knowledge of epidemiology, demography and the social determinants of health and illness, taking action to influence policy, service design and delivery

2.2 critically analyse the factors that may lead to inequalities in health outcomes, and their associated ethical dilemmas, to plan care in partnership with people, families and communities to improve them

2.3 recognise health as a fundamental human right and evaluate the effects of social influences, health literacy, individual circumstances, behaviours and choices on people's current and future mental and physical health

2.4 critically assess health needs in partnership with people, families, communities and populations, to support them to take decisions and actions that improve their own mental, physical, and behavioural health and wellbeing

2.5 maximise opportunities for people, families, communities and populations to use their personal strengths and assets to make informed choices about their own health and wellbeing

2.6 conduct, interpret and evaluate health and social care assessments, screening and profiling activity for people and communities, to take appropriate action to improve health outcomes

2.7 apply specialist knowledge of social prescribing to support individual and community health outcomes

2.8 critically analyse and assess the characteristics of communities, their assets and any areas for development in order to build networks and alliances that can enhance health outcomes for people and families

2.9 promote and support people, communities and populations to connect effectively with local initiatives, support networks, programmes and third sector organisations that support their health and wellbeing

2.10 utilise and evaluate the impact of networks to enhance and support the mental and physical needs of people, families and communities, and identify and address any deficiencies in support

2.11 understand the role and application of genomics and epigenetics in sufficient detail to inform and advise people about the implications for personalised health care

2.12 apply a range of advanced communication skills to develop public health information that is accessible and enables people to make informed decisions about their health and wellbeing

2.13 share information regarding communicable diseases and approaches necessary for communicable disease surveillance, infection prevention and control, including immunisation and vaccination programmes

2.14 mitigate risks of environmental factors and other pollutants that have the potential to affect the health and wellbeing of people now and in the future.

Platform 3: Assessing people's abilities and needs, and planning care

People of all ages receive care and support at home and in the community. They may have complex acute care needs, or are living with life limiting or long term conditions, or have multiple co-morbidities that affect their mental and physical health.

All registered nurses with a community nursing specialist practice qualification have the knowledge, skills and attributes to be the lead professional in caring for people within their intended field of community nursing practice. Their specialist knowledge and skills gives them the ability to exercise a high level of professional judgement and be capable of complex decision making. They are highly skilled in using an evidence-based approach, and see the person before the condition, in order to undertake an individualised holistic assessment. They co-produce evidence-based care plans with people, taking the wider social and environmental context into account, along with each person's mental, physical, cognitive, behavioural, social and spiritual abilities and needs.

They develop therapeutic relationships with people, their families, carers or nominated person to facilitate shared decision making. They take into account the diverse experiences, abilities, needs, preferences and challenges people are living with in order to make sure that plans are achievable and capable of delivering positive outcomes.

They provide information and support people, and their families, carers or nominated persons where needed, to make decisions about how their care is delivered and agree opportunities for supported self-care. They identify and provide the appropriate level of support, education and knowledge for others such as parents, family, formal and informal carers, or nominated person. They assess and manage risks when making referrals to, or receiving referrals from other interagency teams.

Platform 3: Outcomes

Registered nurses with this qualification in their intended field of practice, will be able to:

3.1 create and apply a person-centred approach to care, working in partnership to support shared decision making within the assessment and care planning process when working with people, their families or carers, and communities

3.2 use advanced communication strategies and relationship management skills when interacting with people, including families and carers, who may have a range of mental, physical, cognitive, behavioural and social health challenges

3.3 recognise and apply the principle of the presumption of capacity, and the requirement to seek informed consent throughout the assessment and planning process

3.4 make reasonable adjustments to maximise opportunities for people to understand the outcome of their abilities and needs assessment, and the implications for their treatment and care

3.5 make best interests decisions within the required legislative framework if, after seeking informed consent and making reasonable adjustments, their professional judgement is that a person lacks capacity to make a decision or give consent at that time

3.6 assess and plan the care of people when they are vulnerable, agreeing on the required level of support needed to ensure maximum levels of independence throughout the continuum of care

3.7 escalate, report, plan and coordinate immediate and continuing care for people in need of safeguarding

3.8 proactively obtain and distil information from formal and informal sources to inform individual assessments, involving others as required

3.9 critically analyse complex assessment information and data, distinguishing between normal and abnormal findings, recognising when prompt action is required, including requesting additional investigations, and involving others when appropriate

3.10 critically apply clinical reasoning to decision making, taking into account differential diagnosis and the potential for diagnostic overshadowing

3.11 maximise the potential use of technology and informatics to assist with assessment and diagnosis

3.12 apply knowledge and understanding of new and emerging science and technology, including genomics, to inform assessment and treatment options, when agreeing personalised care plans with people and their families, carers or nominated persons

3.13 apply a range of problem solving, influencing and negotiation skills to maximise opportunities for shared decision making when co-producing care plans

3.14 assess individual abilities and needs when co-producing plans of care, agreeing opportunities for supported self-care and treatment interventions

3.15 take into account the impact of people's preferences, their close relationships and support systems, their home environment, and the influence of social, environmental and spiritual factors when agreeing the plan of care

3.16 create and maximise opportunities for people, and where needed their families, carers or nominated person, to remain independent and to facilitate self-care

3.17 effectively communicate the benefits and risks of different care and treatment options, explaining how the person and their family or carers will be supported in the choices they make

3.18 anticipate and explain the impact that unexpected events and changes may have on the plan of care.

Platform 4: Providing and evaluating evidence-based care

All registered nurses with a community nursing specialist practice qualification take the lead in providing evidence-based, person-centred and safe interventions, in the context of the specific client groups and settings within their intended field of SPQ practice. They are able to initiate and deliver a range of care and treatment that can be supportive, curative, symptom relieving or palliative. They ensure that the care they provide or delegate is flexible, dynamic and is of a consistently high standard.

They are independently able to undertake a range of interventions to positively impact a person's health and wellbeing, and to manage complete episodes of care in relation to their intended field of SPQ practice.

They can communicate complex information in a way that supports, advocates for, enables and seeks to maximise the involvement of people, their families, carers or nominated person. They support people to make decisions and choices about their care and treatment, taking into account the benefits and opportunities for supported self-management, and any risks.

They work in partnership with people, peers and interdisciplinary and interagency colleagues to assess the impact of care on an ongoing basis, including supporting and managing transition between services. They evaluate the care outcomes and whether planned interventions continue to be effective and in line with the wishes, preferences and desired outcomes of the person receiving care, which may change over time.

Platform 4: Outcomes

Registered nurses with this qualification in their intended field of practice, will be able to:

4.1 autonomously manage and evaluate complex episodes of care from referral to service and admission, to discharge from caseload, or referral to other appropriate services or agencies

4.2 assess and manage transition of people to other services or agencies, proactively collaborating with colleagues of other disciplines and agencies to find solutions to mitigate any risks

4.3 agree and negotiate with the person and where necessary their family, carer or nominated person, the implications of delegation of any aspect of their care to an alternative person

4.4 recognise reduced concordance, changes in motivation or dissatisfaction with the care and treatment plan, and work in partnership with people to influence and negotiate any revisions to the plan

4.5 proactively engage with, and effectively advocate for, people using services provided by other professionals or agencies to identify and find solutions where there is inconsistency, disagreement or conflict

4.6 initiate a range of evidence-based care and treatment, including care, therapeutic interventions and social prescribing, that may be supportive, curative, symptom relieving or palliative

4.7 safely and effectively manage complex medicines administration, optimisation and medicines reconciliation, and continually evaluate to ensure optimum effectiveness

4.8 evaluate and adjust plans to ensure adequate safeguards for people when they are vulnerable

4.9 maintain therapeutic relationships with people, their families and/or carers throughout the episode of care and treatment, and actively address any differing views

4.10 understand and apply a range of techniques to educate people, their families, carers or nominated persons about their condition, treatment and care, to promote independence and confidence in supported self-care and self-management

4.11 work in partnership with people, their families, carers and other members of the team to continuously monitor and evaluate the care and treatment provided

4.12 include people and their families or carers in making decisions about their care and mitigate any risks as a result of changes in a person's mental and physical health, their living environment, or social arrangements

4.13 make autonomous decisions in challenging and unpredictable situations, and be able to take appropriate action to assess and manage risk

4.14 work with people and where appropriate their families, carers or nominated person to agree and provide evidence-based person-centred nursing care for those who are dying or near to the end of life

4.15 sensitively accommodate the preferences, beliefs, cultural requirements and wishes of the deceased and people who are bereaved

4.16 clearly explain and accurately record the rationale for decisions, actions taken and resulting outcomes either in writing, or using digital technology, which can be shared with the person, their family, carers, nominated person and interdisciplinary and interagency teams.

Platform 5: Leading, supporting and managing teams

All registered nurses with a community nursing specialist practice qualification provide, manage and lead services related to their intended field across a variety of settings. They act as role models for good practice in the delivery of evidence-based treatment, nursing, interdisciplinary and interagency care. They are responsible for leading services, effectively managing the coordination of care of individuals, groups of people or defined caseloads. They put the abilities, needs, preferences and best interests of people first when taking action to manage the specific risks associated with their intended field of community nursing practice and the setting in which care takes place.

They are accountable for the delegation of activities to team members, including delegation to other interdisciplinary and interagency professionals and those colleagues who are not on a professional register, and to carers. They are able to teach and support the professional development of colleagues and students.

In leading and managing an interdisciplinary team, they are able to collaborate and communicate effectively. They are able to recognise and address any disagreement or conflict between those planning and delivering care, using the skills of negotiation and advocacy to arrive at mutually acceptable solutions that recognise the abilities, needs, preferences and best interests of people receiving care. Using their influencing and negotiation skills, they build professional working relationships within and between agencies to achieve seamless effective delivery of person-centred services.

Platform 5: Outcomes

Registered nurses with this qualification in their intended field of practice, will be able to:

5.1 demonstrate leadership in applying human rights, equality, diversity and inclusion, to improve the health and wellbeing of people, families and communities

5.2 demonstrate compassionate leadership when managing community nursing, interdisciplinary and interagency teams, to promote equality, diversity and inclusion, support individual professionals' wellbeing, motivate, and encourage team cohesion and productivity

5.3 lead, promote and influence the nursing profession in wider health and social care contexts and know how to influence and improve the care of communities through partnership working

5.4 identify available local community assets and engage with a range of providers, including third sector and faith-based support organisations and networks, to enhance the support and care of people

5.5 evaluate a range of indicators to determine the skill mix and appropriate characteristics of the workforce required to meet the needs of specific caseloads

5.6 review, lead and manage the people, financial and other resources required to safely meet caseload requirements, making professional risk based decisions when necessary to resolve resource issues

5.7 construct cogent arguments and effectively communicate complex information to justify decisions about resource allocation

5.8 delegate responsibility for the management of budget, people and other resources to team members, while retaining overall accountability

5.9 critically analyse their personal workload requirements and that of the wider team to lead and prioritise activities in order to manage demand and capacity

5.10 safely and effectively delegate responsibilities to team members based on an assessment of their level of knowledge, skill and confidence

5.11 use digital technology to maximise the use of resources across interdisciplinary and interagency teams

5.12 procure equipment and other items in line with relevant procurement policies, value for money considerations and health and safety requirements

5.13 articulate a clear and evidence-based rationale for complex decision making and professional judgment when leading teams in challenging situations

5.14 continually reflect on their own leadership approach and take action to adapt their leadership style to different situations, including but not limited to when working with diverse teams who may be geographically dispersed

5.15 effectively use systems to measure the impact, quality, productivity and cost efficacy of interdisciplinary and interagency teams to allow effective leadership and performance management

5.16 conduct conversations with team members to provide opportunities for positive reinforcement and challenge, and agree any development plans or remedial actions in line with appraisal processes

5.17 lead the development of a positive learning culture for interdisciplinary and interagency teams

5.18 use a range of approaches and resources available to educate, support and motivate people, manage talent and succession plan

5.19 apply a range of leadership strategies that are effective in supporting positive team development and cohesion across disciplines and agencies

5.20 select, implement and evaluate strategies which are appropriate to the composition of the team, to enable supervision, reflection and peer review

5.21 recognise individual abilities and learning needs when applying the standards of education and training for pre- and post-registration nursing, midwifery and nursing associate students, in order to educate, supervise and assess effectively.

Platform 6: Leading improvements in safety and quality of care

All registered nurses with a community nursing specialist practice qualification lead the development and implementation of strategies to improve care, treatment and services, to enhance the health and wellbeing of the specific client group they serve. They are proficient in quality improvement and research methodologies.

They are able to capitalise on their specialist knowledge, skills and experience to mitigate and manage the range of risks, complaints and concerns associated with providing care in diverse community settings. They are able to synthesise the outcomes of risk management activities and use these to develop strategies to promote learning and improvement.

They are able to lead evidence-based quality improvement initiatives. They are able to influence decision making across the interdisciplinary team and in interagency settings in relation to the wider service and specifically in relation to their intended field of specialist community nursing practice.

Platform 6: Outcomes

Registered nurses with this qualification in their intended field of practice, will be able to:

6.1 interpret health and safety legislation and regulations in order to develop local policy and guidance to support staff working across the range of home and community environments

6.2 evaluate the outputs and recommendations of internal and external risk reporting to enable prioritisation, decision making and the development of action plans to mitigate risk

6.3 exercise the knowledge, skills and professional judgement required to balance competing risks and priorities, undertaking quality impact assessments that reflect the balance between safety, quality and least restrictive practices

6.4 co-produce strategies and plans for service design with people, families and communities to improve care outcomes

6.5 use innovative and emerging technology effectively to ensure collection and storage of data to allow analysis and forecasting to inform service improvement and safety plans

6.6 devise methods of systematically and effectively capturing and evaluating people's lived experiences of care to lead improvements in the quality of service delivery

6.7 evaluate different research designs and methodologies and their application to develop and address research questions and generate evidence for service improvement

6.8 initiate and lead a continuous quality improvement programme, selecting an appropriate improvement methodology, collating and presenting results and proposing improvement actions

6.9 critically appraise published results of service evaluation, research findings, improvement data and audit, and distil relevant learning that can be applied in practice to bring about service improvement

6.10 present relevant research, quality and audit findings and proposals for care improvement to a range of audiences.

Platform 7: Care coordination and system leadership

All registered nurses with a community nursing specialist practice qualification have an extensive understanding of relevant social, political and economic policies and the way they impact on the broader community, and of the wider determinants of health and health inequalities.

They understand in detail the functions of the range of different agencies within the community that have a direct or indirect impact on health and wellbeing. They understand the political and economic drivers of each agency, and the resulting opportunities, constraints and risks, which enables them to successfully build appreciative and productive working relationships for the benefit of people, families and communities they work with.

They are able to design and deliver an effective model of person-centred community nursing services, addressing the requirements of the specific client group by integrating within, and maximising the contribution of, other agencies and services. This will include an understanding of those agencies and services beyond their intended field of specialist community nursing practice, to support integration and system wide approaches and collaboration.
All registered nurses with a community specialist qualification have the knowledge, skills and attributes to influence and work collaboratively with other agencies and professionals to design and deliver coordinated, sustained and productive change within the specific context in which they work.

They are able to use their specialist community nursing knowledge, skills and experience to influence and bring about evidence-based change at a local, regional and national level for the benefit of people, families and communities.

Platform 7: Outcomes

Registered nurses with this qualification in their intended field of practice, will be able to:

7.1 critically analyse political and economic policies and drivers that may have an impact on the health, care and wellbeing of local communities

7.2 understand the economic principles that drive health and social care, and their impact on resource allocation in integrated primary and community care services

7.3 synthesise epidemiological, demographic, social, political and economic trends to forecast their impact and influence on current and prospective community nursing services

7.4 build relationships between teams within different systems in health and care, appreciating the value of different approaches, skill sets and expertise

7.5 maximise effectiveness of different services within the system through collaboration and co-design, ensuring that services work seamlessly together to meet the needs of people and communities

7.6 apply a range of methodologies to drive continuous service improvement within the variety of different organisations and agencies that deliver services

7.7 proactively lead on the creation and development of effective system networks that enhance communication and decision making across organisations and agencies

7.8 demonstrate cultural competence and leadership when challenging discriminatory, oppressive cultures and behaviours at a system level

7.9 develop the skills required to influence the health and social care strategies and policies at a local, regional and national level

7.10 effectively work in partnership with peers at a strategic level to promote and influence change and improve health outcomes for the people and communities served.

Glossary

The words in the glossary have been included to explain their specific meaning in the context of these regulatory standards. The meaning might expand on or be slightly more nuanced than the dictionary meaning of some of these words.

Best interest decision: a decision made for and on behalf of a person who has been assessed as lacking capacity to make a decision at that time. This is one of the key principles underpinning mental capacity legislation across the United Kingdom.

Caseload: a caseload refers to the people served and all the activities involved in supporting people requiring care from community nursing services over a specified period in a specified locality.

Community assets: resources that can be used to contribute to developing and improving local health and wellbeing. It may include people and their knowledge, skill, networks and relationships, physical structures, local services, businesses, charities and funds.

Community nursing: care provided by nurses in the community including but not limited to nursing care provided where people live, at home or close to home, in adult social care settings, educational settings, primary care, community clinics, outreach centres, health and justice and other community settings or establishments.

Concordance: an agreement reached after negotiation between a person receiving care and a healthcare professional that respects the beliefs and wishes of the person, for example, in determining whether the plan of care is being carried out as agreed, or when and how medicines are to be taken.

Co-design: in health and care involves the equal partnership of representative professionals, people or groups of people who come together to design care pathways, develop new pathways and revise existing services, models or systems.

Co-produce: a partnership approach which brings people together to find shared solutions and involves partnering with people from the start to the end of any initiative or change that affects them.

Cultural competence: demonstrating the knowledge, skills and behaviours that are respectful of and responsive to the cultural needs of diverse people and communities when providing health and care services.

Determinants of health: includes the social and economic environment, the physical environment and the person's individual characteristics and behaviours.

Evidence-based care: care given that reflects up to date evidence in the area, making sure it takes into account the personal abilities, needs and preferences of the person. It also includes the nurse making a personal judgement based on experience, observations and the abilities, needs and preferences of the person when evidence is limited.

Examination: a mental and physical assessment undertaken with consent on a person receiving care.

Back to text

Nominated person: in parts of the UK, the role of nominated person exists in mental health/ capacity legislation. This is someone that an individual selects to represent them. If the person lacks capacity to nominate, an interim nominated person will be appointed by an approved mental health professional (AMHP) until the person has capacity to make their own nomination. In Scotland the equivalent term is 'Named person'.

People: individuals, groups or populations who receive services from nurses, midwives and nursing associates, healthy and sick people, parents, children, families, carers, nominated persons, also including educators and students and others within and outside the learning environment.

Person-centred: where the person is at the centre of decision making, focusing care on the abilities and needs of a person, ensuring that people's preferences, abilities, needs and values guide clinical decisions, and providing care and support that is respectful of and responsive to them.

Principle of presumption of capacity: one of the five key principles under the mental capacity legislation of the United Kingdom. The principle states that every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means we can't assume that someone can't make a decision for themselves just because they have a particular medical condition or disability.

Specialist practice: surpasses the expectation of the standards of proficiency for registered nurses in areas such as assessment, diagnosis, decision making, care planning, coordination of care and care delivery specific to a particular person, context, setting or client group.

Transition of care: transitions of care are an integral part of a person's journey across health and care systems. Transition of care is recognised to pose risks for a number of reasons. Managing the coordination and transition of people safely and effectively from one place of care to another, or between different professionals, therefore requires effective collaboration to ensure seamless, risk-free, person-centred continuity of care. This may include: transition from children and young people services to adult care services, from primary and community focused care to specialist inpatient care provision, from home to adult social care, from home to hospice care or transfer of care from a professional in one discipline to another professional in a different profession.

Vulnerable: people who may be vulnerable at a particular time and in particular situations (but not in others), due to their personal characteristic(s), situation(s) or neglect, and therefore at a higher risk of potential or actual harm. The type of harm may be emotional, physical, sexual, psychological, material or financial.

Back to text

The role of the Nursing and Midwifery Council

What we do

Our vision is safe, effective and kind nursing and midwifery that improves everyone's health and wellbeing. As the independent regulator of more than 758,000 nursing and midwifery professionals, we have an important role to play in making this a reality.

Our core role is to **regulate**. First, we promote high professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects less than one percent of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.

To regulate well, we **support** our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to **influence** health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

23 Portland Place, London W1B 1PZ

T +44 20 7333 9333

nmc.org.uk

@nmcnews

@nmcuk

Nursing & Midwifery Council

The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Registered charity in England and Wales (1091434) and in Scotland (SC038362)

These standards were approved by Council at their meeting on 26 May 2022.

Exhibit 22

MAHI - STM - 212 - 862

Nursing & Midwifery Council

Programmes leading to Specialist community public health nurse qualifications and programmes leading to Community nursing specialist practice qualifications

Part 3: Standards for post-registration programmes

Published 7 July 2022

About these standards

Our education and training standards help nursing and midwifery students achieve the NMC proficiencies and programme outcomes.

All nursing and midwifery professionals must practise in line with the requirements of the Code, the professional standards of practice and behaviour that nurses, midwives and nursing associates are expected to uphold.

Realising professionalism: Standards for education and training includes the *Standards framework for nursing and midwifery education, Standards for student supervision and assessment*, and programme standards specific to each approved programme.

Our Standards for education and training are set out in three parts:

Part 1: Standards framework for nursing and midwifery education

Part 2: Standards for student supervision and assessment

Part 3: Programme standards

- Standards for pre-registration nursing programmes
- Standards for pre-registration midwifery programmes
- Standards for pre-registration nursing associate programmes
- Standards for prescribing programmes
- Standards for return to practice programmes
- Standards for post-registration programmes

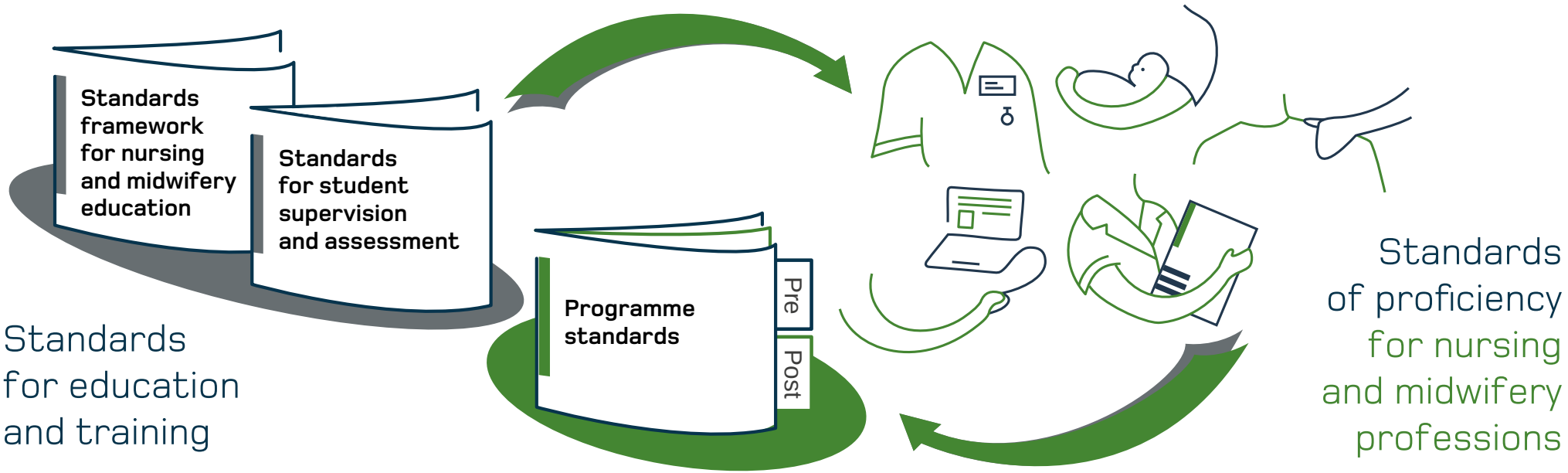
Introduction

Our Standards for specialist community public health nurses (SCPHN) and community nursing specialist practice qualification (SPQ) programmes set out the legal requirements, entry requirements, requirements for the curriculum and practice learning, requirements for supervision and assessment, and information on the awards for these post-registration programmes.

Public safety is central to our standards. Registered nurses and midwives undertaking these programmes are post-registration students in this context. They will be in contact with people throughout their education. It's important they grow in confidence, and further develop their knowledge and skills in a safe, supportive and effective way.

These programme standards must be read with our *Standards framework for nursing and midwifery education* and *Standards for student supervision and assessment* which apply to all NMC approved programmes.

NMC approved education institutions wishing to deliver post-registration education programmes must comply with all these standards to run an approved programme.



Education providers structure their programmes to comply with our programme standards. They design their curricula around the proficiencies we set. Proficiencies are the knowledge, skills and behaviours that nurses and midwives need in order to practise.

Curricula for specialist community public health nurses and community nursing specialist practice qualifications may be flexible to accommodate opportunities for shared learning, including between post-registration programmes and the differing fields of SCPHN and community nursing SPQ practice that reflect the range of learning opportunities and needs and in recognising prior experience as registered professionals.

Students are assessed against proficiencies for their intended field of SCPHN practice or SCPHN public health nurse practice.

The awards are as follows:

- SCPHN: health visitor, school nurse, occupational health nurse
- SCPHN: public health nurse[1].

Students are assessed against proficiencies for their intended community nursing SPQ practice.

The awards are as follows:

- Community nursing SPQ: in the field of community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing
- Community nursing in health and social care SPQ: for which other fields of community nursing may be specified[2].

Successful completion of the programme confirms the student is capable of providing safe and effective care in a specific field of practice SCPHN role, a SCPHN public health nurse role, in a specific field of practice community nursing SPQ role or in a community nursing in health and social care SPQ role.

We publish *Standards of proficiency for Specialist Community Public Health Nurses* and *Standards of proficiency for community nursing* SPQs.

We also publish Standards of proficiency for registered nurses, Standards of proficiency for midwives, Standards of proficiency for nursing associates *(England only)*, Return to practice standards *and* the Royal Pharmaceutical Society's Competency Framework for All Prescribers as our standards of proficiency for nurse and midwife prescribers.

1 The SCPHN public health nurse qualification (PHN) qualification does not have a predetermined field of SCPHN practice
2 The community nursing SPQ in health and social care field of practice is not predetermined by the NMC. However the field of practice must be specified by the AEI as part of the NMC programme approval process.

Through our quality assurance (QA) processes we check that education programmes meet all of our standards, that the programme outcomes relate to the proficiencies for particular qualifications and that approved education institutions (AEIs) and practice learning partners are managing risks effectively. We monitor risks to quality in education and training using internal and external intelligence. This intelligence gathering includes analysis of system regulators' reports.

Before any programme can run, we make sure it meets our standards. We do this through an approval process in accordance with our Quality Assurance Framework.

Overall responsibility for the day-to-day management of the quality of any educational programme lies with the AEI in partnership with its practice learning partners.

Legislative framework

Article 5(2) of the Nursing and Midwifery Order 2001 ('the Order') requires the NMC to establish the standards of proficiency necessary to be admitted to each part of the register and for safe and effective practice under that part of the register. This article applies to SCPHN standards of proficiency.

Article 15(1) of the Nursing and Midwifery Order 2001 requires the NMC to establish the standards for education and training which are necessary to achieve the standards of proficiency for admission to any part of the register. This article applies to SCPHN programme standards.

Article 19(6) of the Nursing and Midwifery Order 2001 allows the NMC to establish standards of education and training for any additional qualifications that may be recorded on the register. Articles 15(3) to (9) and articles 16 to 18 shall apply in respect of those standards as if they were standards established under article 15(1)(a). This means the NMC may establish standards of education and training and may approve a course of education or qualification in relation to SPQs.

These post-registration programme standards are established under these provisions.

Post-registration SCPHN and community nursing SPQ programmes

Our standards for education and training highlight the need for programmes to adopt an inclusive approach to recruitment, selection and progression, ensuring admissions and all other academic processes are open, fair, transparent and demonstrate an understanding of and take measures to address underrepresentation.

The student journey

In conjunction with Parts 1 and 2 as outlined above, standards for specialist community public health nurses and community nursing specialist practice qualification programmes follow the student journey and are grouped under the following five headings:

1. Selection, admission and progression

Standards about an applicant's suitability and continued participation in a specialist community public health nurse programme or community nursing specialist practice qualification programme

2. Curriculum

Standards for the content, delivery and evaluation of programmes for specialist community public health nurse and community nursing specialist practice qualifications

3. Practice learning

Standards specific to learning that takes place in practice settings for students undertaking programmes leading to specialist community public health nurse and community nursing specialist practice qualifications

4. Supervision and assessment

Standards for safe and effective supervision and assessment for specialist community public health nurse and community nursing specialist practice qualification programmes

5. Qualification to be awarded

Standards which state the award and information for:

- Specialist community public health nurse in the field of: health visitor, school nurse, occupational health nurse
- Specialist community public health nurse (public health nursing)
- Community nursing specialist practice qualifications: community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing
- Community nursing in health and social care specialist practice qualification (for those in other identified field(s) of community nursing practice).

1. Selection, admission and progression

Approved education institutions, together with practice learning partners, must:

1.1. ensure that the applicant is an:

1.1.1. NMC registered nurse (level 1) or NMC registered midwife capable of safe and effective practice at the level of proficiency appropriate to the NMC approved Specialist Community Public Health Nurse (SCPHN) programme before being considered as eligible to apply for entry

1.1.2. NMC registered nurse (level 1) with relevant professional registration, capable of safe and effective practice at the level of proficiency appropriate to the NMC approved Community Nursing Specialist Practice Qualification (SPQ) programme before being considered as eligible to apply for entry

1.2. confirm on entry that each applicant selected to undertake a SCPHN or community nursing SPQ programme has the academic capability to study at the level required for that programme

1.3. provide opportunities that enable eligible[3] NMC registered nurses and/or NMC registered midwives, including NHS, non-NHS, self-employed or self-funded applicants to apply for entry onto an NMC approved SCPHN programme

1.4. provide opportunities that enable eligible NMC registered nurses, including NHS, non-NHS, self-employed or self-funded applicants to apply for entry onto an NMC approved community nursing SPQ programme

1.5. confirm that the necessary arrangements and governance structures are in place to support practice learning, including employer support and protected learning time, to enable students to undertake and be appropriately supported throughout the programme

3 SCPHN applicants must be RN1, midwife or both. SPQ applicants must be RN1.

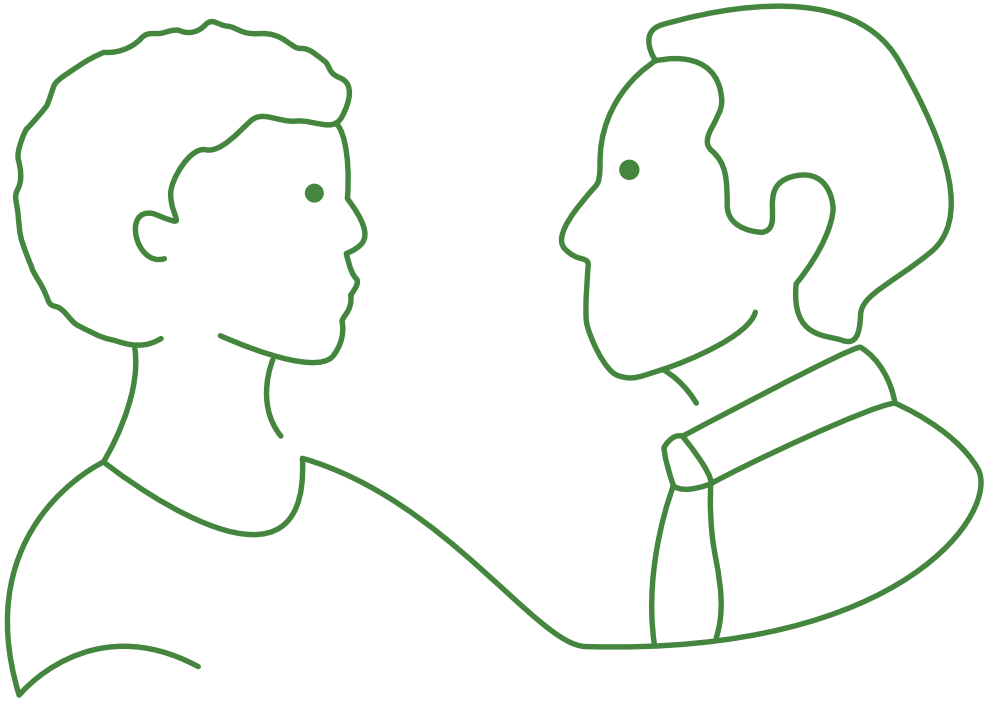
1.6. consider recognition of prior learning that is capable of being mapped to the:

1.6.1. programme learning outcomes and standards of proficiency for the applicant's intended field of SCPHN practice or SCPHN public health nurse practice

1.6.2. programme learning outcomes and standards of proficiency for the applicant's intended field of community nursing SPQ practice or in other specified field(s) for the community nursing SPQ in health and social care practice

1.7. where programmes intend to offer SCPHN and/or SPQ students admission to an NMC approved independent/supplementary (V300) prescribing programme consider recognition of prior learning that is capable of being mapped to the *RPS Competency Framework for all Prescribers*[4] for applicants, and

1.8. where programmes intend to offer admission to an NMC approved independent/supplementary (V300) prescribing programme to SCPHN and/or SPQ students, ensure that the applicant is a registered nurse (level 1) and/or a registered midwife before being considered as eligible to apply for entry.



4 https://www.nmc.org.uk/standards/standards-for-post-registration/standards-for-prescribers/royal-pharmaceutical-societys-competency-framework-for-all-prescribers/

2. Curriculum

Approved education institutions, together with practice learning partners, must:

2.1. confirm programmes comply with the NMC *Standards framework for nursing and midwifery education* including the confirmation of appropriately qualified and experienced people for programme delivery[5] for:

2.1.1. all selected fields of SCPHN practice and/or SCPHN PHN practice and/or for

2.1.2. all selected fields of community nursing SPQ practice and/or in other specified fields of community nursing SPQ in health and social care practice

2.2. confirm SCPHN and/or SPQ programmes comply with the NMC *Standards for student supervision and assessment*

2.3. confirm SCPHN and/or community nursing SPQ programmes that include admission to NMC approved prescribing programme comply with the NMC *Standards for prescribing programmes*[6]

2.4. state routes within the programme for:

2.4.1. students to enter the SCPHN register in a specific field of SCPHN practice: health visitor, school nurse, occupational health nurse

2.4.2. students to enter the SCPHN register for the public health nurse qualification

2.4.3. students to annotate their registration in a specific field of community nursing SPQ practice: community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing

2.4.4. students to annotate their registration in community nursing SPQ practice in health and social care

2.5. ensure programme learning outcomes reflect the:

2.5.1. core and field specific standards of proficiency for SCPHN and for the intended field(s) of SCPHN practice: health visiting, school nursing, occupational health nursing

2.5.2. core standards of proficiency for SCPHN that are tailored to SCPHN public health nursing

2.5.3. standards of proficiency for community nursing SPQ that are tailored to the intended field and related context of community nursing practice. These may be within community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing or in specified field(s) for community nursing SPQ in health and social care practice

5 See Part 1: Standards framework for nursing and midwifery education 2.14, 2.18 and 5.4
6 See: https://www.nmc.org.uk/standards/standards-for-post-registration/standards-for-prescribers/standards-for-prescribing-programmes/

2.6. set out the general and professional content necessary to meet the:

2.6.1. core and field specific standards of proficiency for each intended field of SCPHN practice: health visiting, school nursing, occupational health nursing,

2.6.2. core standards of proficiency for SCPHN public health nurse qualification

2.6.3. standards of proficiency for the community nursing SPQ that is tailored to the intended field of community nursing practice. These may be within community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing, or in other specified field(s) of community nursing in health and social care

2.7. set out the content necessary to meet the programme outcomes for each intended field of:

2.7.1. SCPHN practice: health visiting, school nursing, occupational health nursing and/or SCPHN public health nursing,

2.7.2. community nursing SPQ practice: community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing and/or in other specified field(s) of community nursing in health and social care

2.8. ensure technology-enhanced and simulated learning opportunities are used effectively and proportionately across the curriculum to support learning and assessment

2.9. ensure that the curriculum provides a balance of theory and practice learning opportunities, using a range of learning and teaching strategies

2.10. ensure programmes delivered in Wales comply with legislation which supports use of the Welsh language, and

2.11. ensure programmes are:

2.11.1. of suitable length to support student achievement of all proficiencies and programme outcomes for their intended SCPHN or community nursing SPQ award

2.11.2. no less than 45 programmed weeks of theory and practice learning for full-time programmes/pro rata for part time programmes.

3. Practice learning

Approved education institutions must:

3.1. ensure that suitable and effective arrangements and governance for practice learning are in place for all students, including arrangements specifically tailored to those applicants who are self-employed and/or self-funded

Approved education institutions, together with practice learning partners, must:

3.2. ensure that students work in partnership with the education provider and their practice learning partners to arrange supervision and assessment that complies with the NMC *Standards for student supervision and assessment*

3.3. provide practice learning opportunities that allow students to develop, progress and meet all the standards of proficiency for their:

3.3.1. intended field of SCPHN practice: health visitor, school nurse, occupational health nurse or,

3.3.2. SCPHN public health nurse

3.3.3. intended community nursing SPQ: these may be within the fields of community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing or,

3.3.4. in other specified field(s) of community nursing in health and social care nursing

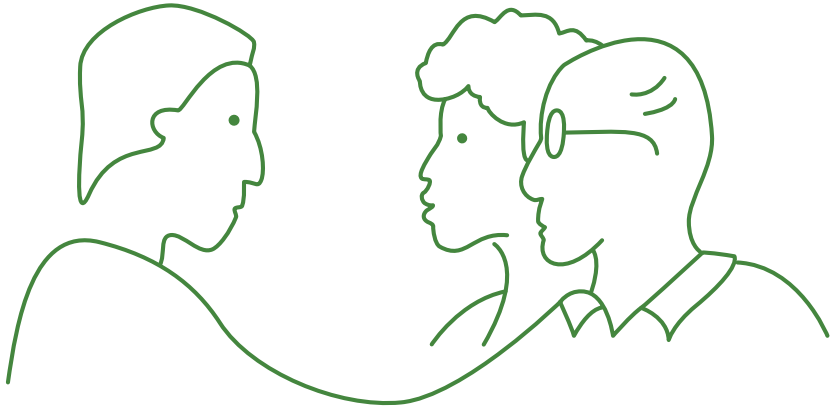
3.4. ensure that practice learning complies with the NMC *Standards for student supervision and assessment*

3.5. take account of students' individual learning needs and personal circumstances when allocating their practice learning, including making reasonable adjustments for students with disabilities, and

3.6. ensure learning experiences are tailored to the student's stage of learning, proficiencies and programme outcomes culminating in a period of practice learning. This is dependent on the individual learning needs of the student to demonstrate overall proficiency and achieve the programme learning outcomes for their:

3.6.1. intended field of SCPHN practice, SCPHN PHN practice or

3.6.2. their intended field of community nursing SPQ practice or community nursing SPQ in health and social care practice.



4. Supervision and assessment

Approved education institutions, together with practice learning partners, must:

4.1. ensure student support, supervision, learning and assessment complies with the NMC *Standards framework for nursing and midwifery education*

4.2. liaise, collaborate and agree the necessary approach to the preparation, education, training, ongoing learning, support and expertise necessary for practice supervisors, practice and academic assessors that support SCPHN and community nursing SPQ student learning and assessment[7]

4.3. ensure practice supervision, the assessment of practice and academic assessment complies with the NMC *Standards for student supervision and assessment*

4.4. ensure practice supervisors:

4.4.1. have undertaken a period of preceptorship in line with the NMC principles for preceptorship as SCPHN or community nursing SPQ qualified professionals or

4.4.2. can evidence prior learning and relevant practice supervisor experience that enables them to facilitate effective evidence-based learning opportunities for post-registration SCPHN or community nursing SPQ students

4.5. ensure practice and academic assessors:

4.5.1. have undertaken a period of preceptorship in line with the NMC principles for preceptorship as SCPHNs or community nurses with a SPQ or

4.5.2. can evidence prior learning and relevant practice assessor experience that enables them to engage in fair, reliable and valid assessment processes in the context of SCPHN and/or community nursing SPQ

4.6. ensure the student is assigned to a practice assessor who is an experienced registered SCPHN or community SPQ nurse for the programme the student is undertaking

4.6.1. in exceptional circumstances, the same person may fulfil the role of practice supervisor and practice assessor for a part of the programme where the SCPHN/community nursing SPQ student is undergoing education and training in a practice learning setting. In such instances, the student, practice supervisor/assessor and the AEI will need to evidence why it was necessary for the practice supervisor and practice assessor roles to be carried out by the same person

7 This links directly to Part 1: Standards framework for nursing and midwifery education and in particular requirement 4.7

4.7. provide constructive feedback to students throughout the programme to support their learning and development for meeting the standards of proficiency and programme learning outcomes for:

4.7.1. their intended field of SCPHN practice: health visitor, school nurse, occupational health nurse,

4.7.2. SCPHN public health nurse,

4.7.3. their intended SPQ in the field of: community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing, or

4.7.4. other specified field(s) of community nursing SPQ in health and social care

4.8. ensure all SCPHN proficiencies and/or community nursing SPQ proficiencies are recorded in an ongoing record of achievement which confirms SCPHN and/or community nursing SPQ proficiencies have been met

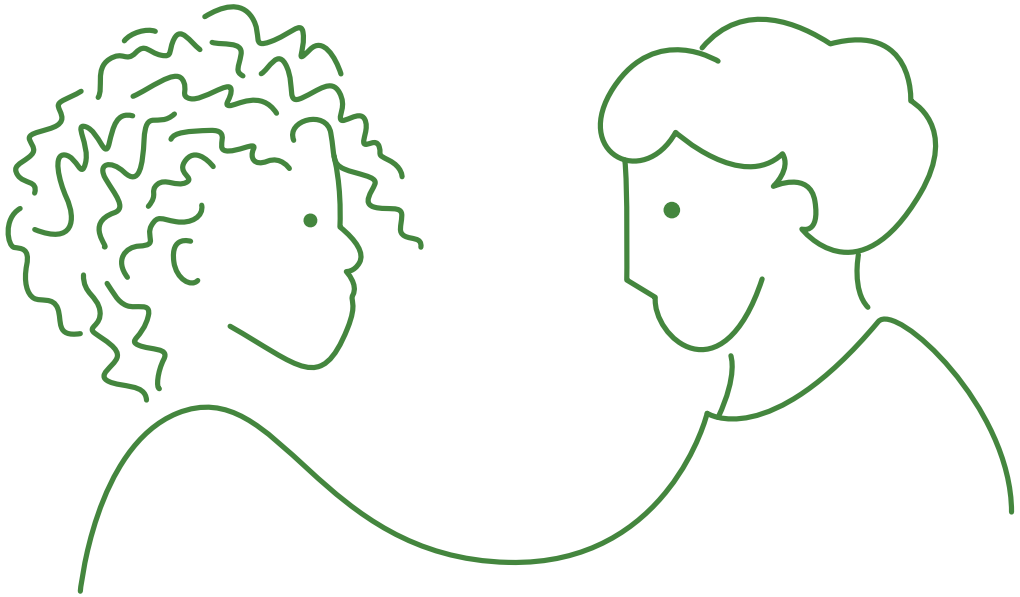
4.9. assess the student's suitability for award and confirm overall proficiency based on the successful completion of all practice learning relevant to:

4.9.1. their intended field of SCPHN practice: health visitor, school nurse, occupational health nurse,

4.9.2. SCPHN public health nurse practice,

4.9.3. their intended SPQ in the field of: community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing, and/or

4.9.4. other specified field(s) of practice for the community nursing SPQ in health and social care.



5. Qualification to be awarded

Approved education institutions, together with practice learning partners, must:

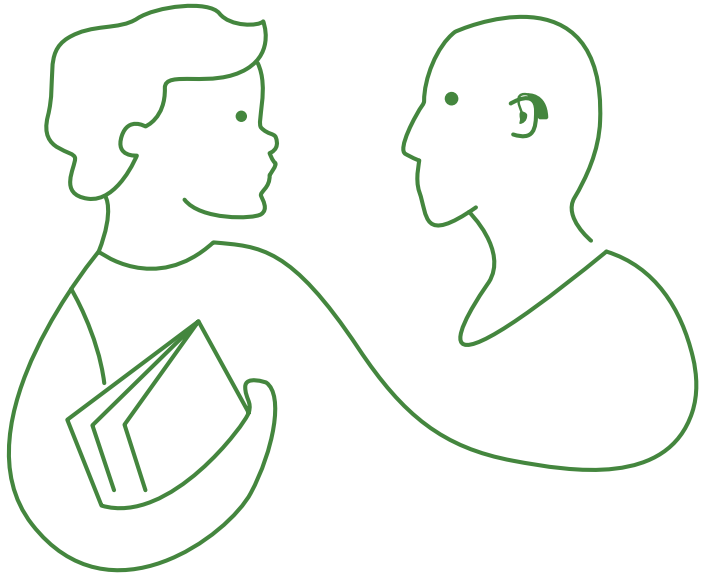
5.1. ensure that the minimum academic level for SCPHN and community nursing SPQ is at postgraduate masters' level

5.2. inform the student that the SCPHN award[8] must be registered with us within five years of successfully completing the programme and if they fail to do so they will have to undertake additional education and training or gain such experience as specified in NMC standards for the award to be registered

5.3. inform the student that the community nursing SPQ award[9] must be registered with us within five years of successfully completing the programme and if they fail to do so they will have to undertake additional education and training or gain such experience as specified in NMC standards for the award to be added as an annotation to their professional registration

5.4. inform the SCPHN and/or community nursing SPQ student that following successful completion of an NMC approved programme of preparation for SCPHN or community nursing SPQ, which included an NMC approved independent/supplementary prescribing qualification, the V300 award must be registered with us within five years of successfully completing the prescribing programme. If they fail to do so they will have to retake and successfully complete the programme in order to qualify as a prescriber, and

5.5. inform the SCPHN and/or community nursing SPQ student that they may only prescribe once their prescribing qualification has been annotated on the NMC register and they may only prescribe from the formulary they are qualified to prescribe from and within their competence and scope of practice.



8 SCPHN registration https://www.nmc.org.uk/registration/your-registration/scphn-registration/
9 Recordable qualifications https://www.nmc.org.uk/registration/your-registration/recording-qualifications/

Glossary

Approved education institutions (AEIs): the status awarded by the NMC to an institution, or part of an institution, or combination of institutions that work in partnership with practice placement and work placed learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

Community nursing: care provided by nurses in the community including but not limited to nursing care provided where people live, at home or close to home, in adult social care settings, educational settings, primary care, community clinics, outreach centres, health and justice and other community settings or establishments.

Formulary: an official list giving details of prescriable medicines. The main function of a nursing and midwifery prescription formulary is to specify those particular medications that are approved to be prescribed by nurses and midwives, depending on the level of qualification they have obtained.

Other specified field(s) of community nursing in health and social care: this is including but not limited to nurses practicing in the context of offender health, the social care sector, hospice sector, as determined by the AEI and their learning practice partner.

People: individuals or groups who receive services from nurses and midwives, healthy and sick people, parents, children, families, carers, representatives, including educators, students and others within and outside the learning environment.

Practice learning partners: organisations that provide practice learning necessary for supporting pre-registration and post-registration students in meeting proficiencies and programme outcomes.

Protected learning time: time in a health, care or other setting during which students are learning and are supported to learn. Students must be supervised during protected learning time. The level of supervision required is a matter of professional judgment and will depend on the competence and confidence of the student, and the risks associated with the intervention being delivered.

Quality assurance: NMC processes for making sure all AEIs and their approved education programmes comply with our standards.

Reasonable adjustments: where a student requires a reasonable adjustment related to a disability. We also use it to mean adjustment relating to any protected characteristics as set out in the equalities and human rights legislation.

Recognition of prior learning (RPL): a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes. This means it includes both theory and practice achievement.

Simulation: an educational method which uses a variety of modalities to support students in developing their knowledge, behaviours and skills, with the opportunity for repetition, feedback, evaluation and reflection to achieve their programme outcomes and be confirmed as capable of safe and effective practice.

Student: any individual enrolled onto an NMC approved education programme whether full time or less than full time.

Back to text

The role of the Nursing and Midwifery Council

What we do

Our vision is safe, effective and kind nursing and midwifery that improves everyone's health and wellbeing. As the independent regulator of more than 758,000 nursing and midwifery professionals, we have an important role to play in making this a reality.

Our core role is to **regulate**. First, we promote high professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects less than one percent of professionals each year. We believe in giving professionals the chance to address concerns, but we'll always take action when needed.

To regulate well, we **support** our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

Regulating and supporting our professions allows us to **influence** health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

23 Portland Place, London W1B 1PZ

T +44 20 7333 9333

nmc.org.uk

@nmcnews

@nmcuk

Nursing & Midwifery Council

The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Registered charity in England and Wales (1091434) and in Scotland (SC038362)

These standards were approved by Council at their meeting on 26 May 2022.

Evaluation of post-registration standards of proficiency for specialist community public health nurses and the standards for specialist education and practice standards

Nursing and Midwifery Council

February 2019

CONTENTS

1. Introduction

1.1 The Nursing and Midwifery Council (NMC) is the independent regulator of nurses and midwives for England, Wales, Scotland and Northern Ireland. The primary role of the NMC is to protect patients and the public through effective and proportionate regulation of nurses and midwives.

1.2 As part of its role, the NMC sets education standards that shape the content and design of programmes and identify the competences of a nurse, midwife or nursing associate. It approves education institutions to deliver the programmes and quality assures these approved programmes. Nurses and midwives who successfully complete their programmes, and are able to practise, are listed on Part 1 and 2 of the NMC's public register.

1.3 To ensure that the education standards are fit for purpose and that nurses, midwives and nursing associates are equipped to deliver high quality safe care now and in the future, the NMC has embarked on a four year change programme for nurse and midwifery education. Phase 1 of the reforms was approved in March 2018 and includes:

- **Standards framework for education and training** for providers of pre and post-registration nursing and midwifery programmes;
- **Standards for student supervision and assessment**;
- **Standards for pre-registration nursing programmes** describing entry criteria, programme length and award;
- **Standards of proficiency for registered nurses** that describe the knowledge and skills that nurse should have at the point of joining the register;
- **Standards for prescribing programmes**; and
- **Adoption of the Royal Pharmaceutical Society's competence framework** which describes the knowledge and skills that nurse and midwife prescribers should have.

1.4 In April 2018, the NMC commissioned Blake Stevenson Ltd to undertake an evaluation of the existing standards for post-registration education for nurses and midwives.

Post-registration education

1.5 Once a nurse or midwife has joined the NMC register they can undertake further education and training to join the Specialist Community Public Health Nurse (SCPHN) part of the register (third part) or be noted as having a Specialist Practitioner Qualification (SPQ) on the register. As of January 2018, there were 29,752 SCPHN registrations and there were 23,657 nurses and/or midwives who had an SPQ annotation.

1.6 SCPHNs can be undertaken by registered nurses and midwives looking to work in the public health roles as health visitors, school nurses or occupational health nurses. Those

who have undertaken NMC-approved SCPHN courses that incorporate the ten recognised public health competencies. They have historically been considered to be a high risk group of registrants as they usually undertake sole practice and often provide care and support for vulnerable patients and families in their own homes. They also work not just with individuals, but with particular populations, to improve their health as a whole.

1.7 Specialist practice was originally intended to allow a nurse to demonstrate that they were capable of exercising higher levels of judgement, discretion and decision making in clinical care in a specific practice area. The NMC approves SPQ programmes which meet standards for specialist education and practice in relation to nine areas which include district nursing and General Practice nursing. It is important to note that many nurses undertake specialist practice without holding the NMC recordable qualification.

Aims of the evaluation

1.8 Both SCPHN and SPQ standards have not been updated for some time and the primary aim of the research was to explore whether the current standards are fit for purpose and how far they meet the needs of the current and future nursing and midwifery workforce.

1.9 Through desk-based research, a UK-wide survey and interviews with a wide range of stakeholders, registrants, students and service users, key research questions were explored. These included:

- Are the current standards appropriate to prepare nurses and midwives for future post-registration practice?
- To what extent do the standards protect the public and maintain public confidence in the profession?
- What role are annotations and entries to the third part of the register playing?
- To what extent are the SPQ and SCPHN standards known and understood?
- If the standards for SCPHNs and SPQs were withdrawn what would be the consequences?
- What should future regulatory post-registration standards take account of and where might they come from?

Approach to research

1.10 The evaluation involved a multi-faceted approach, agreed in discussion with the NMC commissioners and delivered over three phases.

1.11 The first phase, planning and preparation, included several key activities. The standards mapping activity provided a deeper understanding of the relationships between the various (sets of) standards and ensured that the researchers could explore perceptions of the standards among the various respondent groups in greater depth. The mapping

report, produced in addition to this report, is also designed to support the NMC in its examination of the fitness for purpose of the SCPHN and SPQ standards.

1.12 The relevance of non NMC-approved courses to evaluating the NMC standards was recognised but considered to be out with the scope of this research.

1.13 Identifying the research sample and recruiting participants was another key element of phase 1 of the evaluation. To ensure a comprehensive evaluation of the NMC standards, evidence was gathered from a wide range of contributors:

- Key senior **stakeholders** from nursing organisations and professional and government bodies from the four countries
- **Registrants** who hold SCPHN and SPQ qualifications
- Representatives from all **Approved Education Institutions** (AEIs) which offer SCPHN and/or SPQ courses
- **Nurses and midwives** currently undertaking post-registration courses that lead to a SCPHN or SPQ qualification
- **Employers** of nurses and midwives
- **Public and patients** involved in curriculum design at AEIs

1.14 It was important to ensure that a geographically, demographically and professionally diverse group of representatives were selected to participate in the research to capture the depth and breadth of views. A sampling approach was devised to achieve this, which included a sample of registrants that reflected the profile of the NMC register. Evaluation participants were recruited via two routes- through nominated contacts at AEIs or through the NMC from their existing contacts and from the register.

Definitions

1.15 Throughout this report we refer to:

- Registrants (meaning nurses and/or midwives who have a post-registration qualification following successful completion of a SPQ and/or SCPHN qualification);
- Students (meaning nurses and/or midwives who are currently undertaking a SPQ or SCPHN post-registration qualification); and
- Nurses and midwives (meaning a person who is registered as a nurse and/or midwife with the NMC).

Evidence gathering

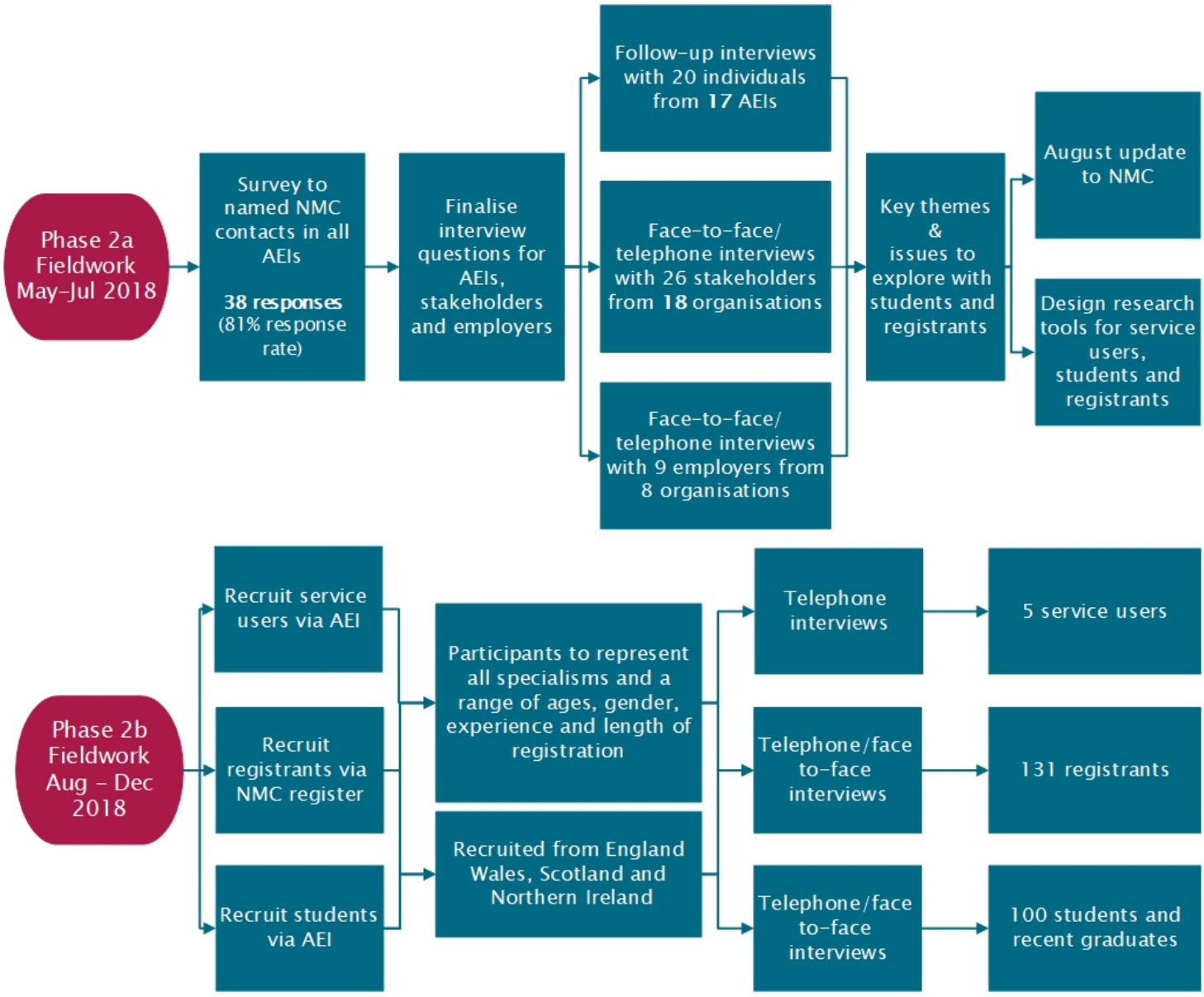
Table 1.1 Sampling strategy

Participants	Sampling priority	Sampling approach
AEIs	✓ Geographic spread ✓ Post-registration courses offered	A shortlist of AEIs to invite for follow-up interviews was compiled based on location of the university and the NMC-approved post-registration courses offered at the AEI.
Stakeholders	✓ Geographic spread ✓ Organisation (nursing and midwifery bodies, faculties, associations, unions)	The NMC were able to identify stakeholders from a range of nursing and midwifery organisations across the UK, with a devolved nation or UK-wide remit.
Employers	✓ Geographic spread	The NMC were able to identify employers from across the UK.
Students	✓ Geographic spread ✓ Qualification studying toward ✓ Demographic diversity	A shortlist of AEIs to assist with recruitment of students was compiled based on location of the university and NMC-approved post-registration courses offered at the AEI.
Registrants	✓ Reflecting the profile of the NMC register (registration, geography age, gender, ethnicity, qualification type)	Using the profile breakdown from the NMC register, a sampling frame was created. We selected a representative sample based on the information provided in the online profile form completed by registrants interested in participating in the research.
Service users	✓ Geographic spread ✓ Demographic diversity	A shortlist of AEIs to invite for follow-up interviews and to assist with the recruitment of service users was compiled based on location.

1.16 Phase 2 of the evaluation was the evidence gathering phase and this took place over a six month period. It involved several research elements that explored the key questions with the different stakeholders. It began with the AEI survey which aimed to provide an overview and understanding of the use of the SCPHN and SPQ standards, rationale for course offerings, future plans, options and potential consequences of changes/reform.

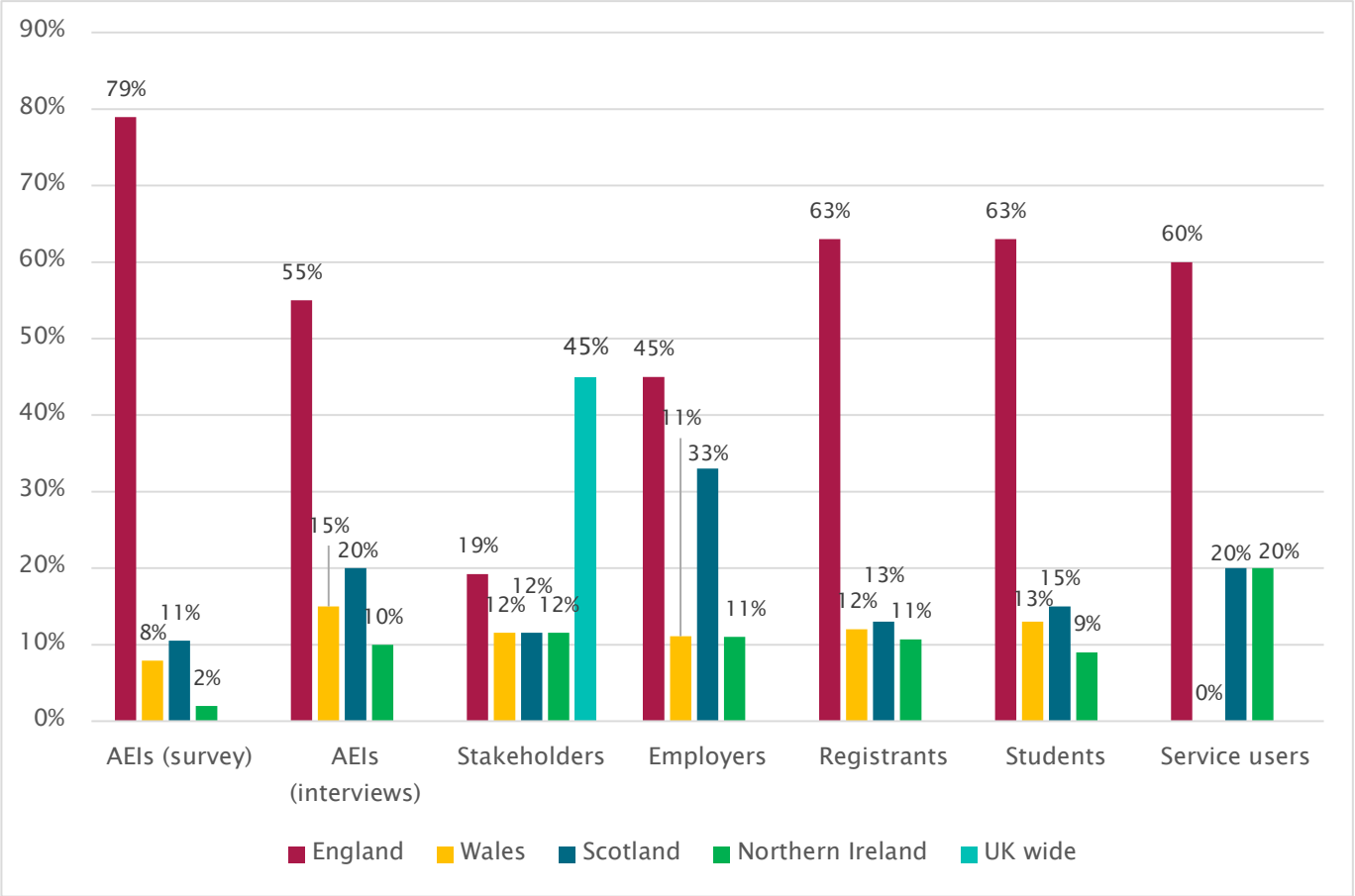
1.17 The survey analysis was used to refine the research tools for the remainder of the evaluation period. The key stages and timing of the evidence gathering phase are summarised in Figure 1.1 overleaf.

Figure 1.1: Phase 2 Evidence gathering



1.18 In addition to 38 survey responses from the AEIs, 291 individuals contributed to this evaluation. The following diagram presents the profile of all participants by nation (Figure 1.2).

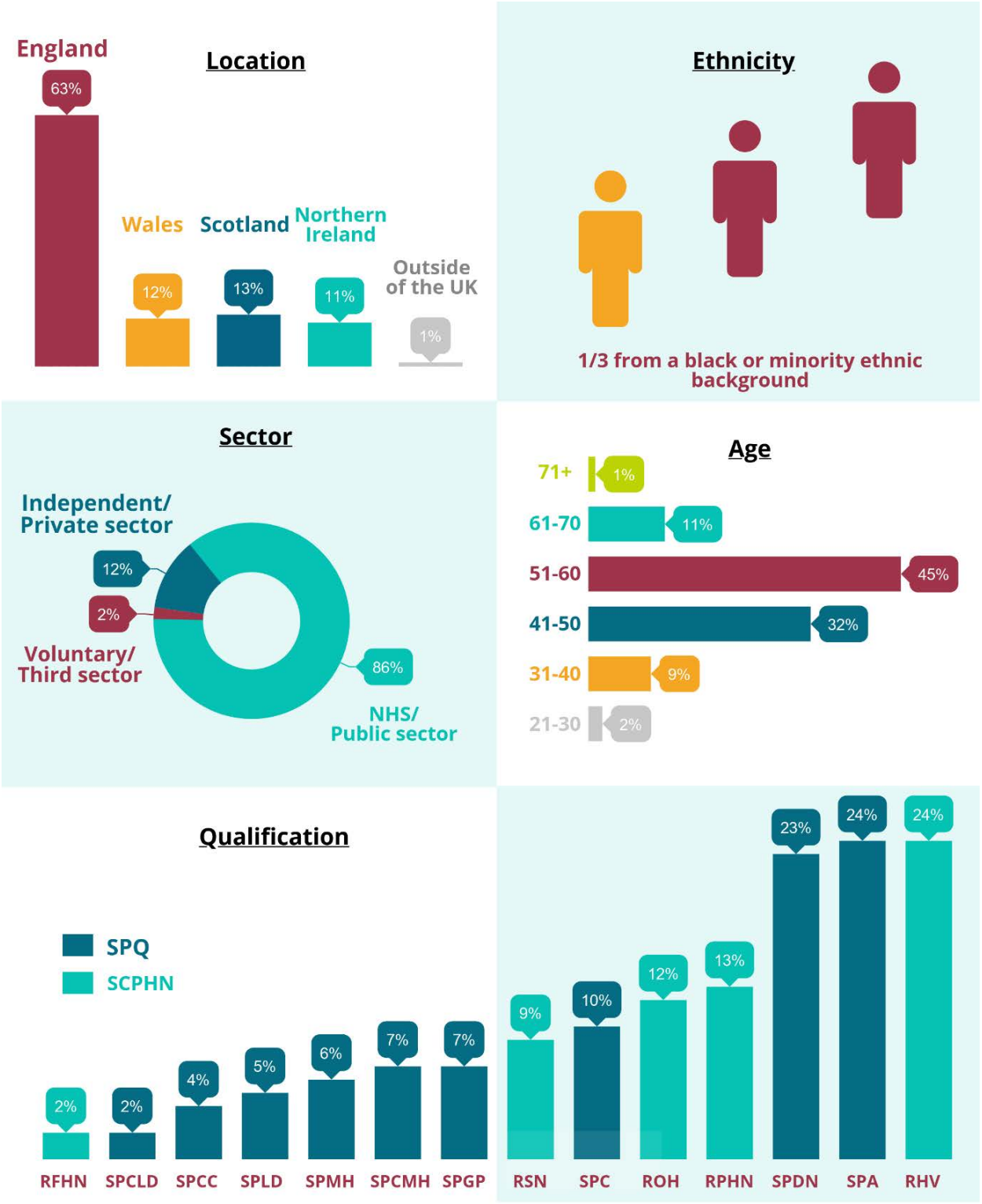
Figure 1.2: Geographic profile of all evaluation participants (n=329 including AEI survey respondents)



*Registrant percentages add up to 99% as 1% came from outside of the UK (not shown in chart)

1.19 The infographic on the next page summarises the overall profile of the registrants (Figure 1.3).

Figure 1.3: Profile of registrants (n=131)



Report structure

1.20 The content of this report is based on the desk research and evidence gathering from contributors from across all four nations. The remainder of the report is set out as follows:

- Chapter 2 provides an overview of the research context, based on findings from the desk research;
- Chapter 3 explores the qualifications that represent the standards;
- Chapter 4 presents findings around the standards themselves; and
- Chapter 5 provides a summary of the evaluation findings and considers actions and next steps.

2. The Research Context – findings from desk research

2.1 The desk research focused on two key questions:

- What does the SCPHN/SPQ context look like in each of the four home countries of the UK?
- How do the SPQ and SCPHN standards relate to each other, and to the new pre-registration standards?

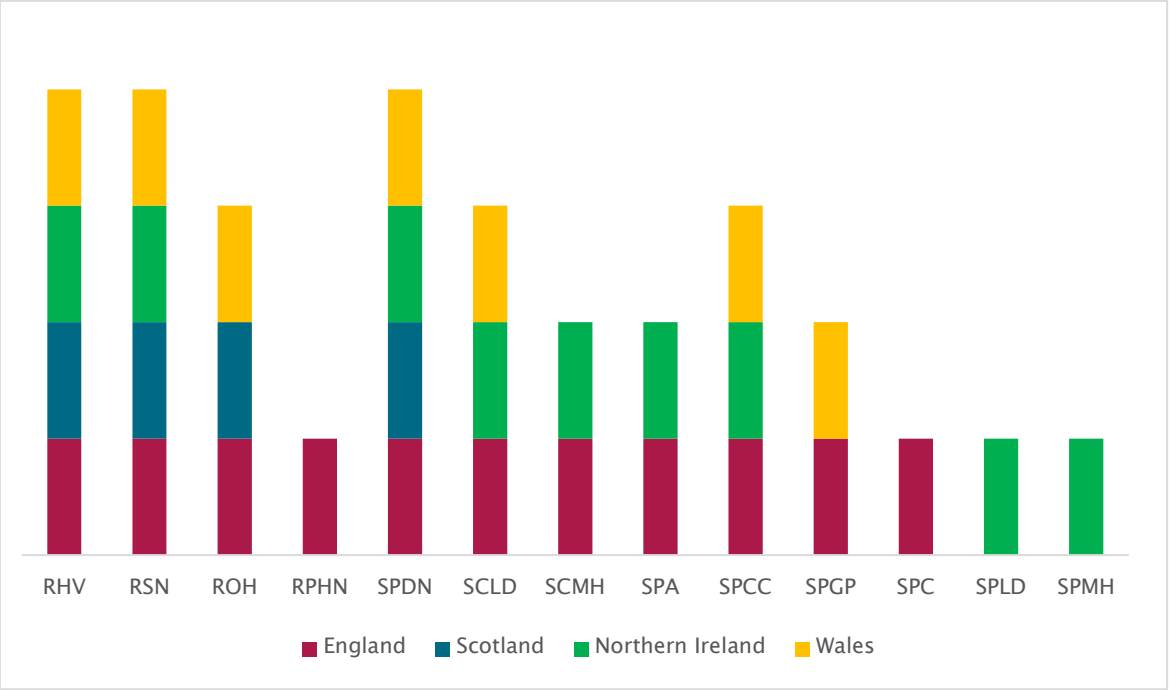
2.2 It was recognised that respondents' views were likely to be informed by the policy contexts within which they were working. A key aim of the research was therefore to identify if, and how, these contexts resulted in differences in the perceptions of the various groups of respondents, and where commonalities could be identified across those contexts.

2.3 There is an overlap in the range of roles addressed by the two sets of NMC post-registration standards. As a result, it was important to understand how the standards relate to one another in order to explore the potential implications of choosing between two qualifications that are designed for the similar roles. Similarly, understanding if and how the new pre-registration standards relate to the SCPHN and SPQ would help identify if progression could be identified between the pre- and post-registration standards.

The four home nations

2.4 The desk research identified significant differences in the use of SPQs and/or SCPHNs as a result of policy differences in the four devolved nations of the UK. These differences included the availability of SPQ and SCPHN qualifications programmes for example, England is the only country currently offering the SPQ in Children's Nursing and Northern Ireland is the only country currently offering SPQ courses in Mental Health and Learning Disabilities. The only SPQ available in Scotland is in District Nursing (Fig 2.1).

Figure 2.1. SPQ and SCPHN accredited providers by country



2.5 Each country has established their own standards and advanced practice frameworks which are mapped against the SCPHN/SPQ standards but reflect current policies and national frameworks underpinning the work of the various specialist nurse roles within their nations. An example of direct referencing to SPQ standards was found in the Scottish District Nursing framework. Some policies and/or frameworks integrated SCPHN or SPQ qualifications into the requirements for a specific role. Examples included the requirement in the School Nursing Framework in Wales[1] for all schools to have a SCPHN-qualified school nurse, and the requirement in Health Education England's District Nursing and General Practice Nursing Service Education and Career Framework for the District Nursing SPQ for District Nurse roles.[2]

2.6 These findings suggested that there was likely to be marked differences between respondents from different UK nations relating to their awareness and use of the standards and the priorities or profile of the different specialist roles in their nations.

[1] https://gov.wales/docs/phhs/publications/170523schoolnurseen.pdf
[2] https://www.hee.nhs.uk/sites/default/files/documents/Interactive%20version%20of%20the%20framework_1.pdf

Standards mapping exercise

2.7 The exercise identified some enablers and barriers to identifying the relationship between the different groups of standards, which may be helpful to inform future standards development. Some of the key findings also informed the next stages of the research. These included:

- *SPQ Standards*: There are nine separate sets of SPQ standards, each of which contextualises a core 'preparation' standard. However, the majority of the nine standards provide little contextualisation in addition to the preparation standard.
- *SCPHN Standards*: School Nursing, Health Visiting and Occupational Health have their own shared set of standards.
- *SPQ/SCPHN.* A key finding of this aspect of mapping related to the how practitioners work. Whilst the SPQs primary focus is on specific actions carried out by individual practitioners, the SCPHN statements include a strong focus on working with others to achieve an overall objective. This is likely to be linked to the role of SCPHNs to improve the health of populations as a whole, not just individuals.
- *The extent to which the content and wording of the standards appeared to reflect changing priorities and potentially a changing environment*: The standards examined in the mapping were published at different times: the SPQ standards in 2001; the SCPHN standards in 2004. The difference in emphasis between the two sets of standards noted above, relating to how practitioners work, suggests that service priorities may have changed in the intervening period. When compared with the new pre-registration standards (2018), we find that one area which has emerged in these newer standards is a focus on managing risk. These changes in emphasis suggest that, when standards are developed, they reflect not only the skills needed by registrants but the concerns of the external environment in which care is delivered. This has an important implication for efforts to 'future proof' any new standards that NMC may develop: changes in the external environment may be difficult to predict and this may prove a challenge for any future proofing goals.

2.8 The findings highlighted that the contextualised SPQ standards and links with the SCPHN standards indicate that some (such as School Nursing, Health Visiting and Occupational Health) might have separate or stronger professional identities than others.

2.9 A key area for investigation was therefore how identity was perceived, and the role of standards in supporting this perception. Another consideration that emerged from these findings was the changing focus of the standards over time, and the absence of issues relating to risk and personal accountability, which indicated the importance of exploring the applicability of the specialist standards to current and future practice.

2.10 Finally, the limited information available within the SPQ and SCPHN standards documents about the intended audience and use of the standards suggested that some respondents

may not be fully aware of the standards or, if they were, that they might be unsure how they should be used. This finding proved to be particularly relevant during the interview phase. Many participants were able to discuss qualifications, however, there was limited awareness of the content of the standards underpinning those qualifications. As a result, the findings from the evidence gathering and interviews with participants are structured into two separate sections: perceptions relating to the qualifications, and perceptions relating to the standards *per se*.

Summary of Chapter Findings

- There are significant differences in the use of SPQs and/or SCPHNs as a result of policy differences in the four devolved nations of the UK. Each country also has different links between SCPHN/SPQ standards and current policies and other frameworks underpinning the work of the various specialist community nurse roles, which are likely to affect the awareness and use of the standards.
- Some community nursing roles, such as School Nurses, Health Visitors and Occupational Health Nurses, appear to have more distinct professional identities than other roles to which the standards apply.
- There is an overlap in the range of roles addressed by the NMC post-registration standards but despite this there are significant challenges in the relationships between them, and between the post-registration standards and the new pre-registration standards for the future nurse. This may be explained, in part, by changes in the external environment affecting priorities for nursing. This influence of external issues has implications for any aims to 'future proof' any new standards which NMC creates.
- There is a lack of clarity about the intended audience and use of the standards which contributes to a low level of detailed understanding about them and their use.

3. The Qualification

3.1 The information within this chapter is drawn from the AEI survey, and the interviews across all participant groups. As detailed in Chapter 1, we spoke with a wide variety of research participants to gather evidence on the NMC post-registration education standards.

Awareness of standards

3.2 While the AEIs and key stakeholders demonstrated good knowledge of the standards, knowledge among other groups was generally lower. Among students, this low awareness of the standards may be due in part to the fact that many of the students that were interviewed had only recently started their course.

> "I am fairly familiar with them, I couldn't recite them but I think that's because I haven't had a huge amount of time yet to look at the domains or read the standards start to finish."
> District Nursing student

3.3 Registrants' awareness of the standards varied hugely depending on their role, with those that are teachers or practice educators generally having an in-depth knowledge and the remaining (majority of) registrants having only a very limited knowledge, if any, of the standards. All groups that we spoke to felt that there was very little awareness of the standards among employers.

> "I don't really think my employer knows about them."
> Mental Health SPQ registrant
>
> "My employer knows about them because I have educated them – but few school communities are aware of the standards."
> School Nursing registrant

3.4 Despite the low general awareness of the standards amongst students, registrants, employers and service users, all participants were able to discuss the standards in the context of the qualification that the standards underpin.

Provision of SCPHN and SPQ programmes

3.5 SPQ and SCPHN programmes are delivered by 48 AEIs located throughout the UK. In total, there are 106 SCPHN programmes (93 of which are for Health Visiting or School Nursing), and 78 SPQ programmes currently approved around the UK. The NMC data on registrations shows that, with the exception of the District Nursing SPQ, the number of

nurses and midwives gaining SPQ and SCPHN qualifications has declined over the past two-three years.

3.6 From the AEI survey responses, 313 courses were delivered across the 38 AEIs with the majority (77%) taking place every academic year. Most programmes (78%) were delivered face-to-face with the choice of studying full time over one year (93%) or part-time over two years (87%).

3.7 The AEIs identified that the main drivers behind decisions to offer a particular NMC-approved course were a combination of:

- demand from local employers (95%);
- current and future government/NHS policy (55%);
- expertise available at the institution (21%); and
- student demand (16%).

3.8 These AEIs also delivered non NMC-approved courses and again, the rationale for offering alternative post-registration provision was employer demand (80%) and current and future government/NHS policy (45%).

Alignment to the NMC post-registration standards

3.9 In general, students felt that their SPQ or SCPHN course was closely aligned to the standards, reporting that the standards were integrated into the modules, course work, portfolios, and learning outcomes.

3.10 For those who were familiar with the standards, most felt that the standards were general enough to cover the full range of areas included in the course. However, it was noted that the course materials generally provide significantly greater detail than the NMC standards themselves, to interpret their meaning in practice and provide guidance around more complex topics such as safeguarding. The widespread use of AEI materials that include the SPQ and SCPHN standards rather than the NMC documentation itself may contribute to the generally low awareness of the standards.

> "The portfolio was split into the core components of the standards. We didn't look at the standards [themselves], but they were well-matched within the course."
> Community Children's Nursing SPQ student

Motivations for pursuing NMC post-registration qualification

3.11 Students and registrants identified their motivation for a specialist qualification. The most common reason was career progression with respondents across every qualification

reporting the use of the SPQ/SCPHN to gain increased responsibilities, promoted posts and/or higher salaries.

"I wanted to further myself."
School Nursing student

"It looks good on my CV."
District Nursing student

"It was a natural progression in terms of my role. I did lots of in house things but nothing academic."
Community Mental Health SPQ registrant

3.12 This was particularly the case in professions that often require the qualification, such as district nursing which in many areas can require the SPQ to undertake a team leader role.

"The main reason was for career progression, to move on to the next level of district nursing. I've been in community nursing for 14 years, and couldn't progress or go any further without the SPQ. I had a lot of experience on the management side, but felt other staff members in the team didn't listen to me because I was a Band 5– I didn't have same respect as Band 6 District Nurse because I hadn't done the course. I didn't have that voice or influence which made me frustrated, I wanted to make a difference in the community."
District Nursing student

"I wanted to stay in school nursing. I was a staff nurse in a school nursing team and the SCPHN was a requirement for promotion."
School Nursing registrant

3.13 When asked about the programmes and qualifications that they had considered, most had not explored other options beyond the NMC-approved qualification identified or funded by their employer or national government.

3.14 While most students and registrants emphasised the wider value of completing the specialist education programme, there were some participants that achieved the qualification in order to formally recognise the role or skills that they already held. For others, they wanted to supplement their practical experience with academic understanding of nursing theory, and were interested in having a more detailed knowledge of their specialism.

"I enjoy learning, pushing myself and seeing what I am capable of."
District Nursing student

3.15 Many participants also reported undertaking the qualification to expand or update clinical skills and knowledge, particularly for those moving into a new professional environment. This motivation was most common for those who were doing/had done Health Visiting and School Nursing SCPHNs with limited previous experience in the community.

3.16 There were some common factors for midwives who moved into the health visiting role. They explained that their move was to address their desire to continue working with families and developing relationships with them for a more prolonged period, which they could do as a Health Visitor.

I was working as a midwife, but wanted to be more involved in the family support rather than just the birth and the short time after it, so decided to become a health visitor."
Health Visiting registrant

3.17 There were a few examples also of policy change that had influenced registrants' decisions, for example the Best Start Maternity Review[3] in Scotland and revised midwife role had prompted a career change for a few registrants, and the Call to Action in 2013[4] encouraged some registrants to pursue specialist community nurse roles.

3.18 As well as advancing or changing their careers, many students and registrants highlighted that the SPQ/SCPHN enabled them to move into a role in the community which, because of the traditional working pattern of the role would provide a better work-life balance. In addition, others enjoyed the autonomy that came with a caseload in the community.

"I had a young family at the time and I was a community midwife but I worked unusual hours. Health visiting provided me with an opportunity to do more regular hours."
Health Visiting registrant

[3] https://www.gov.scot/publications/best-start-five-year-forward-plan-maternity-neonatal-care-scotland/
[4] https://www.england.nhs.uk/wp-content/uploads/2013/07/nhs-belongs.pdf

Factors influencing the choice of programme provider

3.19 From our interviews, it was apparent that nurses and midwives are often not given choice when selecting the qualification or the AEI for their post-registration education programme. Registrants from across all the SPQ and SCPHNs reported that the employer was the main influencing factor when they selected the AEI. The second most common consideration (given instead of/in addition to the employer) was the location of the AEI, with a number of participants also indicating that there was only one AEI that offered the qualification in an accessible location.

3.20 Those participants who did report active selection of the AEI were generally self-funded and/or in areas such as London where there is a greater density of AEIs offering the course. These participants cited a range of considerations when selecting their AEI, including:

- specific aspects of the course, such as formats that provided opportunities for a return to practice programme;
- the learning approach, like remote learning, and part-time completion;
- the accessibility of the application process;
- the course modules;
- cost; and
- the reputation of the AEI and its programme.

> "I chose [the provider] because it is local to me- I live and work in [the area]….I wanted to find a course that fits around my life- I have kids so am doing it part time."
> Learning Disabilities SPQ registrant

Post-registration education experience

3.21 The students and registrants were asked about how the programme transformed their practice and enabled them to work within their specialist role.

The learning environment

3.22 While the courses to achieve the SPQ and SCPHN qualifications were often described as "intense", students and registrants noted the importance of a new learning environment that involved both an academic and practice setting. Participants felt that this was essential to develop theoretical specialist knowledge that builds on their nursing and midwifery experience and supports a broad understanding of the field.

> "I enjoy learning and getting more skills. In practice, you don't always get the chance to ask questions but you can do this at uni."
> School Nursing student

3.23 Many participants from across the qualifications felt that leaving their existing role for a new academic and clinical environment within the qualification programme was important to facilitate transformational shifts in perspectives and skills. In particular, supernumerary status was vital to translate learning into care delivery and ensure transformational change.

> "[It's about] giving people the opportunity to actually apply what you are learning. If you are working part time and learning in your own environment then it's quite easy to be absorbed into the team. Being outside and supernumerary allows you really to focus on the development."
> District Nursing registrant

3.24 The value of practical experience to implement what they had recently learned and identify any difficulties was consistently highlighted as key to ensure impact of the qualification. Key to the success of the placement and students' confidence and performance in the setting was the quality and consistency of their mentor/practice teacher. Where there were difficulties regularly accessing a mentor/practice teacher this significantly undermined students/registrants opportunities to practise clinical skills and affected the confidence in their abilities. Several Occupational Health registrants, among others, provided examples of this were from when studying their SCPHN.

> "Very much so, but mainly down to an amazing practice teacher."
> Health Visiting student, when asked if the course had improved her skills

3.25 Stakeholders and registrants both highlighted that learning must continue post-registration to recognise that newly qualified SCPHNs and specialist practitioners are able to practice in a specialist field but at an entry, rather than advanced practice, level. They therefore require support to build competence over time before they are able to work with full autonomy.

Multi-disciplinary learning

3.26 In the AEI survey, 78% of respondents identified that their SCPHN/SPQ programmes usually share modules with other courses such as advanced practice courses (230 of 295 courses where details are provided). Modules shared with other courses, for example,

MSc Health and Social Care; MSc Public Health; MSc Advanced Clinical Practice, included research/dissertation work, leadership, prescribing, evidence-based practice, long-term condition management, enhanced communication strategies and service improvement. This multidisciplinary learning was often supplemented with learning sets separated by SPQ/SCHPN, for example with separate groups for Health Visiting, School Nursing and Community Children's Nursing students.

3.27 The SCPHN students were typically taught as one cohort and some research participants that hold/are working towards SPQs also reported sharing elements of their course with other SCPHNs (for example some District Nurses reported shared classes with Health Visitors). Some participants felt that this contributed to an increased awareness and ability to work across teams and disciplines:

> "I was the only LD nurse on the course and the course was geared towards adult nurses. I learned about how we overlap and complement the skills of other nurses."
> Learning Disabilities SPQ student

3.28 However, others felt that much of the content was not as relevant to them. For example, a Health Visitor registrant explained that the focus of prescribing was on the adult doses and types of medication with limited reflection of the type of prescribing they would be doing as part of their role in caring for children.

3.29 Participants from all the SCPHN qualifications reported feeling that much of the taught core curriculum was not as applicable or relevant to their profession as it could be.

> "I'd been doing the role in England before moving to Wales. I found my original programme really inspiring but this course was very much a Health Visitor course so there was no support for School Nurses- I saw a School Nurse tutor once. There were only 21 School Nurses on my programme so we are very much in the minority. All the other staff had Health Visitor backgrounds and didn't know about school nursing so it was always very biased towards Health Visitors. We had only two basic lectures on school nursing, I felt like a forgotten specialism. The university was very defensive when I said this."
> School Nursing registrant

3.30 While students and registrants did identify components that were helpful for all three professions (such as the high level public health context and approaches, and external speakers for example talking about domestic violence) many felt that more time could be dedicated to their specific qualification and the clinical skills it requires. This view was particularly strong amongst Occupational Health nurses, who unanimously felt that their profession was too divergent from school nursing and health visiting for the shared curriculum to have value. They identified more of a focus on working practice, policy and

legislation in industry settings alongside more practical consideration of the impact of the workforce health on business to increase the impact of the qualification in practice.

3.31 Some Health Visitor registrants also felt strongly that Health Visiting should have a completely separate curriculum, and felt that direct entry to this (separate to the pre-registration nursing qualification and midwifery qualification) would be most appropriate to prepare people for the role of health visiting.

Gaps and relevance of the qualification for post-registration practice

3.32 In general, registrants felt that their SPQ/SCPHN qualification had equipped them for their new roles but many felt there was potential to further increase this preparation and this usually related to the opportunities to practise the clinical skills necessary for their role.

> "It prepares you to an extent but learn after you have qualified – by experience and from experts/ experienced midwives."
> Health Visiting registrant
>
> "It gave me a good grounding for working in occupational health. I got lots of hands on experience when doing the course, although others found it more difficult to get good practice placements (we had to find our own). [The course] prepared me well and I got lots of support."
> Occupational Health registrant

3.33 Some of the reported gaps in their post-registration education related to clinical procedures or responsibilities that they had not been able to undertake in a practice setting and that could not be realistically recreated in a skills lab. The prescribing examples were common, again unable to practise during the programme or the content of the V100 prescribing element was not tailored to the role they would be undertaking.

3.34 The students and registrants identified areas that needed to be better reflected within the post-registration education programmes for SPQs and SCPHNs. Some aspects were considered as gaps across all the qualifications and these included greater recognition of the complex care environment; reflection of the integration of health and social care, self-management, social prescribing and strength-based approaches to care; and risk management.

3.35 Some students/registrants identified particular areas that they would like to have covered in more depth in their post-registration education programmes:

- Health Visiting – more individual family work rather than community wide initiatives, focus on 0-5s or 0-19s rather than the traditional cradle to grave, Adverse Childhood Experiences (ACEs), better recognition of the limited opportunities for public health promotion;

- Learning Disabilities, Children's Nursing and Children's Community Nursing – identified more explicit reference to working with individuals, carers and family members
- District Nursing – highlighted more content on end of life care, telehealth and telecare and safeguarding;
- Occupational Health – less on general public health and greater reflection on workforce health, case management and health surveillance to support organisational needs.

The value of the SPQ/SCPHN qualifications

3.36 There is a wide range of alternative options to the NMC-approved post-registration education and 55% of the 38 AEIs surveyed also reported running courses that do not lead to an NMC-recordable qualification, like MSc Public Health Nursing; MSc Advanced Clinical Practice; MSc Contemporary Nursing and BSc (Hons) Clinical Practice.

3.37 Some registrants had undertaken further post-registration education in addition to their SCPHN/SPQ, like Masters in Mental Health Interventions, Masters in Public Health to further enhance their clinical knowledge and skills.

3.38 While consideration of non NMC-approved qualifications was outwith the scope of this project, as part of the discussions with research participants about the reasons for moving away from the SCPHN and SPQ programmes, some examples did emerge. For some AEIs alternative post-registration programmes were delivered to address local demand, while others faced challenges in meeting the criteria for approved AEI status, with the lack of availability of practice teachers proving increasing difficult. Another reason for changing the programme offer was the need for more contemporary programme content and delivery, as shown in the example from Robert Gordon University (see Box 1).

3.39 The students and registrants from across the qualifications considered the SPQs/SCPHNs as having an added value compared to other specialist qualifications. They felt the qualifications were prestigious, had more gravitas, were more legitimate and appropriately recognised their higher level of skills and knowledge. They felt that their employers were more invested in the NMC-approved qualifications and that their UK-wide recognition provided them with more opportunities to work in other parts of the UK.

Box 1. Robert Gordon University (RGU), Aberdeen – a new approach to delivering Occupation Health (OH) education

RGU used to deliver the SCPHN OH course but, in response to general concerns about the readiness of OH nurses to practice in the workplace and a review of evidence about OH education, they undertook a consultation about their OH programme that attracts applicants from across the UK. The response from students, registrants, employers, users of OH services, and stakeholders like the Health and Safety Executive, led RGU to the decision that they needed to take action to ensure that their programme content and delivery met the needs of future OH professionals.

A new OH course was developed that fulfilled the University's academic standards and validation process. The programme is solely focused on OH and does not combine with any other public health courses. Its main themes are:

- workplace health risk management;
- fitness for work;
- mental wellbeing
- health promotion and wellbeing; and
- leadership, quality and OH management.

It is delivered over two academic calendar years (60 weeks) through a mix of traditional distance learning formats and contact days to address key skills such as audiometry and lung function testing. Successful programme participants graduate with a BSc Occupational Health; RGU no longer offers the NMC-approved SCPHN programme for OH nurses.

Impact of the SPQ/SCPHN qualification on skills, knowledge and confidence

3.40 Students and registrants widely reported that they found their SPQ/SCPHN programme to be transformative. Most students who participated in the research had a clear idea of what they wanted to use the qualification for, from working at a more senior level to transitioning into a new profession, and the majority felt the qualification was supporting them towards these goals.

> "Best thing I ever did- it opened so many doors for me."
> District Nursing registrant

3.41 Many noted that they learned or updated a range of specific technical skills, particularly around prescribing and clinical assessments. Those who held Children's Nursing or Community Children's Nursing SPQs particularly identified the value of having a specialist course for clinical skills development specifically for children, while those with/currently

working towards a SCPHN identified training in public health techniques as supporting a shift in their perspective and approach to nursing.

3.42 The skills most commonly described as having transformational impacts in all the qualifications were skills around leadership, management, communication and evidence assessment. While these skills were transferable, participants recognised the value of them being contextualised in the qualification, for example with participants reporting the leadership skills in the Health Visitor SCPHN centred on management of caseloads and a team that is spread out and working independently in the community, rather than together within a hospital.

> "I don't think I developed my skills a great deal as I already had the experience, but it made me think differently in how I analyse and look for evidence. It made me think about things more critically– this has been a lasting impact of this qualification. I've gone on to do more postgraduate qualifications, but I don't think my career would have developed in the way it has done without this qualification."
> Community Mental Health SPQ registrant

3.43 Students and registrants felt that these skills contributed to an increased ability and confidence to work autonomously in complex situations that often require advanced decision making. For example, participants had used improved analytical skills to undertake new research, question practice and inform decision making and critical thinking. Their improved communication skills had supported their interactions and positive engagement with patients.

3.44 The qualification increased the confidence of most registrants to share learning, make decisions, and to apply to more senior roles. Registrants, particularly those with a SCPHN qualification, felt the qualification exposed them to new models of care and enhanced their confidence, ability, and willingness to work in a multidisciplinary manner.

> "I felt quite motivated and empowered to be able to share my skills and my understanding of standards. Having had really good support I was able to help others too. You also look at the population in a different way. I was definitely more confident – I'm still nervous with some things like presentations but overall a lot more confident. Because you are encouraged to develop innovation it encourages you to encourage others to do this. In terms of my District Nurse role, I already had an interest in reflective practice and being able to reflect in practice and on my practice was really important. You need this self-awareness to interact with patients, and you have to adapt to individual needs. The course let me do this."
> District Nursing registrant

Maximising impact in their new specialist community nurse role

3.45 The SPQ and SCPHN qualifications were highly valued by research participants, and considered to be addressing areas of great need but to maximise the impact of their learning, they required a role that allows autonomous working, expanded responsibility and the opportunity to use and share their learning.

3.46 There was general acceptance that newly qualified SCPHN and SPQ registrants are novices in a specialist field who still need to build competence over time before being able to work with full autonomy. This requires a working environment that supports the post holder to reinforce their new skills and knowledge, ideally with an initial period of preceptorship, continued formal mentor support, and a limited caseload.

"[The course included] a lot of practical stuff and a good grounding in public health. I learned most from the practice elements, but it took past the 10 week consolidation to start to feel confident."
Health Visiting registrant

"There is a need for consolidation years post-registration and we need to agree what those consolidation years are."
Stakeholder

Summary of Chapter Findings

- The main motivations for undertaking a SCPHN or SPQ are career development, and registrants have limited choice as to the course and programme provider as these decisions are driven by the employer.
- The NMC-approved qualifications are highly valued by students and registrants, as they viewed them as prestigious, highly recognised and transferable throughout the UK.
- Whilst the participants identified gaps in the course content with potential to make it more contemporary and relevant, the programme is described as transformational and provides theoretical and clinical challenge to develop the skills, knowledge and confidence to move into a specialist role.
- The programme prepares the registrant for beginning their specialist post at a novice level, but appropriate support and working environment are required for them to grow into their new role.

4. The Standards

4.1 As described in earlier chapters, many research participants lacked a detailed understanding of the standards of proficiency for SCPHNs or the standards of proficiency for specialist education and practice and so much of those discussions focused on the qualifications that underpinned them. Those with the best insight were people involved in education and policy development, mainly AEI representatives and key stakeholders.

4.2 With knowledge of the standards and their purpose, the interviews considered the accessibility of the standards, the role of the standards and the extent to which they prepared nurses and midwives for specialist practice. The discussions also explored alternatives and future needs and the key points raised by research participants are presented in this chapter.

Accessibility of the standards

4.3 The language, format and applicability of the standards to academic and practice settings was considered as part of the discussions with the research participants. All contributors acknowledged the extent to which the standards were out of date, having been last published in 2001 (SPQs) and 2004 (SCPHNs). Therefore the language and references do not reflect the current landscape and the environment in which specialist practitioners' work.

> "The language is very dated and they don't meet what's needed now– they are overdue to be renewed."
> District Nursing registrant

4.4 Discussions about the language used also identified that the standards are wordy, repetitive and difficult to interpret. The layout and format are not user friendly and there is no summary or short version to refer to. Importantly, even amongst those who were familiar with the standards, there was not a consensus as to their target audience – are they designed for students to achieve learning outcomes or for registrants to use as professional standards?

4.5 There was agreement that any future standards should have a clearly articulated purpose with a defined audience so that there is a shared understanding and greater awareness of the standards.

Applicability of standards to academic and practice settings

4.6 Overall the students, registrants, AEIs and service users considered the SCPHN and SPQ standards as a necessary and valuable element of the post-registration education for their profession. The view of the wider stakeholders was mixed and often related to the organisation and or specialism they represented.

4.7 Those that commented on the detail of the standards identified that:

- The standards were very generic which gave them a breadth that meant they could be easily interpreted and provided flexibility for programme design. However, this reduced the consistency between and across programmes, and therefore led to variability between students' knowledge, skills and experience;
- as already mentioned, students that complete the qualifications are ready to enter a specialist area but only at an entry level– i.e. they are novices in a specialist area and this distinction is often missed; and
- they need to be supplemented by specialist standards (detailed guidance for specialisms) so that there is more clarity about what the specialist practitioner is should know and be able to do in their defined roles. There was no consensus on who should be responsible for these.

> "I don't think they reflect the current role and the level of clinical skills you need to have as a specialist practitioner."
> Community Children's Nursing SPQ registrant
>
> "[The SPQ standards] don't reflect current nature of practice, for district nurses and others. The way in which nurses are now leading, managing risk, and the complexity of the environment and what they are dealing with and the kind of patients that are now being cared for in the community – even ventilated patients– the standards don't reflect that."
> Stakeholder

SCPHNs

4.8 The response to the two sets of standards differed. Research participants who commented on the SCPHNs overall felt that the generic principles were still relevant and could apply to any domain but lacked detail.

4.9 Stakeholders from across a wide range of professionalisms considered health visiting, school nursing and occupational health nursing as too different to be encompassed under the single SCPHN banner. There were repeated calls for this differentiation to be recognised and that these different roles working with different populations required different skill sets and, therefore, different NMC standards.

4.10 Within the SCPHN group, overwhelmingly those working in health visiting wanted to keep the third part of the register and promoted the need for a direct entry, explaining that the health visitor role lent itself to its own field, similar to midwifery. With such marked differences in the health visitor practice across the nations, it was felt even more critical to retain the UK wide standards for health visiting with the NMC playing a key role.

4.11 In contrast those interviewed that represented Occupational Health felt little affiliation to the third part of the register and were generally dissatisfied with the SCPHN standards and recognised that more relevant non NMC-approved educational programmes would be better suited to develop the confidence and practical skills OH nurses need to be ready to meet the needs of a diverse workplace. Only nine AEIs offer the programme and challenges in finding practice educators and securing placements exacerbates the consolidation of learning.

4.12 The School Nursing registrants and students, like the other SCPHNs, felt that the SCHPHN title was outdated, not understood and that they would like to reclaim the title, as has happened in some parts of the UK so that the School Nurse, Health Visitor and Occupational Health Nurse become protected titles. Occupational Health registrants also wanted to see Occupational Health Nurse become a protected title, although not necessarily underpinned by the NMC Occupational Health SCPHN standards.

> "I don't think we should be governed by the NMC, we are very much a square peg in a round hole and would be better served by the IOSH."
> Occupational Health registrant

SPQs

4.13 Across the SPQs and SCPHNs the uptake of the programmes has generally been declining in the past two-three years. However, the District Nursing SPQ, which is still required for a District Nurse role in many NHS Boards and Trusts, is an exception to this trend.

4.14 The usability of the SPQs has been revitalised by the voluntary standards developed by the Queen's Institute (QNI)/Queen's Institute Scotland (QNIS). These standards, initially for the District Nursing and now for some of the other SPQs, were mapped against the SPQs and has enabled AEIs to deliver the SPQ programmes with the support of the voluntary standards.

> "I'm aware of them because I am a practice teacher, but I am more familiar with the QNI voluntary standards. These are far more up-to-date and pertinent."
> District Nursing registrant

4.15 Some stakeholders consider that the SPQs, like Adult Nursing, Learning Disabilities, and Mental Health have limited value because the new standards of proficiency for the future nurse have blurred the distance between the pre-registration standards and the post-registration standards. The General Practice Nursing SPQ was generally not perceived by registrants to be well aligned to the role and its value not widely recognised by GP practices. In contrast, the District Nursing SPQ is strongly embedded in workforce development and career pathways. Representatives for district nursing and those national

stakeholders where the District Nursing SPQ was still an important element of education provision for this role were keen to see the SPQ remain and retain a recognised qualification.

Role of standards

4.16 The role of the standards were discussed in terms of their role in protecting the public, maintaining public confidence in the profession and supporting professional development.

Protecting the public and maintaining public confidence

4.17 Students and registrants both place high value on national standards for the protection of public safety and confidence but without articulating how they fulfilled this beyond setting out the skills and knowledge the specialist practitioner should hold and quality assuring programme of education delivered by an AEI.

4.18 AEI representatives, employers and stakeholders in the main considered that registrants being live on the the relevant part of the register, Part 1 nurse and Part 2 midwife, and their adherence to the NMC Code as that registered professional protects the public. This is because these are the standards that enable someone to join the register for the first time and the person must continue to meet their requirements for renewal and readmission as a nurse or a midwife, rather than the post-registration standards. They identified that an SPQ is a recordable qualification but that the annotation in itself would not necessarily be used in instances where an individual's fitness to practise was queried. Registrants had mixed views on the value of the SPQ annotation, with some ambivalence towards it but many feeling that it recognised their achievement of the qualification.

> "I'm proud of myself in that I've achieved that, but it has no great value beyond that."
> Community Mental Health SPQ registrant

4.19 There were also inconsistent views about the third part of the register. Some felt it was unnecessary and predominantly functioned as a 'badge of honour' for the SCPHNs, but those on the third part of the register felt it appropriately reflected the posts they held, although they did not associate with the title.

> "I think it's very important for most SCPHN nurses, it gives credence and value to what you've done. I think it was a very important thing for me that we have that recognition."
> School Nursing registrant

4.20 However, stakeholders on two occasions explained that the third part of the register and the standards underpinning the SCPHN protected title had enabled them to refer practitioners to the fitness to practise process because it was clearer how they had failed in duties as a SCPHN rather than as a nurse on Part 1 of the register.

4.21 The research participants acknowledged that the specialist practitioners and SCPHNs were more autonomous in the community setting, and so registrants needed skills and experience to fulfil the more specialised roles, therefore it was helpful to recognise/acknowledge this on the register. However:

- There is no requirement for registrants working in specialist practice to record their SPQ;
- Even if members of the public were aware that they could search the register, as the service users discussed, without more detail of the skills, qualifications, then they would not necessarily be better informed by the annotation or the registrant being on part three;
- The third part of the register does not show the area of practice so the value of recognising the specialist knowledge and skills is lost; and
- The protected title of SCPHN is not widely understood and the public would identify better with the titles of School Nurse, Health Visitor or Occupational Health Nurse.

4.22 Therefore a more useful register would support public confidence.

4.23 Most service users were unaware of the third part of the register, but those who were aware felt that it allowed service users to have more confidence in the person delivering care.

> "It [the third part of the register] engenders transparency and public confidence."
> Service user

4.24 Two service users noted that if the register was populated with additional qualifications and their details, not just the NMC-approved programmes like SPQs, then anyone looking at it would know that a registrant is fit to undertake a certain role.

4.25 Several stakeholders held the view that the stronger case for protecting the public was in the NMC's role in regulating advance practice. They felt that this was becoming critical now that nurses are expanding into medical areas and it was time for consistency with accredited courses that are noted on the register. This is discussed later in the chapter.

Supporting professional development

4.26 Both sets of standards were viewed as providing clarity as to what is expected in the content of the education programmes and the skills and experience that the specialist

nurses and midwives will have. The absence of the SPQs and SCPHNs would lead to huge variation in programme provision that many participants considered unacceptable.

> "The courses are recognised throughout the UK and this is because they are all based on the same standards."
> General Nursing student

4.27 The participants still acknowledged the limitations of the current standards and that policy and practice had moved on with the various pathways, career development frameworks and advanced practice frameworks across the four nations. Nevertheless they considered the NMC-approved post-registration standards provided a professional focus and accountability and without them is could lead to fragmentation across the UK and in the absence of this protection of the standards then some respondents feared that there was be nothing to stop the quality of the education and training provision from being 'dumbed down' and the lines between appropriate provision becoming blurred.

> "It needs to be our professional body that sets standards, we need to protect our professional reputation- we could end up with multiple standards and I would be very concerned if that was the case. We shouldn't have different standards in different locations and be unsure which ones to follow."
> Health Visiting registrant

4.28 In contrast a few participants, from devolved national organisations, felt that the standards were so out of date that there would be limited impact if they were withdrawn and if the NMC played no role in post-registration education. They perceived that this might release capacity within AEIs to look at alternatives and be more creative in the delivery of their post-registration programmes and responsive to local need and national policy.

Regulation across all nurse and midwifery education

4.29 As already mentioned, many participants expressed concern and at times frustration at the NMC's absence in the regulation of advanced practice. The registrants repeatedly commented on value of some clarification from the NMC about specialist and advanced

> "My role is similar to the advanced nurse practice role so it is strange that they make such a distinction between the two."
> Children's Nursing SPQ student

practice. Some felt that is was being left to local employer to define and agree who delivers care and in what role. These registrants felt the NMC needed to step in to protect the public and the SCPHN and SPQ registrants themselves.

4.30 Stakeholders also felt that although this evaluation was focused on specialist practice that this was the opportunity to have a wider debate and dialogue with the four governments about where post-registration education sits and the NMC's role within it, so that the public can be protected and the credibility of the profession can be retained across the UK. These stakeholders felt that there should be a solution where this can be achieved with sufficient consistency across the UK but with flexibility that enables innovation and delivers programmes that meet local and national needs.

> "We are increasingly aware that there is a big difference between specialist and what we term advanced. You come out of the specialist programme, and it's about how you then become able to work at an advanced level. We are setting people up to become disillusioned if we don't say this is what you have, and this is how you can then become an advanced practitioner."
> UK-wide stakeholder

Summary of Chapter Findings

- The accessibility and purpose of the standards were questioned by participants with any future standards required to have greater clarity of content, be more user friendly and be designed for a defined audience;
- The generic principles and broad content of the standards allow them to be applied flexibly but mean they lack the detail needed for the different specialisms;
- The health visitor, school nurse and occupational health nurse are no longer considered as sharing common public health nurse elements within their roles. Different specialisms are more wedded to the SCPHNs/SPQs than others and feel strongly about the continuation of the standards and the NMC's role;
- There were mixed views as to the extent to which the standards provide protection to the public, the Code and Parts 1 and 2 of the register were considered the most appropriate tools. The helpfulness of the register and the information it currently holds was viewed as limited;
- Most, but not all, participants were concerned about the profession and the fragmentation and loss of quality of post-registration education in the absence of the SPQs/SCPHNs and the NMC's regulatory role; and
- Stakeholders called on the NMC to become involved in the regulation of advanced practice where they viewed a greater need for public protection.

5. Summary and actions to consider

5.1 This chapter summarises the key findings in response to the evaluation questions and identifies actions to consider.

Are the current standards appropriate to prepare nurses and midwives for future post-registration practice?

5.2 The evaluation has shown that there is a limited understanding of the SCPHN and SPQ standards, which were last published in 2001 and 2004. The standards are not fit for purpose and approved NMC programmes are addressing the needs of the current nursing and midwifery workforce by the reinforcement of standards and competencies produced by other bodies.

5.3 Whilst the course content needs to be more contemporary and relevant, the programmes are still described by registrants and students as transformational and provides theoretical and clinical challenge to develop the skills, knowledge and confidence for registrants to move into a specialist role as a novice, with specialist knowledge and practice developing as they perform the role.

> "[The course] made me much more of a confident and safe practitioner."
> Adult Nursing SPQ registrant

To what extent are the standards known and understood?

5.4 There is a lack of clarity about the intended audience and use of the standards which contributes to a low level of detailed understanding about them and their use. Are the standards for underpinning the post-registration education programmes or the professional standards under which post-holders work?

5.5 The content of the standards is generic and lacks specifics needed to understand the competencies required for each specialism. The language needs to be clear and concise and the documents need to be user friendly.

To what extent do the standards protect the public and maintain public confidence in the profession and what role are annotations on the register playing?

5.6 There were mixed views as to the extent to which the standards provide protection to the public. The code and Part 1 and 2 of the register were considered the most appropriate tools although there were two examples of the third part of the register being used to raise fitness to practise issues. The annotations were considered of limited help whilst the register holds information about registrants in its current form.

If these standards were withdrawn and this option was no longer available what would be the consequences?

5.7 Many participants were concerned about the impact on the profession and the fragmentation, dilution and loss of quality of post-registration education if the SPQs/SCPHNs were withdrawn and the NMC stopped regulating this aspect of post-registration education. Some professions (such as district nursing), bodies and nations (such as Northern Ireland) are very attached to the standards. However, there is a decreasing number of AEIs approved to deliver the SPQ/SCPHN qualification and it will reach a point, if already not the case, where alternative, more contemporary non NMC-approved programmes fill the gap. The regulation of all post-registration education and practice needs greater consideration.

What should future post-registration standards take account of and where might they come from?

5.8 In the period since the standards were published, organisations, professional bodies, nations have developed and progressed standards frameworks and pathways for specialist and advanced practice. So, there are host of options, from the QNI/QNIS voluntary standards, to the Scottish health visiting pathway across the specialisms that are a starting point for any revised standards, or that can be considered as a replacement.

> "I don't think the specialist practice standards necessarily need to be NMC standards given the SPQ is only a recordable qualification, but we still need standards."
> Employer

What future role should the NMC play?

5.9 There are repeated calls from across all stakeholder and registrant groups for the NMC to widen the discussion and become involved in the regulation of advanced practice. Their feeling was that there is likely to be a greater risk to the public from those practising in the unregulated area of advanced practice. There is a patchwork of education of advanced and specialist practice across the UK and there is the opportunity to draw this together and rationalise under the leadership of the regulator.

Actions to consider

5.10 SCPHNs

- Explore options as to whether to recognise and reiterate the distinct roles of the current SCPHN group and disinvest in the generic SCPHN; and

- Consider options to resolve the lack of understanding around the protected titles and the better awareness that exists amongst titles of School Nurse, Health Visitor and Occupational Health Nurse.

5.11 SPQs

- In light of the new pre-registration standards and the future nurse training, consider which, if any, SPQs are needed to develop that higher level of skills to work in a specialist area; and
- In decisions about any future standards, recognise the role that the QNI/QNIS voluntary standards are now playing.

5.12 NMC role

- Reflect on the NMC's role in setting standards and how they align/mirror the career pathways created in part of the UK or by particular bodies;
- Consider how the register can hold more up to date information about registrants' scope of practice so that it is more helpful to those making enquiries; and
- Engage the four devolved nations in a dialogue about their advance practice frameworks and regulation of them.

Nursing & Midwifery Council

Review of post-registration standards

Report of pre-consultation communications and engagement activities

November 2020

Contents

Background

Once a nurse or midwife is registered with the NMC, they can do a NMC-approved programme to become a specialist community public health nurse (SCPHN) for a public health role, including working as a school nurse, health visitor or occupational health nurse.

Nurses can also gain NMC approved specialist practice qualifications (SPQs) on completion of an NMC approved SPQ programme in community nursing, including district nursing, general practice nursing, community children's nursing, community learning disabilities nursing and community mental health nursing.

We're reviewing the standards of proficiency and the associated programme standards we set for these roles. This is to ensure practitioners are equipped with the knowledge, skills and attributes they need to deliver high quality care now and in the future.

We have formed a post-registration standards steering group to advise on the direction of the work. This is made up of representatives from the four countries of the UK, the Chief Nursing Officers, lead education bodies, professional organisations, unions, and subject matter experts.

We have also set up a number of standards delivery groups to help us define the content and draft the standards. These are each focusing on: all specialties of community nursing; school nursing; occupational health nursing; and health visiting. Each is led by an independent chair.

We want our new standards to be ambitious and transformative, and we know we'll only achieve that if we work collaboratively with our stakeholders. We need to draw on their experience and hear a diverse range of voices from all backgrounds, including practitioners, patients, people who use services, employers, educators, students and other partners to co-create the new standards.

To ensure that our draft standards are shaped by all these voices, we have undertaken a range of activities through the summer and autumn of 2020. Due to the coronavirus pandemic and restrictions on travel and meeting in person, these have all been online digital opportunities.

Purpose of this report

This report covers the engagement activities held between June and October 2020, ahead of our formal consultation in 2021.

The report outlines the numbers of people who attended our events, details about these individuals where we have them, their feedback, and learning for how we can improve our engagement activity in the future.

A separate report will be published setting out what people told us during this engagement.

Objectives for communication and engagement activity

During the pre-consultation period we wanted to give people the opportunity to get involved in the development of new post-registration standards from an early stage.

For this phase of activity, our key audiences were nurses and midwives with a SCPHN qualification, those holding a SPQ, professionals seeking to undertake these qualifications and those involved in the education, training or employment of these specialist nursing roles.

In addition we wanted to reach out to other professions who work closely with these roles, those working in policy, research, and advocacy and third sector organisations dealing with these specialist community roles.

Virtual postcard

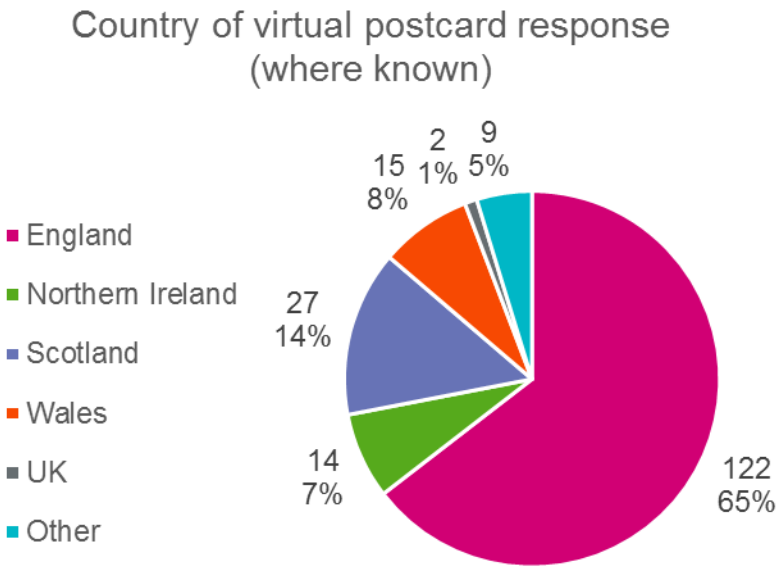
We published a form on our website for people to send in responses to.

We received more than 250 submissions via our virtual postcard on the website over the six weeks. The postcard asked two key questions:

- What important factors for community and public health nursing practice do you think we should account for in developing our new post-registration standards?
- What themes do you think our new standards for specialist community and public health nursing should cover?

For about 75% of these submissions, we know which country / location the individual is based in. These responses represent a spread across the four nations of the UK and beyond.

Country of individuals submitting virtual postcards (where known)



Data from 189 virtual postcard submissions.

Our engagement activities

We engaged with people in three main ways: webinars, virtual roundtable discussions and 1-1 meetings. By necessity, all these were held virtually using the GoToWebinar and GoToMeeting platforms.

1. Webinars

Webinars enabled a wide audience to hear from the NMC team and our independent chairs about the development of our standards.

The use of webinar polls increased audience engagement and enabled us to gain valuable feedback throughout the sessions.

Webinar attendees could submit comments and questions throughout the webinars. Although these comments were visible to organisers only, we shared some of the points raised with the presenting panel live in the sessions and posed some of the questions for immediate response. Comments submitted during the webinars are included in our separate report setting out what people told us during this engagement.

Table 1: Number of attendees at each webinar

Date	Topic	Number attended*
29 June	**SCPHN core** Introduction to the review for all audiences interested in SCPHN	646
30 June	**SPQ** Introduction to the review for all audiences interested in SPQs	558
10 July	**School nursing** Introduction specifically for school nursing audiences	324
15July	**Occupational health nursing** Introduction specifically for occupational health nursing audiences	275
21 July	**Health visiting** Introduction specifically for health visiting audiences	460
1 September	**SPQ general practice nursing** Update and detail for those interested in the general practice nursing SPQ	63
9 September	**SPQ community mental health nursing** Update and detail for those interested in the community mental health nursing SPQ	53
9 September	**SPQ community learning disabilities nursing** Update and detail for those interested in the community learning disabilities nursing SPQ	95
10 September	**SPQ community children's nursing** Update and detail for those interested in the community children's nursing SPQ	49

Date	Topic	Number attended*
10 September	**SPQ district nursing** Update and detail for those interested in the community district nursing SPQ	117
20 October	**SCPHN update** Progress update for those interested in the SCPHN standards	131
22 October	**SPQ update** Progress update for those interested in SPQs	136

*Some people attended more than one webinar, so the numbers do not necessarily refer to unique people.

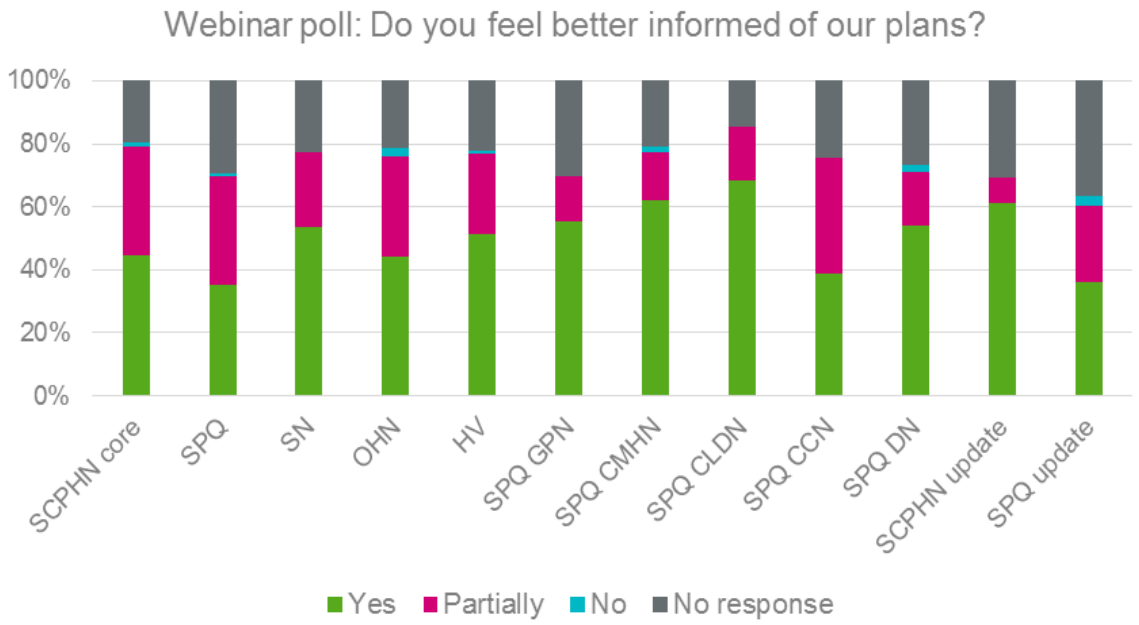
2,907 attendees at 12 webinars. 513 attended more than one webinar.

Webinar polls

We asked participants a series of questions during the webinars. Not all questions were asked every time as the webinars built iteratively on previous feedback, and were specific to the content and audience. We increased our use of polling questions through the webinar series. The software limits potential responses to our poll questions to five possible option responses.

All webinars

Towards the end of each webinar we asked the same question to gauge whether people felt better informed of our plans for reviewing the post-registration standards.

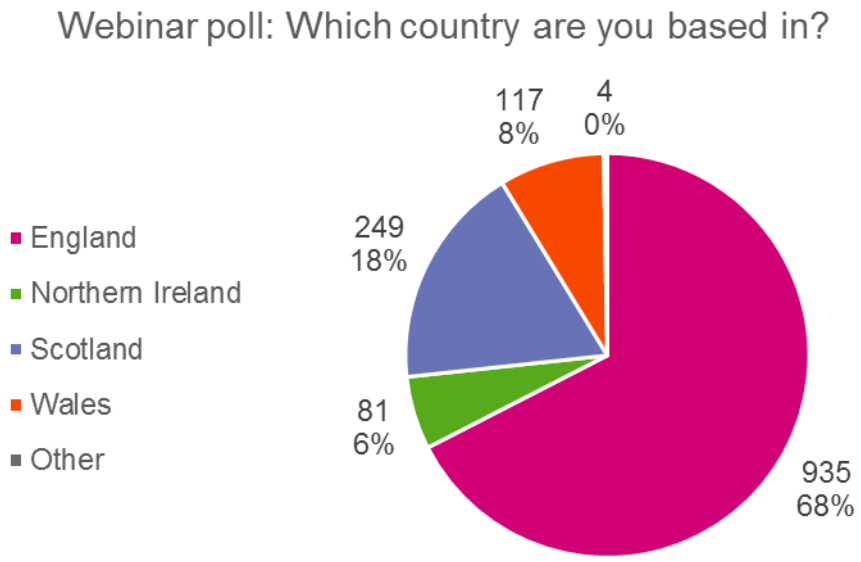


Data from 12 webinars, total number of attendees 2,907. Number attending each webinar as in table 1.

At each webinar, we encouraged those people who responded 'partially' or 'no' to let us know through the comments why they felt that and what else they needed to know in order to feel more informed.

Country

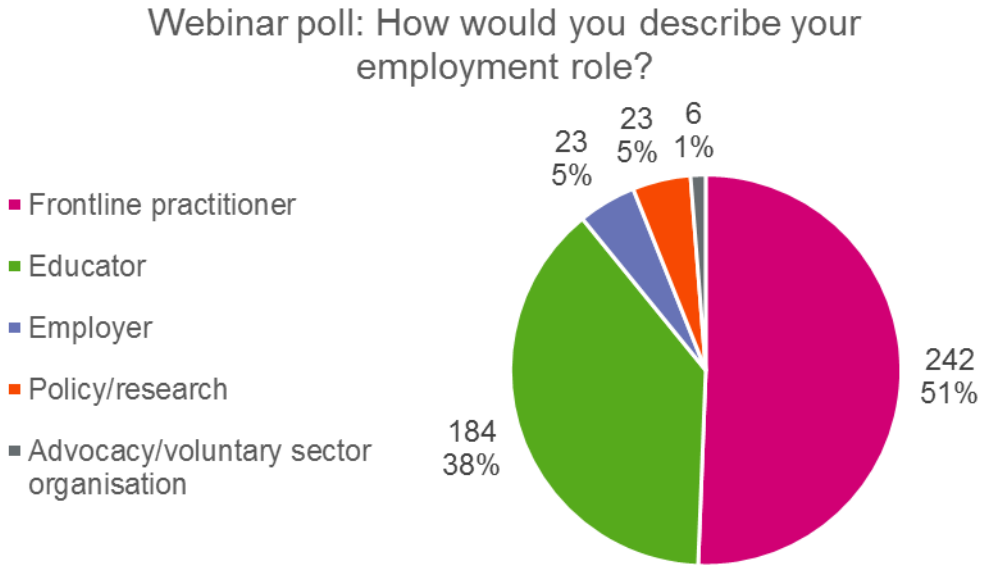
In all but the first two webinars, we asked participants to let us know which country they are based in.



Data from 10 webinars, total number of attendees 1,703, responses 1,386. The data exclude those who did not answer (317).

Employment role

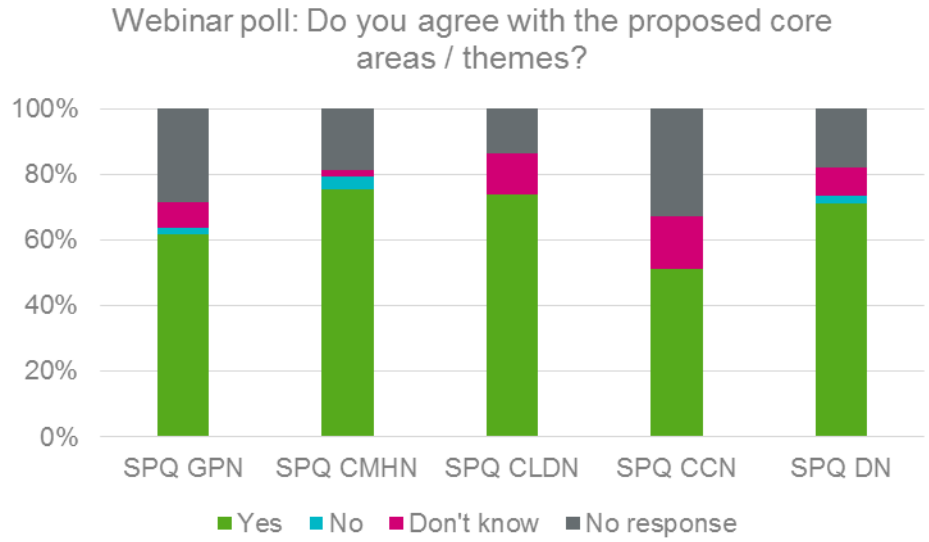
For seven webinars, we asked attendees to tell us about their role.



Data from 7 webinars, total number of attendees 644, responses 478. The data exclude those who did not answer (166).

SPQ webinars

For SPQ specific webinars, we asked people whether they agreed with the proposed core areas / themes of the content of the standards.

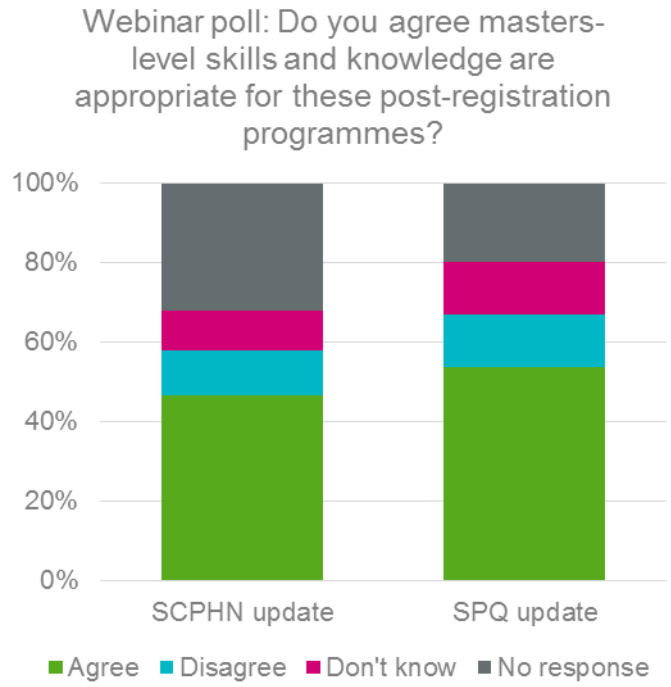


Data from 5 SPQ webinars, number of attendees at each webinar as in table 1.

Overall 68 percent of participants responded yes, only 2 percent responded no, with 9% answering don't know and 21 percent not answering.

Update webinars

We asked both the SCPHN and SPQ update webinars about the skill level required for these post-registration programmes.

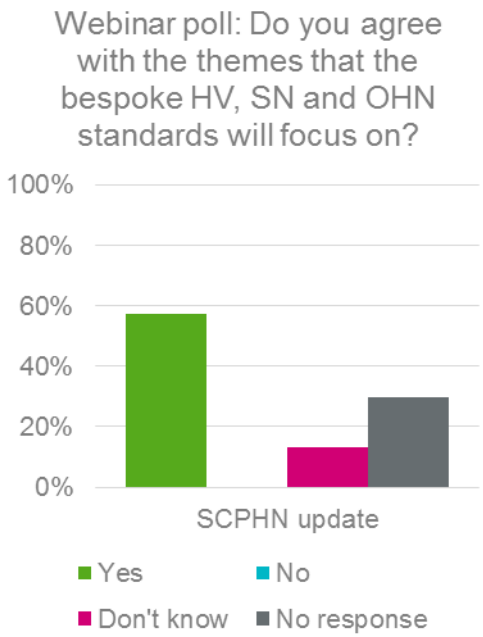


Data from 2 webinars. Number of attendees at each webinar as in table 1.

Overall 50 percent of participants responded agree, 12 percent responded disagree, with 12% answering don't know and 26% not answering.

SCPHN update webinar

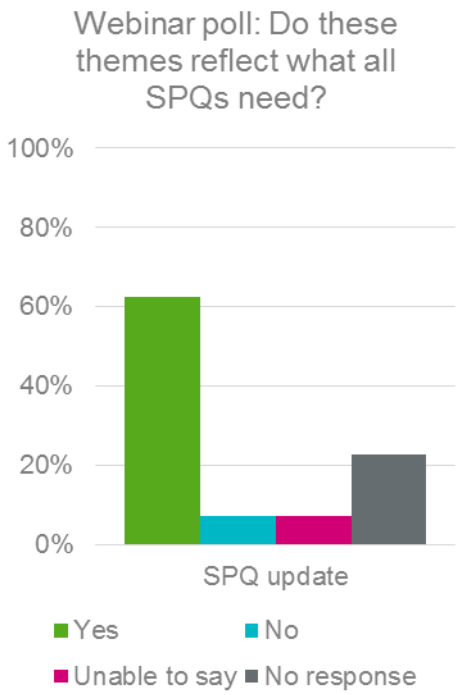
During the SCPHN update webinar, we asked attendees whether they agreed with the outline areas that the standards for each of the bespoke SCPHN areas.

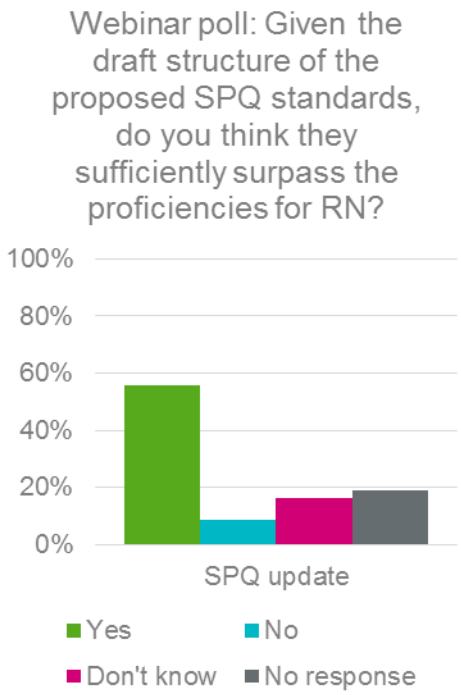


Data from 20 October SCPHN update webinar, 131 participants.

SPQ update webinar

During the SPQ update webinar, we asked attendees about the emerging themes and standards.





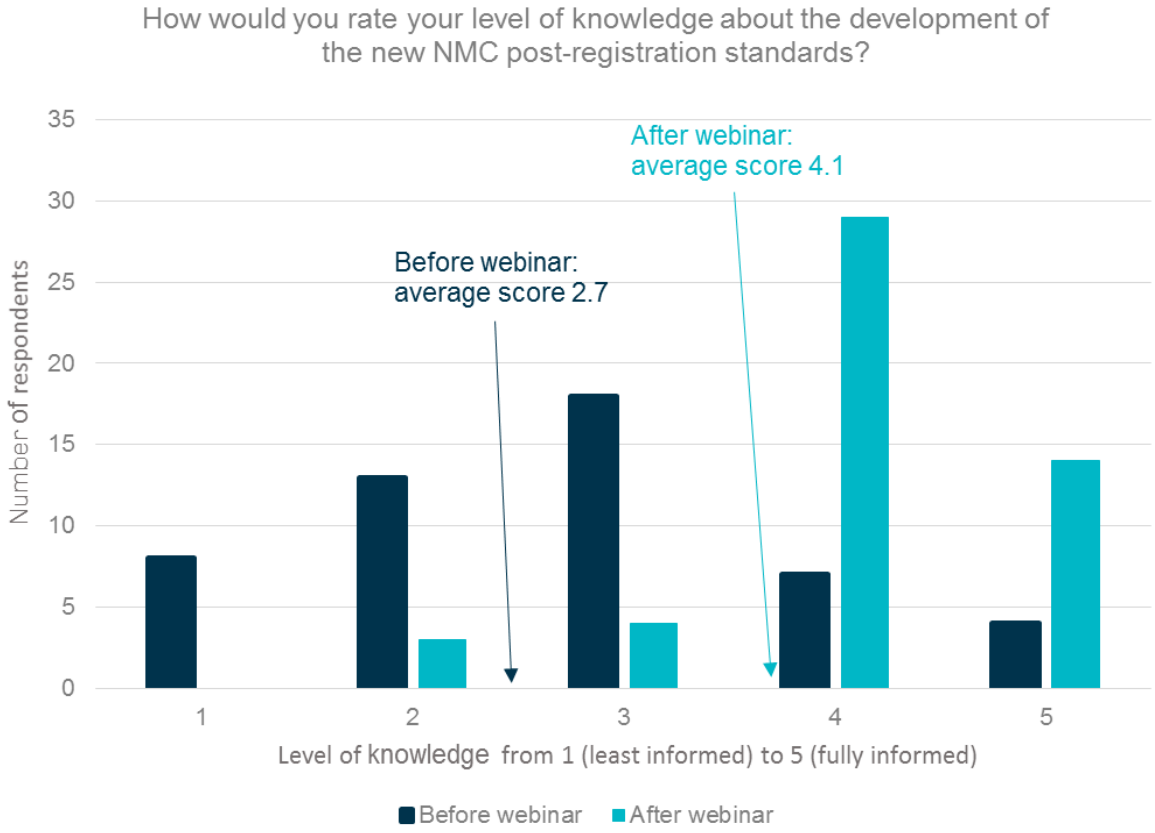
Data from 22 October SPQ update webinar, 136 participants.

Webinar feedback

We sent a follow up feedback survey to all attendees asking for their views on the webinars. We received only a small number of responses – 50 responses from attendees at seven webinars, total of 644 attendees, so an 8 percent response rate. Although the feedback was positive overall, the findings are not a comprehensive representation of attendees' views. All responses were anonymous.

Knowledge about the review

We asked respondents to rate their level of knowledge about the development of the new NMC post-registration standards both before and after the webinar.

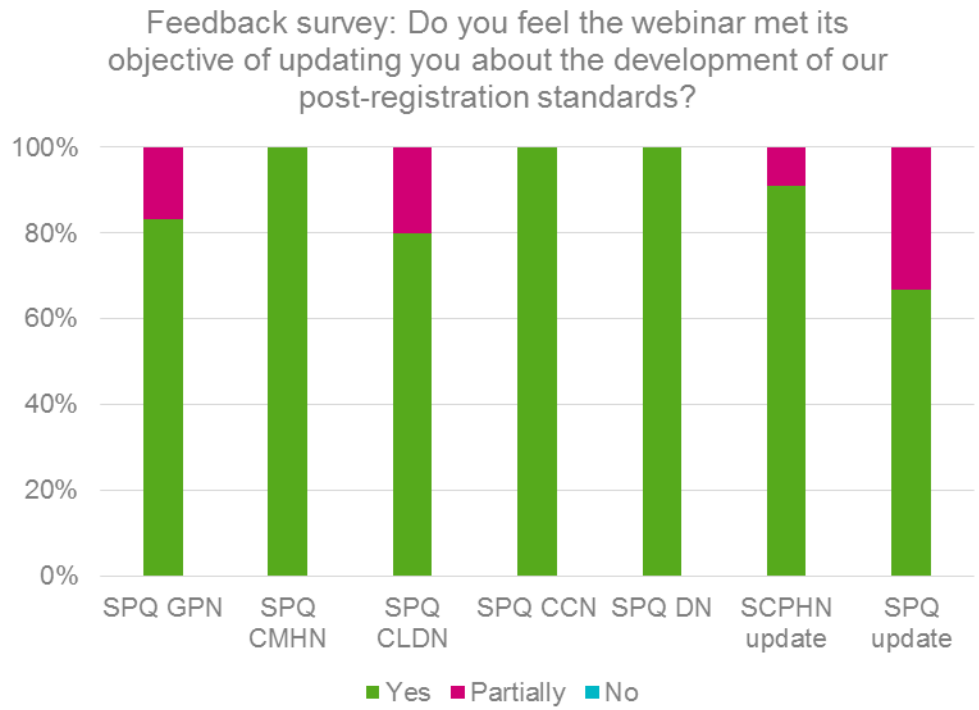


Data from feedback survey after 7 webinars, 50 responses.

Knowledge about the development of the new post-registration standards improved – with people scoring their 'before webinar' knowledge as an average of 2.7 (on a 1 to 5 scale, with 1 being least informed and 5 being fully informed), increasing to an 'after webinar' average score of 4.1.

Meeting objectives

We asked whether respondents felt the webinar met its objectives.

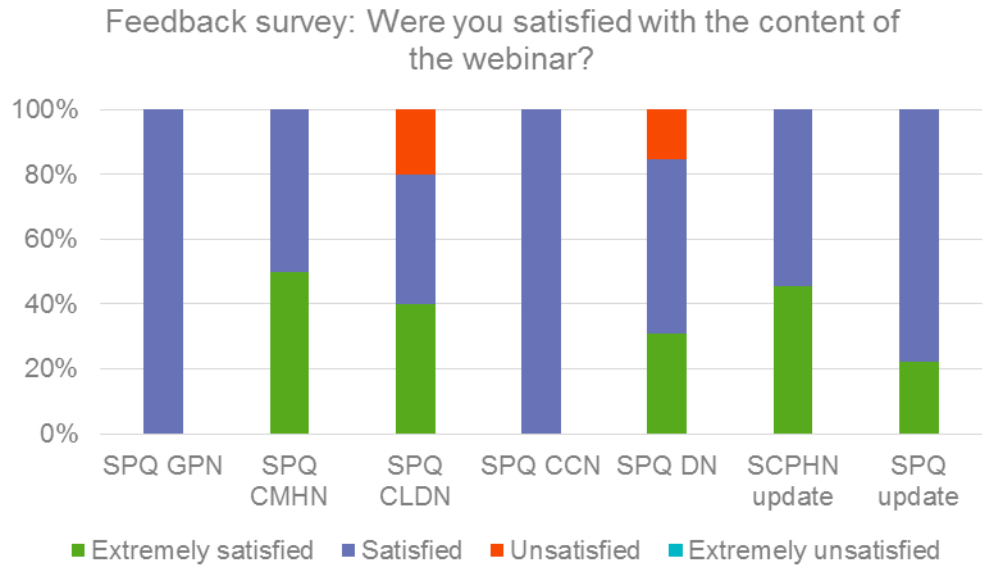


Data from feedback survey after 7 webinars, 50 responses.

Most respondents felt the webinar met its objectives (89%) with 11% stating it only partially met the objectives.

Webinar content

We also asked respondents about the content of the webinar.



Data from feedback survey after 7 webinars, 50 responses.

The overwhelming majority of respondents were extremely satisfied (27%) or satisfied (68%) with the content of the webinar, compared with only 5% reporting they were unsatisfied.

Diversity of respondents

On the anonymous feedback survey, we asked various questions to understand the diversity of respondents. With such a small sample we cannot draw any definitive conclusions, but we do know that the majority of respondents are aged 41-60, work in England, identify as female, white British and heterosexual. Five respondents identified as another ethnic group (not white British). There are some respondents who have disabilities including deaf/hearing loss and mobility.

We will continue to monitor the diversity of respondents and attendees at our events to ensure we are hearing from a range of diverse voices and that we are ensuring all groups can engage with us meaningfully.

2. Virtual roundtables

Virtual roundtables provided an opportunity for more in-depth discussion among a smaller sample group of individuals. We organised a series of virtual roundtables for between 3 and 20 participants, facilitated by members of the NMC team.

Roundtables were small events, so we could hear from all participants and listen to their views. Invitations were sent to individuals who'd been nominated by rep bodies and those who'd contacted us directly and asked to join roundtable discussions. The sessions reflected a broad range of voices with an interest in our post-registration standards development.

The roundtables provided a rich source of feedback helping us to shape the draft standards.

There was a lot of interest from webinar attendees in being involved in the roundtable discussions. The number of roundtables and their small size meant we couldn't involve everyone who expressed interest, but we aimed to achieve a mix of participants from the four countries of the UK and scope of practice. We also heard from a number of advocacy groups, employers and educators.

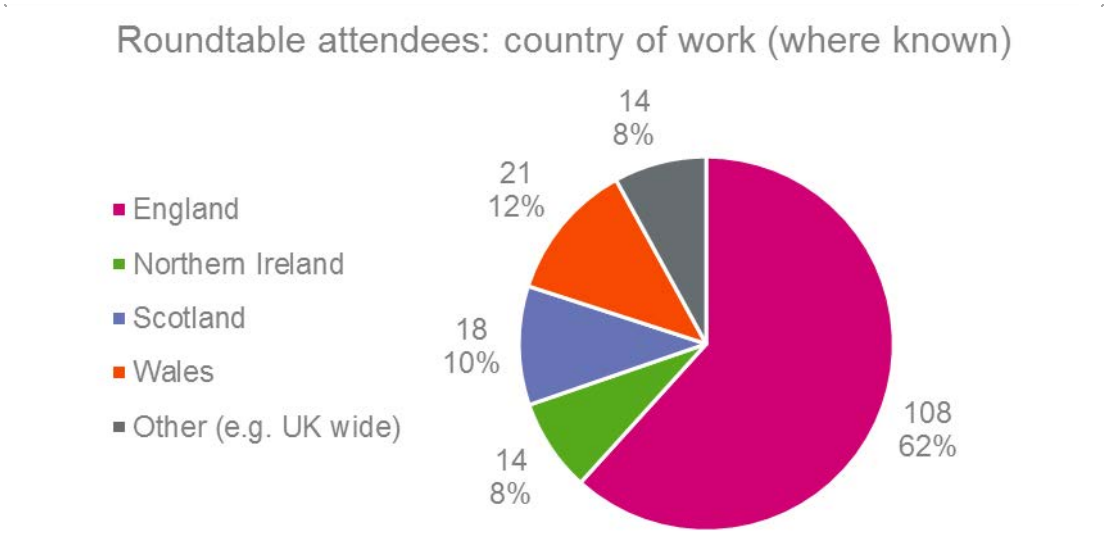
Topic	Date	Number attended*
Frontline practitioners • SCPHN • SPQ (x2) • School nursing • Health visiting • Occupational health nursing	 20 July 22 July & 13 August 24 July 29 July 4 August	 22 38 21 16 22
Educators • SCPHN • SPQ	 23 July 27 July	 23 22

Topic	Date	Number attended*
Employers • Direct employers • Commissioners	 12 August 25 August	 19 5
Social care	20 August	16
Other professions	3 August	3
Advocacy groups • Disability and long term conditions • Older people • Children and young people • Mental health and learning disabilities	 30 July 31 July 6 August 14 August	 3 4 6 8

*A few people attended more than one roundtable due to their roles being relevant to more than one area, so the numbers do not refer to unique people.

There were 228 attendees across 16 roundtables. 11 individuals attended 2 roundtables, the remainder attended 1.

Country



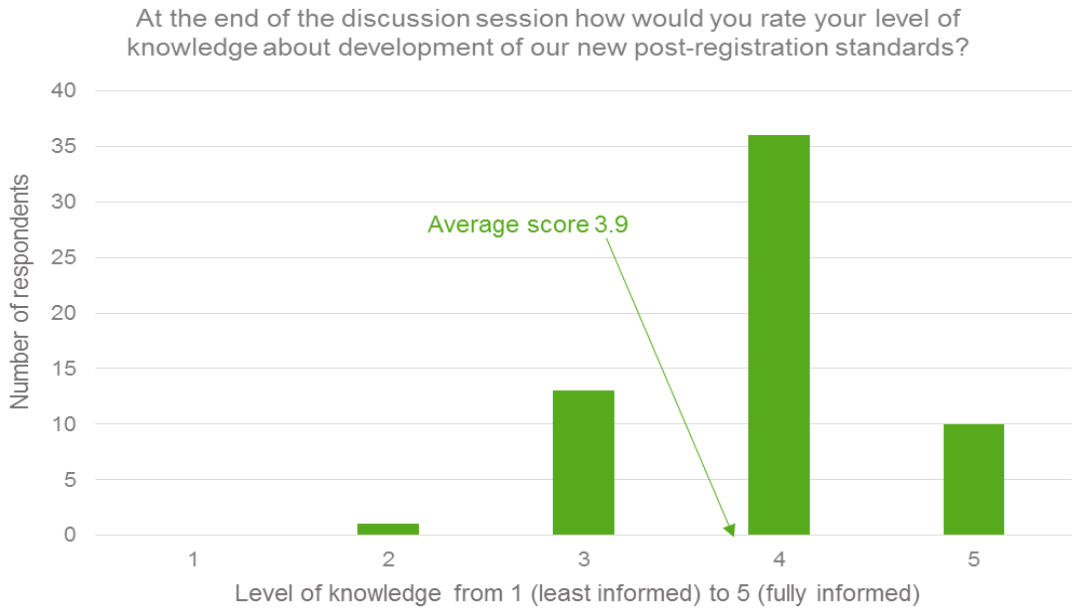
Data from 11 roundtables where country location of roles was recorded – frontline practitioner, educator and employer sessions. Total number of attendees 203, data for 178. The data exclude those for whom we who did not have a specific location recorded (28).

Roundtable feedback

We sent a follow up feedback survey to all roundtable attendees asking for their views on their session. We received only a small number of responses – 60 responses from 228 attendees, 26 percent response rate. Overall the feedback was positive. All responses were anonymous.

Knowledge about our review of post-registration standards

We asked respondents to rate their level of knowledge about the development of our new NMC post-registration standards after each session.

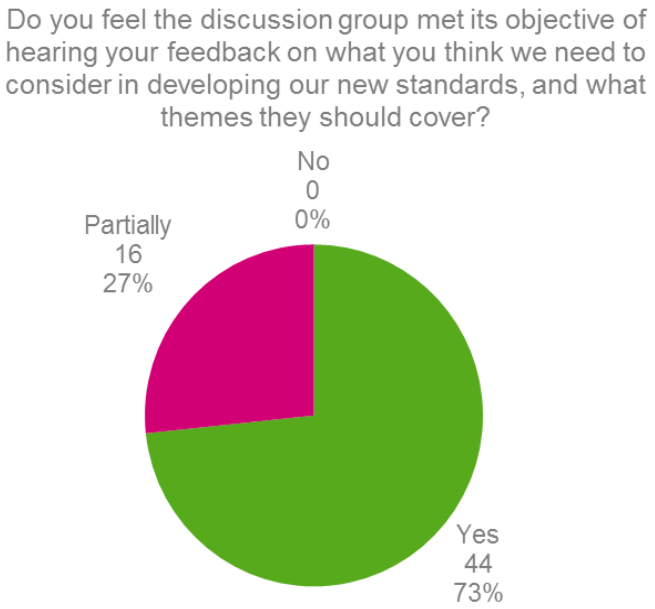


Data from feedback survey after 16 roundtables, 60 responses.

Across all the roundtables, respondents scored an average of 3.9 (on a 1 to 5 scale, with 1 being least informed and 5 being fully informed).

Meeting objectives

We asked respondents if they felt the discussion group met its objective of hearing feedback on what we need to consider in developing our new standards.



Data from feedback survey after 16 roundtables, 60 responses.

73% of people said the session met its objectives, while 27% said it partially met its objectives.

Diversity of respondents

The majority of respondents were female, aged between 41 and 60, identified as white British, heterosexual, Christian, with no disabilities and no caring responsibilities.

We had some responses from men (10%), those with disabilities (10%) and those identifying as LGBT+ (8%).

3. Additional meetings

To ensure we heard from a broad range of voices, we approached organisations who represent those we were not hearing from through other routes.

We met with:

- Professional groups – Royal College of Psychiatrists, Royal College of Paediatrics and Child Health, Royal College of General Practitioners, National Association of Primary Care
- Diversity in nursing – British Sikh Nurses, Mary Seacole Trust, Nigerian Nurses Charitable Association UK
- LGBT+ issues – Stonewall
- Children – children's commissioner for Wales (we contacted children's commissioner for all nations to request input, but to date only the Wales office have responded)

These meetings helped ensure we're hearing from some diverse voices in the shaping of the draft standards.

We know that our standards must reflect the diversity of the people who receive support and care in their homes and communities. So it's important that professionals are able to tailor their communication approaches and use of language to take account of the needs of different population groups.

Other communications activity

In addition to holding webinars and virtual roundtables, we also created a web hub for the post-registration standards review. This hosts all information about the review, enabling people to find out how the work is progressing and to get involved in shaping our work.

We promoted the review and the opportunities to get involved in our existing newsletters to specific audiences such as nurses and midwives and educators.

In August we initiated a regular email update for those who signed up or are part of our post-registration standards community of interest (PRSCOI). This is currently sent to over 500 individuals, and updates have been sent out monthly during the pre-consultation engagement with details of how to sign up to forthcoming events.

We utilised all our NMC social media platforms to promote our virtual engagement opportunities. The main channel used was twitter, with posts also being made on

Facebook and LinkedIn. The posts were mainly to promote the webinars, but also to increase awareness of the review to interested audiences.

Learning for the future

Webinars

There was confusion expressed by a few attendees over the purpose of a webinar versus other engagement opportunities. Webinars by their nature are a broadcast communication channel, although we sought to encourage engagement through the use of snap polls.

We know that some attendees would have liked to see the chatbox comments from others and have opportunities for networking. The platform that the NMC uses, GoToWebinar, does not have this functionality – comments and questions submitted during a webinar are visible to webinar organisers only. However, we did build in opportunities for some comments to be raised with the independent chairs and questions asked so everyone could hear the responses.

We need to ensure we set expectations appropriately so attendees are aware what to expect when they join a webinar, and that we signpost other opportunities to get involved such as smaller group discussions.

Virtual roundtable sessions

Early feedback told us that a pre-discussion briefing or copy of the slides to be presented would be helpful. We responded positively to this feedback and as a result, we started sending out slides and briefing in advance after the first few roundtables. We will take this learning into future similar sessions.

To ensure that everyone has an opportunity to contribute at virtual roundtable sessions, we should involve no more than 20 attendees, or make use of breakout rooms.

Feedback was received on the limitations of the GoToMeeting platform, for instance there is no hand raising function or breakout room facility.

Participants also reported that they struggled to focus on both the chat box, the presentation and the verbal conversation at the same time. We need to be mindful of what we are asking of participants and how we want them to contribute at future sessions in order to ensure the events are as inclusive as possible.

Advocacy organisations / groups

Engaging advocacy groups was a challenge at times, with many providing feedback that the Covid-19 pandemic had badly affected their resources, with many of their staff made redundant or on furlough and a need to focus on their core purpose

This meant that inevitably numbers for the roundtables for advocacy groups were much smaller than those for frontline practitioners and educators despite our efforts to send bespoke invitations to over 100 organisations. Despite being smaller groups, these sessions were high-quality conversations providing rich feedback.

Organisations who were unable to attend the roundtable session were invited to provide offline responses to questions. A couple of organisations responded in this way ensuring we heard their views to help shape the content of the new standards.

We are now drawing up plans regarding the input we want and can achieve from advocacy organisations to promote the consultation and how we can manage this to be the least time-consuming possible for them.

Appendix

Overall numbers at engagement activities

Date	Type of activity	Topic	Number attended on the scheduled date	Number registered / invited that were unable to attend on the scheduled date but received the relevant presentation*
29-Jun	Webinar	SCPHN core	646	274
30-Jun	Webinar	SPQ	558	359
10-Jul	Webinar	School nursing	324	198
15-Jul	Webinar	Occupational health nursing	275	228
21-Jul	Webinar	Health visiting	460	365
20-Jul	Roundtable	SCPHN core	23	17
22-Jul & 13 Aug	Roundtable	SPQ (x2)	40	32
23-Jul	Roundtable	SCPHN educators	23	23
24-Jul	Roundtable	School nursing	22	18
27-Jul	Roundtable	SPQ educators	22	19
29-Jul	Roundtable	Health visiting	15	22
30-Jul	Roundtable	Advocacy groups: disability	3	42
31-Jul	Roundtable	Advocacy groups: older people	4	25
03-Aug	Roundtable	Other professions	3	18
04-Aug	Roundtable	Occupational health nursing	22	23
06-Aug	Roundtable	Advocacy groups: children and young people	6	20
12-Aug	Roundtable	Employers	19	64
14-Aug	Roundtable	Advocacy groups: mental health / learning disabilities	8	27
20-Aug	Roundtable	Social care	16	47
25-Aug	Roundtable	Commissioners	5	23
01-Sep	Webinar	SPQ general practice nursing	63	43

09-Sep	Webinar	SPQ community mental health nursing	53	27
09-Sep	Webinar	SPQ community learning disabilities nursing	95	46
10-Sep	Webinar	SPQ community children's nursing	49	34
10-Sep	Webinar	SPQ district nursing	117	80
20-Oct	Webinar	SCPHN update	131	85
22-Oct	Webinar	SPQ update	136	92

* For webinars this is the number of individuals who registered but didn't attend the session. For roundtables this is the number of individuals who were invited but unable to attend on the scheduled date of the event. Those individuals who were unable to attend on the scheduled date received the relevant presentation and were given the opportunity to send in further feedback.

Themes from pre-consultation stakeholder engagement for the Post Registration standards review

November 2020

Pye Tait Consulting
Royal House, 110 Station Parade, Harrogate
HG1 1EP
01423 509 433
info@pyetait.com
www.pyetait.com

Cert No: QEC19593371/0/Q

A report prepared by:

Pye Tait Consulting

Registered in England, Company No: 04001365, VAT No: 755 8312 14

Registered office: Royal House, 110 Station Parade, Harrogate, North Yorkshire, HG1 1EP

Tel: 01423 509 433

email (enquiries related to this report): m.pye@pyetait.com

email (general enquiries): info@pyetait.com

website: www.pyetait.com

Contents

Executive Summary

Introduction

In January 2020 the Nursing and Midwifery Council (NMC) announced their intention to develop new standards of proficiency for three areas of Specialist Community Public Health Nursing (SCPHN) practice: Health Visiting (HV), Occupational Health Nursing (OHN) and School Nursing (SN). The NMC also announced that they will begin to scope out the content for a new Specialist Practice Qualification (SPQ) standard of proficiency in community nursing. This would cover the five existing areas of community nursing practice for which NMC approved SPQs are already available: Community Children's Nursing (CCN), District Nursing (DN), General Practice Nursing (GPN), Community Learning Disabilities Nursing (CLD) and Community Mental Health Nursing (CMH). In addition, the NMC will develop associated programme standards for NMC approved education programmes for SCPHN and SPQ.

In July 2020 the NMC approached Pye Tait Consulting to thematically analyse their webinars, roundtable events and other engagement events that took place between June and September 2020 with a variety of frontline practitioners, educators, employers, advocacy groups and other stakeholders to understand what subjects might be covered in both core bespoke standards. The online webinars and roundtables had a combined total of 3,135 attendees.[1] The NMC also encouraged people to 'post' virtual postcards answering two set questions regarding the standards and themes pertaining to the nursing roles. In total, 252 of these were received. All other email communications received into the organisation on the future of the post-registration standards and regulation from our stakeholders were also collected, detailing people's comments, experiences, views and questions. There were 206[2] of these and they too were manually analysed and are also included in the pre-engagement analysis.

Analytical method

In total there were 28 online webinars and roundtable events, and in addition there were 11 other engagement events, making a total of 39, all of which were analysed by Pye Tait Consulting to identify the emerging themes. The events varied in size from webinars attracting hundreds of participants to some smaller focussed 'roundtable' or discussion events usually consisting of a handful of participants. Analysis for each event was prepared on a thematic basis utilising commentary from the webinar and comments from the chat box. The analysis noted the respondent's name, job details and country (where known).

Key findings

The key findings from the analysis are summarised and presented below. It is worth noting that the virtual postcards and email responses largely echoed the themes that emerged during the online events.

Themes of special interest

During the webinars, roundtable events and other engagement events several themes emerged that

[1] This figure refers to the number of participants who attended the online webinar and roundtable events only.

[2] This figure comprises comments that came via a variety of platforms. They have been manually analysed in different sections of this report.

brought a deeper level of understanding to the nursing role under discussion that had not previously been debated. These 15 themes are of special interest to understanding the different areas of advanced practice for SCPHN and SPQ nurses and will now be considered during the development of the new standards. Examples include frailty, self-care and self-management, diagnostic overshadowing and gerontology.

Common themes

Six common themes frequently emerged from the online events, virtual postcards and email responses when discussing what is needed for future SCPHN and SPQ practitioners and will be considered for each set of new draft standards. These are:

- Advanced communication skills
- Collaborative working
- Leadership
- Prescribing
- Public health
- Safeguarding

Specialist Community Public Health Nursing (SCPHN)

A total of 41 themes were identified as being pertinent to all SCPHN fields of practice roles. Based on the responses and comments from a range of frontline practitioners, educators and other stakeholders the following themes are believed to be significant to all SCPHN practitioners: *Biopsychosocial model, community asset, influencing policy / influencing change, technology, health informatics and epidemiology, numeracy skills, leadership not management, value.*

SCPHN – Health Visiting (HV)

A total of 29 themes were identified as being pertinent to the Health Visitor field of practice. Based on the responses and comments from a range of frontline practitioners, educators and other stakeholders the following themes are believed to be significant to Health Visitors**:** *Age profiles; breastfeeding / infant feeding; the health visitor's role in the wider community; early life / the first 1,000 Days; family-centred care; identifying vulnerable and high-risk families / persons; mental health; and the use of technology in health visiting practice.*

SCPHN – Occupational Health Nursing (OHN)

A total of 43 themes were identified as being pertinent to the Occupational Health Nurse field of practice. Based on the responses and comments from a range of frontline practitioners, educators and other stakeholders the following themes are believed to be significant to Occupational Health Nurses: *Business and commercial acumen; influencing skills; knowledge of relevant legal frameworks and legislation; mental health; accessibility of training courses and practice teachers; understanding the role; the work environment; the OHNs role in the issuing of fit notes; health and safety; and working as single-handed practitioners.*

SCPHN – School Nursing (SN)

A total of 35 themes were identified as being pertinent to the School Nurse field of practice. Based on the responses and comments from a range of frontline practitioners, educators and other stakeholders

the following themes are believed to be significant to School Nurses: *Adverse Childhood Experiences (ACEs); age profiles; consistency of approach and service delivery across areas; sexual health and contraception; mental health; emotional health and wellbeing; social media and digital technology; adolescence; empowerment; and immunisations.*

Specialist Practice Qualification (SPQ)
A total of 36 themes were identified as being pertinent to all Specialist Practice Qualifications Based on the responses and comments from a range of frontline practitioners, educators and other stakeholders the following themes are believed to be significant to SPQ practitioners*: Frailty; self-care and self-management; regulation; terminology and emergent technology.*

SPQ – Community Children's Nursing (CCN)
A total of 26 themes were identified as being pertinent to the Community Children's Nurses. Based on the responses and comments from a range of frontline practitioners, educators and other stakeholders the following themes are believed to be significant to Community Children's Nurses: D*ifferential diagnosis; educating others; recognising a deteriorating child; and transition to adult services*

SPQ – District Nursing (DN)
A total of 43 themes were identified as being pertinent to the District Nurses. Based on the responses and comments from a range of frontline practitioners, educators and other stakeholders the following themes are believed to be significant to District Nurses: *Age profiles; the range of practice environments; managing caseloads; managing teams; managing risk; complex care; educating others; and the District Nurse title.*

SPQ – General Practice Nursing (GPN)
A total of 32 themes were identified as being pertinent to the General Practice Nurses. Based on the responses and comments from a range of frontline practitioners, educators and other stakeholders the following themes are believed to be significant to General Practice Nurses: *Adaptability, autonomous practice, consistency, employment, influencing skills and managing resources.*

SPQ – Community Learning Disabilities Nursing (CLD)
A total of 26 themes were identified as being pertinent to Community Learning Disabilities Nurses. Based on the responses and comments from a range of frontline practitioners, educators and other stakeholders the following themes are believed to be significant to Community Learning Disabilities Nurses: *Assessments, evidence-based practice, legal frameworks and legislation and therapeutic interventions.*

SPQ – Community Mental Health Nursing (CMH)
A total of 22 themes were identified as being pertinent to Community Mental Health Nurses. Based on the responses and comments from a range of frontline practitioners, educators and other stakeholders the following themes are believed to be significant to Community Mental Health Nurses: *Addiction; professional boundaries; managing risk; therapeutic interventions; consistent use of appropriate language / terminology; managing diverse teams; and the interaction between mental and physical health.*

Programme standards

Differing views emerged regarding the SCPHN and SPQ standards. Practitioners, educators and stakeholders explained that each SCPHN and SPQ nursing role is unique, however if the standards were to be combined, the preferred option would be to have a shared set of core standards with pathways for each specialism with separate sets of standards that would focus on those specific skills required for each public health or community nursing role. An overwhelming majority of participants believe that both SCPHN and SPQ programmes should be offered at Masters level, reflecting the advanced and specialist level of practice required for these roles.

Regulation is important to participants as it maintains standards, quality, consistency and protects the public. Many participants however are concerned that some nurses can call themselves a District Nurse or a School Nurse without completing a SCPHN or SPQ programme and see this as an issue concerning public trust and safety. Some participants would like to see nurse titles regulated by the NMC in the future.

Prescribing was an extremely popular and important topic with regard to both SCPHN and SPQ practice, generating 270 comments during the online events alone. Some of the comments demonstrated a concern that for some roles, for example Community Children's Nursing, prescribing was not an essential requirement because some nurses were not using their prescribing qualification at all or they very rarely needed to prescribe. Others however explained how the ability to prescribe had enhanced their practice through being able to deliver a timely and holistic service to patients. It is important to note that deciding not to prescribe medicines was also relevant to many discussions, especially for those working within mental health and learning disabilities services. These specialist community nurses therefore require demonstrable knowledge of therapeutic interventions as an alternative to prescribing to support the patient. Although some participants were cautious about integrating prescribing into the two programmes, the general belief was that prescribing, particularly the V300 independent prescribing qualification, would be a useful skill required by most specialist public health and community nurses to deliver high quality care in the future.

As already alluded to, the pre-engagement online events, virtual postcards and email responses largely echoed each other in their emergent themes, and have provided an incredible and vast collection of what current frontline practitioners, educators, employers and other stakeholders believe are the core and unique qualities, skills and attributes of SCPHN public health nurses and SPQ community nurses.

This report and accompanying spreadsheet prepared by Pye Tait Consulting (with over 2,120 rows of information and 250 themes gained through extensive virtual engagement activity) presents the NMC with a wealth of qualitative data. The data will help influence and shape the new draft standards of proficiency and accompanying programme standards in preparation for public consultation as part of the process to determine what future specialist practitioners need to know and be able to do to fulfil SCPHN and SPQ roles.

1. Introduction and aims

1. In January 2020 the Nursing and Midwifery Council (NMC) announced their intention to develop new standards of proficiency for three areas of Specialist Community Public Health Nursing (SCPHN) practice. The NMC also announced that they will begin to scope out the content for a new Specialist Practice Qualification (SPQ) standard of proficiency in community nursing for five areas of SPQ nursing. In addition, the NMC will develop associated programme standards. (NB: This report does not include any reference to the new proposal that was put to PRSSG in November 2020).

2. To join the SCPHN part of the register, registered nurses or midwives have to undertake an approved SCPHN programme and achieve the standards of proficiency. The three areas of SCPHN practice include Health Visitors (HV), School Nurses (SN) and Occupational Health Nurses (OHN).

3. SPQ are optional recordable qualifications that meet NMC standards but do not lead to admission to a part of the register. The five SPQ community nursing roles include Community Children's Nurses (CCN), District Nurses (DN), General Practice Nurses (GPN), Community Learning Disabilities Nurses (CLD) and Community Mental Health Nurses (CMH).

4. In line with its standards development methodology the NMC has engaged extensively with stakeholders to seek and listen to professional opinions and views to inform their draft standards on which they will be holding a formal consultation in 2021.

5. In July 2020 the Nursing and Midwifery Council (NMC) approached Pye Tait Consulting to thematically analyse their pre-engagement virtual webinars and roundtables. These took place between June and September 2020 (ending 11 September 2020) with a variety of practitioners, educators, employers, advocacy groups and other stakeholders to understand what might form core and specialist or bespoke standards. From mid July 2020 Pye Tait Consulting were invited to attend live webinar and roundtable discussions producing a thematic analysis for each online discussion, including previous webinars from the end of June 2020.

6. The aim of the thematic analysis work was to capture and analyse the key themes arising from the online webinar and roundtable events, enabling the identification of any differences in themes across different audiences, such as profession or country, where feasible and identifiable, to help NMC with the next stage of developing the standards of proficiency and the programme standards. A turnaround date was provided for each event which Pye Tait met either on the day or earlier, thus allowing the NMC to review the themes before progressing with the subsequent online events.

2. Analytical method and report structure

7. The NMC commissioned Pye Tait Consulting to analyse extensive amounts of qualitative spoken and written data which emerged from online webinars and meetings in order to highlight key themes and topics that will feed into the new SCPHN and SPQ nursing standards to be completed.

8. Three different approaches to gathering qualitative data from nursing professionals, stakeholders, educators, and advocacy groups were employed by the NMC: via 1) online webinars/roundtables and discussion groups of which a comprehensive list is provided overleaf, 2) virtual postcard responses to two specific questions, and 3) a dedicated mailbox to which any member of the public could send queries, questions or views on topics of their choosing.

Online Events

9. A total of 39 webinars were attended by Pye Tait Consulting with some events listened to after the event took place. On some occasions, up to three online webinars took place in one day, and one webinar was split into five separate specialist groups. The events varied in length, some were longer with hundreds of attendees but with minimal spoken feedback, and others were more focussed containing detailed discussions with smaller numbers of attendees. Often, different events had different questions asked of the attendees or the attendees themselves sometimes brought up and wanted to discuss questions or issues that were not on the official agenda.

10. Understanding of each event was achieved by reviewing the webinar live as an observer or listening back to a recording provided by the NMC to acquire a sense of the tone and direction of feedback prior to the analysis. For each event, attendees were encouraged to type comments and questions into the chat box especially if attendees were unable to contribute to the spoken discussion, therefore adding an extra layer of qualitative data to each event. In some cases, separate discussions took place in the chat box alongside the spoken commentary. All audio feedback was transcribed and cleaned which includes removing all unnecessary words (e.g. “umm” and “err”) and correcting spelling or grammatical errors that were in the written chat box. An analysis for each event was compiled into a thematic basis on a spreadsheet including relevant commentary from the webinar and the chat box whilst taking note of the respondent’s name, job details and country (if known).

11. In some instances, over 20 themes were distinguished in one event and for one webinar there were over 80 comments pertaining to one theme. A quick turnaround was required for NMC in order to inform their following webinars and discussions with some analysis being submitted the day after the event took place. A chronological list of all webinars that Pye Tait Consulting attended and thematically analysed is listed as table 1 in the annex. Table 2 in the annex displays the event re-presented by SCPHN and SPQ.

12. Alongside, these events, two Post-registration Standards Steering Groups (PRSSG) meetings took place on 2nd September. Pye Tait Consulting were asked to review and present these back to the NMC in a question and answer format. The chat box function was extremely active and allowed attendees to submit questions to the NMC team who were able to respond in real time. Pye Tait reviewed the chat box contents for each meeting and formatted the questions and answers highlighting the issues raised during the discussions.

Virtual postcard responses

13. As well as the online webinars, NMC invited nursing staff to send in virtual postcard responses to two questions that were posted on their website. The two questions asked:

> What important factors for community and public health nursing practice do you think we should account for in developing our new post-registration standards?
>
> What themes do you think our new standards for community and public health nursing should cover?

14. 252 virtual postcard responses were received from 18 June to the 4 August 2020. The data provided by the virtual postcard responses were cleaned (removing any spelling or grammatical errors) and manually analysed.

Dedicated mailbox

15. Webinar attendees and others working in the profession were also encouraged to send any feedback or additional comments to a dedicated mailbox (PRSCOI@MNC.uk-org). The contents of the mailbox were sent to Pye Tait Consulting on 17 September 2020.

16. The report is structured as follows:

Section 2 explains the methodological approach and how the report is structured.

Section 3 provides detail on the themes that emerged from the webinars as having special interest to NMC as they were either unique, unusual or noteworthy.

Sections 4 to 7 detail the outcome of the webinars.

Section 8 details the discussions on the Programme Standards.

Section 9 provides the analysis of the virtual postcard survey and the mailbox.

Section 10 is a summary conclusion.

The separately supplied spreadsheet, comprising themes from all 39 events, is sortable by field/column.

17. As a result of all of the events listed, the first section (3) describes a short collection of themes that covered both the SCPHN and SPQ programmes that were interpreted as being slightly different, unique and gave extra meaning to these specialist public and community nursing roles. Common themes are described in section 4.

18. In section 5 the first area of specialism to be reviewed is the overall occupation of **Specialist Community Public Health Nursing (SCPHN).**

19. The structure follows, as requested by NMC, a process of clarifying who said what about SCPHN practice during the online webinars and roundtables, i.e. what they believe should be included in the standards for public health nurses with this specialist qualification.

20. This is presented firstly by '**who'**: – practitioners, educators, other professionals, etc – displaying common themes that arose from the discussions, with less prominent themes or topics described towards the end.

21. The themes highlight the different opinions and experiences of various stakeholders who work with, teach or use the services delivered by SCPHN practitioners.

22. Where known, the **country** of those providing the comments is also noted in order to emphasise similarities and differences across the four nations.

23. The analysis then focusses on the different **areas of SCPHN practice** – Health Visiting (HV), Occupational Health Nursing (OHN) and School Nursing (SN) - detailing the themes that arose from the specific discussions pertaining to each role. These comments have come from practice-specific webinars or comments from other webinars and roundtables that explicitly focussed on a particular SCPHN area of practice.

24. **Specialist Practice Qualifications (SPQ)** follows, detailing again what stakeholders said about SPQ practice, stating the country if known. This is followed by '**who**' – practitioners, educators, other professionals, etc – and structured by common themes as described above.

25. Continuing with SPQ the next sections look separately at the five **areas of SPQ community nursing** – Community Children's Nursing (CCN), Community Learning Disabilities Nursing (CLD), Community Mental Health Nursing (CMH), District Nursing (DN) and General Practice Nursing (GPN). These themes and topics arose from the practice specific webinars and online discussions.

26. Webinars and roundtables also took place with **other professions and advocacy groups** which discussed both SCPHN and SPQ by examining what skills and areas of knowledge these community and public health specialist practitioners will need to have in their toolkits in order to deliver an enhanced level of practice to people with differing needs in communities across the four nations.

27. The online discussions that focussed on the **programme standards** are presented separately.

28. Practitioners, educators, and other stakeholders were invited by the NMC to submit virtual postcards answering two questions relating to the themes of community and public health nurses and what factors they think should be considered when developing the post-registration standards. These answers have been thematically analysed and presented in parallel with the webinar and roundtable analysis. The NMC also invited webinar and roundtable attendees and other stakeholders to email in their thoughts, comments, ideas and questions concerning the development of the post-registration standards and the roles of SCPHN and/or SPQ practice. These emails, varying in length and detail, have being thematically analysed in accordance with other material to show 'who said what' about a certain area of practice or programme.

29. Table 3 in the annex details the number of themes presented in each section.

3. Themes of special interest

30. During the online webinars and roundtable discussions several themes arose that brought a deeper level of understanding to the field of SCPHN and SPQ practice that had not previously been debated. These themes are of special interest to understanding the different areas of advanced practice for SCPHN and SPQ nurses and should be considered when developing the new standards. Fifteen of these special themes were identified throughout the 39webinars, roundtable events and other engagement events. These are listed below with a summary detailing which area of specialist practice the theme correlates to and who said it, if this information is known.

3.1 Decision making in unpredictable circumstances

31. This theme arose during the SCPHN / SPQ Research and Evidence meeting by an educator based in England. Not only do specialist nurse practitioners have to make decisions autonomously based on the evidence that they have gathered, but many specialist nurses have to make decisions autonomously when the evidence is not conclusive, for example, when a patient is presenting multiple problems. This quality is recognised as an advanced skill that sets SCPHN and SPQ qualified nurses apart from the Future Nurse standards.

3.2 Diagnostic overshadowing

32. Diagnostic overshadowing was referenced five times during the online webinars and roundtables when discussing individuals with a mental health illness or learning disability. According to participants, diagnostic overshadowing can be linked to the premature deaths of people with a learning disability or mental health condition because symptoms or behaviours have been overlooked due to their learning disability or mental health. Therefore, specialist nurse practitioners need to have an extensive understanding of the leading physical causes of illness and underlying illnesses when working with individuals with a learning disability or mental health condition in order to prevent diagnostic overshadowing.

33. There are some people who see the diagnosis before they see the child [or person], that's what we call 'diagnostic overshadowing'.

Paediatric Continence Specialist, England

3.3 Differential diagnosis

34. This theme was mentioned four times, three times in relation to Community Children's Nursing and once regarding District Nursing. It was claimed that these specialist nurse practitioners need to be equipped with the skills to offer differential diagnosis – the ability to differentiate between two or more conditions with similar symptoms – in order to keep the patient out of hospital and to prescribe where necessary.

35. If we want to futureproof the role of the Community Children's Nurse it will be to keep children at home and the need to have that differential diagnosis to do that so we can assess what problems there are and prescribe if required so children don't have to go into hospital.

Community Children's Nurse Team Leader, Scotland

3.4 Digital / technological competency

36. The increasing use of digital technology was frequently mentioned during the online webinars and roundtables, especially in light of the recent Coronavirus pandemic. The future of nursing relies on the ability to communicate digitally and make use of technological advancements to enhance service, gather information and keep records up to date. Social media was also referenced as a platform in which to keep in touch with patients.

3.5 Frailty

37. Frailty was discussed a total of 11 times in relation to SPQ community nursing. Although frailty is mainly associated with the older population it was highlighted that frailty is a condition that can affect young people too as well as those with a mental health condition or learning disability, for example, a teenager with an eating disorder will be frail.

3.6 Gerontology

38. Gerontology was referenced four times during the Social Care Roundtable by participants based in Scotland and Wales. Those working in social care believe that the specialism of gerontology has declined and, as the UK population are living longer, there needs to be more nursing practitioners with this specialist knowledge to care for older people.

39. There's a lot of learning in relation to that type of specialism and we need to draw from that so we have staff fit for the future.

National Workforce Lead for Nursing, Scotland

3.7 Motivational interviewing

40. This theme was referenced five times during SCPHN and SPQ discussions relating to Health Visitors, District Nurses, School Nurses and Community Mental Health Nurses. Motivational interviewing relies on advanced communication skills to gain a deeper understanding of the patient and / or family and to encourage behaviour change and support self-care. One participant from Northern Ireland claimed motivational interviewing should be used as a "prime method of communicating with clients."

41. The profession should use motivational interviewing at an advanced level so they can understand the personal situation and complexities [the patient is] in. We use motivational interviewing a lot and do it well, but there is too great a variation in standards.

Health and Social Care professional, Northern Ireland

3.8 Positive Behaviour Support (PBS)

42. Positive Behaviour Support is discussed seven times in relation to learning disabilities and mental health nursing and is considered an advanced level skill that challenges behaviours and develops positive support strategies requiring clinical leadership. A participant in England believes that, moving forward, PBS is an intervention that could be used for both children and older people who may be suffering from anxiety, and could be acknowledged as a future core skill for all specialist nurse

practitioners. Another participant noted that a great deal of training is required to perform PBS and there are risks if this is not conducted correctly.

3.9 Professional curiosity

43. Professional curiosity was mentioned twice during the online discussions in relation to School Nursing and Health Visiting – nurses who predominantly work with children and families – and is considered a higher level and core skill. Utilising learned communication skills to sensitively ask questions, make connections and trigger conversations in order to understand what is happening beyond the surface, and provide support for a family or child with other disciplines or services, composes professional curiosity.

3.10 Recognition of a deteriorating child

44. Referenced three times during Community Children's Nursing discussions by practitioners in Wales only, recognising a deteriorating child before they become severely unwell was highlighted as a specific and specialist skill. One practitioner felt there is a gap in the skills and knowledge between conducting a physical assessment and recognising the determinants of a deteriorating child and the standards should offer more guidance on how to identify this.

45. Recognition of a deteriorating child is an important development for the future particularly in relation to early discharge and hospital avoidance.

Senior Community Children's Nurse, Wales

3.11 Therapeutic interventions

46. There were 30 comments concerning therapeutic interventions as opposed to prescribing during the Community Mental Health Nursing and Community Learning Disabilities Nursing discussions. These specialist nurse practitioners should be equipped with the skills to consider and deliver therapeutic mediations, such as Cognitive Behavioural Therapy for example, instead of, or before, reaching for the prescription pad. Although it was recognised that prescribing may benefit these practitioners depending on the patient and circumstances, knowledge of, and the ability to conduct, therapeutic approaches is important.

47. Doesn't the specialist practitioner need a higher level of other non-prescribing interventions? This needs to be identified on the post-registration qualification, not just prescribing.

CAMHS Clinical Nurse Specialist, England

3.12 Unconscious bias

48. Unconscious bias was highlighted during the Advocacy Roundtable with mental health and learning disability groups and was discussed at length four times. Specialist nurse practitioners, especially those working with individuals with a mental health condition or learning disability, require a thorough understanding of unconscious bias, where is comes from, how to navigate those attitudes and how to challenge them when they arise. Unconscious bias – making assumptions of someone based on their learning disability or mental health – is said to lead to diagnostic overshadowing, therefore understanding of these two areas is a required skill to future proof these community nursing roles.

49. There needs to be a deeper understanding of the subject of unconscious bias and implicit attitudes and what to do when you know you're coming across it and navigating that.

Health Training Lead

3.13 Self-care / self-management

50. Self-care and self-management were discussed in relation to both SCPHN and SPQ practice, particularly in relation to individuals with long-term health conditions and communities where public health is below average. This entails having the advanced communications skills to educate others and encourage behaviour change, via approaches like motivational interviewing, so individuals are able to manage aspects of their own health.

51. In our area […] our public health is quite shocking, so we need to try and get those people to take some elements of care for themselves and it ties into the public health agenda. We need some sort of guidance in the standards relating to self-care.

District Nurse Practice Educator, England

3.14 Legislation

52. In total there were 30 comments pertaining to legislation and legal frameworks concerning both SCPHN and SPQ programmes. Advanced knowledge of legislation relating to a nurse's area of practice, plus the confidence to apply that legislation in practice, is a requirement of specialist public health and community nurses. Specialist practitioners should keep up to date with new legislation also. It was noted that legislation varies depending on each nation and the standards will need to reflect this.

3.15 Physical assessments / physical examinations

53. Advanced physical assessments and physical examinations were mentioned five times in relation to SPQ practice, predominantly Community Mental Health Nursing. The knowledge and skills required by specialist nurses working within mental health and learning disabilities services to perform physical assessments and examinations alongside mental health assessments was highlighted as an essential requirement to understanding an individual's overall health condition.

4. Common themes

54. Six common themes were identified during the analysis that appeared across various SCPHN and SPQ areas of practice. These common themes and corresponding analysis are presented together accordingly meaning the reader can easily digest the comments and opinions relating to each common theme.

4.1 Advanced communication skills

55. Advanced communication skills were frequently mentioned and is considered a core skill for several SCPHN and SPQ practitioners. It is ultimately defined as managing and communicating complex and sensitive issues (e.g. end of life decisions) and supporting the patient to process and understand

what is being communicated to them. Specialist practitioners require the skills to communicate effectively with a wide range of different individuals such as patients, family members, GPs, police, social care workers and other teams and services. A model purported to support this advanced skill is the consultation model as it makes practitioners consider how they are going to communicate an important or complex message to a patient.

56. What I can see is those consultation models are reflected not only in prescribing but in other situations within practice and they're [SPQ students] coming back to the consultation model because it works well with communications modelling as well.

Community Nursing Programme Director, England

57. School Nurses require advanced communication skills to build trust, assure confidentiality, discuss sensitive topics, ask difficult questions and explain things with clarity. Communicating with adolescents requires a different approach therefore School Nurses need to recognise the distinct needs of this age group and know how to navigate difficult topics whilst being approachable.

58. Our specific skill is to communicate and engage with the hard to reach teenager.

School Nurse webinar participant, Northern Ireland

59. It was said that School Nurses and Health Visitors should develop skills around **motivational interviewing** to find solution focussed outcomes and is key to managing complex discussions and personal situations.

60. Probably one of the areas you get too much variation in Health Visiting is the way we communicate with parents. We use motivational interviewing and that's how we manage our conversations. SCPHNs should be using motivational interviewing as a prime method of communicating with clients.

Stakeholder, Northern Ireland

61. From a Health Visiting perspective, advanced communication skills work alongside relationship management. Educators explain that they must be confident asking intimate questions concerning the antenatal period and have the skills to manage the complexities of an individual's life, for example, a single mother with limited income with no family support. Health Visitors need to be able to influence and support parents to respond to complex issues they face.

62. Similar to School Nurses, Community Children's Nurses require advanced communication skills to build trust with the child or young person taking into consideration learning disabilities and mental health issues. Community Children's Nurses should adapt their communication skills accordingly depending on who they are working with and tailor those skills to the community they are working in. Advocacy groups stated that active listening skills are key for specialist nurse practitioners working with children and young people. They need to listen to the concerns of the parents / carers who are the experts of their unwell child.

63. Remember, people communicate differently. Public health messages may be different depending on where you're working and it's understanding that at a higher level and adapting the messaging for community-based evidence.

Community Children's Nurse, England

64. District Nurses must be versatile and sensitive communicators, be "peace makers" and support service users discuss their options, their rights and their choices. It was noted that District Nurses in particular will need the skills to communicate with compassion and empathy information that may leave the patient and family emotionally distressed.

65. They [District Nurses] are faced with a number of sensitive situations and they need to be able to contextualise the work in a way that would be easy to receive, for example, end of life care where a patient has just received news from a consultant that they don't have long left to live.

Practitioner, England

66. According to one practitioner in England, there is a particular nuance with the population that Community Mental Health Nurses work with as they are likely to be "disconnected, disenfranchised and disengaged" therefore an enhanced level of communication skills are required in order to support those individuals. Another practitioner stated advanced communication skills are needed to understand and work through systems to get the best results for the patient. Advocacy group participants noted that, problematically, many health care workers do not have the confidence to adapt their communication skills effectively with individuals who have a learning disability and mental health illness. Some health care workers are also unaware of the different tools that people with learning disabilities carry with them that explain how they want to be communicated with. Another important point highlighted that service users need to be listened to and included in the decision-making process that concerns their care.

67. Being assertive and being able to communicate on what I would call a really holistic level, because I'm surprised by some of the poor communication skills of some nurses.

Health Training Lead, England

4.2 Collaborative working

68. Working collaboratively with other nurse practitioners, services, sectors and partnerships such as the voluntary sector, housing and police services, was cited as a popular skill for SCPHN practitioners. However, collaborative working was only elaborated on during Health Visitor and Community Children's Nursing events – two nursing roles working with children, young people and families. Both of these specialist practitioners are required to work with a range of other professions and services, however one practitioner acknowledged that whilst collaborative working is key Community Children's Nurses need to ensure they are not overlapping roles with Health Visitors and School Nurses whilst also making every contact count.

69. Collaboration and partnership working are key but also the Community Children's Nurse understanding the boundaries of their role.

Nurse Consultant in Child Health, Wales

70. Interdisciplinary working was also cited and sometimes overlapped collaborative working, especially in relation to SCPHNs. Interdisciplinary working was called "vital" and participants would like this to be made clearer in the standards. To work collaboratively and interdisciplinary was interpretated as working seamlessly and confidently with other services in and out of the health care system.

71. The discussions around shoulder to shoulder working are key points within the specialist population health area and [being able to] recognise the impact of housing and social demographic within the SCPHN role. There should be a core aspect of this and then maybe further points within specific skills where relevant [to the role].

4.3 Leadership

72. Leadership was a theme that arose when discussing both SCPHN and SPQ programme and each specialist nursing role by a range of frontline practitioners, educators, advocacy groups and other stakeholders. Generally, participants want to see the leadership element strengthened within the standards for both SCPHN and SPQ practitioners. These specialist practitioners will be compassionate leaders of the future in clinical practice influencing change at the forefront and developing the service

73. Employers and educators believe that leadership is a core skill required for all SCPHNs however employers highlighted that these nurses are to be leaders and *not* managers.

74. One of the things being spoke about sounds very much management orientated and management activities and I think we have to be very careful here that it's not about creating a manager. It's about leadership within the public health arena.

Associate Director of Nursing, Wales

75. As Occupational Health Nurses lead diverse multidisciplinary teams' practitioners in England claimed leadership needed greater focus in the standards to full prepare practitioners for this element once qualified. They require the competence and confidence to take the lead on occupational health and wellbeing issues and they should not be led by others. This was similarly the case for School Nurses who are local leaders. As well as working collaboratively, these nurses must demonstrate advanced leadership skills to hold others to account and co-ordinate across teams.

76. *We're looking at leadership locally and our school nurses having a bit of a public health intelligence lead within a cluster of schools, so they are the public health expert that works with multi-disciplinary teams to co-ordinate things across that.*

0-19 Learning and Development Lead, England

77. Several participants believe that leadership is more pertinent to the District Nurse role compared to other SPQ practitioners. District Nurses are required to lead and manage large teams and caseloads and thus require the skills to challenge and empower teams, develop and improve service, the ability to effectively delegate care and the confidence to refer patients to more appropriate services.

4.4 Prescribing

78. Prescribing is a very contentious and popular area of discussion. It was generally felt by most participants that, moving forward, SCPHN and SPQ practitioners will likely need some form of prescribing qualification to deliver a holistic service to patients. Prescribing will offer a timely one-stop-shop consultation instead of referring them onto a GP and will enhance autonomy. The V100 (Community Nurse Prescribing Course) qualification is considered relatively redundant, especially for Health Visitors, however the V300 (Independent Prescribing Course) qualification should be considered for integration into the standards. It was acknowledged by all participants, including employers and commissioners, that "in an ideal world" advanced practitioners should be prescribing but recognise that it may not be necessary for all SCPHN and SPQ roles across the 4 nations. One educator in Wales believe a "culture change" is required that should be embraced by everyone to move these health care professionals forward and make the standards fit for the future.

79. Integrating the V300 qualification across both programmes was favoured by educators from all four nations however this may prove challenging thus the V300 may only be integrated for SPQs and left optional for SCPHNs. It was highlighted that if prescribing were to be integrated into the SCPHN programme, pre-registration nurses would not be able to directly enter the programme for they need to be qualified for one year prior to admission. Those in Scotland stated that employers would prefer applicants to consolidate their pre-registration knowledge first.

80. From an England perspective, no way we will deliver the long-term plan unless we have those clinicians who are leading care, delivering end to end care and that includes prescribing.

Head of Community Nursing, NHS England

81. Participants in Scotland explained that the prescribing qualification had been removed from SCPHN courses as it was not required by employers. Some participants claimed that prescribing was replaced with an Emotional Health and Wellbeing course at one Welsh university as it was deemed more appropriate. Elsewhere in Wales, an educator claimed that prescribing is a core module for Health Visitors and School Nurses. Whereas some educators in England feel that there needs to be a greater focus on mental health rather than making prescribing mandatory, especially for SCPHNs. Prescribing discussions revealed the many differences and needs across the nations that NMC will have to acknowledge when developing the standards.

82. It's about keeping the standards as open as possible and flexible where there's uncertainty around how they'd use that prescribing practice if they were to be required to prescribe… across the four countries there are very different practices that go on and we need to be cognisant of that.

Associate Professor, Scotland

83. Prescribing was mentioned 94 times in relation to Health Visiting. Some practitioners and stakeholders believe that prescribing is not needed due to circumstances in their local areas or because a lot of medication can now be obtained over the counter. Many Health Visitors however believe that independent prescribing would elevate and enhance their autonomous role and improve equity. Opinions are generally coherent across the nations. In Northern Ireland, Health Visitor's ability to

prescribe during the Coronavirus pandemic proved vital as GP surgeries closed or limited opening hours and thus "improved people's access to help for minor illnesses."

84. I feel it is essential for Health Visitors to prescribe independently so that we can prescribe formula milks for babies with Cow's Milk Protein Allergy (CMPA) or antibiotics for mastitis, etc. As fewer GPs have obstetric and paediatric experience, and as we have extensive experience, we should be the ones prescribing for our patients.

Health Visitor, Scotland

85. Occupational Health Nurses and educators based in England, Northern Ireland and Scotland are in favour of prescribing also. Prescribing is necessary for administering vaccinations and essential to those working in isolated areas and who specialise in travel health. There are differing views as to whether it is a core skill with one drawback being that Standards for Student Supervision and Assessment (SSSA) would be particularly challenging. Those in the private sector claim their workload consists of absence management and helping people get back to work, not prescribing. Further consultation on this topic would be beneficial according to an educator in Northern Ireland.

86. I think prescribing would be beneficial as we have to refer people onto GPs, and this causes delays. My biggest frustration is getting anyone in my organisation to support prescribing HIV Post-exposure prophylaxis (PEP) for a health care worker exposed to blood borne viruses (BBV) when our Occupational Health Consultant is not available. If we could do this, we could mitigate all risks of BBV by doing [it] in a timely manner.

Practitioner, Scotland

87. Some School Nurses and stakeholders believe they should focus on "improving the health literacy of families and young people" and empowering them to make decisions and access appropriate services rather than prescribing. School Nurses in Orkney however highlighted that the V300 qualification is valuable due to their rural location, especially when prescribing contraception. Other practitioners in Scotland, and Northern Ireland, do not believe prescribing is essential for School Nurses. Educators in England and Scotland thus believe that, depending on location, some School Nurses are likely to prescribe more than others but are cautious that this ability may distract from the public health role and turn into a medicalised model.

88. I feel we shouldn't [prescribe] because what we're trying to teach young people is to build self-efficiency to access services and access support when needed.

School Nurse, Northern Ireland

89. Most practitioners from England and Scotland are in favour of introducing prescribing, namely the V300 qualification, to SPQ programmes, especially for District Nurses believing it to enhance autonomous practice. A handful of practitioners do not wish to see prescribing integrated in the standards as the SPQ specialisms are all different and the demand will change across the four countries. According to practitioners, the prescribing qualification should be optional and not a core requirement of the SPQ programme.

90. My view is the V300 should not be mandatory but could be an additional qualification for those who have an interest in this specific aspect of nursing.

SPQ Webinar attendee

91. *The V300 is an essential for SPQ. Our District Nursing students have expressed an interest in this feeling it would fit with their advanced practitioner role.*

Director of Studies for Specialist Practice, England

92. Children's Community Nurses and stakeholders did not think that the V300 qualification is a priority for their role because a great deal of medicines cannot be given to children, however they did acknowledge that it is something to aspire to in the future hence they may have an optional place in the standards. Practitioners based in England and Scotland discussed independent prescribing in relation to **differential diagnosis** stating that these advanced skills will facilitate keeping children at home rather than admitting them to a hospital. Educators in England and Wales would like to see Children's Community Nurses undertaking the V300 qualification, citing that this is already happening at some universities in England.

93. Dressings and creams would be really helpful [to prescribe]. I think it needs to be in there somewhere but not a priority. And there is such a wide variation in the Children's Community Nursing world and what this service looks like so that complicates things.

Children's Community Nurse, England

94. District Nurses and educators in England, Scotland and Wales are in favour of prescribing for many are lone workers dealing with complex caseloads; thus, prescribing will allow for treatment in a timely manner providing person-centred and holistic care to the service user. There have however been issues with some GPs in England prescribing at a District Nurses' request therefore having the advanced skills and knowledge to prescribe will greatly enhance treatment and service for both patient and practitioner. An educator from England mentioned District Nurses should be qualified in social prescribing also.

95. Registration as an independent prescriber is necessary to ensure that individual episodes of care can, where possible, be completed in as timely, safe and effective manner as possible.

Nurse Consultant, Scotland

96. Prescribing did not generate much discussion with General Practice Nurses. The small number of comments indicate that that they are in favour of social prescribing and the V300 qualification which would allow them to manage long-term conditions.

97. For Community Learning Disabilities Nurses and Community Mental Health Nurses, the standards should acknowledge non-medical prescribing and therapeutic approaches as opposed to prescribing. Medical intervention may be required if other therapeutic approaches do not work.

98. Community Learning Disabilities practitioners [are] working with a heavily medicated group of patients with side effects who would benefit from having someone close to the patient to really support and monitor medicines in an effective way.

Associate Professor, Scotland

99. Participants from advocacy groups would like to see practitioners working with older people, disabilities and long-term conditions be able to prescribe. Prescribing is essential to delivering seamless care which will be needed in the future and it also strengthens the patient and practitioner relationship ensuring people are getting the correct medication in time.

100. In terms of thinking about the workforce going forward and that availability it's important we've got those appropriate standards and nurses trained to independently prescribe.

Head of Learning and Workforce, UK-wide charity

101. Prescribing highlighted a number of concerns: how would this qualification fit into the one-year course? Why integrate prescribing when some nurses rarely prescribe in practice and some medicines are now available over the counter? What would happen if a student failed their course but passed the V300 qualification, and vice versa? Some employers and commissioners are resistant to certain practitioners prescribing which could potentially hold back the level of service. Several practitioners are unable to prescribe as they are employed by a local authority and not the NHS and practitioners in Scotland may not need to prescribe due to the Minor Ailments scheme and community pharmacies.

102. I'm happy to prescribe if it is easy to do, at the minute it is complicated and time consuming. In addition, GP's don't necessarily want us to 'interfere'.

Health Visitor, Northern Ireland

103. I used to prescribe more regularly in clinics but as we no longer have clinics in the area I work, there is less timely opportunity to prescribe. I do not think I would need to be an independent prescriber.

Health Visitor, England

104. As a provider it would be helpful to be prescribers, however it is more complicated than simply saying yes or no. Out of whose budget would the costs come? Currently it would come out of the GPs.

Head of Public Health Nursing, England

4.5 Public health

105. Public health covered many SCPHN and SPQ discussions with participants stating the standards should be firmly rooted in the public health agenda, focussing on population health and wellbeing and reducing health inequalities. This has recently been reinforced due to the Coronavirus pandemic.

106. Occupational Health Nurses believe they are uniquely placed to support public health and prevention in the workplace however educators state that employers are more interested in employee health, not population health. An independent practitioner highlighted that the public health agenda needs to be correlated to the workforce population to "show value return on intervention".

107. *I see public health as being essential to the Occupational Health Nurse role. I often hear that people, even from our own specialty, don't see us as a public health intervention role so I think that's a valid point.*

Nurse Tutor, England

108. District Nurses take the lead on public health initiatives like admission avoidance, yet many District Nurses do not necessarily recognise their work as public health which needs to change. A focus on public health was requested by one practitioner especially as many SPQ nurses are being encouraged to join Primary Care Networks (PCNs).

109. I do think District Nurses have a mental block about public health thinking they don't do it or recognise that they do it. Given that they are community practitioners working in different communities with different socioeconomic demographics, they should be cognisant of public health in those communities.

Senior Lecturer, England

110. Due to the variety of different people General Practice Nurses see every day, participants in England, Northern Ireland and Wales believe they are situated in a distinct position to identify public health needs. This includes identifying the needs of disadvantaged communities as well as working to improve the health profile of the practice population, promoting good health and establishing relationships with service users. Participants stated that both District Nurses and General Practice Nurses working in communities identify public health needs which can be missed by GPs.

111. I think the role is about public health, using the General Practice Nurse to promote health and improve the health of the practice population is the crux of the role. [The] pivotal role of the GPN is profiling and identifying needs within populations and establishing relationships to improve health.

Advanced Nurse Practitioner, Northern Ireland

112. Population health is sometimes missed by GPs and is essential for nursing to bring to primary care.

Lecturer in General Practice Nursing, Wales

113. Several employers believe the standards should be developed with other frameworks in mind that link to the wider public health workforce and a clear and attractive career pathway that sits within public health needs to be considered.

114. As standards are developed, I would have an eye on the public health framework from Public Health England, because any element with public health contained within it can be mapped against that framework.

Consultant, England

4.6 Safeguarding

115. Safeguarding is considered a core requirement for each SCPHN role with participants to online events often surprised it did not feature more prominently. SCPHNs are in unique positions to pick up "safeguarding subtleties" in their communities and practitioners emphasise that safeguarding older individuals is just as important as safeguarding children and young people.

116. We need that holistic safeguarding that includes children and adults and those with mental health and learning disabilities.

Health Visitor, England

117. Health Visitors would like to see a focus on risk assessment and early intervention to prevent safeguarding issues acknowledged in the new standards. Some practitioners claimed that the standards do not currently reflect the safeguarding role of Health Visitors or the complexity of cases. To support families, Health Visitors should focus on a strength-based approach rather than risk management. It was said that recognition of trauma informed practice, motivational interviewing and a multi-agency approach to dealing with, and managing, safeguarding issues is also essential for this role.

118. A large part of our role involves safeguarding children, recognising and responding to safeguarding issues. Cases are becoming more complex and I feel this needs [to be] reflected in the standards.

Health Visitor, Northern Ireland

119. I would say it [safeguarding] is core, but distinct to Health Visitors is supporting families to work with a strength-based approach and move away from the negative connotations of risk.

Educator, England

120. Occupational Health Nurses must also have the knowledge to identify potential safeguarding issues such as physical marks, alcohol or drug abuse and mental health issues. They will need to know how to approach sensitive topics with individuals and understand how these issues may affect others. School Nurses in England and Wales state safeguarding currently takes up the majority of their roles and feel this may be hindering their visibility to other service users. Safeguarding duties vary depending on the area of School Nursing team. Moving forward, it was suggested safeguarding should work alongside Trauma Informed Practice**.**

121. Participants working in social care based in England, Scotland and Wales state it is important that specialist practitioners have the knowledge to progress cases further, take responsibility and have a sound understanding of key safeguarding legislation. Allowing people in care services to live with a certain amount of risk to live fulfilled lives was discussed in relation to safeguarding also. A participant from England believes that it is more important to support people to live with risk rather than safeguarding people, managing those risks on a day to day basis.

122. It's important to think about risk and the balance between allowing people, specifically people with a learning disability or mental health illness, to experience a certain amount of risk as it's too easy to become overprotective and defensive. Risk is about living a full life.

Executive Director of Adult Social Care, England

5. Specialist Community Public Health Nursing (SCPHN)

123. The following themes have been identified as specifically relevant to Specialist Community Public Health Nurse (SCPHN) practitioner as discussed by attendees to the webinars, roundtable events and other engagement events. These events include:

SCPHN Webinar
SCPHN Roundtable with Employers
SCPHN Roundtable with Educators
SCPHN Prescribing Meeting
SCPHN Follow up Roundtable: SCPHN Core
SCPHN Programme Standards Meeting

5.1 SCPHN General themes and discussions

124. In total 41 themes were identified during the webinars, roundtable events and other engagement events where the discussions are pertinent to Specialist Community Public Health Nursing. Some of the themes arose during several different events whereas other themes emerged in specific webinars or roundtables where attendees were drawing on their personal specialist knowledge and experience.

125. In some instances, themes are discussed at great length whereas other themes are less frequently mentioned or contain little detail. It is worth noting that some of the themes listed below arose during the SCPHN Programme Standards meeting and will therefore be described in greater depth in the Programme Standards section of this report. The 41 themes discussed in relation to the SCPHN Nurse practitioner are as follows:

Adolescence (1)
Advanced practice (4)
Aging workforce (1)
Advanced practice (4)
Biopsychosocial model (13)
Clarity of roles (3)
Collaborative working (8)
Community (5)
Coronavirus (8)
CPD (1)
Cultural competence (2)
Disabilities (1)
Education (1)
Employers and commissioners (6)
Epidemiology (1)
Family-centred (2)
Holistic care (1)
Identifying vulnerability and inequality (2)

Infant mental health (1)
Influencing policy / influencing change (5)
Interdisciplinary working (21)
Integrated system / working (2)
Leadership (2)
Leadership, not management (2)
Legal frameworks and legislation (2)
Life course (1)
Mental health (1)
Module flexibility (1)
Numeracy skills (4)
Prescribing (24)
Prevention (1)
Public health (12)
Quality Improvement (QI) (1)
Research (3)
Risk (2)
Safeguarding (16)
Social justice (1)
Technology (7)
Training and experience (11)
Trusting relationships (2)
Value (3)

126. The following description provides a summary account of the most pertinent, unique themes to SCPHN practice and those themes that attracted a great deal of discussion. The thematic analysis is structured to show what themes were said by who – a practitioner, educator or stakeholder. Where it is known, the country is specified to determine similarities and differences of SCPHN practice across the four nations.

5.1.1 Practitioners and stakeholders on SCPHN

Biopsychosocial model

127. Practitioners believe that the biopsychosocial model should form part of the SCPHN standards, and it is an important approach to seeing an individual as a whole. Some participants discussed the biopsychosocial model as opposed to a medical model and adapting the medical model whilst working on the biopsychosocial approach on a case by case basis.

Community assets

128. Understanding, engaging with and utilising the assets within communities was highlighted by one nurse as a core section of SCPHN education and advanced practice. Actively engaging with what is available in their community, what and who they can work with in order to focus on other agendas will give them the opportunities to be influential leaders within their communities.

129. There is infinite need and finite demands and therefore we need to capitalise on what asset is already available within any given community.

Roundtable SCPHN Core participant, England

Influencing policy / influencing change

130. Having the knowledge and the ability to influence policies and influence change is an elevated level of practice and this sentiment is echoed by educators also. Having the confidence to challenge dominant discourses and utilising the information and evidence of a population in order to positively influence change or policies is an essential proficiency for SCPHN practitioners according to frontline practitioners and educators from England, Scotland and Wales.

131. I would like to see that [influencing policy] more explicitly stated as tackling health inequalities requires policy changes.

Health Visitor, Wales

Technology

132. Practitioners and educators in England and Wales discussed the use of technology in their practice. It was noted that data analytics, for example, can influence positive outcomes for the population and communities. The Coronavirus pandemic has meant that those in healthcare, as in other sectors, have had to adapt to virtual appointments and processes with some practitioners gaining greater contact with those in isolated or challenging areas. Face to face appointments however are still vital. Moving forward, technology is important to communication, record keeping, gathering data and identifying trends. One Health Visitor in England however commented on the difficulty of accessing organisations databases depending on whether they are part of the NHS or not.

There are still many struggles about organisations and their databases. When Health Visitor's and School Nurses were part of the NHS this was not a problem. It is hard for some areas to see and share records.

Health Visitor, England

5.1.2 Educators on SCPHN

Health informatics and epidemiology

133. One lecturer based in England stated that the knowledge and skills required to "understand data, [the] sources it arises from, interpretation, analysis and synthesis of what comes from that" is a core element across all three SCPHN areas of practice. According to a practitioner in Northern Ireland, the Coronavirus pandemic has demonstrated that epidemiology is important for the future of SCPHN practice.

134. Learning from Covid-19 we need to think more [about], and understand, epidemiology. The future is to know those skills.

Lead Children's Nurse, Northern Ireland

Numeracy skills

135. Educators from England and Wales stated that SCPHNs need to be able to demonstrate a good degree of numeracy skills. The Future Nurse curriculum requires that students demonstrate that they are numerate, therefore the SCPHN standards should include the ability to understand and utilise numeracy, especially if these advanced practitioners are required to independently prescribe to patients. One educator stated that numeracy is a key skill to looking at epidemiology health needs assessments.

136. Nurses need to understand mathematics, not just statistics. Using numeracy in SCPHN practice will impact the action SCPHNs can take.

Chair of Community Health, Wales

5.1.3 Employers on SCPHN

Integrated working

137. An employer based in Scotland felt that integrated working and working closely with other primary care teams was missing from the SCPHN discussions, claiming that integrated working is a critical factor for SCPHN practice. For example, SCPHN practitioners work closely with mental health and learning disabilities teams. They also highlighted the difference between England and Scotland as NHS Trusts in England are separated whereas they are integrated in Scotland.

138. I feel that there is a missing link around working with mental health and learning disabilities teams because it's a critical factor.

Deputy Nurse Director, Scotland

Value

139. Employers would like to see the SCPHN standards reflect the value of the courses and the value a SCPHN qualified specialist nurse brings to the community, service users and the workplace. Employers in England and Scotland feel that this has changed over time with the value of these courses been lost although this may be down to levels of funding and remuneration.

140. An issue that comes up constantly across the four countries, and with recent changes in England, has meant that people working in advanced practice roles, or practicing at that level of complexity, with the advent of generic Advanced Training Practice (ATP), have not been recognised or valued and that's come out very strongly with the modelling we did for Health Education England (HEE).

Chair of Healthcare and Workforce Modelling, England

5.2 SCPHN- Health Visiting (HV)

141. The following themes have been identified as specifically relevant to the SCPHN Health Visitor (HV) practitioner as discussed by attendees to the webinars, roundtable events and other engagement events. These events include:

SCPHN Webinar
SCPHN Health Visiting Webinar
SCPHN Roundtable with Health Visitors
SCPHN Programme Standards Meeting
SCPHN Prescribing meeting

142. In total 29 themes were identified during these webinars, roundtable events and other engagement events as being themes pertinent to Heath Visiting. Some of the themes are mentioned during several different events whereas other themes are more specific to a particular group of webinar or roundtable attendees based on their specialist knowledge and experience. In some instances, themes are discussed at great length, for example the prescribing theme received a staggering 94 comments revealing how important this topic is for Health Visitors. Other themes however received a small handful of comments but were just as relevant and pertinent to the analysis. Some other themes were less frequently mentioned or contained little detail. The 29 themes discussed in relation to Health Visiting practice are as follows:

Advanced communication skills (2)
Age profiles (9)
Assessment of the parent / infant relationship (3)
Breastfeeding / infant feeding (7)
Child protection (3)
Collaborative working (13)
Community (9)
Covid-19 (1)
Early life / First 1,000 days (5)
Family-centred (8)
Health (1)
Identifying vulnerable and high-risk patients (11)
Infant mental health (1)
Influencing policy / change (1)
Interdisciplinary working (1)
Leadership (1)
Life course (2)
Mental health (13)
New-born examinations (6)
Prescribing (94)
Safeguarding (28)
Scotland (2)
Social justice (3)
Solutions focussed (1)

Students (1)
Systems approach (3)
Technology (11)
Trauma informed practice (1)
Trusting relationships (7)

143. The following analysis provides a summary account of the most pertinent, unique themes to this area of practice and those themes that attracted a great deal of discussion. The thematic analysis is structured to show what themes were said by who – a practitioner, educator or stakeholder. Where it is known, the country is specified to determine similarities and differences of Health Visiting practice across the four nations.

5.2.1 Practitioners and stakeholders on Health Visiting

Age profiles

144. There were differing opinions from participants based in England, Scotland and Wales regarding the age profile of the population that come under the Health Visitors remit. Some participants from England and Wales were keen to see Health Visitors being educated in meeting the needs of all ages of the population whereas other participants based in England and Scotland were in favour of keeping the Health Visitor age profile focus on 0-5 year olds, but playing a significant role within the family. This would entail knowledge of adult health as well as child health in order to understand the importance of early childhood and how this impacts the child's life course. According to another participant, expanding the age profile for this role would dilute the impact Health Visitors have on children and families and therefore they did not believe that the Health Visitors remit includes the elderly population. Other participants commented on the positive impact Health Visitors have had on older patients.

145. Only focussing on 0-5-year olds does not future proof the standards.

Stakeholder, England

Breastfeeding / infant feeding

146. Breastfeeding / infant feeding was discussed by practitioners and educators based in England, Scotland and Wales. Participants in England and Wales stated infant feeding is key to the role of the Health Visitor as is supporting and encouraging mothers with breastfeeding / infant feeding and providing new mothers with post-partum care. A practitioner from Scotland stated that being able to independently prescribe would benefit the Health Visitor role and support infant feeding as they are the practitioners who undertake the feeding assessments. Independent prescribing would add to the Health Visitor's autonomous practice as they could prescribe, if needed, after conducting the assessment.

147. Infant feeding is key to the Health Visitor role and lasts for longer than in the midwifery field.

NHS Locality Nurse, Wales

Community

148. A community and population focussed approach to Health Visiting is important to practitioners. Being culturally aware, engaging with the local community and assessing the needs of the family at a community level as well as identifying and reducing inequalities in a community are all important skills required of a Health Visitor. Practitioners from Northern Ireland and Wales emphasised the public health needs of the community focussing on families and the pre-school population and believe this should be reflected in the standards. A Community Prescriber based in Scotland claims that their prescribing ability is appreciated by service users in their community. Another Scottish participant noted that people are disengaging from their communities and Health Visitors are in a position to try and improve community engagement.

149. If you are working in advanced practice, then communities and [the] people you're working with should feel like they're in control of their own health and wellbeing. It's [about] using that skill at [an] advanced level.

Health Visitor, Northern Ireland

150. We're front line and we need to improve that independence in the community, work with families and build community insight for their children.

Practitioner, Scotland

Early life / First 1,000 Days

151. Being part of a child and parent's life from pregnancy to post-natal care, building a relationship with the family and assessing against the determinants of health is a unique and important aspect of the Health Visitor role according to practitioners in England and Scotland. The First 1,000 Days and the Solihull Approach are considered important programmes to the Health Visitor role and some practitioners feel this needs to be reflected in the standards.

152. Really getting in there in the early stages helps to reinforce the role that we're there for them and their needs.

Health Visitor, England

Family-centred

153. Health Visitors are family-centred practitioners who see the whole extended family, not just the child under 5 years old. They educate family members in their homes, establish trusting relationships and they can improve child health by working with parents and other family members by supporting and influencing the decisions they make and providing alternatives based on the family's circumstances.

154. We are unique because we're advocates for the patients and we provide practical health education in the home. Very often you've got young mums who are isolated and haven't got anybody to give them basic support. We are uniquely placed.

Health Visitor, England

Identifying vulnerable and high-risk families / persons

155. Participants in England and Scotland agree that Health Visitors are in a unique position to identify vulnerable and high-risk families, emphasising that anyone or any family can quickly become vulnerable. Those persons or families who are, or become, vulnerable or high risk may not have access to other support systems and Health Visitors are uniquely placed to be that individual they can turn to. A lecturer from England explained that being vulnerable means a person or family can be invisible, thus skills in "proactivity and searching for health needs" is an important requirement of Health Visitors for public benefit.

Mental health

156. Practitioners and educators based in England, Scotland and Wales believe that greater understanding of mental health is needed in the standards. This should include the mental health of the mother, other family members and infant mental health too.

Technology

157. Stakeholders and educators from England, Scotland and Wales commented positively on the use of technology and that it can enhance the profession although there was a strong emphasis from practitioners that technology should not replace face to face contact with service users. It is felt that using and driving technology will improve communication, understanding the profile of families and track progress.

158. The children on our caseloads are our parents of the future and they are IT literate at an early age. We need to evolve how we deliver health promotion to continue reaching clients in ways that they find convenient and acceptable to ensure the biggest reach.

Health Visitor, Scotland

5.2.2 Educators on Health Visiting

Breastfeeding / infant feeding

159. Educators in England and Wales echoed the importance of breastfeeding and infant feeding and believe it should feature more prominently in the Health Visitor standards. One lecturer in England stated that breastfeeding especially should have a focus with all the SCPHN areas of practice for breastfeeding is a "massive poverty equaliser" and is a topic that all SCPHNs should be aware of.

Community

160. A lecturer based in Scotland believes that Health Visitors can be "community-based health promotors" providing a service to populations that are currently unidentified. This is because many

people do not have access to health promotion services unless they become unwell or reach a certain age. They explained that the majority of health promotion and disease prevention services in the community are based around GP patient populations, however Health Visitors could engage with those community members who are missing out on vital health information.

161. I believe we need community-based health promoters that can work with community development and identify high-risk populations that are currently not catered for. When I qualified many years ago, I had a geographic caseload and therefore [I was] able to target at risk groups.

Lecturer, Scotland

5.3 SCPHN- Occupational Health Nursing (OHN)

162. The following themes have been identified as specifically relevant to the SCPHN Occupational Health Nurse (OHN) practitioner as discussed by attendees to the webinars, roundtable events and other engagement events. These events include:

SCPHN Webinar
SCPHN Occupational Health Nursing Webinar
SCPHN Roundtable with Occupational Health Nurses
SCPHN Prescribing Meeting
SCPHN Core Follow up Roundtable

163. In total 43 themes were identified during these webinars, roundtable events and other engagement events as being themes pertinent to Occupational Health Nursing. Some of the themes are mentioned during several different events whereas other themes are more specific to a particular group of webinar or roundtable attendees based on their specialist knowledge and experience. In some instances, themes are discussed at great length whereas other themes are less frequently mentioned or contain little detail. The 43 themes discussed in relation to the Occupational Health Nurse practitioner are as follows:

Alternative training routes (7)
Autonomous practice (1)
Biopsychosocial model (3)
Business and commercial acumen (21)
Clarity of roles (2)
Collaborative Working (2)
Commissioners (1)
Communication (1)
Coronavirus (8)
Disabilities (3)
Education (3)

Employer buy-in (1)
Employer understanding role (11)
Employment (8)
Enabling patients (1)
Experience (1)
Fit notes (3)
Funding (3)
Health and safety (3)
Holistic care (1)
Immunisations (1)
Influencing skills (8)
Interdisciplinary working (1)
Lack of work-related experience (8)
Leadership (5)
Legal frameworks and legislation (7)
Long term conditions (2)
Mental health (10)
Mentorship (2)
Multidisciplinary working (4)
Occupational hygiene (2)
Placements (1)
Prescribing (15)
Prevention (4)
Private providers (2)
Public health (14)
Research
Risk assessments (2)
Safeguarding (4)
Single-handed practitioners (1)
Surveillance (1)
Training courses and practice teachers (14)
Work environment (3)

164. The following analysis provides a summary account of the most pertinent, unique themes to this area of practice and those themes that attracted a great deal of discussion. The thematic analysis is structured to show what themes were said by who – a practitioner, educator or stakeholder. Where it is known, the country is specified to determine similarities and differences of Occupational Health Nursing practice across the four nations.

5.3.1 Practitioners and stakeholders on Occupational Health Nursing

Business and commercial acumen

165. Improving business and commercial acumen was a popular discussion point for practitioners in England and Scotland who would like to see this integrated into the standards. Occupational Health Nurses need to understand how businesses are run, create business cases for service development through co-production and have the skills to work with multiple stakeholders. The ability to influence management whilst instilling a public health focus into the workplace and supporting employees is also important. Understanding business and commercial acumen is critical for Occupational Health Nurses according to those based in England, as many roles are outside of the NHS and in the private sector.

166. Occupational Health Nurses need to be able to understand the risk profile of businesses and base their practice on legal must, should and could.

Webinar participant, Scotland

167. I completely agree that business acumen is essential as many Occupational Health roles are outside of the NHS. Contract management, project management and presentation skills are all a major part of my role and suggest these are integral to training / development.

Practitioner, England

Influencing skills

168. Influencing managers, employees and decisions is considered an important skill to this area of practice. Influencing skills links to commercial acumen and how the practitioner communicates, and builds relationships, with managers and HR leaders. One practitioner in England noted that single-handed practitioners require advanced influencing skills as they are usually visiting SMEs running on minimal budgets and are sometimes influencing companies to meet the minimum occupational health and safety standards. This differs to Occupational Health Nurses who work in larger companies.

169. Younger people aren't staying in one organisation for their whole career, they are moving around. So much has changed, and I think you need to have influencing skills to embrace and facilitate change.

Occupational Health Manager, Northern Ireland

170. Influencing employers to see the value of having competent and appropriately trained nurses is important. My concern is that employers can hire people cheaply and that doesn't mean they're giving the best service so we have to influence the employer, because if we never raise the bar then we'll never raise the importance of why you need Occupational Health Nurses in businesses.

Head of Occupational Health and Wellbeing, England

Lack of work-related experience

171. Participants commented on the lack of work-related or practical experience for students which becomes evident once the student finds employment. Gaining more practice-based experience during

the course would benefit those who are qualifying as specialist practitioners and this should be accounted for when developing the programme standards.

Legal frameworks and legislation

172. Practitioners and some educators based in England stated that knowledge and understanding of relevant legal frameworks and legislation is paramount to advanced practice in this profession and thus needs to be reflected in the standards. According to these practitioners the Occupational Health speciality is broader than the other two SCPHN areas of practice standards as they cover a wide spectrum of legislation. Knowledge of Employment Law, Infection Protection and Control (IPC), Health and Safety Executive Law, Occupational Health Law and the Equality Act 2010 were cited as areas of legislation Occupational Health Nurses will require in their role. One practitioner from England added that knowledge of the Mental Capacity Act is also very important.

173. The Occupational Health role has a lot of integration with the management, therefore, besides the basic qualifications in Occupational Health Nursing, one must know about risk assessment, HSE Law, Occupational Health Law and Employment Law, [and] EQA 2010 (Disability) to practise effectively.

Practitioner

Mental health

174. Mental health is currently a large part of the Occupational Health Nurse's workload according to practitioners and stakeholders in England and Northern Ireland, and they do not see this changing in the future. Coronavirus is cited as a major contributing factor to negatively impacting employee's mental health moving forward, as well as other stressors such as work or home related issues. Practitioners in England said they are trying to educate their employer's understanding of mental health which should be viewed equally to physical health.

175. More mental health training will be required – it is the majority of our workloads.

Practitioner, Northern Ireland

Accessibility of training courses and practice teachers

176. Accessibility of courses and practice teachers and the lack thereof received 11 comments from all four nations. The comments reiterated concerns relating to a lack of skilled practice teachers in Occupational Health and practice placements (particularly in private sector organisations), a lack of access to SCPHN Occupational Health Nursing courses (especially in Northern Ireland), and a lack of training for nurses who may be interested in pursuing a career in this area of practice. The latter correlates to the declining number of SCPHN qualified Occupational Health Nurses according to one attendee. Participants claim more needs to be done to support this profession when undertaking the course to ensure that access to practice teachers and placements is improved.

177. I'm worried about the lack of practice teachers and training nurses for [the] future.

Webinar participant, Scotland

178. Is there intent to change the SCPHN qualification? I am from Northern Ireland; there is no Occupational Health course offered here.

Webinar participant, Northern Ireland

Understanding the role

179. Practitioners and stakeholders in England and Northern Ireland state that many employers, GPs and other nursing professionals do not entirely understand the role of the Occupational Health Nurse. Some practitioners in England claim it is down to the Occupational Health Nurse to educate their employers and business leaders and explain how they benefit the workforce. There is a general awareness and understanding of this role within the NHS, but employers usually do not know the Code or the remit of the specialist Occupational Health Nurse. Thereby those working in this profession will need to be prepared to succinctly educate non-practitioners about their role and the advanced level of practice they deliver.

180. It is difficult for managers to know what the standards are that you are working to, but this is about educating and demonstrating the standards to them to show what they should be expecting.

Occupational Health Nurse, England

Work environment

181. A unique aspect of the Occupational Health Nurse is that they focus significantly on how the work environment impacts physical and mental health and the behaviours of workers. The Coronavirus crisis has impacted how people work and many workers across the UK may have to permanently adapt to working from home or different settings. Occupational Health Nurses therefore will need to be equipped with how to deal with the challenges this presents in order to support workers physical and mental health outside the conventional work environment.

182. The flexible work environment may well become an important factor of working life. We will need to consider the impacts of this [working from home] and how we can promote and protect health in that environment, which is likely to be quite unique.

Occupational Health Nurse, England

5.3.2 Educators on Occupational Health Nursing

Fit notes

183. The topic of fit notes was mentioned a number of times with practitioners and educators in England stating that writing fit notes would enhance the role of the Occupational Health Nurse. This ability will also help people stay in work or get back to work. Occupational Health Nurses understand the

working environment and can deliver the care to effectively manage people back to their workplaces safely.

184. I think the way to sell ourselves is taking on the skills employers truly need … [fit notes] is a fantastic opportunity because Occupational Health Nurses know exactly what organisations can do to support that individual back to work – not the GP because they don't know what we know working in Occupation Health. I'd like to see this brought in.

Nurse Tutor, England

Health and safety

185. Educators in England and Northern Ireland suggested the NEBOSH certificate, or a certificate similar, be incorporated into the Occupational Health Nursing course. Conversely other academics and educators in England were against this approach claiming the course needed to supply the student with in-depth knowledge and principles pertaining to health and safety management.

186. Being able to speak about health and safety appropriately and to speak the language of others in the team, including health and safety practitioners, is important.

Professor, England

Single-handed practitioners

187. An educator in England felt that more consideration was needed for single-handed practitioners. These practitioners are engaging with poorer communities and lower paid employees working in SMEs rather than larger companies with bigger budgets. Single-handed practitioners are working autonomously and not within a team therefore their goals may vary when compared to other Occupational Health Nurses who are employed by larger organisations. The wording of the standards will need to reflect the work of single-handed practitioners to ensure the requirements of their role are catered for.

5.4 SCPHN- School Nursing (SN)

188. The following themes have been identified as specifically relevant to the SCPHN School Nurse (SN) practitioner as discussed by attendees to the webinars, roundtable events and other engagement events. These events include:

SCPHN Webinar
SCPHN School Nursing Webinar
SCPHN Roundtable with School Nurses
SCPHN Prescribing Meeting
SCPHN Core Follow up Roundtable

189. In total 35 themes were identified during these webinars, roundtable events and other engagement events as being themes pertinent to School Nursing. Some of the themes are mentioned during several different discussions whereas other themes are more specific to a particular group of webinar or roundtable attendees based on their specialist knowledge and experience. In some instances, themes are discussed at great length whereas other themes are less frequently mentioned or contain little detail. The 35 themes discussed in relation to the School Nurse practitioner are as follows:

Adolescence (8)
Advanced communication skills (2)
Adverse Childhood Experiences (ACE) (4)
Age profiles (16)
Biopsychosocial model (2)
Clarity of roles (3)
Commissioners (4)
Community (5)
Confidentiality (2)
Consistency (23)
Contraception and sexual health (10)
Co-production (7)
Education (1)
Emotional health and wellbeing (4)
Empowering (6)
Family (3)
Gender orientation support (1)
Hard to reach individuals (4)
Immunisations (6)
Interdisciplinary working (1)
Leadership (6)
Life course (3)
Mental health (1)
Motivational Interviewing (1)
Prescribing (31)
Professional curiosity (1)
Safeguarding (11)
School Nursing (9)
SEND (6)
Sexual health (2)
Social media and digital technology (5)
Transition services (1)
Visibility (13)
Young carers (1)
Youth violence (1)

190. The following analysis provides a summary account of the most pertinent, unique themes to this area of practice and those themes that attracted a great deal of discussion. The thematic analysis is

structured to show what themes were said by who – a practitioner, educator or stakeholder. Where it is known, the country is specified to determine similarities and differences of School Nursing practice across the four nations.

5.4.1 Practitioners and stakeholders on School Nursing

Adverse Childhood Experiences (ACEs)

191. There are sometimes misconceived ideas of the School Nurse being a 'nit nurse' and there to administer paracetamol when required however School Nurses are increasingly supporting children and young people who have been affected by Adverse Childhood Experiences (ACEs). A School Nurse in Scotland states that the majority of their role focusses on dealing with children and young people with ACEs and others agreed that knowledge of ACEs needed greater prominence within the School Nurse standards as it is different to safeguarding.

Age profiles

192. Determining the age profiles of the children and young people who come under the remit of the School Nurse varies across the four nations. Other factors are considered such as children and young people with special educational needs and those who have been in the care system. Age profiles also seemed to vary locally across the nations.
Practitioners from England state that they work with children from five to 19 years old, unless someone has a learning disability then they can be seen by a School Nurse up to the age of 24 or 25 years (depending on locality). Children who start school at four years old also come under the care of the School Nurse. Some practitioners in England say that they do not see a role for the School Nurse for those over the age of 19, particularly considering the small number of School Nurses on the register. Others are developing 0-19 services in their local areas.

193. In Suffolk, [the] Local Authority [is] very much working on the up to 25-year olds for those with Special Educational Needs (SEND), but at the moment public health commissioning [is] up to 19 year olds.

School Nurse webinar participant, England

194. Participants from Northern Ireland and Scotland claims work with children from 0-24 or 25 years taking into consideration those with learning disabilities or those who have been in care. In Northern Ireland they also take into account young adults living at home with parents due to external pressures and the cost of living. Children with learning disabilities in Scotland can remain in education up to the age of 19 years old. A School Nurse from Wales claims that the target age group of children and young people needs to be clarified and School Nurses should align their service to that target age group.

195. Age 0-24 - the impact of what has happened with children from conception has such an impact on their life course.

School Nurse, Northern Ireland

196. [The age profile should be] 5-19 years old. I feel if it's up to 25, then that is not [for a] School Nurse.

School Nurse, Scotland

Consistency

197. School Nurses from England, Scotland and Wales commented on the differing levels of consistency of the service depending on locality and what they are commissioned to undertake. According to a practitioner from Scotland this is because different job titles are being used and people expect different things from the School Nurse. Ensuring School Nurses are doing the same thing will be important when protecting children moving from one country to another as responsibilities and roles will be the same across the borders. Some School Nurses explained that their roles vary depending on their area with some nurses focussing on safeguarding whilst others focus on other matters.

198. The vision for the School Nurse is everyone doing the same thing. Everything is so mixed up with different titles and expectations.

School Nurse, Scotland

199. It's difficult as it depends on what you are commissioned to provide. There are some things mentioned on the School Nurse word cloud that some of us are not commissioned to do.

School Nurse, England

Community

200. For the School Nurse, community means several things depending on the community one is situated in. School Nurses and educators in Scotland were mindful of children and young people living in rural and remote areas and the specific challenges this presents when providing a service for young people. A School Nurse based in England is focusing on the services needed in their local community, not the whole local authority, and have therefore established local community hubs.

201. Working in partnership with the voluntary sector has to be the way forward especially in the more rural communities.

School Nurse, Scotland

Contraception and sexual health

202. School Nurses have differing opinions on whether they should be prescribing medication to children and young people, however prescribing contraception was viewed as essential to some practitioners. Prescribing contraception is important because they are providing young people with the sexual health services they need without needing to refer to a GP. School Nurses in England explained that Patient Group Directions (PGDs) will enable emergency contraception to be given to young people, with one School Nurse stating that contraception is the most frequently requested service from young people in their area.

203. School Nurses in Scotland and Wales however are mindful of the rural populations they serve and the difficulty these locations pose to young people who need emergency contraception. Being able to prescribe contraception in these instances would benefit the young person greatly for they won't have to travel a sexual health clinic or GP surgery in another area. Apart from prescribing contraception, School Nurses are however unsure what else they would need to prescribe for young people.

204. I'm a prescriber because I did it on my SCPHN course and I've never used it. However, with sexual health, particularly for rural areas like ours where young people aren't able to access the morning after pill, we are now looking to prescribe this.

School Nurse and Community Practice Teacher, Wales

Mental health, emotional health and wellbeing

205. Wellbeing is simultaneously linked to both mental health and emotional health and School Nurses believe this topic will be significantly more important to the profession in the future as it is becoming a more frequent issue in their day to day practice. School Nurses in England are already incorporating wellbeing into their service.

206. We've introduced a year six wellbeing session to look at "universal" delivery of emotional literacy, wellbeing and building some understanding and resilience [there].

SCPHN School Nurse, England

207. School Nurses need to be equipped with the tools to recognise when a child or young person is encountering issues that are causing emotional or mental distress and be able to offer support. A School Nurse in England however feels that their practice is being overwhelmed by mental health issues and they feel that this role should focus on a child's physical health only.

Social media and digital technology

208. Offering advice digitally or seeing children and young people via digital technology should be developed for the role of the School Nurse, according to some practitioners in England. Young people are expert navigators of social media thus School Nurses may need to broaden their approach in order to interact and respond with families in an effective way.

209. With regards to technology and social media, maybe consider virtual clinics to speak to hard to reach cohorts of young people.

School Nurse webinar participant, England

5.4.2 Educators on School Nursing

Adolescence

210. School Nurses regularly support adolescents who are going through what can be a confusing and difficult stage in their development to adulthood. Educators emphasise that School Nurses need to

communicate effectively with adolescents and become a trusted source of information. It is important that a School Nurse is an advocate of how to use the health service in an adolescent's later life and they should help prepare and empower them for adulthood. Knowledge of teenage brain development, early attachment, and ACEs were cited as important areas School Nurses should have knowledge of as well as national themes and evidence pertinent to their local population.

211. There is little mention [so far] of adolescence as a distinct stage of the life span development. Some of the feedback from young people has specifically identified that they want people with the right skills and the right communication skills to be able to liaise with them. This is very important.

Senior Lecturer, England

Empowerment

212. Educators and practitioners alike across England and Scotland stated it is part of the School Nurse role to empower children, young people and their families. Promoting healthy relationships and working with young people to prepare them for adulthood is important to this role.

Immunisations

213. Immunisations was a pertinent subject given the recent Coronavirus pandemic and what this holds for the future School Nurse role. A School Nurse in Scotland stated that all immunisations are delivered by a special immunisations team and therefore School Nurses do not take part in the programme. An educator in England however highlighted that immunisations are part of the public health role and School Nurses may need to be prepared for this especially considering new viral infections.

214. I recognise delivering immunisations as important to the public health role and it raises the profile of the School Nurse. It also gives us greater access to young people but given the number of School Nurses and school aged children, School Nurses could spend a whole year doing vaccines just in England.

Senior Lecturer and Pathway Lead for SCPHN School Nursing, England

6. Specialist Practice Qualification (SPQ)

6.1 SPQ General themes and discussions

215. The following themes have been identified as specifically relevant to the Specialist Practice Qualification (SPQ) as discussed by attendees to the webinars, roundtable events and other engagement events. These events include:

SPQ Webinar

SPQ Follow up Roundtable: Frontline Practitioners
Additional SPQ Roundtable Discussion
Additional SPQ Roundtable Discussion Session (with QNI and BME nurses)
SPQ IDG 2
SPQ IDG 3

216. In total 36 themes were identified during these webinars, roundtable events and other engagement events as being themes pertinent to SPQ practice. Some of the themes are mentioned during several different events whereas other themes are more specific to a particular group of webinar or roundtable attendees based on their specialist knowledge and experience. In some instances, themes are discussed at great length whereas other themes are less frequently mentioned or contain little detail. The 36 themes discussed in relation to SPQ are as follows:

Advanced communication skills (3)
Advanced practice (3)
Advocacy (1)
Apprenticeships (5)
Autonomous practice (2)
Broad vs specific standards (15)
Community (4)
Community matrons (5)
Community nursing (12)
Complexity (3)
Coronavirus (3)
Employer buy-in (1)
Frailty (8)
Holistic assessment (3)
Influencing skills (2)
Language / terminology (4)
Leadership (6)
Motivational Interviewing (2)
Organisations' understanding of SPQ (3)
Other qualifications (1)
Patients with learning disabilities (2)
Political awareness and navigating the system (1)
Positive Behaviour Support (PBS) (1)
Prescribing (35)
Public health (7)
Public protection (1)
Qualifications (3)
Regulation (8)
Research (1)
Safeguarding (2)
Self-care (2)
Self-management and self-care (4)

Specialist Learning Disabilities nurses (3)
SPQ courses (9)
Technology (6)
Training – Core competencies vs specialist learning (16)

217. The following analysis provides a summary account of the most pertinent, unique themes to this area of practice and those themes that attracted a great deal of discussion. The thematic analysis is structured to show what themes were said by who – a practitioner, educator or stakeholder. Where it is known, the country is specified to determine similarities and differences of SPQ practice across the four countries.

6.1.1 Practitioners and stakeholders on SPQ

Broad vs specific standards

218. There were differing views by participants in England on whether the NMC should develop fairly broad or specific standards for the five community nursing SPQs. A Community Children's Nurse saw the benefit of having broad standards as some of the specialisms overlap. Other were more cautious as the training and expectations are very different even though there are areas that cover more than one specialism.

219. There are definitely pathways where we should be working together but I want to give a word of caution as the expectations of each role are so different.

Deputy Director for Hospitals, Mental Health and Learning Disabilities, England

Frailty

220. Frailty is a condition that should be recognised by all SPQ nurses as frailty does not just affect older members of the population. SPQ nurses should look beyond the stereotypical association that older people are or will become frail and recognise that young people too can become frail due to a complex physical or mental illness. Frailty is not limited by age yet the term itself is not commonly used within community children's nursing currently therefore the standards should highlight the skills required to recognise this condition in all areas of SPQ practice and across the life course.

221. Frailty is separate [from dementia] as this can affect all ages, children with complex needs, people with eating disorders, people with learning disabilities and mental health as well as the older population, and the list goes on.

Deputy Director for Hospitals, Mental Health and Learning Disabilities, England

Self-care and self-management

222. Although the topic of self-care isn't relatively new it is still very welcomed by practitioners, educators and stakeholders. Self-care and self-management links to the public health agenda. Where patients are neglecting their health and wellbeing SPQ nurses require the skills to encourage, educate and support patients to incorporate self-care and self-management strategies into their lives. One

District Nurse practitioner highlighted that public health will vary across the four nations and within countries and SPQ nurses require the skills to recognise this agenda and implement change to improve health outcomes. Interestingly, a participant stated that the Coronavirus pandemic demonstrated that people could practice self-care and self-management when needed.

223. One key focus of the new programme needs to be enabling and promoting self-management and self-care. One thing we have learned during lockdown is that patients are willing to self-care when they can, and we must not lose this.

SPQ Practitioner

Technology

224. The Coronavirus pandemic and subsequent lockdown across the UK necessitated a swift move to utilising technology to keep in contact with patients and conduct digital consultations. Practitioners believe that using technology will be a future requirement of the SPQ nurse and should be acknowledged in the standards. There were concerns from those working within mental health and learning disabilities services who emphasised the importance of regular face to face consultations as these provide opportunities to recognise if an individual is displaying behaviours that cannot be picked up through technology, for example, if someone smells of alcohol. Social media was a useful platform to contact individuals with learning disabilities when practitioners were unable to visit them during lockdown.

225. In our area we have a digital health team within care homes who have done assessments through Skype and it's worked really well and prevented hospital admissions so it's whether we can build on something like that to benefit patients.

District Nurse Practice Educator, England

6.1.2 Educators on SPQ

Broad vs specific standards

226. An educator from England was in favour of keeping the standards fairly broad in order to make the programme student specific. Another educator from England however highlighted that if SPQ nurses have the V300 prescribing qualification then they will need an advanced level of expertise when prescribing in a certain area of specialism.

227. If the standards are broader, we can get students to do it specifically for their area needs.

Course Co-ordinator, England

228. Other educators based in England and Northern Ireland emphasised the different specialisms of SPQ practice claiming, "there cannot be a one size fits all approach". It was suggested that a set of core common standards for community SPQ could be developed. This would mean students will have a

shared curriculum, and then a specific set of standards for each SPQ area of practice resulting in a specific curriculum for that area supported in turn by specific skills.

229. There are common modules across SPQ pathways but what a District Nursing student may require (at a clinical level) differs from that of another SPQ student on a different programme.

Lecturer, Northern Ireland

6.2 SPQ - Community Children's Nursing (CCN)

230. The following themes have been identified as specifically relevant to the SPQ Community Children's Nursing (CCN) practitioner as discussed by attendees to the webinars, roundtable events and other engagement events. These events include:

SPQ Webinar Community Children's Nursing
SPQ 5X Specialism Discussion: Community Children's Nursing
Additional SPQ Roundtable Discussion Session (with QNI and BME nurses)

231. In total 26 themes were identified during these webinars, roundtable events and other engagement events as being themes pertinent to Community Children's Nursing. Some of the themes are mentioned during several different events whereas other themes are more specific to a particular group of webinar attendees based on their specialist knowledge and experience. In some instances, themes are discussed at great length whereas other themes are less frequently mentioned and contain little detail. The 26 themes discussed in relation to the SPQ Community Children's Nurse practitioner are as follows:

Acute and short-term conditions (2)
Advanced Communication skills (4)
Advocacy / empowering (1)
Assent vs consent (1)
Assessments (1)
Biopsychosocial model (1)
Broad or specific standards (1)
Collaborative working (8)
Complex and life limiting conditions (1)
Confidence (1)
Diagnosis (1)
Differential diagnosis (3)
Educating others (5)
Education (1)
Impact (2)
Leadership (1)
Negotiating skills (1)
Prescribing (2)
Prevention (1)

Quality Improvement (QI) (2)
Recognising a deteriorating child (3)
Safeguarding (2)
Special Educational Needs and Disabilities (SEND) (1)
Technology (1)
Transition services (2)
Value (1)

232. The following analysis provides a summary account of the most pertinent, unique themes to this area of practice and those themes that attracted a lot of detailed discussion. The thematic analysis is structured to show what themes were said by who – a practitioner, educator or stakeholder. Where it is known, the country is specified to determine similarities and differences of Community Children's Nursing practice across the four nations.

6.2.1 Practitioners and stakeholders on Community Children's Nursing

Differential diagnosis

233. Practitioners from England and Scotland stated differential diagnosis is a key and significant skill to Community Children's Nursing. Differential diagnosis is only mentioned again briefly during a District Nursing discussion. In order to futureproof this profession, Community Children's Nurses need the skills and knowledge to use differential diagnosis in order to assess what problems the child or young person is displaying and conduct physical examinations. They may also need to prescribe, if required, to keep the child or young person out of hospital. A Consultant Nurse in England believes that children's nursing teams in universities should work alongside children's nursing teams in the communities to establish those senior level skills.

234. To futureproof Community Children's Nursing, enable services and to ensure that we can facilitate early discharge and keep children at home, Community Children's Nursing education needs to include independent prescribing and differential diagnosis.

Team Leader Community Children's Nursing, Scotland

Educating others

235. A diverse and important skill pertinent to this role is educating parents, carers and family members with the skills required to care for their child in the home. They will need to have the confidence to educate, supervise and enable family members to use clinical skills in order to care for children with acute or complex health needs as well as those needing end of life care. Practitioners from England, Scotland and Wales all agreed that this is a unique skill required of Community Children's Nurses – utilising their advanced clinical skills and imparting the knowledge and skills to others to enable them to provide care for the child.

236. Our roles as children's nurses is to educate and enable rather than deliver all and that's important.

Nurse Consultant in Child Health, Wales

Recognising a deteriorating child

237. Three practitioners from Wales presented a unique and critical skill applicable to the Community Children's Nurse practitioner of the future – recognising a deteriorating child. This may be a subject area only taught at universities in Wales as this was not discussed by practitioners from England, Northern Ireland or Scotland, however it is an important area that deserves further enquiry as to whether this is incorporated into the standards. One practitioner feels there is a gap between the skills relating to physical assessments and recognising when a child is deteriorating, and this skillset should be brought together and strengthened in the standards.

238. Recognition of the deteriorating child is an important development needed for the future particularly in relation to early discharge and hospital avoidance.

Senior Community Children's Nurse, Wales

Other comments

239. Four general comments and questions arose during the SPQ Community Children's Nursing Webinar that did not exclusively fit into the other themes. One questioned the difference between this role and Health Visiting, another comment approved of the identified themes, a separate comment was about current students and the fourth comment related to a past project regarding the programmes.

240. The decline in numbers of commissions is a real challenge, but we have managed to reverse this trend this year at our University. We have 10 students [who] commenced this week, with 5 scheduled to join in January. But this has demanded Herculean efforts to apply 'pressure' in the system both with HEE (EoE) and with CCN Teams/Provider Services.

Consultant Nurse, England

241. Back in the days of Project 2000 there was an idea that at pre-registration level, rather than the then common foundation programme and 4 different branches of nursing, children's nurses could train as a common foundation with others working with children, e.g. teachers, those in early years, etc. and then the branches would be children's nursing, teaching etc. So rather than SPQ as 'we know it', should something similar be considered? That is the common foundation programme, but the specialist for children working with others who work with children, social workers.

Associate Lecturer, England

242. We are already struggling with only four HEIs currently running the CCN SPQ, what sense do you have of these changes bringing more 'traction' to encourage more HEIs to offer programmes which include specific standards that would be relevant for CCNs?

Consultant Nurse, England

6.3 SPQ - District Nursing

243. The following themes have been identified as specifically relevant to the SPQ District Nurse (DN) practitioner as discussed by attendees to the webinars, roundtable events and other engagement events. These events include:

SPQ Webinar
SPQ Webinar District Nursing
SPQ 5X Specialism Discussion: District Nursing
SPQ Follow up Roundtable: Frontline Practitioners
Additional SPQ Roundtable Discussion Session (with QNI and BME nurses)

244. In total 43 themes were identified during these webinars, roundtable events and other engagement events as being themes pertinent to District Nursing. Some of the themes are mentioned during several different events whereas other themes are more specific to a particular group of webinar or roundtable attendees based on their specialist knowledge and experience. In some instances, themes are discussed at great length whereas other themes are less frequently mentioned or contain little detail. The 43 themes discussed in relation to the SPQ District Nurse practitioner are as follows:

Advanced communication skills (6)
Advanced practice (1)
Age profiles (7)
Apprenticeships (3)
Assessing for others (1)
Assessments (2)
Autonomous practice (2)
Care planning (1)
Community (2)
Complex care (6)
Confidence (2)
Coronavirus (2)
Decision making (2)
Diagnosis (1)
Differential diagnosis (1)
Digital competency (1)
Educating others (5)
Education (8)
Empowering (1)
End of life care (4)
Environment (8)
Evidence based practice (1)
Frailty (2)
Future focussed (1)
Influencing skills (1)
Inherited disorders (1)

Integrated system / working (1)
Leadership (15)
Lone working (1)
Lynchpin (4)
Managing caseloads (10)
Managing teams (10)
Negotiation skills (2)
Physical examinations (1)
Prescribing (9)
Public health (6)
Regulation (1)
Relationship management (2)
Research (1)
Risk (11)
Safeguarding (4)
Self-management and self-care (3)
Systems thinking (1)

245. The following analysis provides a summary account of the most pertinent, unique themes to this area of practice and those themes that attracted a great deal of discussion. The thematic analysis is structured to show what themes were said by who – a practitioner, educator or stakeholder. Where it is known, the country is specified to determine similarities and differences of District Nursing practice across the four nations.

6.3.1 Practitioners and stakeholders on District Nursing

Age profiles

246. In some areas of England District Nurses do not work with patients under the age of 18 years, this is because some areas have a local Community Children's Nursing service. However, a practitioner from Scotland may treat patients from five to 100 years of age. A practitioner from Northern Ireland claims that the age profile varies depending on the local area District Nurses serve. Although there does not appear to be a particular age profile for this role one practitioner in England would like to see a specific age range limit introduced for this service and for it to be consistent across the board.

247. It varies from place to place so it is difficult to pin down an age for District Nursing as from my experience we work with all age groups.

Practice Education Co-ordinator, Northern Ireland

Environment

248. Both practitioners and educators in England highlighted that District Nurses work in complex and changing environments. During their education student practitioners should be made aware of the challenges this poses and the challenges that arise when treating a patient in the home. It was also

noted that during advanced clinical physical assessments District Nurses assess the impact of the patient's environment as well as other social and psychological factors. Hence, the theme of environment alludes to assessing the environment that the patient lives in and being aware of the challenges that occur when delivering care in different environments which often offers a different level of complexity to the service. Many District Nurses work alone which can add to the level of complexity.

249. Making sure the wider influences that may impact care are acknowledged throughout training, how this is being delivered and being in the home environment which is different to how District Nurses deliver other elements of care.

Clinical Service Development Lead – District Nursing, England

Managing caseloads

250. Managing complex, dynamic and changing caseloads was cited during three different online events as an advanced skill required of a District Nurse, more so than any other SPQ nursing role. Practitioners, mainly from England and Scotland, commented on the large volume of caseloads with a high level of risk that District Nurses need to manage, whilst also managing changing priorities and having the underpinning knowledge of the patient's needs. However, a Lead Practitioner in England stated that senior District Nurses in their area do not have the underpinning theories or standards required relating to caseload management, indicating that this knowledge varies across the UK and should be integrated into the standards to ensure quality and consistency.

251. The balance of care has definitely shifted to community in our area, but community doesn't have a maximum capacity like a ward and managing these increased caseloads are a challenge to the leadership and management of the teams by the SPQ District Nurses.

Lead Nurse Community Nursing, Scotland

Managing teams

252. Managing teams across multiple locations is a specific skill pertinent to the District Nurse, more so than other SPQ roles. It was requested that the standards clearly define the challenges that come with managing large teams of people with different qualifications and skill sets and the risks that come with that.

253. Today you might have one [District Nurse] managing 10 or 20 newly qualified band four or five nurses. You're talking about managing a high level of risk and complexity with a highly skilled mixed team.

Senior Matron for Community Nursing, England

Risk

254. Managing risk is a key skill required of District Nurses according by both practitioners and educators based in England and Scotland. Risk management links to other advanced skills such as relationship management with the patient, identifying risks and having the confidence to "stand back

and allow a higher level of risk". One practitioner in England noted that the theme of risk also includes risks relating to a lack of funding, agency and bank nurses and managing teams with a mixed skill set.

255. Balancing risk is even more prevalent at present with Covid-19.

Lead Nurse Community Nursing, Scotland

6.3.2 Educators on District Nursing

Complex care

256. Managing complex care is a specific skill concerning District Nurses. For one educator in Scotland this means making important objective referrals and clinical decisions for highly complex patients. This is reiterated by an educator in England. They explain that complex care in relation is also about delegating complex care for others to lone work safely whilst delivering care, assessing the impact of the environment, social and psychological factors and conducting advanced clinical physical assessments.

257. For District Nursing complexity is about different homes and managing and responding to different environments.

Senior Lecturer, England

Educating others

258. Educating others is an extremely important skill for District Nurses. District Nurses require confidence and the advanced skills to educate and enable service users, carers, students and other nursing staff within their team to perform complex health care interventions.

District Nurse title

259. Educators in England and Scotland feel strongly about retaining the District Nurse title as a registered qualification as it is an area of practice that brings with it a level of public trust and reflects a higher level of expertise.

260. District Nursing must be retained. It can share overall standards with SCPHN with individual platforms for the different fields.

Senior Lecturer Adult Nursing, England

Other comments

261. It is important to note that 51 more general comments and questions arose during these online webinars and roundtables that did not exclusively fit into the other themes.

262. Eight comments concern the SPQ District Nurse course, six comments point out District Nursing is different to other practitioners and list their District Nursing responsibilities and three comments question whether it was a suitable time to review the standards during a pandemic.

263. Three participants question changing the community nursing SPQ programme, with two others querying how the advanced SPQ programme would differ to other advanced practice roles. Two questions were regarding the District Nursing apprenticeships. The rest of the comments and questions were only mentioned once or twice and concerned workplace support, raising awareness of the SPQ District Nurse qualification and pay levels. Examples of these comments and questions are included below.

264. The number of District Nursing students at our university has risen incrementally over the last six years.

Pathway Leader for Specialist Nursing, Northern Ireland

265. As other advanced practitioners and specialists retain their titles why can't we retain the District Nurse title to evidence our specialism?

District Nurse

266. I did my District Nurse qualification 15 years ago and it is as relevant today as it is was then if not more. I manage District Nurses on a daily basis and see differences between those with and without the qualification.

Integrated Network Team Manager, England

267. Nurses should not be able to call themselves a District Nurse without the SPQ.

Director of Nursing Programmes, England

268. Moving community nursing into a recognised advanced practice would be a welcome move forward. A large percentage of District Nurses in my area work at an advanced autonomous level (and have done for some time) using V300, clinical assessment and advanced pathophysiology skills on a daily basis without recognition for this at an 'advanced' level.

District Nurse, Scotland

269. Have the District Nursing apprenticeship standards been considered within this review?

Senior Lecturer, England

270. I understand about improving and updating the standards and agree but why does the SPQ have to be changed? I don't really think this has been answered. Is the idea to make the SPQ an Advanced Practice qualification?

District Nurse Team Manager, England

271. I agree with themes, but wonder have resources been considered when setting these proficiencies? And how will the people already qualified as District Nurses achieve these?

Nurse Consultant, England

272. Generic standards take individuality away. The title District nurse may not be legislated, it is a title that has been around for many years. Removing this and generally calling it community nursing takes the whole shine off the role.

Practitioner

6.4 SPQ - General Practice Nursing (GPN)

273. The following themes have been identified as specifically relevant to the SPQ General Practice Nurse (GPN) practitioner as discussed by attendees to the webinars, roundtable events and other engagement events. These events include:

SPQ Webinar
SPQ Webinar General Practice Nursing
SPQ 5X Specialism Discussion: General Practice Nursing
SPQ Follow up Roundtable: Frontline Practitioners
Additional SPQ Roundtable Discussion Session (with QNI and BME nurses)

274. In total 32 themes were identified during these webinars, roundtable events and other engagement events as being themes pertinent to General Practice Nursing. Some of the themes are mentioned during several different discussions whereas other themes are more specific to a particular group of webinar or roundtable attendees based on their specialist knowledge and experience. In some instances, themes are discussed at great length whereas other themes are less frequently mentioned or contain little detail. The 32 themes discussed in relation to the SPQ General Practice Nurse practitioner are as follows:

Accountability (1)
Adaptability (4)
Advanced communication skills (3)
Advanced courses (1)
Advanced physical assessments (1)
Apprenticeships (1)
Autonomous practice (7)
Community (3)
Confidence (2)
Consistency (3)
Cultural competence (2)
Employment (5)
Flexibility (1)

Frameworks (1)
Identifying vulnerability and inequality (2)
Imaging (1)
Influencing policy / influencing change (10
Influencing skills (4)
Leadership (2)
Life course (3)
Networking (1)
Overlap of roles (3)
Person-centred (3)
Placement (1)
Prescribing (2)
Public health (6)
Qualifications (3)
Relationships (2)
Resource (3)
Shared learning (1)
Standards (1)
Technology (1)

275. The following analysis provides a summary account of the most pertinent, unique themes to this area of practice and those themes that attracted a great deal of discussion. The thematic analysis is structured to show what themes were said by who – a practitioner, educator or stakeholder. Where it is known, the country is specified to determine similarities and differences of General Practice Nursing practice across the four nations.

6.4.1 Practitioners and stakeholders on General Practice Nursing

Adaptability

276. Being adaptable during consultations is referenced by two practitioners based in England and Northern Ireland and is only discussed in relation to the General Practice Nurse. Whilst other community nurses focus on health promotion and prevention, a General Practice Nurse needs to be skilled to adapt their approach to each consultation, especially when a patient presents them with an unexpected issue.

277. *You have to adapt very quickly to being the first person this patient is seeing, and they might have revealed something to you or ask you something unexpected. It can be complex. It's a different role that terrifies all of us when we first do it but it's the one you're most proud of.*

Consultant, England

Autonomous practice

278. Practitioners from England and Northern Ireland emphasised the autonomous role of the General Practice Nurse who can often feel "professionally isolated". These nurses need to have the confidence to make decisions on their own during a consultation, advising immediate additional care if

required. It was felt that working autonomously in this particular area of practice differs from other community nurses for they should not leave the patient alone in the consultation room in order to seek advice from colleagues. General Practice Nurses therefore require the advanced clinical skills and confidence to make decisions on their own alone with the patient.

279. It's quite an isolated role, one of the biggest difficulties is General Practice Nurses often feel professionally isolated. [General Practice Nurses] need confidence in this role.

Advanced Nurse Practitioner, Northern Ireland

Consistency

280. Practitioners and educators from England and Northern Ireland discussed that there is a lot of variation in the role of the General Practice Nurse with people, including GPs, not truly understanding the role or what they are able to do. The standards should make clear how this role is specialist, and the requirements nurses have to meet to be classed as a General Practice Nurse should be made clearer and standardised.

Employment

281. It was felt that the terms and conditions of General Practice Nursing employment should be given some consideration according to practitioners and an educator based in England, Northern Ireland and Wales. The standards should acknowledge that General Practice Nurses are limited by their employment and this can often impact how they access continuous professional development.

282. There is huge potential for the General Practice Nursing role, but the way they are used boils down to the vision of the employer and that's often constructed by financial objectives of the practice.

Advanced Nurse Practitioner, Northern Ireland

6.4.2 Educators on General Practice Nursing

Influencing skills

283. Educators and some practitioners in England believe that influencing skills are a key element of community nursing, and General Practice Nurses require the skills to influence policy, influence resources and also influence and shape the provision of services.

Resource

284. One educator from England emphasised the ability for General Practice Nurses to influence the use of resources and, as a specialist clinician, "act as a resource for other clinicians and stakeholders."

6.5 SPQ - Community Learning Disabilities Nursing (CLD)

285. The following themes have been identified as specifically relevant to the SPQ Community Learning Disabilities Nursing (CLD) practitioner as discussed by attendees to the webinars, roundtable events and other engagement events. These events include:

SPQ Webinar Community Learning Disabilities Nursing
SPQ 5X Specialism Discussion: Community Learning Disabilities Nursing
Additional SPQ Roundtable Discussion Session (with QNI and BME nurses)
SCPHN/SPQ Post Registration Standards: Prescribing

286. In total 26 themes were identified during these webinars, roundtable events and other engagement events as being themes pertinent to Community Learning Disabilities Nursing. Some of the themes are mentioned during several different events whereas other themes are more specific to a particular group of webinar or roundtable attendees based on their specialist knowledge and experience. In some instances, themes are discussed at great length whereas other themes are less frequently mentioned or contain little detail. The 26 themes discussed in relation to the SPQ Community Learning Disabilities Nursing practitioner are as follows:

Adolescence (1)
Advocacy (1)
Assessments (14)
Children (1)
Community asset (1)
Delegation (1)
Educating others (1)
Employer buy-in (1)
Epilepsy (1)
Evidence based practice (3)
Four nations (1)
Identifying vulnerability and inequalities (3)
Inclusion (1)
Leadership (5)
Legal frameworks and legislation (11)
Managing teams (3)
Prescribing (1)
Public health (2)
Quality Improvement (QI) (1)
Reasonable adjustments (1)
Regulation (1)
Remote working (1)
Research (1)
Systemic support (1)
Therapeutic interventions (10)
Transition services (2)

287. The following analysis provides a summary account of the most pertinent, unique themes to this area of practice and those themes that attracted a great deal of discussion. The thematic analysis is structured to show what themes were said by who – a practitioner, educator or stakeholder. It is worth noting however that during the discussion of this community nursing practitioner the majority of the attendees to the specific webinars cited above were practitioners. Where it is known, the country is specified to determine similarities and differences of Community Learning Disabilities Nursing practice across the four nations.

6.5.1 Practitioners and stakeholders on Community Learning Disabilities Nursing

Assessments

288. Practitioners from England and Northern Ireland highlighted that Community Learning Disabilities Nurses require advanced assessment skills and to recognise that what some may consider 'normal' health looks different to individuals with learning disabilities. Physical health assessments training is to prevent diagnostic overshadowing and to ensure that patients with learning disabilities get the correct diagnosis. They also need to be able to conduct mental health assessments on patients with a learning disability. These advanced practitioners should be the advocates for the bespoke assessments that individuals with learning disabilities need.

289. Advanced assessment is being able to think outside the box because we know that a lot of people with learning disabilities are outside of normal parameters. We also need to be advocating for checks and key important assessments that many people with learning disabilities are not getting right now, and because they're not getting them diagnoses are being missed.

Senior Learning Disabilities Nurse, England

290. I think given that we still have people with serious health needs going undiagnosed then our skills lie in both the mental and the physical.

Community Nurse and Learning Disabilities Team Manager, Northern Ireland

Evidence based practice

291. Two practitioners in England emphasised that the standards should acknowledge evidence from reports, notably the LeDeR (Learning from deaths) report, and other policies and guidelines such as STOMP (Stop over medicating people with a learning disability, autism or both) to base practice on.

292. In the LeDeR report there are five to six healthcare conditions that are key causes of death with people with disabilities. I think it would be worth exploring that as part of proficiencies … this is a key area of Learning Disabilities Nursing.

Senior Learning Disabilities Nurse, England

Legal frameworks and legislation

293. Practitioners from England and Scotland highlighted that advanced practitioners working within this area of practice need to understand and be able to act on legal frameworks and legislation.

Therapeutic interventions

294. Knowledge of and the ability to deliver therapeutic interventions as an alternative to prescribing is important according to practitioners and some educators from England, Northern Ireland and Scotland. Therapeutic interventions that Community Learning Disabilities Nurses require include trauma based therapies, Autistic Spectrum Disorder (ASD) and ADHD assessments in children, Cognitive Behavioural Therapy (CBT), Behavioural Family Therapy (BFT) and guided self-help approaches.

295. I deliver CBT to people with learning disabilities after having studied my postgraduate certificate. It has been incredible!

Community Learning Disabilities Nurse, Scotland

6.5.2 Educators on Community Learning Disabilities Nursing

Legal frameworks and legislation

296. An educator in Scotland suggests that advanced practice requires practitioners to act on legal frameworks rather than having others sign legal paperwork. This requires having a legal responsibility in supporting the application of mental health legislation. It is also important that the different legal systems from across the four nations are covered in the standards.

297. It is important to be responsible for our own practice, as such being able to action legal frameworks rather than having others sign off on this.

Lecturer, Scotland

Other comments

298. It is important to note that 17 other general comments and questions arose during these online webinar and roundtables that did not exclusively fit into the other themes.

299. Four comments questioned how the course could be taken, three vague comments related to Community Learning Disabilities Nursing skills, two questions concerned the qualification in relation to SCPHN and two comments concerned the Advanced Clinical Practitioner course. Examples of these comments are listed below.

300. I wonder given the range of courses we need to have sitting alongside each other, whether this needs to become a public health qualification for learning disabilities rather than trying to cover all aspects of the myriad of learning disabilities nursing roles.

Consultant Nurse Approved Clinician, England

301. How do you ensure that pre-registration qualifications marry up with post-registration e.g. a Children's Nurse taking post-reg in specialist areas and vice versa for an adult trained working with children in the community?

Paediatrician, Scotland

302. Will prior learning be considered?

Professional Nurse Lead, Scotland

303. If community specialist qualification is at an advanced practice level what will this mean for staff who are not yet ready for that level of practice? In community learning disabilities services, we have a number of newly qualified/band 5 nurses who value the experience and are valuable members of the team.

Senior Community Learning Disabilities Nurse, England

304. When will this be available and what will the entry requirements be (I qualified before the degree came in)?

Learning Disabilities / Autism Spectrum Disorder Team Manager, England

305. The uptake of annual health checks and working with liaison nurses in hospitals.

Continuing Healthcare Nurse, England

6.6 SPQ - Community Mental Health Nursing (CMH)

306. The following themes have been identified as specifically relevant to the SPQ Community Mental Health Nursing (CMH) practitioner as discussed by attendees to the webinars, roundtable events and other engagement events. These events include:

SPQ Webinar Community Mental Health Nursing
SPQ 5X Specialism Discussion: Community Mental Health Nursing

307. In total 22 themes were identified during these webinars, roundtable events and other engagement events as being themes pertinent to Community Mental Health Nursing. Some of the themes are mentioned during several different events whereas other themes are more specific to a particular group of webinar or roundtable attendees based on their specialist knowledge and experience. In some instances, themes are discussed at great length whereas other themes are less frequently mentioned or contain little detail. The 22 themes discussed in relation to the SPQ Community Mental Health Nursing practitioner are as follows:

Addiction (1)
Advanced communication skills (3)
Challenging discrimination (1)
Diagnostic overshadowing (1)
Dual diagnosis (1)
Frailty (1)
Holistic care (1)
Inclusive decision making (1)
Language / terminology (7)
Leadership (4)
Legal frameworks and legislation (1)
Managing diverse teams (3)
Mental Health Act (1)
Motivational interviewing (1)
Organisational skills (1)
Physical health (3)
Prescribing (1)
Professional boundaries (1)
Public health (2)
Regulation (2)
Risk (2)
Therapeutic interventions (20)

308. The following analysis provides a summary account of the most pertinent, unique themes to this area of practice and those themes that attracted a great deal of discussion. The thematic analysis is structured to show what themes were said by who – a practitioner, educator or stakeholder. It is worth noting however that during the discussion of this community nursing practitioner the majority of the attendees to the specific webinars cited above were practitioners. Where it is known, the country is specified to determine similarities and differences of Mental Health Nursing practice across the four nations.

6.6.1 Practitioners and stakeholders on Community Mental Health Nursing

Addiction

309. Addiction is only mentioned during discussions concerning individuals with a mental health condition is described as a “far more advanced skill” and one that is disappearing. Understanding addiction as separate from physical health should be captured in the standards, according to the Head of Mental Health Nursing for NHS England. They go on to explain that diagnostic overshadowing of mental health is particularly high for individuals with addictions and addiction not only covers substance abuse but other areas such as gambling.

310. Experience around addictions […] is so different to physical health. I would like to see an element of that captured as well as just physical health.

Head of Mental Health Nursing, England

Professional boundaries

311. Maintaining professional boundaries is said to be relevant to practitioners working with individuals suffering with a mental health illness. Community Mental Health Nurses should be aware that the blurring of professional boundaries may occur when working with vulnerable individuals and as one stakeholder from England claimed, it is about being "a friendly professional rather than a professional friend". Although relationships and attachments are formed within other areas of practice when working closely with a patient, it was said that this was particularly different within mental health services.

312. Ethical dilemmas around those professional boundaries and maintained professional boundaries […] are important especially when working with people who have particular vulnerabilities around attachments and relationships. It is very nuanced.

Head of Mental Health Nursing, England

Risk

313. Advanced risk assessments, positive risk assessments and public protection are key areas concerning Community Mental Health Nurses. These are important skills that are delivered to keep individuals who suffer with a mental health illness within their community safely and for as long as possible. One practitioner based in England also mentioned **Positive Behaviour Support (PBS)** as another important skill which needs to be conducted at an advanced level, especially for those practitioners working autonomously. This is because they are taking risks with patients with ASD and personality disorders. Another key element around mental health is public protection. Mental health practitioners will need to advocate for an individual with a mental health illness, and may be the only person doing so, taking into consideration the risk they pose to themselves and to others.

314. When I have those conversations and interactions at a systems level, I'm the lone voice in a room advocating for someone who may not have any family, whilst also thinking about public protection and balancing public protection against the patient's needs.

Head of Mental Health Nursing, England

Therapeutic interventions

315. The theme therapeutic interventions as opposed to prescribing generated 20 comments relating to Community Mental Health Nurses. The majority of practitioners in England and Scotland were in favour of therapeutic interventions, such as Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), suicide prevention, Behavioural Activation and family therapy to name a few, being recognised as effective resources to supporting individuals. One practitioner from England claimed that

in their Children and Adolescent Mental Health Service (CAMHS) specialism, therapeutic interventions are often more relevant and effective, and although prescribing is important it is sometimes viewed as "the easiest thing" to do. Social prescribing was cited as an important skill for this area of practice; however, the standards need to acknowledge that there are other methods in which to treat patients with a mental health illness.

316. There needs to be the opportunity for Specialist Mental Health Nurses to become Advanced Clinical Practitioners in other therapeutic interventions / therapies, not prescribing. This will bring balance to specialist practice.

CAMHS Clinical Nurse Specialist, England

317. As an independent prescriber working as a Community Mental Health Nurse, the number of prescriptions I write is minimal. The qualification is however invaluable in terms of deprescribing, resisting requests to prescribe and to formulate and confidently 'prescribe' non-pharmacological interventions.

Community Psychiatric Nurse Team Leader, Scotland

6.6.2 Educators on Community Mental Health Nursing

Language / terminology

318. An educator in Wales did not feel that the term 'diagnosis' was relevant to mental health nursing as it is a very medically charged word. Instead, 'formulation' is a more suitable term to use in the mental health context. However, it was noted that the terminology and understanding of diagnosis and formulation varies across the UK and different areas. An educator in England highlighted that 'working diagnosis' as well as formulation is a term familiar to them. The standards should acknowledge the different interpretations and usage of language across the UK when setting the standards for Community Mental Health Nursing.

319. The talk of 'nursing diagnosis' doesn't resonate with me in the context of mental health. It feels alien. It's not something that students or colleagues write or talk about.

Mental Health Nursing Professor, Wales

Managing diverse teams

320. It is important to note that the composition of mental health teams makes this service distinct to other services. Peer workers, social workers, psychologists and other professionals in mental health teams are probably more diverse than anywhere else in community nursing because they usually have a lived experience of mental health. Managing a diverse team with different experiences of mental health issues requires an advanced level of skill to communicate and manage those roles which needs to be acknowledged in the standards.

321. *The composition of those teams will be different. I think peer support workers, whose place in the mental health team is by dint of having a lived experience of mental health difficulties and abusing services themselves, that's maybe a little bit distinct.*

Mental Health Nursing Professor, Wales

Physical health

322. Practitioners require advanced practice skills to assess a patient's overall health condition alongside their mental health, utilising advanced physical and mental health assessments. One educator in Scotland was concerned that the core SPQ standards would focus on physical care skills stating that the standards should reflect the need for evidence based mental health interventions to provide a meaningful and holistic service of care to the service user.

Other comments

323. It is important to note that 15 other general comments and questions arose during these online webinar and roundtables that did not exclusively fit into the other themes. Four comments questioned how a single community SPQ would relate to other qualifications, two comments concerned the course logistics, two comments related to educational providers and strategies and all other comments were mentioned once.

324. One comment was against a single community SPQ, one questioned whether mental health specialisms would be identified in a single community SPQ, another participant questioned how this would differ to the current qualification and another comment concerned funding. Examples of these comments and questions are included below.

325. How will the SPQ differ from Advanced Clinical Practice (ACP) programmes? As someone who has a role in determining our commissioning requirements for programmes, I would require more information on where the SPQ sits in terms of ACP programmes which do offer specialist pathways. Why would we choose SPQ over ACP?

Director of Nursing, England

326. Still not sure how they differ from the old qualifications.

Primary Care Mental Health Practitioner, England

327. How will the SPQ link with, or be different to, the Diploma in Integrated Community Nursing?

Lead Nurse Community Mental Health Nurse, Scotland

328. These roles are all very different and having one community qualification is not the way to go. Yes, there are some core areas but the application of these is different for each specialist practice qualification. Making this one community SPQ devalues the specialisms and will make it even less attractive for practitioners.

Director of Nursing Programme, England

329. Will the single SPQ have the scope to recognise that community mental health nurses may specialise in dementia care, CAMHS, Addictions or adult mental health so have differing views of what constitutes advanced practice?

Lecturer, Scotland

330. More emphasis needs to focus around how to consider supervision/caseload discussion/delivery of group work/digital influences and how to maintain health and wellbeing working in a complex healthcare setting.

Consultant Nurse (Mental Health), Scotland

7. Joint commentary relating to SCPHN and SPQ

331. Webinars, roundtable events and other engagement events took place with a range of stakeholders that jointly discussed the SCPHN and SPQ programmes and the skills and proficiencies required of these specialist practitioners. The following themes have been identified as relevant to both SCPHN and SPQ practitioners. These webinars and roundtables include:

SCPHN / SPQ Roundtable with Educators (*this originally was titled as SCPHN only*)
SCPHN / SPQ Roundtable with Educators and Students (*this originally was titled as SPQ only*)
SCPHN / SPQ Employer reps / Commissioners
SCPHN / SPQ Social Care
SCPHN / SPQ Other Professions
Advocacy Group Roundtable discussions
Children and young people
Disabilities and long-term conditions
Mental health and learning disabilities
Older people

7.1 Educators – joint SCPHN and SPQ

332. During the roundtable event with educators[3] 10 separate themes were discussed. The most pertinent themes are summarised at length below. The 10 themes include:

Advanced communication skills (1)
Compassionate care (8)

[3] Based on the recorded attendance to this roundtable event there were no participants from Northern Ireland.

Critical thinking (4)
Cultural competence (3)
Leadership (3)
Mental health (9)
Person-centred (4)
Prescribing (8)
Professional identity (6)
Shared learning and joint standards (13)

Compassionate care

333. Cultivating compassion and delivering culturally appropriate and compassionate care to patients, families and professionals are advanced skills that educators believe are fundamental to the SCPHN and SPQ programmes. Delivering compassionate care links into value-based nursing, encourages the practitioner to reflect on how they are working with the individual and recognising the context in which service users are living in.

334. Compassionate care should be indicative of working in partnership with the patient/client and building therapeutic relationships which is a higher-level skill than pre-registration.

Lecturer in Primary Care and Public Health Nursing, Wales

Mental health

The standards need a stronger emphasis on mental health and the skills needed to manage and treat people with mental health issues. The topic of mental health generated discussions concerning therapeutic interventions and advanced communication skills as well as the need for practitioners to be able to prescribe. Some educators in England stated that prescribing should not be a requirement if there was more of a focus on mental health.

335. An increased development of skills to promote and manage mental health issues would have a far greater impact on the people that we support and work alongside.

Senior Lecturer, England

Person-centred

336. The standards need to reflect person-centred practice and person-centred leadership according to an educator in Scotland. This theme was also echoed by a lecturer in England. Person-centred practice entails taking a cultural view of the person being cared for and making them more visible. Educators also emphasised that person-centred practice relates to others in a team that nurses would be working with, not just those they are providing a service to.

337. It's more than compassion, it's seeing that whole person.

Lecturer, Scotland

Professional identity

338. Educators in England and Scotland feel that SCPHN and SPQ nurses need to have clear professional identities moving forward as there were concerns that they could blend into one. Shared learning between SCPHN and SPQ programmes is received well, however it was felt their professional identities need to be kept separate and unique.

339. Curriculum design might be too arbitrary at times. We all need to be clear about the distinct identities of the different SCPHN and SPQ professions.

Senior Lecturer SCPHN, England

Shared learning and joint standards

340. Some educators from England, Scotland and Wales spoke positively of running SCPHN and SPQ programmes together. They were in favour of joint standards with a common core, but specific standards should be tailored to each pathway to accommodate the specialisms in each area of practice. Shared learning with core subjects is seen as a logical progression to some educators.

341. Previously SPQ and Health Visiting ran together and worked, so there's no reason why the programme standards should not be joint and then more specific standards for each pathway.

Lecturer, Wales

342. Other based in England and Wales are keen that the standards are kept separate due to the specialist areas of practice and have concerns that distinct elements of knowledge pertinent to specialist fields will be overlooked if joint standards were created.

343. I would be concerned of the impact on SCPHN registration in the long term if we moved to a joint standard. I can see SPQ moving towards advanced practice standards that we already run on a separate programme. We do already share half of our training across both our SCPHN and SPQ programmes. I am concerned in losing BSc and MSc programmes.

Director of Studies for Specialist Practice, England

344. I would advocate for two different sets of standards – these are quite different roles in so many ways. There are common links within public health and other areas, but one set could likely be overly generic and important distinctions lost.

Programme Lead Advanced Clinical Practice, England

7.2 Educators and students – joint SCPHN and SPQ

345. During the educators and student's roundtable event 11 themes were distinguished relating to SCPHN and SPQ programmes. It is important to note that the majority of comments are attributed to educators as student information was not provided. The 11 themes include:

Advanced clinical assessment (3)
Advocacy (1)
Autonomous practice (6)
Co-production (2)
District Nursing (7)
Holistic assessment (2)
One or two sets of standards (9)
Political awareness and navigating the system (1)
Prescribing (6)
Public health (5)
Safeguarding (2)

Advanced clinical assessments

346. Two educators based in England and Wales support the idea of SCPHN and SPQ practitioners conducting advanced clinical assessments and see this linking with the ability to prescribe.

347. I like the idea of advanced clinical assessments. We are going to develop these moving forward if they need that assessment knowledge and skills to be able to provide care in the future.

Programme Lead for Post Registration Programmes, Wales

Autonomous practice

348. The advanced practitioner of the future will need to demonstrate a high level of autonomy, consistent with Masters level education, when undertaking and managing episodes of care independently.

349. I think of autonomy as absolute rather than a relative concept. I would urge [you] to think of the notion of autonomy as continuum not as an off-type concept.

Programme Lead Advanced Clinical Practice, England

One or two sets of standards

350. Participants were posed with the question of whether the NMC should develop one set of standards for SCPHN and SPQ or if there should be separate standards. Two participants saw the advantage of having one set of standards however the majority of participants, although acknowledging similarities between the two, believe that these programmes are unique and their specialisms should be preserved. There were concerns how one set of standards would work regarding the duration of the courses.

351. I can see where advanced health assessment and V300 prescribing would benefit the District Nurse to achieve more autonomy in practice. However, what the programme would look like in terms of duration is unclear.

Lecturer in Nursing, Northern Ireland

352. There could be programme standards that are common but there would be separate proficiencies for SCPHN and community nursing.

Roundtable participant

7.3 Employer reps and commissioners

353. Although some employers and commissioners had attended the larger SCPHN and SPQ webinars a specific roundtable event took place with employer representatives and commissioners who discussed what the SCPHN and SPQ standards should consider. From the information that was provided by the participants, the majority of the employer reps and commissioners are based in England therefore it is worth noting that experiences, services and employment may differ in Northern Ireland, Scotland and Wales to what is detailed below. In total seven themes were identified during this roundtable event of which the most pertinent are analysed below. The seven themes include:

Advanced assessments (3)
Business and commercial acumen (1)
Cultural competence (1)
Integration (8)
Prescribing (5)
Quality measurement (1)
Technology (3)

Advanced clinical assessments

354. Advanced practitioners require advanced assessment skills and should be able to adapt their approach with these skills when assessing children, young people and older adults. Advanced assessment skills were highlighted by one commissioner in England as a particular key skill for Health Visitors who are working with vulnerable families with mental health issues, substance abuse issues and domestic abuse.

355. Advanced assessment skills for children is very different from advanced assessment skills for adults. We are potentially missing an opportunity if we don't differentiate between these.

Employer rep / Commissioner

Integration

356. Practitioners need to be integrated workers who are able to effectively work with other services and professionals such as social workers, GPs, midwives, etc. in order to support a family or service user. Two commissioners however claimed that although integrated working is encouraged, they do not think it is demonstrated well by current practitioners. Another commissioner / employer rep stated that to be successful integrated practitioners they must have knowledge of their local communities which is not something they believe all local practitioners have.

357. As a commissioner I still see a very siloed way of working - we have a structure which promoted an integrated way of working but how practitioners demonstrate that integration is not always apparent.

Senior Health Improvement Commissioner Children and Young People, England

Technology

358. Due to the recent Coronavirus pandemic employer reps and commissioners believe that technology will become more of a requirement for practitioners in the future. Practitioners will need to be familiar with the virtual environment, delegating and managing workloads online and be able to offer effective assessments and consultations via digital platforms especially with the older population where human contact has been reduced.

7.4 Social care professionals

359. NMC wanted to hear from professionals and stakeholders working in social care services to understand what they believe to be the most important factors and challenges to public health and community nursing. They were also interested in hearing what social care professional thought the standards of proficiency should include to meet the needs of service users in the future. A SCPHN/SPQ Roundtable with Social Care professionals took place on 20 August 2020 at which all four nations were represented. The most popular and significant themes are thematically analysed below. These 19 themes include:

Advanced practice (2)
Advocacy (1)
Children (2)
Clarity (7)
Community (1)
Coronavirus (5)
Diagnostic overshadowing (1)
Digital competency (1)
Empowering (1)
Gerontology (4)
Holistic care (3)
Integrated working (1)
Legal frameworks and legislation (8)
Need (1)
Person-centred care (1)
Prescribing (1)
Risk (4)
Safeguarding (6)

Specialist qualification for social care workers (2)

Clarity

360. Social care professionals believe the standards should clearly define the nature of social care services, what social care practitioners can do and the qualifications they hold. Participants from across the UK stated that there is a misunderstanding of what social care roles and services provide. Public health and community nurses should be aware of the tasks and complexities social care nurses work with and social care developments. It was cited three times that many community nurses across the four nations do not understand the differences between residential care, domiciliary care, nursing care and supported living.

361. Working at leadership and multidisciplinary level it's important that we all understand each other's roles and what's unique to those roles as well as how we complement each other. You have to understand where and how we sit within the system e.g. within independent and private sector versus within the statutory sector, and how those interfaces operate as well.

Director of Regulation and Standards, Northern Ireland

Gerontology

362. Participants from Scotland and Wales specified that specialist knowledge of gerontology should be included in the standards to ensure that nursing staff are equipped for the future. As the UK population are living longer nursing staff need to have the specialist knowledge and skills to care for older people.

363. As we are trying to attract nurses into the sector, gerontology-based specialisms would be helpful for social care.

National Workforce Lead for Nursing, Scotland

Legal frameworks and legislation

364. Knowledge of legislation is a key area that needs to be recognised in the standards, particularly legislation around safeguarding, mental health and capacity, Declaration of Liberty Services (DoLs) and the Human Rights Act. Knowledge of legislation relating to the field practitioners are working in enables them to advocate for, advise and protect patients in care. It was recognised that legislation across the UK is different, however professionals should be able to understand and apply legislation in their own area whilst also having an underpinning knowledge of UK-wide legislation.

365. From a regulatory perspective it's critical for any training programme that the fundamentals around legislation are understood. Obviously across the UK we have different legislation in place so whilst that is a challenge, it clearly needs to be part of the education process, so professionals understand the context they're working within.

Senior Manager, Wales

Specialist qualification for social care workers

366. Specialist qualifications for social care workers were considered in a positive light. Many participants however emphasised that those working in social care require specialist skills that are unique compared to other areas of nursing, for example, working in care homes for the elderly and working in children's care homes. The different environments where social care nursing is delivered differs from the clinical environment, and the care delivered, which sometimes includes highly technical clinical procedures, which requires different skill sets.

367. Yes, we should recognise it as a specialist role, and we need to upskill them, but actually there needs to be some integration with the current graduation standards in order that we don't split health and social care separately.

Lead Quality Development Manager, England

7.5 Other professions

368. The NMC held a roundtable event on 3 August 2020 with people from other professions to understand what specialist nurse practitioners need to know and be able to do, in addition to their pre-registration training and qualifications, to meet the needs of patients using public health and community nursing services. The participants who attended the roundtable event worked for UK-wide organisations and therefore individual nations are not specified unless this was distinguished during the discussion. The discussion mainly focussed on advanced practice and integrated working with other themes mentioned only a handful of times with little detail or explanation. This is probably due to the small number of participants in this discussion. The most significant themes that were discussed at length are summarised below. The ten themes include:

Advanced practice (6)
Autonomous innovation (1)
Communication development for children (2)
Integrated working (3)
Leadership (1)
Learning from others (1)
Lynchpin (1)
Person-centred (1)
Research (1)
Safeguarding (1)

Advanced practice

369. Participants discussed what elements they consider to be of a more advanced level of practice compared to pre-registration nurses and midwives. The core competencies that reflect advanced practice are: being a leader of change, researching and utilising research in practice, local knowledge,

public health knowledge and safeguarding knowledge of all ages plus those with learning disabilities and mental health illnesses.

370. I'd want someone who is a locality expert, someone who was an expert navigator of the local system. I'd want them to be comfortable with complexity, well connected and […] to lead change.

Chief Executive

Integrated working

371. Successful integrated working involves building networks with others, utilising those networks and recognising that those working in different areas of practice will have other well-established networks in other areas. Integrated working should not be about hierarchy of service or roles but coming together for the best interests of the patient or family and playing to each profession's assets.

372. I think working 'shoulder to shoulder' is about creative problem solving together, not fighting over territory.

Chief Executive

7.6 Advocacy groups

373. The NMC invited advocacy groups and charity sector workers to attend a series of roundtable events. These focussed on the different groups of service users that public health and community nurse practitioners may encounter, all of which require specific awareness, knowledge and skills. From the information that was provided by the attending participants, the majority of the advocacy group representatives are based in England, Scotland and Wales therefore it is worth noting that experiences, services and views may differ in Northern Ireland to what is detailed below. These different groups were:

Children and young people
Disabilities and long-term conditions
Mental health and learning disabilities
Older people

374. Participants to these roundtable events shared what they believe are the key factors that affect their service and service users, detailing what they would like to see incorporated into the new standards for public health and community nurse practitioners. Participants from across the four nations attended these roundtable events and the most important and significant themes are addressed below. The 58 themes include:

Adolescence (1)

Advanced communication skills / communication skills (11)
Advanced courses (6)
Advocacy (2)
Anticipatory care (1)
Bereavement (3)
Biopsychosocial model (1)
Clarity (3)
Collaborative working (1)
Community (7)
Comorbidity and complexities (4)
Confidence (3)
Continuity (1)
Coronavirus (4)
Decision making (8)
Dementia assessments (1)
Diagnostic overshadowing (3)
Do not attempt resuscitation (DNR) (2)
Emotional support (1)
Empowering (2)
Generic skills (2)
Holistic assessment (2)
Home environment (8)
Incapacity (1)
Lack of diagnosis (1)
Legal frameworks and legislation (1)
Lynchpin (1)
Managing power dynamics (1)
Mental Capacity Act (1)
Mental health (3)
Peer support (1)
Person-centred approach (2)
Physical as well as mental health (1)
Physiology of elderly patients (1)
Political awareness and navigating the system (1)
Polypharmacy (1)
Positive Behaviour Support (PBS) (6)
Positive risk taking (1)
Prescribing (11)
Prevention (5)
Primary care training (2)
Professional boundaries (1)
Public health (4)
Regulation (4)
Research (2)
Risk (1)
Safeguarding (2)
Self-management (2)

Shared learning (1)
Soiling and wetting (3)
Specialist Learning Disabilities Nurses (5)
Technology (1)
Training (1)
Transition (11)
Unconscious bias (4)
Understanding the role of others (1)
Wellbeing (4)
Working as a whole (1)

Bereavement

375. Advocacy group participants believe specialist nurse practitioners need to be able to explain and deal with loss and bereavement and manage the emotional impact this can have on children and young people. The topic of loss and bereavement has been exceptionally significant during the Coronavirus pandemic and it is believed to be a future required skill for those working with this age group.

Community

376. The theme community was cited exclusively by participants based in Scotland from advocacy groups working with children and young people and older people. It is important that practitioner know their community, what other services and information is available and how to utilise these services. They should also support patients to live safely or die comfortably in their own communities. The Coronavirus pandemic emphasised the need for integrated community working between public health and community nurses and other professions such as the third sector to support those in need of care.

377. I think health professionals working in the community need to know how to use secondary and tertiary care services effectively - at present there is often a divide between community and hospital services.

Consultant Paediatrician, Scotland

Comorbidities and complexities

378. Advocacy groups working with the older population believe the standards should integrate comorbidity and complexity as a key proficiency for specialist nurse practitioners. This theme was also mentioned in relation to children and young people for comorbidities can occur in young people too.

379. Developing much broader understanding around comorbidities and complexities is essential in terms of some of the tragedies we've seen in the way other people have been cared for over the years.

Director of Clinical Services, England

Decision making

380. Decision making arose during the roundtable concerning mental health and learning disabilities and correlates with another theme – confidence. Participants from England, Scotland and Wales emphasised that confidence is essential to making important decisions for there is huge responsibility that comes with decision making. There have been numerous occasions when nurses have been too nervous to make a decision independently. Specialist nurse practitioners need to reflect "on the practice before carrying out the practice", consider the steps to making a decision and know how to validate that decision themselves.

381. There seems to be an "I'll lose my pin if I make the wrong decision" thinking, rather than recognising they will lose their pin if they don't make a decision because they have a responsibility to act in the patient's best interests.

CEO, Wales

382. Decision making also relates to communication. The patient's opinions, concerns and wishes need to be taken into consideration instead of the practitioner making decisions without their input or consent.

383. I like people including me in decision making because it concerns my care and medication. I want to be involved rather than being told I'm being taken off a medicine.

Trustee and service user, England

Home environment

384. Advocacy groups, mainly those based in Scotland and UK-wide, who work with older people agreed that specialist practitioners who work with this age group require the skills to care for someone in their own home or homely setting. This increased during the Coronavirus pandemic as people who might have received care in a hospice, for example, received care at home. They also require the skills and knowledge to assist patients who want to die at home. For individuals with vision impairment, specialist practitioners should also recognise the importance of the home environment and how changes in this space can alter their orientation.

385. The environment in someone's home is an important point. It's important for people to be in their own home and know their own space. Adaptations or changes in someone's home or moving furnishings can have a drastic impact on their world.

Senior Policy Officer, Scotland

Positive Behaviour Support (PBS)

386. Positive Behaviour Support (PBS) was mentioned by participants from Scotland and UK-wide charities regarding mental health and learning disabilities services. One participant noted that to conduct PBS a lot of training and clinical theory is required. If not done properly it can be ineffective and have serious negative side effects on the patient. Other participants were in support of including some form of behaviour change therapy or behavioural analysis into the standards.

387. There are huge risks with behavioural interventions, but I think there is potential scope to look at SPQ registration with PBS and change behaviour practice and that could prevent a lot of placement breakdowns and make community services more effective.

Chair, UK-wide charity

Prevention

388. Specialist public health and community nurses need to be thinking at an advanced level to prevent diseases. They need to make people aware of different levels of risk that affect certain communities or age groups, and be able to effectively encourage people to reduce their risks through adapting their lifestyles or behaviours. Discussing risk with patients also requires appropriate communication skills to reinforce a positive health message and support people who may choose a different path from that which the practitioner advises. Specialist nurse practitioners should be aware of different 'unseen' diseases that can develop and how to recognise symptoms.

389. [There's] something to be said about encouraging specialist nurse practitioners in the community to be thinking about prevention with specialist diabetes and management knowledge.

Head of Care, UK-wide charity

Regulation

390. Three participants from UK-wide charities that work with people with disabilities and long-term conditions highlighted how important it is to regulate the knowledge and skills of specialist practitioners. Regulation was not discussed during the other advocacy group roundtable discussions. Regulation will guarantee that specialist practitioners maintain high standards of care and it is reassuring for patients and families to know that those delivering the service are regulated.

391. Not having someone there to ensure people are providing safe and effective care for our community would be a concern, especially at a specialist level.

Head of Care, UK-wide charity

Transition services

392. It is important that children and young people with a disability or complex illness can smoothly transition from paediatric to adult services however participants recall challenges with this process. The transition period should be made more explicit in the standards moving forward in order to improve this area of service. One participant uses the Ready, Steady, Go, Hello programme which can be tailored to young people with certain complex or rare medical conditions and is proven to help prepare young adults and their families for the transition into adult services.

393. [The patients] are scared, they're worried, they need advocates, they need the people looking after them to be educated and knowledgeable about their condition. There needs to be standardisation and the Ready, Steady, Go, Hello programme is really good.

Transition Clinical Nurse, England

Unconscious bias

394. Participants believe that the standards should include the recognition of, and how to challenge, unconscious bias. A deeper level of understanding is required of this subject such as recognising that everyone has unconscious bias, understanding where it manifests in the community and being able to address the behaviour whilst having the confidence to challenge it.

395. You have to get to grips with how others' thinking might be working in the context of someone with a learning disability. If we get it right for people with a learning disability, then we get it right for everyone.

Health Training Lead, UK-wide charity

8. Programme Standards

396. The NMC are developing new programme standards for post registration qualifications for Specialist Community Public Health Nursing (SCPHN) and Specialist Practice Qualification (SPQ) programmes.

397. In order to review existing programme standards and develop the new standards NMC held webinars, roundtable events and other engagement events with educators and stakeholders to discuss these in line with specialist nurse practitioner programmes. The attendees discussed the skills and attributes they believe post-registration SCPHN and SPQ nurses will need in the future to provide an advanced level of service to patients now and in the future.

398. The thematic analysis shows the different themes, ideas and comments to emerge from the webinars, roundtable events and other engagement events. Some of the comments are discussed at length with a great amount of detail whereas some comments are mentioned infrequently. Where it is known, the country is noted in order to compare similarities and differences of how these programmes work across the four nations. The webinars and online events that focussed on the development of the new programme standards and that are incorporated into the following analysis are:

SCPHN Programme Standards meeting
SCPHN Post Registration Health Visiting Standards Discussion Group meeting
SCPHN Post Registration Occupational Health Nursing Standards Discussion Group meeting
SCPHN Research and Evidence Meeting
SPQ IDG 2
SPQ IDG 3
SCPHN / SPQ Post Registration Standards Prescribing meeting

8.1 SCPHN Programme Standards

399. It should be noted that the main event discussing SCPHN Programme Standards meeting also referenced SPQ areas of practice. It is worth noting that only a small number of participants were available to attend this event. From the information that was provided by the attending participants, all participants to this event are based in England and Wales therefore it is worth noting that experiences, services and views may differ in Northern Ireland and Scotland to what is detailed below. There were eight themes that arose during this event which include:

General practice nursing (5)
Learning environment (1)
Masters level (8)
Recognition of prior learning (RPL) (10)
Route specific standards (10)
Standard 1.1 and 1.6 (1)
Standard 1.2 (3)
Standard 1.3 (1)

Masters level

400. Educators from England and Wales agreed that the level of study for the SCPHN programme should be at Masters level 7. The Masters level 7 was deemed appropriate due to the programme being an advanced and specialist level of practice.

Recognition of Prior Learning (RPL)

401. Recognition of Prior Learning (RPL) allows students to claim credits for prior learning that is relevant to the programme of study they are applying for. If a student's RPL application is successful, the credits will count towards their programme of study. Due to the vigorous university process in Wales it is difficult for students to RPL modules, however some exceptions have been made.

402. We have a quite robust university process, so it's difficult for them to RPL any other modules in. We did have a student who had the V300 because she was a practice nurse and came into the Health Visitor route so was able to RPL into V100, but otherwise it's a robust process so makes it difficult for students to RPL in.

Lecturer and Programme Manager, Wales

403. An educator based in England explained that RPL can only be applied for specific modules – leadership, research, prescribing or health assessment. It was highlighted however that RPL can be difficult due to double counting credits, therefore RPL should only take place at a higher level of study. This opinion was reiterated by colleagues in Wales.

404. *It should be kept at a higher level. We need to be aware that if someone has done an MA in Advanced Clinical Practice (ACP), other than prescribing, you cannot bring those credits over because they've been counted as an MA, so we can't double count.*

Dean for Education and Director of Postgraduate Programmes, England

Programme specific standards

405. An educator based in England discussed their perspective on specific standards and what adjustments, if any, they believe should be considered when developing the new programme standards.

406. For standards 1.1 and 1.6 (see annex table 4 and table 7) it was discussed that university staff would learn via the interview process whether an applicant had consolidated or not. However, for programmes that are direct entry, staff would not have any prior knowledge of a student's practice. Therefore standards 1.1 and 1.6 should acknowledge or include directions for staff regarding confirming the capability of an applicant if the programme is direct entry.

407. It is direct entry that would become more problematic. How would you know from a person's application that they were sufficiently consolidated in terms of the pre-registration skills to be able to develop a specialism?

Dean for Education and Director of Postgraduate Programmes, England

408. An issue this educator highlights is with the SPQ programme because at their university applicants are seconded from an NHS employer and are provided with professional support to develop their advanced practice. Those applicants who are not employed by the NHS won't have a support system in place and they will have to locate their own placements. For those applicants not from an NHS Trust this educator believes it is difficult to adhere to the NMC Standards for Student Supervision and Assessment (SSSA) for the educator has little authority where the individual is working (see annex, table 5).

409. I work alongside a Trust and it's completely robust, we know the quality of what's delivered and that's my concern from a public protection point of view. I'd want to have some control of over that person's placement while they're developing those advanced skills.

Dean for Education and Director of Postgraduate Programmes, England

410. The only area of concern regarding standard 1.3 (see annex, table 6) would be applicants who are self-employed because the educators would not necessarily know the applicant's "sphere of activity". Public protection is very important and not having control of the student's development would be a concern. They also questioned if an educator designed a programme of study and excluded self-employed applicants would this still be approved under the standard.

Route specific standards

411. During one discussion educators were asked whether they thought a midwife could learn to become a primary or community care nurse. Participants were against this proposal, citing the need for specific routes for the programmes. A midwifery qualification would not prepare someone to become a community nurse for they lack the underpinning knowledge of general nursing and each area of practice requires specific and specialist skills and knowledge. There were also concerns regarding community nurses with one specialist qualification, e.g. Community Children's Nursing, being able to pick up another specialist community qualification, e.g. Community Mental Health Nursing, for these areas and

skills greatly differ. An educator in Wales stated that there had been no issues for any newly qualified registered nurses going in to a SCPHN Health Visiting role.

412. For public protection, in terms of what these standards will offer, I think there is an argument to be route specific. I'd want to know my child's community nurse had a children's nursing qualification. Therefore, I think those specifics should be written in for each specialist field. You could be dual qualified, but I think you need the qualification for the route that you are taking.

Dean for Education and Director of Postgraduate Programmes, England

413. General Practice Nursing however was recognised as an area of practice which stood apart from other roles. This is because General Practice Nursing practice incorporates the whole lifespan of the patient unlike other specialist roles. Participants also cited that the four pillars of nursing (advanced clinical practice, leadership, facilitation of education and learning, evidence research and development) is particularly relevant and important to this area of practice.

8.2 Research and Evidence

414. Please note that as above both SCPHN and SPQ were discussed in this context.

415. Nurses practicing at an advanced level need to be driven by research and deliver evidence-based practice as well as working to continuously improve the quality of healthcare through Quality Improvement (QI) and person-centred practice. Educators took part in an online Research and Evidence meeting on 7 August 2020 where they discussed the elements of research and evidence they believe should be considered in the new programme standards for both SCPHN and SPQ. Based on the information provided by the attendees, the majority of participants to this event are from England, Northern Ireland and Scotland therefore it is to be noted that views, services and experiences may differ in Wales to what is mentioned below. Fifteen themes were identified and the most interesting and pertinent are analysed below. The fifteen themes include:

Age profiles (8)
Anticipatory care (1)
Confidence (2)
Critical appraisal and making change (6)
Decision making in unpredictable circumstances (3)
Ethics (1)
Evidence based practice (3)
Lack of research opportunities (6)
Leadership (2)
Masters level 7 (12)
Mentorship (2)
Quality Improvement (QI) (4)
Service improvement (3)
Work based projects (1)
Working together (2)

Critical appraisal and making a change

416. What separates pre-registration and post registration nurses is the ability to critically appraise research, apply that research to practice and drive improvement. Being able to critically analyse research and then move one step further to make recommendations, challenge others and change outcomes is a quality that is expected from advanced practitioners. The terminology 'critical analysis' and 'critical appraisal' was discussed. Critical analysis is already classed as an undergraduate skill therefore the standards should clearly define what is expected from those studying at Masters level 7 in terms of critical analysis and appraisal. An educator in Scotland stated advanced practitioners should be able to also synthesize the evidence at MA level, whereas undergraduates are only expected to critically analyse evidence.

417. Recognising [and] being able to gather evidence, using that with research evidence and [being] able to synthesize that and use that within practice, I would say that's moving towards an MA in specialist practitioners.

Senior Lecturer in Community Nursing, Scotland

418. I know it's just semantics but if we're already talking about critical analysis as being an undergraduate skill then we've got to think what that means in terms of what we can expect people at level 7 based post-registration courses.

Community Children's Nursing Professor, England

Decision making in unpredictable circumstances

419. An interesting theme emerged when discussing using evidence in practice – making decisions when the evidence is not available or is conflicting. Advanced practitioners will need to demonstrate that they can make clinical and professional judgements in that space. This ability goes beyond the Future Nurse standards, according to one participant.

Lack of research opportunities

420. Educators acknowledged that there is a lack of opportunities for nurse driven research and many nurses do not have the time available alongside a demanding day job to conduct or drive research studies. It was also highlighted that a lot of nurses lack the confidence to conduct their own research and further support and mentorship is required. An educator for Scotland claimed that the opportunities do exist, but they are viewed as less important compared to day-to-day practice.

421. It wasn't the fact that nurses don't want to do research but it's about creating opportunities and I think what we need to be able to do is show there are opportunities in what a lot of people do in clinical practice.

Professor, Northern Ireland

Masters level

422. Educators from England, Northern Ireland and Scotland unanimously agreed that, considering the research and evidence element of the programmes, both SCPHN and SPQ programmes should be offered at a Masters level 7 only.

423. Masters level - I think we should also be promoting the development of research questions and using their clinical experience to identify areas for research and develop the question.

Professor, Northern Ireland

424. They can meet the research requirements in a level 7 course but beyond that I am not sure how you can expect practitioners to be researchers alongside their day job.

Associate Professor (Learning and Teaching), England

Quality Improvement (QI)

425. There were a small number of comments regarding Quality Improvement, mainly the desire to focus on Quality Improvement and how this leads into research, especially for those on SPQ programmes.

426. I think it is a real issue in community nursing that QI and research is seen as an add on. This does not help community nurses to feel like autonomous flourishing practitioners or have practice-based nurses identifying relevant research.

Senior Lecturer in Community Nursing, Scotland

Work based projects

427. With regards to final assessments educators from England and Scotland felt that work-based projects or service improvement projects were just as appropriate as research dissertations. Work-based projects require students to utilise the evidence base to transform a service giving the student practical experience of applying research to drive change and improve service. One educator noted that work-based projects do not require ethical approval meaning that they are completed in a timely manner.

428. I think we do need to encourage work-based projects that focus on practical research, focussing on 'real' problems.

Senior Lecturer in Community Nursing, Scotland

8.3 SCPHN Post Registration Standards: Health Visiting Standards Discussion Group Meeting

429. A Health Visiting Standards Discussion Group took place on 31 July 2020 with educators and stakeholders from England, Northern Ireland and Scotland. On this occasion no comments were made by participants from Wales therefore this section of the analysis is unable to provide a rounded overview from all four nations. The participants discussed what elements they believe should be included to the programme standards that are specifically relevant to the role of the Health Visitor. The themes that were most popular, pertinent and discussed at length are included in the following analysis. Out of the ten themes identified, the significant themes discussed at length are included in the analysis below. The ten themes include:

Child development (1)
Communication and relationship management (7)
Cultural competence (1)
Elderly (3)
Health informatics and epidemiology (7)
Life course (8)
Motivational interviewing (1)
Multi-agency approach (1)
Professional curiosity (1)
Safeguarding (2)

Health informatics and epidemiology

430. Educators from Northern Ireland and Scotland believe that the recent Coronavirus pandemic should influence the understanding and utilisation of epidemiology and health informatics, especially concerning the role of the Health Visitor. Understanding and using available data to inform practice, shape delivery to improve population health and respond to needs that exist is key to this profession. A participant from Northern Ireland claimed that Health Visitors are not currently using information well at a local level, yet knowledge of epidemiology and health informatics are skills that are imperative to the future.

431. Health Visitors have to understand epidemiology. It ties in with community needs and understanding data and information to inform your practice and the communities you work with and also target how you're going to improve population health. Epidemiology and informatics are really key.

Senior Lecturer, Scotland

Life course

432. A life course approach is favoured by educators and stakeholders. As the Health Visitor is working with the family in the home setting, they are uniquely placed to view the life course of a child, social impacts and the wider health determinants of the family. Being exposed to the wider family

Health Visitors can understand the factors that influence adolescent and adult behaviours. A lecturer in Scotland feels strongly about Health Visitors supporting the elderly due to their knowledge and visibility in the community. There has been proven positive physical and mental health outcomes from Health Visitors attending to elderly communities, as well as minority ethnic communities also.

433. [I] support the life course in terms of promoting equity. There are other areas Health Visitors could make [a] significant health impact too. Health Visitors also follow up with bereaved families and give support there. Health Visitors [have] demonstrated support for the homeless, BAME communities and Roma travellers; they make a significant difference to these groups.

Lead Children's Nurse, Northern Ireland

Professional curiosity

434. Professional curiosity is considered a core element of the Health Visiting role. This entails using the communication skills that they have acquired to explore and ask questions to "make connections which might trigger conversations with other disciplines and agencies" when working with families.

435. A multi-agency approach driven by professional curiosity when working with families.

Consultant, England

8.4 SCPHN Post Registration Standards: Occupational Health Nursing Standard Discussion Group Meeting

436. An Occupational Health Nursing Standard Discussion Group took place on 7 August 2020 with educators and stakeholders. The participants discussed what elements they believe should be included in the programme standards that are specifically relevant to the role of the Occupational Health Nurse. Based on the information provided by the attendees, the majority of participants are based in England and Northern Ireland, therefore it is to be noted that views, services and experiences may differ in Scotland and Wales to what is mentioned below. In total 19 themes were identified during this discussion. The themes that were most popular, pertinent and discussed at length are included in the following analysis. Some of the participants did not state which country they are based in therefore where this information is known, it will be included in the analysis. The 19 themes include:

Business and commercial acumen (5)
Education (5)
Future needs (2)
Health and safety (2)
Health risk management (3)
Influencing skills (1)
Life course (3)
Mental health (1)
Placements (5)

Prescribing (5)
Promoting (3)
Public health (3)
Research (1)
Shared learning (5)
Single-handed practitioners (1)
Standards (1)
Value (1)
Work as a health outcome (2)
Work environment (1)

Business and commercial acumen

437. Occupational Health Nursing students should be provided with the environment to be able to cope in a business setting, this includes learning about business acumen, being able to pitch, return on investment and applying technological advances. The SEQOHS standards were cited as business standards that should be included to shape the future programme standards for Occupational Health Nurses in order for them to be leaders, "not to be led".

438. I see our role as not waiting to be told what to do in an organisation but to be able to go and profile that business and set out what the needs are and what the leadership strategy needs to look like.

Independent practitioner, England

Future needs

439. The standards need to reflect the future needs, the societal impact and the occupational required impact of the next generation of workers taking into consideration technology, gaming, flexible contracts and working from home.

440. We need to be aware that there is a difference in how and where people work. Younger people aren't staying in one organisation for their whole career, they are moving around.

Manager, Northern Ireland

Health risk management

441. Occupational Health Nurses should be able to utilise the data they receive from assessments and use health risk management to inform workplace interventions. Health risk management is considered important to future proofing this role because they will be able to inform the design of the workplaces of the future which leads to good health outcomes.

442. It's about being on the front foot instead of waiting for disease or illness to happen.

Chief Operating Officer and Head of Occupational Health and Wellbeing, England

Life course

443. One educator believes that the standards should focus on the working age population, which will continue to increase in the future. However, another educator in England believes that the life course focus should include the wider family members of a worker for "healthy workers will raise healthy families". They believe that this supports co-education alongside other advanced practitioner roles such as School Nurses and District Nurses.

444. I have concerns regarding the life course approach. We should focus on the working age population – it is hard enough to include the required learning for that group.

Emeritus Professor of Occupational Health

Mental health

445. Promoting and understanding mental health issues in the workplace was viewed as a positive step forward. However, a lecturer in England voiced their concerns about teaching this as they themselves have not undertaken mental health training. They saw this as an issue if delivering mental health training to students was added to the new standards.

Practice placements

446. A lack of practice placements and the impact this has had on students developing their skills and careers is an important topic for educators. In England it was said that finding practice placements is becoming more difficult with universities having to turn students away from courses. This is due to organisations stating that student practice placements are not a core requirement for their business, or they do not have the time. This was stated to be particularly worse for self-funding students who have worked for free and still cannot secure a placement.

447. I had to turn down six applications last year because they hadn't got a placement in which to work which is heart breaking. To tell a student that they can't come on the course because they haven't found a placement is really bad.

Senior Lecturer in Post-Graduate Health Care, England

448. In Northern Ireland however education councils have been proactive in helping students find practice placements and have been placing students in an array of settings to get them a wider and richer experience. It was therefore felt that that standards should acknowledge this issue to retain students.

449. In Northern Ireland our education councils have been very proactive and want to place students in any setting. They're knocking on doors and […] trying to engage with undergraduates, just anywhere they can get them into so they can get a richer and wider experience.

Chief Nurse (Occupational Health), Northern Ireland

Shared learning

450. An educator in England claims that shared learning works well at their university for they provide an occupational health focus at the end of each keynote lecturer incorporating health coaching and behaviour change into shared modules. However, another educator felt that students need to graduate as experts in their area of practice rather than generalists and shared learning does not provide students with the specific skills and knowledge required to practice Occupational Health Nursing at an advanced level.

8.5 SPQ Programme Standards

451. The NMC are scoping what the content might be for standards of proficiency for a new SPQ in community nursing with the potential to move community nursing into regulated advanced practice. The NMC are proposing for one SPQ programme to be developed with core standards that will apply to all SPQ roles with bespoke standards for different areas of practice that are required. Two SPQ Initial Discussion Groups (IDG) meetings took place with educators and stakeholders to discuss the skills and knowledge required of SPQ community practitioners of the future. Based on the information provided by the attendees, the majority of participants appear to be based in England only, therefore it is to be noted that views, services and experiences may differ in Northern Ireland, Scotland and Wales to what is mentioned below. Twelve themes emerged from these two meetings and the most common and pertinent are included in this analysis. The 12 themes include:

Community (2)
Complexity (3)
Employer buy-in (2)
Holistic assessment (3)
Language and terminology (4)
Organisations' understanding of SPQ (3)
Prescribing (1)
Qualifications (4)
Regulation (8)
Specialist Learning Disabilities Nurses (3)
Technology (1)
Core competencies and specialist routes (16)

Language and terminology

452. Stakeholders from England believe that the SPQ programmes should be classed as advanced practice and the language used in the standards should therefore be adapted to this level. The language should be inclusive and appropriate for all levels and role expectations. It was also noted that the

definition of community needs to be clearly defined so community nurses understand that this qualification is designed for them.

453. There is no point adapting the language to an advanced level if this isn't going to be called an advanced practice standard. That language has to fit the level and the role expectations.

Head of Division, England

Regulation and nursing titles

454. Participants stated that regulation is important for community nurses for it shows that they have had to meet high standards to practice at that level. Several participants were concerned that, currently, other nursing professionals can call themselves a District Nurse, for example, without completing the SPQ. Participants proposed that the NMC consider regulating the nursing titles in the future to strengthen public protection and public trust.

Core standards and specialist routes

455. Some participants felt it would be a great loss to lose a route specific title in community nursing, especially District Nursing, if there was only one specialist route. If the SPQ was only one qualification, then the specialism would be difficult to determine. Generally, participants are in favour of core standards for SCPHN and SPQ with route specific standards for each specialism as many students across public health and community nursing are already studying together with good outcomes. It was strongly felt that each of the SPQ areas of practice, particularly District Nursing and Community Children's Nursing, are all advanced and unique and they should not become generalised in order to make way for one SPQ route. There were also concerns regarding the interpretation of a more generic SPQ which would then devalue each specialism.

456. I think there could be core standards for SCPHN and SPQ, route specific standards and skills annexes - this will provide economies of scale. It would also allow advanced practice to join as a specific route, not to supersede the routes. Route specific titles support patient safety.

Dean for Education and Director of Postgraduate Programmes, England

457. I think that we need to tread very carefully. Far too many person specifications contain the words "or equivalent" in the essential requirement column. There is no "equivalent" for the DN or CCN SPQ, but if we create a more generic qualification, then this creates the potential for interpretation of equivalence that would dilute the value of the qualification.

Consultant Nurse, England

9. Email feedback analysis and virtual postcard responses

9.1 Analysis of open response data from the dedicated PRSCOI email inbox

458. The following sections provide an overview of the key themes emerging from analysis of feedback provided by practitioners and other professionals via email following events held as part of this consultation.

459. It explores feedback specifically for the Specialist Community Public Health Nursing (SCPHN), Specialist Practice Qualifications (SPQ), and the programme standards for these.

9.1.1 Specialist Community Public Health Nursing (SCPHN)

460. A total of 53 participants provided feedback specifically relating to SCPHN. Key themes mostly related to the content they believed the standards should consider and reflect, this included:

Person or family-centred 'life-course' approach

461. Participants, particularly Health Visitors, often noted the importance of ensuring the standards reflect supporting the holistic needs of the individual and how the family can be part of the process. It was felt that this would ensure continuous support at all ages, although it was not an 'all-age' approach due to the need for specific specialisms and focus on different age categories.

462. Life course approach should be adopted. Care needs to be holistic and continuous.

Health Visitor

Public health and wellbeing

463. Ensuring promotion, education, and support for general public health was important to participants from a range of roles. It was noted this could include healthy eating, hygiene, and self-care (a few participants also highlighted the need for professional self-care). Several also mentioned that reference should be made to immunisation and infection control.

464. Are there any discussions underway around health promotion specialism and standards?

Educator

Equality, diversity, and responding to the needs of the community

465. Participants from a range of roles also noted the importance of ensuring practice promotes health equality and meets the needs of the local community and specific communities within this.

Critical thinking and data management

466. The ability for a SCPHN to effectively utilise critical thinking (including research, evaluation, and use of evidence-based practice) and data management to contribute to service improvement was also

seen as important by participants across the roles. In addition, a small number of participants mentioned that service improvement (including through use of technology) and working towards targets and goals should also be considered.

Safeguarding and risk management

467. Participants (particularly Health Visitors) also noted the importance of including safeguarding and risk management skills for SCPHNs and understanding the nuances of child protection.

468. Focus of role must be on delivering children's needs. Safeguarding and child protection can lead to conflicts of interest as that also involves the needs of the parents.

Health Visitor

Prescribing

469. Prescribing was discussed particularly by Health Visitors. Most Health Visitors who commented supported prescribing in the role, only one did not support this. A small number of those in occupational health also discussed prescribing, seeking clarity on what this and social prescribing would involve for their role.

Consideration of existing standards and terminology

470. Participants, mostly from the SCPHN core group, also highlighted the importance of ensuring the new standards were mapped and rationalised with existing standards and frameworks. These included PHSKF, UKPHR/FPH, and key public health principles. It was also noted that terminology used needs to be consistent with existing language and inclusive of those working outside of NHS settings.

Work and health considerations

471. Several participants highlighted specific skills and considerations for those working in occupational health. This includes the need to have business acumen and understanding of the impact of health on delivery; understanding of employment law; skills for full assessments; delivering health surveillance; and devising rehabilitation plans.

Partnership working

472. Some participants commented that the standards should include effective partnership working, both within the profession and with wider partners and agencies.

Strategic, commissioning, and commercial understanding

473. Some participants also noted the standards should include the ability to think and act strategically, particularly with awareness of local and national politics, understanding of the commissioning process, and more commercial acumen. This was of particular importance to those from the SCPHN core group.

474. Big strategic implications for the future of nursing relates to commissioning. There is mentions of commissioning research, but surely SCPHNs should contribute to commissioning development & delivery of public health services?

Stakeholder

Mental health, wellness, and early intervention

475. Several participants, particularly school nurses, thought consideration of mental health should be reflected in the standards. Support for young people and early intervention was key in this. Several participants also noted the importance of advocacy and promoting self-advocacy for patients.

Recognition and reflection of different nursing roles

476. Several participants (mostly non-practitioners) mentioned that the standards should recognise and clarify key differences between different nursing roles and specialities, and ensure content and language used reflect this.

477. Lumping them all as community specialist SCPHNs really does not describe/explain what they do! I think anyone working in the community would and could claim they have specialist community skills.

Leadership

478. More generally, participants (particularly Health Visitors) noted the need for the inclusion of core leadership skills including management of teams and individuals, communication skills, and ability to work autonomously.

Specific skills

479. A number of participants also mentioned the standards should consider specific skills for SCPHNs including complex case management, chronic condition management, and palliative care. Others noted the need for specific medical knowledge and clinical skills.

Programme delivery

480. A small number of respondents also commented on the need to ensure the course was of high quality, noting the importance of the teaching and learning experience. Others thought more clarity should be built into the admissions process and to ensure existing learning is sufficiently recognised.

9.1.2 Specialist Practice Qualifications (SPQ)

481. A total of 23 participants provided feedback specifically related to the SPQ. While feedback was specific to the individual and their key areas of interest, some clear themes were apparent from their feedback.

Ensuring clear consideration and distinction for different specialisms

482. It was important for participants that the overall structure of the SPQs ensure sufficient consideration is given to the specific SPQs that are included and what they comprise. In particular the role of 'Community Nursing' was seen as too broad for some given the diversity in this practice with

specific offshoots including GPs, mental health (particularly among children and young people), Care Home Nursing, Prison Nursing, Homeless Health Nursing. It was also noted by one participant that the language included needs to reflect the wide range of contexts that practitioners may work within.

483. It is with some dismay that General Practice Nurses have not had bespoke standards as our respective colleagues in school nursing, occupation health nursing and health visitors have. Are the NMC aware of the increasing autonomy that General Practice Nurses are working?

General Practice Nurse

Specific training required

484. Several participants also noted areas of practice where additional training and knowledge should be built-in to the qualifications. This included general public health promotion and education, understanding of mental health, advanced clinical skills, working with older people, palliative care, sexual health, and safeguarding.

Leadership

485. Several participants commented that the SPQ should include leadership skills, such as leading and managing teams, strategic awareness, autonomy, critical thinking, education of others, and service development/improvement skills.

Providing clear pathways for progression and levels required

486. It was also important for some participants that there should be clarity regarding ongoing progression routes and the levels at which different skills and care should be required for different roles.

487. My concern is that if the distinct-ness of the routes is lost, services may no longer support/fund/require for more senior roles. Team leadership should require qualification at this level, not for it to be a choice, otherwise, this will be variable and potentially lost.

District Nurse

Mapping to and recognition of existing standards

488. Ensuring the SPQs took into consideration existing standards and qualifications was also important to a number of participants. This included the Advanced Nurse Practitioner role, Apprenticeship standards, QNI/QNIS Voluntary Standards, and Advanced Clinical Practice.

Prescribing

489. Some participants mentioned the including prescribing in the role, with one emphasising the value of social prescribing.

Equality and diversity

490. A small number of participants discussed reflecting the diverse needs of specific communities and individuals, and for SPQ the role and practice to include this.

9.1.3 Programme Standards

491. A total of 9 participants provided feedback specifically relating to the programme standards. Due to the low number of responses specifically relating to this element of the consultation very few clear themes emerged among participants. However, key points for consideration include:

Teaching and learning

492. Most participants focused on the importance of ensuring a high-quality teaching and learning experience. This included: through 360-degree learning between teachers and students; having clear guidance for quality assurance and monitoring; ensuring courses are developed to reflect the specific context and needs of the different learner types and specialities; and ensuring a good balance of theory and clinical practice.

Admissions criteria

493. A small number of participants noted that admissions criteria for those registering on SCPHN need to establish minimum levels of applied experience and qualifications. One participant also mentioned that the admissions should consider experience and learning gained outside of the UK.

Number of standards that will be developed

494. A small number of practitioners commented on the extent to which SCPHN and SPQ could be developed with one set of programme standards. One participant was clear that they felt the differences between the roles need to be very apparent and two sets of standards may be appropriate; however, they acknowledged that there were opportunities for some crossover and joint teaching so long as specific routes were identified within this and maintained professional identity. Another participant felt one set of standards would be appropriate if there was clarity between the commonalities and differences in the different roles.

9.2 Analysis of the virtual postcard responses

495. The following sections provide an overview of the key themes following analysis of open response data from 252 participants who submitted virtual postcards.

496. Broad quantifiers are included in this analysis to provide an indication of the scale of certain themes in the responses; however, these should not be considered to be statistically robust due to the open and qualitative nature of the responses e.g. a respondent not mentioning a particular theme does not mean they would share or not share similar sentiments if asked.

497. It should be noted that in some instances participants have discussed similar themes of interest to them in both questions, and as such there is some crossover in these findings.

9.2.1 Question 1. Important factors that should be taken into account for community and public health nursing practice when developing new post-registration standards

498. In keeping with feedback across the consultation, a wide range of priorities were raised by participants that need to be kept in mind when developing new post-registration standards. The main areas of focus are explored in the following sections.

499. Where possible we explore the key differences observed based on role and area. Low numbers on some of the themes (fewer than 20) mean observations on differences by role and location are limited to some of the more prevalent themes including reflecting the changing nature of the role, recognising how the standards fit with existing systems, general leadership skills, collaborative working, equality and diversity, public health education and ensuring individual and family-focused care.

Ensuring the standards reflect the nature of the role

500. Many (approx. 1 in 5) of the participants noted that the standards should reflect the increasing importance of the role, its complexity, the high level of specialism needed, and its changing nature (for example, through the changing needs of communities and the integration of 0-19 School Nursing and Health Visiting services). It was felt by some that a strong workforce needed to be developed to reflect this and to raise the profile of what they deliver.

501. The specialist role and the extended practice skills underpinned by dynamic theory that fits with a specialist nursing role.

Lecturer/Education role, Wales

502. That they are contemporary and reflect the roles that DN are undertaking.

Lecturer/Education role, England

503. To recognise the value and importance of the roles and the added extra that they bring to community teams.

Lecturer/Education role, England

504. This theme was particularly discussed by lecturers and educators, and managers. Among practitioners (particularly those based in England), several discussed the need to better define and promote the role of school nurses.

Ensuring the standards are clearly defined and rationalised with existing structures

505. Linked to the previous section, many participants (approx. 1 in 5) noted the importance of ensuring the role was clearly defined, with protection and clarity for job titles, and consideration about how the new standards fit in with other existing frameworks and qualifications.

506. Not repeating standards, keep them precise. Current standards are repetitive.

Practitioner

507. A clear pathway is needed to demonstrate how practitioner should move from novice to expert, so defining expert level practice.

Lecture, Wales

508. Again, this theme was of particular importance for lecturers and educators, and managers. A small number drew attention to existing frameworks that needed to be considered including national frameworks for learning disabilities nursing, the NHS Education Scotland Post Registration Career Development Framework, and Apprenticeship standards.

Leadership

509. Leadership skills were also highlighted by participants (approx. 1 in 6) as a key factor for consideration. Within this they particularly noted the importance of communication skills (both in person and using social media), team management (including management of differing skillsets and different management approaches), legal understanding, ability to support service improvement, and accountability.

510. They need to reflect the leadership role and managing large staff numbers in teams.

Lecturer, England

511. Communication across discipline and management boundaries - which includes advocacy, self-belief, challenging the 'status quo'.

Lecturer, England

512. Leadership was most likely to be mentioned by lecturers and educators (particularly those in Scotland). Among practitioners this was a particular area of interest for those with school-facing roles.

513. In addition, some participants (approx. 1 in 13) noted that as part of this the role needed to consider awareness and understanding of political priorities, in both the local and national context. It was felt this should include awareness and understanding of changes to budgets and commissioning.

Collaborative working and integration activities

514. A significant number of participants (approx. 1 in 8) also noted the importance of the need to conduct collaborative working effectively with a range of partners (including community leaders, the voluntary sector, and other health and social care representative). Some noted this was particularly important to ensure successful outcomes.

515. A small number also specifically noted the importance of working within newly integrated structures such as primary care networks.

516. Need to link closely with Primary Care Networks to develop fit for purpose workforce in an Integrated Care system model.

Manager, England

517. The themes and priorities emerging for collaboration were broadly consistent among different role-types, although among practitioners it was particularly important for those who were more generalist in practice and community-based.

518. Collaboration was also seen as a particularly key theme for those from Wales, who were the most likely to mention this.

Equality and diversity

519. Equality and diversity was a key factor for a significant number of participants (approx. 1 in 8) to ensure positive outcomes and health equality for all groups. This included the ability to work with diverse and hard to reach populations, as well as those with protected characteristics, and effectively understanding and meeting the needs of specific populations.

520. Working with vulnerable families, understanding the community requirements.

Practitioner, Wales

521. Looking for/awareness of health inequalities and reducing them.

Practitioner, England

522. Ensuring consideration of quality and diversity was most likely to be mentioned by more senior or strategic respondents, and those with managerial responsibilities. Those in Wales were also more likely to discuss this theme.

Ongoing education and qualifications

523. Some participants (approx. 1 in 10) also emphasised the need for the standards to consider the importance of ongoing education and qualifications to ensure practitioners continue to develop, respond to changing demands, and allow the flexibility to progress in their role. Lecturers and educators were the most likely group to mention this theme.

524. I believe that future practitioners should continue to be able to move between roles through additional study. So much of public health work is transferrable between the different roles.

Practitioner, England

525. A small number also noted the importance for practitioners to also have the skills to provide education and support for their colleagues.

Public health

526. Participants (approx. 1:10) also believed a key area to be reflected in the design of the standards was the ability to provide support to improve public health in the long-term. This would include education, promotion, and prevention activities such a good hygiene practices, healthy eating, and self-care.

527. Self-care, health promotion, holistic care and seeing beyond a clinical need or task.

Practitioner

528. The focus of public health education appears to be more significant not just due to Covid-19 but other potential pandemics and microbial resistance affecting disease recovery. In addition 'epidemics' relating to lifestyle factors such as obesity, diabetes, stress, abuse and ensuring we develop specialists that can tackle these challenges in a creative way, looking at robust evidence and having the skills to test out theories for change that suit the communities they are working within.

Lecturer, England

529. General public health education was most likely to be mentioned by educators and those from Wales. Among practitioners it was particularly important for those who were more generalist in practice and community based.

Person-centred care and family work

530. Linked to the need for ongoing education and prevention of public health, some participants (approx. 1 in 11) emphasised the importance of ensuring the standards reflect the need for community-based work to provide tailored support to individuals, often working with the whole family to improve overall outcomes. This was seen as particularly important for those working with children and young people.

531. Empowering parents to make informed choices by building solid relationships and creative skills to incorporate evidence-based practice.

Practitioner, England

532. To ensure that HVs are equipped with the relevant skills to effectively engage with service users and work in partnership to promote healthy behaviours.

Lecturer, Scotland

533. Again, similarly to the focus on general public health, individual and family-focused work was most likely to be mentioned by educators and those from Wales. Among practitioners it was particularly important for those who were more generalist in practice and community-based and those in school-settings.

Case management

534. Some participants (approx. 1 in 13) noted the importance of case management and in particular the ability to manage more complex cases including chronic and palliative care.

535. Palliative care and end of life care seen as an essential component of the training.

Lecturer, England

536. Complexity of patients and advanced assessment skills required.

Practitioner, England

Lone working and autonomy

537. Another area highlighted for consideration by a small number of participants (1:14) was ensuring the standards reflect the needs or practitioners who often work alone and to ensure that they had sufficient autonomy to be able to do this effectively.

538. Increasing the confidence of becoming even more autonomous practitioners especially able to adapt to remote working.

Lecturer, England

Mental health and emotional wellbeing

539. A small number of participants (approx. 1 in 15) also highlighted the importance of ensuring the standards considered supporting patients with mental health difficulties and worked with them to improve resilience. Several particularly noted the importance of mental health in relation to children and young people.

Critical thinking and data management

540. Critical thinking and data management skills, including understanding of evaluation and evidence-based practice, were also considered key factors for consideration in the standards (mentioned by approx. 1 in 15 respondents). It was felt this would support overall improvement.

541. Critical analytic thinking - so we can disseminate and apply research findings in adjunct with 'lived' practical clinical experience as well as lived 'patient' experience & expertise; this will help us to deliver evidenced based 'care' to our communities.

Practitioner, England

Prescribing

542. A small number (approx. 1 in 16 of participants) discussed the need for the standards to consider prescribing, both medically and socially. Most were in favour of the need for prescribing and specifically for the use of the V300 level, although one Northern Ireland-based respondent did wonder if this may be off-putting to some students.

Other considerations

543. A number of other issues were discussed by a small number of participants (where these amounted to between 10 and 15 respondents), this included ensuring the standards considered:

544. use of technology for improvement;

545. advanced assessment and clinical skills;

546. safeguarding;

547. specialist skills required for occupational health such as knowledge of the law and different employer-types and contexts; and

548. specialist skills required for those delivering support for children and young people.

9.2.2 Question 2. Themes that the new standards for community and public health nursing should cover

549. As noted previously, the themes participants believed the standards should cover are broadly consistent with the factors they felt the design should take into account, although without discussion of the complexities or the role and how the standards will work within existing systems. These themes and their prevalence are discussed further below. Again, where possible we explore the key differences observed based on role and area.

Leadership

550. Approximately 1 in 3 respondents mentioned general or specific leadership skills they believed the standards should include, such as team and caseload management, business management, general professionalism, communication skills (both face-to-face and on social media), and awareness of local and national politics and ecosystems).

551. Professionalism, leadership, accountability.

Practitioner, Scotland

552. Something around business management or project management skills.

Manager, England

553. Leadership, practice development, specialist knowledge and role as educator.

Practitioner, Northern Ireland

554. Lecturers, educators and managers were the most likely to discuss the need for leadership skills. Among practitioners, those who were school-facing were particularly likely to discuss this. When country is considered, those from Wales are the most likely to discuss leadership skills.

Collaborative working

555. Approximately 1 in 4 participants highlighted the importance of collaborative working with various partners, including the community and voluntary sector, and health and social care partners.

556. Inter-professional, interdisciplinary and inter-specialist working, partnership working.

Stakeholder, Scotland

557. Multidisciplinary-cross boundary working.

Practitioner, England

558. Highlighting the need for collaborative working was broadly consistent among respondents; however, practitioners who are school-facing were more likely than others to mention this. Participants from Scotland were the least likely to discuss the need for collaborative working in their responses.

Equality and diversity

559. Approximately 1:5 participants believed the standards should include equality and diversity, in particular working with diverse and hard to reach individuals and communities, including community development work.

560. Social Inequalities / Responding to the needs of BAME communities / Cultural Awareness.

Lecturer, England

561. Working with vulnerable groups...families who are homeless, asylum seeking, drug and alcohol abuse.

Lecturer, England

562. Lecturers and educators were the most likely to discuss the need for equality and diversity skills to be included, particularly those from Wales. Among practitioners, those who were community or school-facing were particularly likely to discuss this.

Public health

Approximately 1:5 participants believed the standards should include consideration of general public health behaviours (including hygiene, healthy eating and exercise, and self-care). They believed practitioners should be involved through education and promotion to help prevent health issues.

563. Health promotion, disease prevention, early identification and improving early years outcomes.

Manager, England

564. Promotion of public health and self-care (personalisation and giving control back to the patient without fear of recrimination / litigation).

Manager, England

565. Lecturers and educators were also the most likely to discuss the need for consideration of long-term public health themes. Among practitioners, those who were school-facing were particularly likely to discuss this. By country participants from Wales are the most likely to discuss this and those from Scotland the least likely.

Person-centred care and family work

566. Linked to public health, approximately 1 in 6 participants discussed the need to ensure the standards included a focus on delivering individual and family-specific support to help tackle their specific needs and improve outcomes.

567. Developing personal and family resilience to tackle and build on good health.

Lecturer, England

568. The focus on the family and individual was of particular importance to practitioners who were community or school-facing and those based in England.

Safeguarding

569. Approximately 1 in 6 participants believed safeguarding should be considered in the standards, typically this involved safeguarding children and young people and the vulnerable, as well as an understanding of risk and how the practitioner may also remain safe.

570. Safeguarding key and ever-growing complexities. Will be more important in predicted falling economy which will also affect widening of inequalities.

Manager, Wales

571. Legal frameworks and risk assessment and management while keeping a safe relationship.

Practitioner

572. Lecturers and educators were the most likely to discuss safeguarding considerations, among practitioners it was also particularly important to those involved in school-based delivery, those in communities, and those with mental health roles. When country is explored, respondents from Wales are the most likely to discuss safeguarding.

Mental health and emotional wellbeing

573. Approximately 1 in 7 participants felt the standards need to ensure consideration of patient mental health and wellbeing, this was particularly the case for children and young people.

574. Practitioners are the most likely to discuss the need for the standards to include consideration of mental health needs, particularly those who are schools-facing. By country, respondents from Wales are the most likely to discuss mental health.

575. A small number also noted the importance of practitioner health and wellbeing.

576. Building a culture of staff wellbeing and resilience.

Practitioner, Scotland

Critical thinking

577. Approximately 1 in 8 participants noted that the standards need to ensure practitioners have an understanding and awareness of research, evaluation, data, and targets to support evidence-based practice and improvement.

578. Protecting and promoting health through clinical evaluative work.

Practitioner, Wales

579. Service development (audit, change management, evaluation of impacts on patient care).

Manager, England

580. Lecturers, educators and managers were the most likely to discuss the need for critical thinking skills. When country is considered, those from Wales are the most likely to discuss this.

Education

581. Approximately 1 in 9 participants noted that the standards should include commitment to providing and receiving education, training, and support. It was felt this would help with overall workforce development, and advance practice.

582. Equitable, evidenced based, life /profession long learning with appropriate specialist skills and learning/academic opportunities including research.

Lecturer, England

583. Lecturers and educators were the most likely to discuss education, among practitioners this was most likely to be mentioned by those in community-facing roles.

Prescribing

584. Approximately 1 in 9 participants believed the standards should cover prescribing (with some specifically mentioning the V300 standard). A small number also mentioned non-medical and social prescribing within this.

585. I think that the independent prescribing should replace the V100 qualification which has very little value in general practice. I feel the independent prescribing would be a better tool to enable the specialist practitioner to be more autonomous and have a better understanding of both chronic disease management and acute minor illnesses.

Manager, Wales

586. V300 included in programme not as additional study.

Lecturer, England

587. The need for prescribing to be included in the standards was most likely to be discussed by managers.

Medical needs and management

588. Approximately 1 in 12 respondents believed the standards should include requirements specifically for complex and chronic case management, and for palliative care.

589. Chronic Disease management/vaccinations/wound management.

590. Proactive planning and supporting patients identified as palliative or at the end of their life.

Lecturer, England

591. The need to include medical needs and management in the standards was most likely to be discussed by practitioners from community and school-based settings, and particular among those in England.

Other considerations

592. A small number of participants also noted wider considerations for the standards including, IT and remote working skills, enabling autonomy, ensuring clinical skills and expertise, sexual health, peri/ante/post-natal health, infectious diseases and immunisation, and understanding of employment law.

10. Summary

Focus of the events

593. The 39 webinars, roundtable events and other engagement events that took place between June and September 2020 generated a wealth of information from a wide range of participants who shared their opinions, experiences, questions and views on the SCPHN and SPQ programmes and the specific public health and community nursing professions. Participants ranged from frontline practitioners, educators, employers and advocacy groups.

594. The focus of each event was to consider the competencies and proficiencies required for specialist nurse practitioners to ensure they are equipped with the knowledge and skills they need to deliver high quality care in the future. This focus sometimes got a little lost during the discussions, mainly with practitioners, who commented on their current practice and current issues. Gentle reminders were sometimes needed in order to encourage participants to think much more widely than the here and now, and to explain exactly what is meant when someone labels a skill or attribute as 'advanced' or 'specialist' – i.e. what do you need to do in order to communicate at an advanced level?

Covid-19

595. The webinars, roundtable events and other engagement events took place during lockdown and the easing of restrictions across the UK as the health service started to recover slightly from the Coronavirus pandemic. This unprecedented experience sometimes shaped the discussions particularly around the use of digital technologies and redeployment.

NMC regulation

596. The majority of participants believe that both SCPHN and SPQ qualified nurses are already practicing at an advanced and specialist level and therefore they should be recognised as such. Regulation maintains standards, quality, consistency and protects the public. Many participants however are concerned that some nurses can call themselves a District Nurse or a School Nurse without completing a SCPHN or SPQ programme and see this as an issue concerning public trust and safety. Some participants would like to see nurse titles regulated by the NMC in the future.

Core Standards

597. Many different stakeholders believe that SCPHN and SPQ programmes could have one set of core standards due to similar areas of learning and the fact some programmes are taught together. However, participants passionately defended each specialism identifying advanced and unique skill sets and areas of knowledge that, they believe, if not included in a core set of standards, would be side-lined and thus have a significant impact on each specialist profession and the care they provide. This was particularly evident from District Nurses who manage large caseloads and teams. They held concerns about losing the title of the District Nurse due to the value this profession holds. Therefore, a good many participants want to keep the standards separate.

However, the preferred option overall would be to have a shared set of core standards with pathways for each specialism with separate sets of standards that could really focus on those specific skills needed for each role.

Common Themes

598. Six common themes emerged during the webinars, roundtable events and other engagement events, virtual postcards and email responses covering both SCPHN and SPQ areas of practice. These are:

Advanced communication skills
Collaborative working
Leadership
Prescribing
Public health
Safeguarding

Each specialist nursing role boasts its own set of themes that may be completely unique or may appear in other specialist nursing roles.

Prescribing

599. An extremely pertinent topic generating a lot of discussion during the webinars, roundtable events and other engagement events, including the virtual postcards and email responses is prescribing. Some nurse practitioners did not feel that prescribing was a requirement for their role based on the fact that they don't need to prescribe currently, or they have a prescribing qualification but hardly use it. This was certainly the case with Community Health Nurses, and with Community Mental Health Nurses especially.

600. There were other areas of nursing that are in favour of prescribing, mainly independent prescribing, as this would offer a timely and holistic service to patients and would be extremely beneficial to those practitioners in rural and hard to reach areas. For many participants, prescribing is viewed as an advanced skill that would elevate their nursing profession and complement their autonomous role.

601. However, other practitioners were concerned that prescribing might be seen as an 'easy option', especially amongst those working within mental health and learning disabilities services. Therefore, these practitioners require demonstrable knowledge of therapeutic interventions instead of solely relying on their ability to prescribe.

602. Educators, although concerned with how a prescribing qualification would fit within the one-year courses, were largely in favour of specialist nurse practitioners being recognised as independent prescribers. The ability to independently prescribe was regarded as a skill these nurses would need in their future toolkit to deliver holistic, autonomous care. They did acknowledge, however, that some students, practitioners and employers may need further encouragement to recognise this.

603. The pre-engagement online events, virtual postcards and email responses provide an incredible and vast collection of what current frontline practitioners, educators, employers and other stakeholders believe are the core and unique qualities, skills and attributes of SCPHN public health nurses and SPQ community nurses. As stated previously, this report and accompanying spreadsheet prepared by Pye Tait Consulting (with over 2,120 rows of information and 250 themes gained through extensive virtual engagement activity) presents the NMC with a wealth of qualitative data. The data will help influence and shape the new draft standards of proficiency and accompanying programme standards in preparation for public consultation as part of the process to determine what future specialist practitioners need to know and be able to do to fulfil SCPHN and SPQ roles.

Appendix – List of all webinars

Table 1: A chronological list of all webinars that Pye Tait Consulting attended and thematically analysed

	Programme	Date	Event Title
1	SCPHN	29th June 2020	SCPHN webinar
2	SPQ	30th June 2020	SPQ webinar
3	SCPHN	10th July 2020	School Nursing webinar
4	SCPHN	15th July 2020	Occupational Health Nursing webinar
5	SCPHN	20th July 2020	Follow up Roundtable: SCPHN Core
6	SCPHN	21st July 2020	Health Visiting webinar
7	SPQ	22nd July 2020	Follow up roundtable with frontline practitioners
8	SCPHN	23rd July 2020	Roundtable with educators
9	SCPHN	24th July 2020	Roundtable with School Nurses
10	SCPHN & SPQ	27th July 2020	Roundtable with educators and students
11	SCPHN	28th July 2020	Prescribing meeting
12	SCPHN	29th July 2020	Roundtable with Health Visitors
13	SPQ	30th July 2020	SPQ IDG 2

14	SPQ	30th July 2020	Follow up roundtable with Advocacy Groups – Disabilities and Long-Term Conditions
15	SCPHN	31st July 2020	Health Visiting standards discussion group meeting
16	SPQ	31st July 2020	SPQ IDG 3
17	SCPHN & SPQ	31st July 2020	Follow up round table with Advocacy Groups – Older People
18	SPQ	3rd August 2020	Specialism Discussion Group with 5 breakout groups: Community Children's Nursing
19	SPQ	3rd August 2020	Specialism Discussion Group with 5 breakout groups: Mental Health Nursing
20	SPQ	3rd August 2020	Specialism Discussion Group with 5 breakout groups: Learning Disabilities Nursing
21	SPQ	3rd August 2020	Specialism Discussion Group with 5 breakout groups: General Practice Nursing
22	SPQ	3rd August 2020	Specialism Discussion Group with 5 breakout group: District Nursing
23	SCPHN & SPQ	3rd August 2020	Roundtable with other professions
24	SCPHN	4th August 2020	Roundtable with Occupational Health Nurses
25	SCPHN	5th August 2020	Programme Standards Meeting

26	SCPHN & SPQ	6th August 2020	Roundtable – Children and Young People
27	SCPHN	7th August 2020	Occupational Health Nursing SDG Meeting
28	SCPHN	7th August 2020	Research and Evidence meeting
29	SCPHN	12th August 2020	Roundtable with employers
30	SPQ	13th August 2020	Additional SPQ discussion
31	SCPHN	14th August 2020	Roundtable with Advocacy Groups – Mental Health and Learning Disabilities
32	SCPHN & SPQ	20th August 2020	Social Care Roundtable
33	SCPHN & SPQ	25th August 2020	Roundtable with employer reps and commissioners
34	SCPHN & SPQ	25th August 2020	Prescribing meeting
35	SPQ	1st September 2020	Webinar: General Practice Nursing
36	SPQ	9th September 2020	Webinar: Community Mental Health Nursing
37	SPQ	9th September 2020	Webinar: Community Learning Disabilities Nursing
38	SPQ	10th September 2020	Webinar: Community Children's Nursing
39	SPQ	10th September 2020	Webinar: District Nursing

Table 2: events re-presented by SCPHN and SPQ

1	SCPHN	29th June 2020	SCPHN webinar
3	SCPHN	10th July 2020	School Nursing webinar
4	SCPHN	15th July 2020	Occupational Health Nursing webinar
5	SCPHN	20th July 2020	Follow up Roundtable: SCPHN Core
6	SCPHN	21st July 2020	Health Visiting webinar
8	SCPHN	23rd July 2020	Roundtable with educators
9	SCPHN	24th July 2020	Roundtable with School Nurses
11	SCPHN	28th July 2020	Prescribing meeting
12	SCPHN	29th July 2020	Roundtable with Health Visitors
15	SCPHN	31st July 2020	Health Visiting standards discussion group meeting
24	SCPHN	4th August 2020	Roundtable with Occupational Health Nurses
25	SCPHN	5th August 2020	Programme Standards Meeting
27	SCPHN	7th August 2020	Occupational Health Nursing SDG Meeting
28	SCPHN	7th August 2020	Research and Evidence meeting
29	SCPHN	12th August 2020	Roundtable with employers

31	SCPHN	14th August 2020	Roundtable with Advocacy Groups – Mental Health and Learning Disabilities
10	SCPHN & SPQ	27th July 2020	Roundtable with educators and students
17	SCPHN & SPQ	31st July 2020	Follow up round table with Advocacy Groups – Older People
23	SCPHN & SPQ	3rd August 2020	Roundtable with other professions
26	SCPHN & SPQ	6th August 2020	Roundtable – Children and Young People
32	SCPHN & SPQ	20th August 2020	Social Care Roundtable
33	SCPHN & SPQ	25th August 2020	Roundtable with employer reps and commissioners
34	SCPHN & SPQ	25th August 2020	Prescribing meeting
2	SPQ	30th June 2020	SPQ webinar
7	SPQ	22nd July 2020	Follow up roundtable with frontline practitioners
13	SPQ	30th July 2020	SPQ IDG 2
14	SPQ	30th July 2020	Follow up roundtable with Advocacy Groups – Disabilities and Long-Term Conditions
16	SPQ	31st July 2020	SPQ IDG 3
18	SPQ	3rd August 2020	Specialism Discussion Group with 5

			breakout groups: Community Children's Nursing
19	SPQ	3rd August 2020	Specialism Discussion Group with 5 breakout groups: Mental Health Nursing
20	SPQ	3rd August 2020	Specialism Discussion Group with 5 breakout groups: Learning Disabilities Nursing
21	SPQ	3rd August 2020	Specialism Discussion Group with 5 breakout groups: General Practice Nursing
22	SPQ	3rd August 2020	Specialism Discussion Group with 5 breakout group: District Nursing
30	SPQ	13th August 2020	Additional SPQ discussion
35	SPQ	1st September 2020	Webinar: General Practice Nursing
36	SPQ	9th September 2020	Webinar: Community Mental Health Nursing
37	SPQ	9th September 2020	Webinar: Community Learning Disabilities Nursing
38	SPQ	10th September 2020	Webinar: Community Children's Nursing
39	SPQ	10th September 2020	Webinar: District Nursing

Table 3: structure of report detailing the amount of themes in each

Section	Content	Coverage	Note
3	Themes of special interest	SCPHN and/or SPQ	3. Themes of special interest
4	Common themes	SCPHN and/or SPQ	4. Common themes4. Common themes4. Common themes
5.1	SCPHN	General summary	5. Specialist Community Public Health Nursing (SCPHN)
5.1.1	SCPHN	Practitioners and stakeholder	4 themes analysed
5.1.2	SCPHN	Educators	2 themes analysed
5.1.3	SCPHN	Employers	2 themes analysed
5.2	SCPHN – Health Visiting	General summary	28 themes in total
5.2.1	SCPHN- Health Visiting	Practitioners and stakeholders	8 themes analysed
5.2.2	SCPHN – Health Visiting	Educators	2 themes analysed
5.3	SCPHN – Occupational	General summary	43 themes in total

	Health Nursing		
5.3.1	SCPHN – Occupational Health Nursing	Practitioners and stakeholders	8 themes analysed
5.3.2	SCPHN – Occupational Health Nursing	Educators	5.3.2 Educators on Occupational Health Nursing
5.4	SCPHN – School Nursing	General summary	35 themes in total
5.4.1	SCPHN – School Nursing	Practitioners and stakeholders	7 themes analysed
5.4.2	SCPHN – School Nursing	Educators	3 themes analysed
6.1	SPQ	General summary	36 themes in total
6.1.2	SPQ	Practitioners and stakeholders	4 themes analysed
6.1.3	SPQ	Educators	1 theme analysed
6.2	SPQ – Community Children's Nursing	General summary	26 themes in total
6.2.1	SPQ – Community Children's Nursing	Practitioners and stakeholders	3 themes analysed
6.3	SPQ – District Nursing	General summary	43 themes in total
6.3.1	SPQ – District Nursing	Practitioners and stakeholders	5 themes analysed

6.3.2	SPQ – District Nursing	Educators	3 themes analysed
6.4	SPQ – General Practice Nursing	General summary	32 themes in total
6.4.1	SPQ – General Practice Nursing	Practitioners and stakeholders	4 themes analysed
6.4.2	SPQ – General Practice Nursing	Educators	2 themes analysed
6.5	SPQ – Community Learning Disabilities Nursing	General summary	26 themes in total
6.5.1	SPQ – Community Learning Disabilities Nursing	Practitioners and stakeholders	4 themes analysed
6.5.2	SPQ – Community Learning Disabilities Nursing	Educators	1 theme analysed
6.6	SPQ – Community Mental Health Nursing	General summary	22 themes in total
6.6.1	SPQ – Community Mental Health Nursing	Practitioners and stakeholders	4 themes analysed
6.6.2	SPQ – Community Mental Health Nursing	Educators	3 themes analysed
7.1	Joint commentary SCPHN and SPQ	Educators	10 themes in total, 5 themes analysed
7.2	Joint commentary	Educators and students	11 themes in total, 3 themes

	SCPHN and SPQ		analysed
7.3	Joint commentary SCPHN and SPQ	Employer reps and commissioners	7 themes in total, 3 themes analysed
7.4	Joint commentary SCPHN and SPQ	Social care professionals	19 themes in total, 4 themes analysed
7.5	Joint commentary SCPHN and SPQ	Other professions	10 themes in total, 2 analysed
7.6	Joint commentary SCPHN and SPQ	Advocacy groups	58 themes in total, 10 themes analysed
8.1	Programme standards	SCPHN programme standards	8 themes in total, 4 themes analysed
8.2	Programme standards	Research and Evidence	15 themes in total, 6 themes analysed
8.3	Programme standards	SCPHN Post-registration standards: Health Visiting	10 themes in total, 3 themes analysed
8.4	Programme standards	SCPHN Post-registration standards: Occupational Health Nursing	19 themes in total, 7 themes analysed
8.5	Programme standards	SPQ Programme standards	12 themes in total, 3 analysed
9.1.1	Email analysis	SCPHN	15 themes
9.1.2	Email analysis	SPQ	7 themes

9.1.3	Email analysis	Programme standards	3 themes
9.2.1	Virtual postcard analysis	Question 1	13 themes
9.2.2	Virtual p analysis	Question 2	11 themes
10.	Summary		

Table 4

Standard 1.1: **Ensure that the applicant is a registered nurse (level 1), a registered midwife or a SCPHN before being considered as eligible to apply for entry onto an NMC approved prescribing programme.**

Table 5

Standard 1.2: **Provide opportunities that enable all nurse (level 1), midwife or SCPHN registrants (including NHS, self-employed or non-NHS employed registrants) to apply for entry onto an NMC approved prescribing programme.**

Table 6

Standard 1.3: **Confirm that the necessary governance structures are in place (including clinical support, access to protected learning time and employer support where appropriate) to enable students to undertake, and be adequately supported**

Table 7

Standard 1.6: **Confirm that the applicant is capable of safe and effective practice at a level of proficiency appropriate to the programme to be undertaken and their intended area of prescribing practice.**

Appendix – Summary of updates to this report

Para/page no.	Amendment	Responsibility	Date
Final para/p10 and p111	Paragraph split into two sentences; final sentence extended.	NMC	27/11/2020
Para 1/p11	November '2019' amended to '2020'.	NMC	27/11/2020
Para 307/p64	Correction: 'Community Learning Mental Health Nursing' amended to: 'Community Mental Health Nursing'.	Pye Tait (author)	16/03/2021
Para 16 and 17/p13	Correct explanation of the structure of the report.	Pye Tait (author)	16/03/2021

Nursing & Midwifery Council

Please tell us what you think about these changes we are planning to make to our standards

This is an easy read survey for members of the public.

We want to know what you think about some changes we are making to our standards.

These are extra standards for registered nurses and midwives who care for people in their own homes or near their homes, not in hospitals.

These standards are about extra things they need to know and be able to do.

You do not have to answer every question, just the ones you want to.

Anything you tell us will be kept private.
No one else will know.

Please tell us what you think by
Monday 2 August 2021

You can tell us what you think by going to **www.pyetait.com/future-community-nurse-easy-read**

Or you can email us at:
consultations@nmc-uk.org.

You can post your answers to:
Research Team
Nursing and Midwifery Council
23 Portland Place
London
W1B 1PZ

Who we are

We are the Nursing and Midwifery Council (NMC).

Our job is to make sure nurses, midwives and nursing associates are safe and kind, and have the skills and knowledge they need to do their jobs well.

This way people will be safe in their care.

Part 1.

Questions about new standards for community nurses who care for you at home or near your home

This includes:

Community children's nurses, community learning disabilities nurses, community mental health nurses, district nurses and general practice nurses.

How important is it for community nurses to be able to:

1. **Work with you and other health and care workers, like physiotherapists, doctors and social workers, to help you make the best decisions about your care?**

☐ Very important

☐ Important

☐ Not important

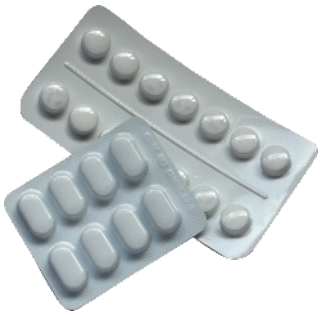
☐ Don't know

2. Support you to live the healthiest life you can?

Very important	Important	Not important	Don't know
☐	☐	☐	☐

3. Examine you if you are worried about your health and plan what needs to be done to help make you better?

Very important	Important	Not important	Don't know
☐	☐	☐	☐



4. Prescribe medicines for you so that you do not need to go to the doctor for your prescription?

Very important	Important	Not important	Don't know
☐	☐	☐	☐

5. Decide when other people are able to look after you and make sure they are doing the right thing?

Very important	Important	Not important	Don't know
☐	☐	☐	☐

6. Make sure that your care is as safe as possible, and stop any accidents or mistakes from happening?

Very important	Important	Not important	Don't know
☐	☐	☐	☐

7. Use their experience and tell others how caring for people like you can be made even better in the future?

Very important	Important	Not important	Don't know
☐	☐	☐	☐

Is there anything else that:

1. **Community children's nurses need to know and do?**

☐ Yes ☐ No

☐ Don't know

Please tell us what

2. **Community learning disabilities nurses need to know and do?**

☐ Yes ☐ No

☐ Don't know

Please tell us what

3. Community mental health nurses need to know and do?

☐ Yes ☐ No

☐ Don't know

Please tell us what

4. District nurses need to know and do?

☐ Yes ☐ No

☐ Don't know

Please tell us what

5. General practice nurses need to know and do?

☐ Yes ☐ No

☐ Don't know

Please tell us what

Should the NMC make sure that other nurses working in the community (like in nursing homes, residential homes or prisons) also know about and are good at doing these extra things that are in the new standards?

☐ Yes ☐ No

☐ Don't know

Please tell us why

Part 2.

Questions about new standards for health visitors, occupational health nurses and school nurses who support you to stay healthy at home, in school or at work

How important is it that health visitors, occupational health nurses and school nurses know how to:

1. Help people get the support they need to keep healthy or be healthier?

Very important	Important	Not important	Don't know
☐	☐	☐	☐

2. Help people who may not have had a full education, cannot work very often, or do not have enough money to be as healthy as possible?

☐ Very important

☐ Important

☐ Not important

☐ Don't know

3. See things that might happen in people's homes, schools or work, that are bad for their health or safety, and try to stop these things from happening (like taking drugs, or falling while at work or school or in their home)?

☐ Very important

☐ Important

☐ Not important

☐ Don't know

4. Notice and act when people do not get the care they need, get harmed, or ignored, and speak up for those people to get help for them?

☐ Very important

☐ Important

☐ Not important

☐ Don't know

5. Prescribe medicine so people do not need to visit a doctor to get their prescription?

☐ Very important

☐ Important

☐ Not important

☐ Don't know

Is there anything else that:

1. **Health visitors need to know and do?**

☐ Yes ☐ No

☐ Don't know

Please tell us what

2. **Occupational health nurses need to know and do?**

☐ Yes ☐ No

☐ Don't know

Please tell us what

3. School nurses need to know and do?

☐ Yes ☐ No

☐ Don't know

Please tell us what

4. Should other nurses who learn to do the things above be able to get a NMC specialist public health nursing qualification?

☐ Yes ☐ No

☐ Do not know

Please tell us why

5. **Is there anything else you want to say?**

Part 3.
More about you

We want to make sure that we have asked lots of different people for their views. So these questions help us do that.

You do not have to answer these questions if you do not want to.

What is your sex? (Please tick one box)

☐ Female ☐ Male

Other (please say)

☐ Prefer not to say

How old are you?

Please say

☐ Prefer not to say

Are you? (Please tick one box)

☐ Bisexual – you fancy both men and women

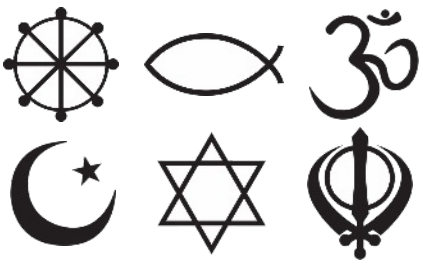
☐ Straight – you fancy people of the opposite sex

☐ Lesbian or gay woman – you fancy other women

☐ Gay man – you fancy other men

Other (please say)

☐ Prefer not to say



Do you have a religion?

Please say

☐ No Religion

☐ Prefer not to say

Are you? Please chose the option that describes you best

Asian, or Asian British

☐ Bangladeshi

☐ Chinese

☐ Indian

☐ Pakistani

Other (please say)

Black, or Black British

☐ African

☐ Caribbean

Other (please say)

Mixed race

- ☐ Asian and white
- ☐ Black African and white
- ☐ Black Caribbean and white

Other (please say)

White

- ☐ English/Northern Irish/ Scottish/Welsh/British
- ☐ Gypsy or Irish Traveller
- ☐ Irish

Other (please say)

Other

☐ Arab

Any other (please say)

☐

☐ Prefer not to say

Do you to have a disability?

☐ Yes ☐ No

☐ Prefer not to say

If yes, please tell us what disability you have.

☐ Blind or can't see very well

☐ Deaf or can't hear very well

☐ Difficulty with speech

☐ Difficulty walking short distances, climbing stairs

☐ Difficulty lifting and carrying objects

- ☐ Difficulties with learning, thinking or remembering
- ☐ Mental health concerns
- ☐ Short of breath or keeping going
- ☐ Autism, Attention Deficit Disorder or Asperger's Syndrome
- ☐ Prefer not to say

Other (please say)

Which country do you live in?

- ☐ England
- ☐ Northern Ireland
- ☐ Scotland
- ☐ Wales
- ☐ Prefer not to say

Other (please say)

Thank you for answering our questions.

Please remember any answers you send will be kept private.

This means we will not see your name when we look at your answers.

Credits

This paper has been designed and produced by the EasyRead service at Inspired Services Publishing Ltd.
Ref ISL201 20. March 2021.

www.inspiredservices.org.uk

It meets the European EasyRead Standard.

Selected photos are from the Inspired.pics EasyRead collection and cannot be used anywhere else without written permission from Inspired Services Publishing Ltd.

www.inspired.pics

The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland. Registered charity in England and Wales (1091434) and in Scotland (SC038362).

23 Portland Place, London W1B 1PZ
T 020 7637 7181
www.nmc.org.uk

ROYAL PHARMACEUTICAL SOCIETY

A Competency Framework for all Prescribers

PUBLISHED: SEPTEMBER 2021

EFFECTIVE DATE: SEPTEMBER 2022

REVIEW DATE: SEPTEMBER 2026

Contents

To support the effective and timely implementation of this framework, organisations, healthcare professional regulators, higher education institutes and individuals will have until September 2022 as a transition period to fully implement the framework in practice. However, higher education institutes and other organisations are encouraged to implement and embed the framework as soon as possible.

1 Introduction

Doctors are by far the largest group of prescribers, who along with dentists, are able to prescribe on registration. They have been joined by non-medical independent and supplementary prescribers from a range of other healthcare professions, who are able to prescribe within their scope of practice once they have completed an approved education programme. This extension of prescribing responsibilities to other professional groups is likely to continue where it is safe to do so and there is a clear patient benefit.

To support all prescribers in prescribing safely and effectively, a single prescribing competency framework was published by the National Prescribing Centre/National Institute for Health and Care Excellence (NICE) in 2012[1]. Based on earlier profession-specific prescribing competency frameworks [2,3,4,5,6,7] , the 2012 single prescribing competency framework[1] was developed because it became clear that a common set of competencies should underpin prescribing, regardless of professional background.

NICE and Health Education England approached the Royal Pharmaceutical Society (RPS) to manage the update of the framework on behalf of all the prescribing professions in the UK. The RPS agreed to revise and update the framework in collaboration with the other prescribing professions and members of the public. The Competency Framework for all Prescribers was first published by the RPS in July 2016. Going forward, the RPS will continue to maintain and publish this framework for all regulators, professional bodies, education providers, prescribing professions and patients/carers to use.

For further information on the 2021 update including why and how it was updated, and the changes made, please see the RPS website here: https://www.rpharms.com/cfap

2 Purpose

This competency framework has been developed and updated to support prescribers in expanding their knowledge, skills, motives and personal traits, to continually improve their performance, and work safely and effectively. When acquired and maintained, the prescribing competencies in this framework will help healthcare professionals to be safe and effective prescribers who support patients in getting the best outcomes from their medicines. This framework has been developed for multi-professional use and provides the opportunity to bring prescribing professions together to ensure consistency in the competencies required of all healthcare professionals carrying out the same role.

This framework can be used by various groups:

- It can be used by any prescriber at any point in their career to underpin professional responsibility for prescribing.
- Prescribers can use the framework as a self-assessment tool when expanding scope of practice, changing scope of practice or returning to practice.
- Regulators, education providers, professional organisations and specialist groups can use it to inform standards, the development of education, and to inform guidance and advice.
- Individuals and their organisations can use it to analyse the way they do their jobs.
- Prescribing trainees can evidence the framework to demonstrate they are delivering the competencies required of their role.

This framework can be used to:

- Bring professions together and harmonise education for prescribers by offering a competency framework for all prescribers.
- Inform the design and delivery of education programmes, for example, through validation of educational sessions (including rationale for need), and as a framework to structure learning and assessment.
- Help healthcare professionals prepare to prescribe and provide the basis for on-going continuing education and development programmes, as well as revalidation processes. For example, use as a framework for a portfolio to demonstrate continued competency in prescribing.
- Help prescribers identify strengths and areas for development through self-assessment, appraisal and as a way of structuring feedback from colleagues.
- Provide professional organisations or specialist groups with a basis for the development of levels of prescribing competency, from 'recently qualified prescriber' through to 'experienced prescriber'.
- Stimulate discussions around prescribing competencies and multidisciplinary skill mix at an organisational level.
- Inform organisational recruitment processes to help frame questions and benchmark candidates' prescribing experience.
- Inform the development of organisational systems and processes that support safe and effective prescribing. For example, local clinical governance frameworks.
- Inform the development of education curricula and relevant accreditation of prescribing programmes for all prescribing professions.
- Inform and assure patients/carers about the competencies of a safe and effective prescriber.

Further examples of uses of the framework in practice can be found on the RPS website here: https://www.rpharms.com/cfap

3 Scope

General scope of the framework:

- It is a generic framework for any prescriber regardless of their professional background or setting. Therefore, it does not contain statements that relate to specialist areas of prescribing.
- It must be contextualised to reflect different areas of practice, levels of expertise and settings.
- It reflects the key competencies needed by all prescribers; it should not be viewed as a curriculum but rather the basis on which one can be built.
- It applies equally to independent prescribers, community practitioner nurse prescribers and supplementary prescribers, but the latter should contextualise the framework to reflect the structures imposed when entering a supplementary prescribing relationship.

4
The Competency Framework for all Prescribers

This competency framework for all prescribers sets out what good prescribing looks like. Its implementation and maintenance are important in informing and improving practice, development, standard of care and safety (for both the prescriber and patient).

Prescribers are encouraged to use their own professional codes of conduct, standards and guidance alongside this framework. Prescribers are also responsible for practising within their own scope of practice and competence, including delegating where appropriate, seeking support when required and using their acquired knowledge, skills and professional judgement.

It is important to recognise that healthcare professionals need to apply professionalism to all aspects of their practice. The principles of professionalism are the same across the professions and these are behaviours that healthcare professionals should always be demonstrating, not just for prescribing. There are elements of wider professional practice that will impact on how healthcare professionals behave when they prescribe. These include the importance of maintaining a patient-centred approach when speaking to patients/carers, maintaining confidentiality, communication skills, leadership, the need for reflection, maintaining competency and continuing professional development, and the importance of forming networks for support and learning.

STRUCTURE OF THE FRAMEWORK

DOMAINS

The competencies within the framework are presented as two domains and describe the knowledge, skill, behaviour, activity, or outcome that prescribers should demonstrate:

Domain one – the consultation
This domain looks at the competencies that the prescriber should demonstrate during the consultation.

Domain two – prescribing governance
This domain focuses on the competencies that the prescriber should demonstrate with respect to prescribing governance.

COMPETENCY AND SUPPORTING STATEMENTS

Within the two domains there are ten competencies, as shown in Figure 1.

Each of these competencies contains several supporting statements related to the prescriber role which describe the activity or outcome that the prescriber should actively and routinely demonstrate.

PLEASE NOTE

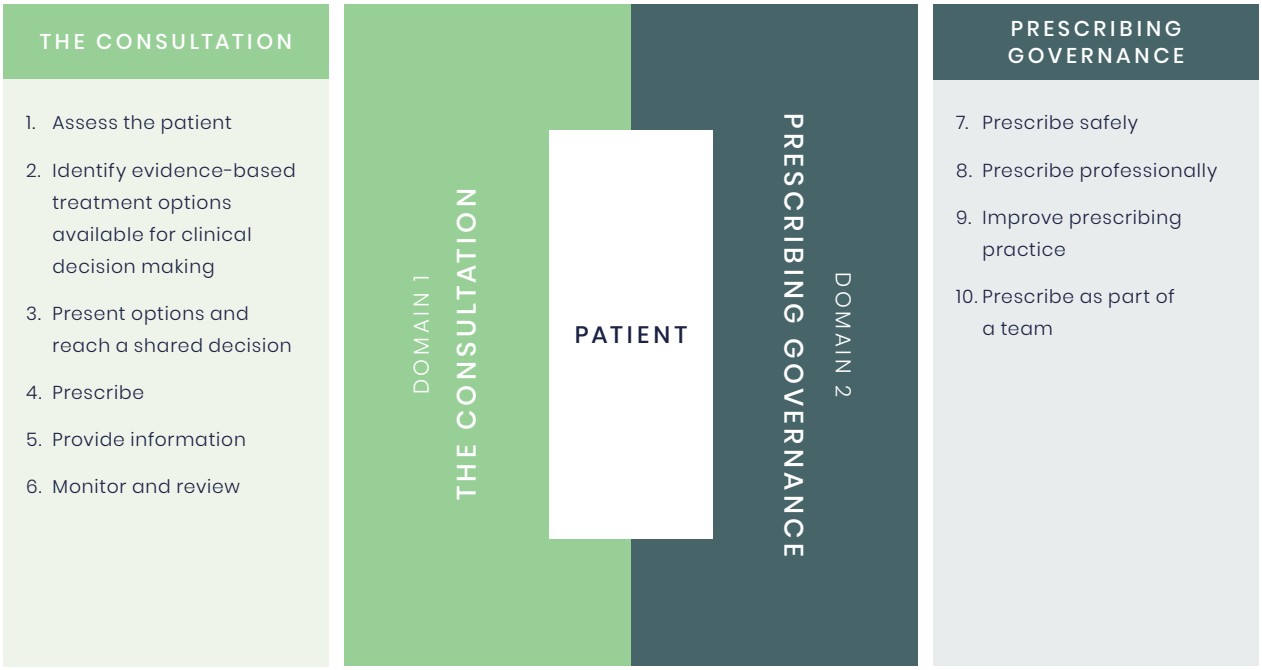
- The framework competencies and supporting statements are not in any particular order. The numbering is mainly to support mapping purposes and does not reflect the level of importance of the statement. They are not designed to be used as a script or in isolation as they may overlap with others.
- Due to the generic nature of the framework, it may be that not every competency or supporting statement is relevant to your practice or setting. However, you should still be able to consider how you could demonstrate the supporting statement.

FURTHER INFORMATION

The further information sections under each competency provide prescribers with information and examples (list not exhaustive or definitive), which provide clarity and meaning to the supporting statements. The recommendation for this framework is to use it alongside any relevant further information sections to support implementation into practice.

For further supporting resources, please see the RPS website here: https://www.rpharms.com/cfap

Figure 1:
The Competency Framework for all Prescribers



1 The Consultation

1. ASSESS THE PATIENT

STATEMENTS SUPPORTING THE COMPETENCY

1.1. Undertakes the consultation in an appropriate setting[a].

1.2. Considers patient dignity, capacity, consent and confidentiality[b].

1.3. Introduces self and prescribing role to the patient/carer and confirms patient/carer identity.

1.4. Assesses the communication needs of the patient/carer and adapts[c] consultation appropriately.

1.5. Demonstrates good consultation skills[d] and builds rapport with the patient/carer.

1.6. Takes and documents an appropriate medical, psychosocial and medication history[e] including allergies and intolerances.

1.7. Undertakes and documents an appropriate clinical assessment[f].

1.8. Identifies and addresses potential vulnerabilities[g] that may be causing the patient/carer to seek treatment.

1.9. Accesses and interprets all available and relevant patient records to ensure knowledge of the patient's management to date.

1.10. Requests and interprets relevant investigations necessary to inform treatment options.

1.11. Makes, confirms or understands, and documents the working or final diagnosis by systematically considering the various possibilities (differential diagnosis).

1.12. Understands the condition(s) being treated, their natural progression, and how to assess their severity, deterioration and anticipated response to treatment.

1.13. Reviews adherence (and non-adherence[h]) to, and effectiveness of, current medicines.

1.14. Refers to or seeks guidance from another member of the team, a specialist or appropriate information source when necessary.

FURTHER INFORMATION ON THE SUPPORTING STATEMENTS FOR COMPETENCY 1

a. Appropriate setting includes location, environment and medium.

b. In line with legislation, best practice, regulatory standards and contractual requirements.

c. Adapts for language, age, capacity, learning disability and physical or sensory impairments.

d. Good consultation skills include actively listening, using positive body language, asking open questions, remaining non-judgemental, and exploring the patient's/carer's ideas, concerns and expectations.

e. Medication history includes current and previously prescribed (and non-prescribed) medicines, vaccines, on-line medicines, over-the-counter medicines, vitamins, dietary supplements, herbal products, complementary remedies, recreational/illicit drugs, alcohol and tobacco.

f. Clinical assessment includes observations, psychosocial assessments and physical examinations.

g. Safeguarding children and vulnerable adults (possible signs of abuse, neglect, or exploitation), and focusing on both the patient's physical and mental health, particularly if vulnerabilities may lead them to seek treatment unnecessarily or for the wrong reasons.

h. Non-adherence may be intentional or non-intentional.

2. IDENTIFY EVIDENCE-BASED TREATMENT OPTIONS AVAILABLE FOR CLINICAL DECISION MAKING

STATEMENTS SUPPORTING THE COMPETENCY

2.1. Considers both non-pharmacological[a] and pharmacological treatment approaches.

2.2. Considers all pharmacological treatment options including optimising doses as well as stopping treatment (appropriate polypharmacy and deprescribing).

2.3. Assesses the risks and benefits to the patient of taking or not taking a medicine or treatment.

2.4. Applies understanding of the pharmacokinetics and pharmacodynamics of medicines, and how these may be altered by individual patient factors[b].

2.5. Assesses how co-morbidities, existing medicines, allergies, intolerances, contraindications and quality of life impact on management options.

2.6. Considers any relevant patient factors[c] and their potential impact on the choice and formulation of medicines, and the route of administration.

2.7. Accesses, critically evaluates, and uses reliable and validated sources of information.

2.8. Stays up to date in own area of practice and applies the principles of evidence-based practice[d].

2.9. Considers the wider perspective including the public health issues related to medicines and their use, and promoting health.

2.10. Understands antimicrobial resistance and the roles of infection prevention, control and antimicrobial stewardship measures.

FURTHER INFORMATION ON THE SUPPORTING STATEMENTS FOR COMPETENCY 2

a. Non-pharmacological treatment approaches include no treatment, social prescribing and wellbeing/ lifestyle changes.

b. Individual patient factors include genetics, age, renal impairment and pregnancy.

c. Relevant patient factors include ability to swallow, disability, visual impairment, frailty, dexterity, religion, beliefs and intolerances.

d. Evidence-based practice includes clinical and cost-effectiveness.

3. PRESENT OPTIONS AND REACH A SHARED DECISION

STATEMENTS SUPPORTING THE COMPETENCY

3.1. Actively involves and works with the patient/carer to make informed choices and agree a plan that respects the patient's/carer's preferences[a].

3.2. Considers and respects patient diversity, background, personal values and beliefs about their health, treatment and medicines, supporting the values of equality and inclusivity, and developing cultural competence.[b]

3.3. Explains the material risks and benefits, and rationale behind management options in a way the patient/carer understands, so that they can make an informed choice.

3.4. Assesses adherence in a non-judgemental way; understands the reasons for non-adherence[c] and how best to support the patient/carer .

3.5. Builds a relationship which encourages appropriate prescribing and not the expectation that a prescription will be supplied.

3.6. Explores the patient's/carer's understanding of a consultation and aims for a satisfactory outcome for the patient/carer and prescriber.

FURTHER INFORMATION ON THE SUPPORTING STATEMENTS FOR COMPETENCY 3

a. Preferences include patient's/carer's right to decline or limit treatment.

b. In line with legislation requirements which apply to equality, diversity and inclusion.

c. Non-adherence may be intentional or non-intentional.

4. PRESCRIBE

STATEMENTS SUPPORTING THE COMPETENCY

4.1. Prescribes a medicine or device[a] with up-to-date awareness of its actions, indications, dose, contraindications, interactions, cautions and adverse effects.

4.2. Understands the potential for adverse effects and takes steps to recognise, and manage them, whilst minimising risk.

4.3. Understands and uses relevant national, regional and local frameworks[b] for the use of medicines.

4.4. Prescribes generic medicines where practical and safe for the patient, and knows when medicines should be prescribed by branded product.

4.5. Accurately completes and routinely checks calculations relevant to prescribing and practical dosing.

4.6. Prescribes appropriate quantities and at appropriate intervals necessary[c] to reduce the risk of unnecessary waste.

4.7. Recognises potential misuse of medicines; minimises risk[d] and manages using appropriate processes.

4.8. Uses up-to-date information about the availability, pack sizes, storage conditions, excipients and costs of prescribed medicines.

4.9. Electronically generates and/or writes legible, unambiguous and complete prescriptions which meet legal requirements.

4.10. Effectively uses the systems[e] necessary to prescribe medicines.

4.11. Prescribes unlicensed and off-label medicines where legally permitted, and unlicensed medicines only if satisfied that an alternative licensed medicine would not meet the patient's clinical needs.

4.12. Follows appropriate safeguards if prescribing medicines that are unlicensed, off-label, or outside standard practice.

4.13. Documents accurate, legible and contemporaneous clinical records[f].

4.14. Effectively and securely communicates information[g] to other healthcare professionals involved in the patient's care, when sharing or transferring care and prescribing responsibilities, within and across all care settings.

FURTHER INFORMATION ON THE SUPPORTING STATEMENTS FOR COMPETENCY 4

a. 'Medicine' or 'device' includes all products (including necessary co-prescribing of infusion sets, devices, diluents and mediums) that can be prescribed, supplied or recommended for purchase.

b. Frameworks include local formularies, care pathways, protocols and professional guidelines, as well as evidence-based guidelines from relevant national, regional and local committees.

c. Amount necessary for a complete course, until next review or prescription supply.

d. Minimises risk by ensuring appropriate safeguards are in place.

e. Systems include medicine charts, decision support tools and electronic prescribing systems. Also, awareness and avoidance of potential system errors.

f. Records include prescribing decisions, history, diagnosis, clinical indications, discussions, advice given, examinations, findings, interventions, action plans, safety-netting, referrals, monitoring and follow ups.

g. Information about clinical conditions, medicines and their current use (where necessary and with valid consent). Ensuring that private and personal data is protected and communicated securely in line with relevant legislation/regulations.

5. PROVIDE INFORMATION

STATEMENTS SUPPORTING THE COMPETENCY

5.1. Assesses health literacy of the patient/carer and adapts appropriately to provide clear, understandable and accessible information[a].

5.2. Checks the patient's/carer's understanding of the discussions had, actions needed and their commitment to the management plan[b].

5.3. Guides the patient/carer on how to identify reliable sources[c] of information about their condition, medicines and treatment.

5.4. Ensures the patient/carer knows what to do if there are any concerns about the management of their condition, if the condition deteriorates or if there is no improvement in a specific timeframe.[d]

5.5. Encourages and supports the patient/carer to take responsibility for their medicines and self-manage their condition.

FURTHER INFORMATION ON THE SUPPORTING STATEMENTS FOR COMPETENCY 5

a. Information about their management, treatment, medicines (what they are for, how to use them, safe storage, disposal, expected duration of treatment, possible unwanted effects and what to do if they arise) monitoring and follow-up—in written and/or verbal form.

b. Management plan includes treatment, medicines, monitoring and follow-up.

c. Reliable sources include the medicine's patient information leaflet.

d. Includes safety-netting advice on when and how to seek help through appropriate signposting and referral.

6. MONITOR AND REVIEW

STATEMENTS SUPPORTING THE COMPETENCY

6.1. Establishes and maintains a plan for reviewing[a] the patient's treatment.

6.2. Establishes and maintains a plan to monitor[b] the effectiveness of treatment and potential unwanted effects.

6.3. Adapts the management plan in response to on-going monitoring and review of the patient's condition and preferences.

6.4. Recognises and reports suspected adverse events to medicines and medical devices using appropriate reporting systems[c].

FURTHER INFORMATION ON THE SUPPORTING STATEMENTS FOR COMPETENCY 6

a. Plan for reviewing includes safety-netting appropriate follow-up or referral.

b. Plan for monitoring includes safety-netting monitoring requirements and responsibilities, for example, by the prescriber, patient/carer or other healthcare professional.

c. Reporting systems include following established clinical governance procedures and the Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Card scheme.

2 Prescribing Governance

7. PRESCRIBE SAFELY

STATEMENTS SUPPORTING THE COMPETENCY

7.1. Prescribes within own scope of practice, and recognises the limits of own knowledge and skill.

7.2. Knows about common types and causes of medication and prescribing errors, and knows how to minimise their risk.

7.3. Identifies and minimises potential risks associated with prescribing via remote methods[a].

7.4. Recognises when safe prescribing processes are not in place and acts to minimise risks[b].

7.5. Keeps up to date with emerging safety concerns related to prescribing.

7.6. Reports near misses and critical incidents, as well as medication and prescribing errors using appropriate reporting systems, whilst regularly reviewing practice[c] to prevent recurrence.

FURTHER INFORMATION ON THE SUPPORTING STATEMENTS FOR COMPETENCY 7

a. Remote methods include telephone, email, video or communication via a third party.

b. Minimising risks include using or developing governance processes that support safe prescribing, particularly in areas of high risk such as transfer of information about medicines and prescribing of repeat medicines.

c. Reviewing practice include clinical audits.

8. PRESCRIBE PROFESSIONALLY

STATEMENTS SUPPORTING THE COMPETENCY

8.1. Ensures confidence and competence to prescribe are maintained.

8.2. Accepts personal responsibility and accountability for prescribing[a] and clinical decisions, and understands the legal and ethical implications.

8.3. Knows and works within legal and regulatory frameworks[b] affecting prescribing practice.

8.4. Makes prescribing decisions based on the needs of patients and not the prescriber's personal views.

8.5. Recognises and responds to factors[c] that might influence prescribing.

8.6. Works within the NHS, organisational, regulatory and other codes of conduct when interacting with the pharmaceutical industry.

FURTHER INFORMATION ON THE SUPPORTING STATEMENTS FOR COMPETENCY 8

a. Prescribing decisions include when prescribing under a shared care protocol/agreement.

b. Frameworks for prescribing controlled drugs, unlicensed and off-label medicines, supplementary prescribing, and prescribing for self, close family and friends.

c. Factors include interactions with pharmaceutical industry, media, patients/carers, colleagues, cognitive bias, financial gain, prescribing incentive schemes, switches and targets.

9. IMPROVE PRESCRIBING PRACTICE

STATEMENTS SUPPORTING THE COMPETENCY

9.1. Improves by reflecting on own and others' prescribing practice, and by acting upon feedback and discussion.

9.2. Acts upon inappropriate or unsafe prescribing practice using appropriate processes[a].

9.3. Understands and uses available tools[b] to improve prescribing practice.

9.4. Takes responsibility for own learning and continuing professional development relevant to the prescribing role.[c]

9.5. Makes use of networks for support and learning.

9.6. Encourages and supports others with their prescribing practice and continuing professional development.[d]

9.7. Considers the impact of prescribing on sustainability, as well as methods of reducing the carbon footprint and environmental impact of any medicine.[e]

FURTHER INFORMATION ON THE SUPPORTING STATEMENTS FOR COMPETENCY 9

a. Processes include whistleblowing, regulatory and professional guidance, and employer procedures.

b. Tools include supervision, observation of practice and clinical assessment skills, portfolios, workplace competency-based assessments, questionnaires, prescribing data analysis, audits, case-based discussions, personal formularies and actively seeking regular patient and peer feedback.

c. By continuously reviewing, reflecting, identifying gaps, planning, acting, applying and evidencing learning or competencies.

d. By considering mentoring, leadership and workforce development (for example, becoming a Designated Prescribing Practitioner).

e. Methods of reducing a medicine's carbon footprint and environmental impact include proper disposal of medicine/device/equipment waste, recycling schemes, avoiding overprescribing and waste through regular reviews, deprescribing, dose and device optimisation.

10. PRESCRIBE AS PART OF A TEAM

STATEMENTS SUPPORTING THE COMPETENCY

10.1. Works collaboratively[a] as part of a multidisciplinary team to ensure that the transfer and continuity of care (within and across all care settings) is developed and not compromised.

10.2. Establishes relationships with other professionals based on understanding, trust and respect for each other's roles in relation to the patient's care.

10.3. Agrees the appropriate level of support and supervision for their role as a prescriber.

10.4. Provides support and advice[b] to other prescribers or those involved in administration of medicines where appropriate.

FURTHER INFORMATION ON THE SUPPORTING STATEMENTS FOR COMPETENCY 10

a. Working collaboratively may also include keeping the patient/carer informed or prescribing under a shared care protocol/agreement.

b. Advice may include any specific instructions for administration, advice to be given to the patient/carer and monitoring required immediately after administration.

5 Glossary

Adherence: Adherence presumes an agreement between prescriber and patient about the prescriber's recommendations. Adherence to medicines is defined as the extent to which the patient's action matches the agreed recommendations. Non-adherence may limit the benefits of medicines, resulting in lack of improvement or deterioration in health.[8]

Antimicrobial stewardship: An organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness.[9]

Carer: A person who provides support and assistance, be that formal or informal, with various activities to patients. This may be emotional or financial support, as well as hands-on help with a range of tasks. *Carer*, in this document, is also an umbrella term used to cover parents, legal guardians, patient advocates or representatives, including paid and unpaid carers.[10]

Competency framework: A structure which describes the competencies (demonstrable knowledge, skills, characteristics, qualities and behaviours) central to a safe and effective performance in a role.[11]

Deprescribing: The process of stopping or reducing medicines with the aim of eliminating problematic (inappropriate) polypharmacy, and then monitoring the individual for unintended adverse effects or worsening of disease. It is essential to involve the individual (and their carer) closely in deprescribing decisions to build and maintain their confidence in the process.[10]

Designated Prescribing Practitioner (DPP): An umbrella term used in the RPS A Competency Framework for Designated Prescribing Practitioners to describe the experienced prescribing practitioner responsible for supervising the non-medical prescribing trainee's period of learning in practice. For further information, please see the RPS A Competency Framework for Designated Prescribing Practitioners[12].

Independent prescriber: A prescribing healthcare professional who is responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.

Material risk: According to the Montgomery ruling, a material risk occurs if "a reasonable person in the patient's position would be likely to attach significance to it, or if the doctor is or should reasonably be aware that their patient would be likely to attach significance to it".[13] This is applicable to all prescribing professionals. All prescribers have a duty of care to ensure that their patient is aware of any material risks involved in proposed treatment and of reasonable alternatives.

Non-medical prescriber (NMP): This term encompasses healthcare professionals (excluding doctors and dentists) working within their clinical competence as an independent and/or supplementary prescribers or community practitioner nurse prescribers.[13] Further information on the types of non-medical prescriber and what they can prescribe can be found in the British National Formulary (BNF).

Off-label: Using a licensed medicinal product outside the terms of its marketing authorisation (licenced use).[14]

Patient: Umbrella term to cover the full range of people receiving or registered to receive medical treatment or healthcare; this includes children and young adults, pregnant women, service users and clients.[10]

Polypharmacy: Means 'many medicines' and has often been defined as being present when a patient takes five or more medicines. Polypharmacy is not necessarily a bad thing; it can be both rational and required; however, it is important to distinguish between appropriate and inappropriate polypharmacy. For further information, please see the RPS Polypharmacy guide.[10]

Psychosocial: Involving both psychological and social aspects.[15]

Scope of practice: The activities a healthcare professional carries out within their professional role. The healthcare professional must have the required training, knowledge, skills and experience to deliver these activities lawfully, safely and effectively. They must also have appropriate indemnity cover for their prescribing role. Scope of practice may be informed by regulatory standards, the professional body's position, employer guidance, guidance from other relevant organisations and the individual's professional judgement.[16]

Supplementary prescribing: A voluntary partnership between a doctor or dentist and supplementary prescriber, to prescribe within an agreed patient-specific clinical management plan (CMP) with the patient's agreement. At the time of publication, nurses, midwives, optometrists, pharmacists, physiotherapists, podiatrists, radiographers, paramedics and dietitians may become supplementary prescribers. Once qualified, they may prescribe any medicine (including controlled drugs) within their clinical competence, according to the CMP.

Unlicensed (also known as *specials*): A medicinal product without a valid UK marketing authorisation. These may be medicinal products that are imported, procured or manufactured under a UK specials manufacturing licence. They are prescribed to meet the special clinical needs of an individual patient on the direct personal responsibility of the prescriber.[14]

6 References

1. National Prescribing Centre (2012) A single competency framework for all prescribers, Available at: https://www.webarchive.org.uk/wayback/archive/20140627111233/http://www.npc.nhs.uk/ (Accessed: 22nd February 2021).
2. National Prescribing Centre (2001) Maintaining Competency in Prescribing. An outline framework to help nurse prescribers. NPC, Liverpool.
3. National Prescribing Centre (2003) Maintaining Competency in Prescribing. An outline framework to help nurse supplementary prescribers. NPC, Liverpool.
4. National Prescribing Centre (2003) Maintaining Competency in Prescribing. An outline framework to help pharmacist supplementary prescribers. NPC, Liverpool.
5. National Prescribing Centre and General Optical Council (2004) Competency framework for prescribing optometrists. NPC, Liverpool.
6. National Prescribing Centre (2004) Maintaining Competency in Prescribing. An Outline Framework to help Allied Health Professional Supplementary Prescribers. NPC, Liverpool.
7. National Prescribing Centre (2006) Maintaining Competency in Prescribing. An outline framework to help pharmacist prescribers. Second edition NPC, Liverpool.
8. NICE Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence [CG76] (January 2009). Available from: https://www.nice.org.uk/guidance/cg76/chapter/Introduction. [Accessed: 30th June 2021].
9. Department of Health and Social Care and Public Health England (2013) Antimicrobial prescribing and stewardship competencies. Available from: https://www.gov.uk/government/publications/antimicrobial-prescribing-and-stewardship-competencies. [Accessed: 22nd February 2021].
10. Royal Pharmaceutical Society (2019) Polypharmacy: Getting our medicines right. Available from: https://www.rpharms.com/recognition/setting-professional-standards/polypharmacy-getting-our-medicines-right. [Accessed: 22nd February 2021].
11. Whiddett S, Hollyforde, S. The Competencies Handbook. Institute of Personnel and Development, 1999.
12. Royal Pharmaceutical Society (2019) Competency Framework for Designated Prescribing Practitioners. Available from: https://www.rpharms.com/resources/frameworks/designated-prescribing-practitioner-competency-framework. [Accessed: 22nd February 2022].
13. UK Supreme Court judgement in 'Montgomery v Lanarkshire Health Board'. Mar 2015 Available from: https://www.supremecourt.uk/cases/uksc-2013-0136.html. [Accessed: 22nd February 2021].
14. Royal Pharmaceutical Society (2016) Prescribing Specials Guidance for the prescribers of Specials Available from: https://www.rpharms.com/resources/pharmacy-guides/specials. [Accessed: 21 June 2021].
15. Stedman's Medical Dictionary (2016). Available from: https://online.statref.com/document/agSgx7Uq0raRoiZktrvQit?categoryType=Dictionary [Accessed: 30th June 2021].
16. Health and Care Professions Council (2020) Information on scope of practice. Available from: https://www.hcpc-uk.org/registration/meeting-our-standards/information-on-scope-of-practice/. [Accessed: 22nd February 2021].

7
Acknowledgements

Task and Finish Group for the 2021 review

Professor Angela Alexander (Chair)
Professor Emerita, University of Reading

Chris Bell
Standards Development Specialist, The Nursing and Midwifery Council

Dr Paramdeep Bilkhu MCOptom
Clinical Adviser and Independent Prescriber, The College of Optometrists

Olivia Bird
Policy Manager, The Health and Care Professions Council

Hazel Boyce
Skull Base Specialist and Neuro Review Radiographer, Bristol Cancer Institute, University Hospitals Bristol NHS Trust (also representing Society and College of Radiographers)

Dr Rachel Bruce
Principal Lead (Prescribing and Clinical Skills), NHS Education for Scotland

Kat Hall
Associate Professor of Clinical Education Director, Centre for Inter-Professional Postgraduate Education and Training (CIPPET)

Peter Hawkes
Lay representative

Parbir Jagpal
Director of Postgraduate Studies, School of Pharmacy, University of Birmingham; Independent Prescriber

Caroline Lecky
Associate Senior Professional Officer, Northern Ireland Practice and Education Council

Andrew Lilley
Pharmacy Professional Services Manager, Lead Pharmacist and Advanced Practitioner – Respiratory, Homecare Alder Hey Children's Hospital

Carmel Lloyd
Head of Education and Learning, The Royal College of Midwives

Dr Frances Lloyd
Associate Postgraduate Pharmacy Dean, Queen's University Belfast, Northern Ireland

Simon Matthews
Associate Chief Pharmacist – Clinical Services, Kings College Hospital NHS Foundation Trust

Dr Trudi McIntosh
Senior Lecturer in Pharmacy Practice. Course Leader MSc, Robert Gordon University Advanced Pharmacy Practice including Pharmacist Independent Prescribing

Andrew Mikhail
Chief Pharmaceutical Officer's Clinical Fellow and Specialist Inspector, The General Pharmaceutical Council

Eleri Mills
Association for Prescribers Committee member, Programme Leader NMP, Glyndwr University

Adele Mott
Lead Pharmacist for GI Services, University College London Hospitals

Catherine Picton
Competency Framework Author and Health Policy Consultant

Heather Randle
Professional Lead for Education, The Royal College of Nursing

Debra Roberts
Associate Dean (Pharmacy), Head of Programme Development and Advanced Practice, Health Education and Improvement Wales (HEIW)

James Rodger
Musculoskeletal Extended Scope Practitioner, Musculoskeletal Sonographer

David Rovardi
Pharmacist Independent Prescriber and Registered Paramedic, College of Paramedics

Peter Saul
Joint Chair, Royal College of General Practitioners Wales

Debbie Sharman
Consultant Podiatrist – Diabetes, Professional lead for Podiatry Visiting Lecturer (University of Southampton), Dorset HealthCare University Foundation Trust

Katherine Timms
Head of Policy and Standards, The Health and Care Professions Council

Wendy Thompson
Academic general dental practitioner at University of Manchester, also representing The British Dental Association

Jonathan Underhill
Associate Director, Medicines and Prescribing Centre, The National Institute for Health and Care Excellence

Nigel Westwood
Lay representative

Pip White
Professional Adviser, Chartered Society of Physiotherapy

RPS Staff

Regina Ahmed (Lead Author)
Senior Guidance Pharmacist and Independent Prescriber, RPS

Dr Karen Hodson
Practice & Policy Lead – Wales, RPS. Programme Director, Independent Prescribing, Cardiff University

Jonathan Lloyd Jones
Policy and Engagement Lead – Wales, RPS

Annamarie McGregor
Head of RPS Local, RPS

Wing Tang
Head of Professional Support and Guidance, RPS

Stuart Carter
Digital Content Lead (External Comms)

Nick Hard
Planning Unit

ROYAL
PHARMACEUTICAL
SOCIETY

MAHI - STM - 212 - 1112

Table of Contents

Interim orders, their purpose, and when we impose them

Reference: INT-1 Last Updated: 02/10/2023

In this guide

What types of interim order are available?

A panel of one of our practice committees is able to impose:

- an interim conditions of practice order, or
- an interim suspension order

on a nurse, midwife or nursing associate's practice while a fitness to practise case is ongoing. This will only happen in cases which satisfy the test for interim orders to be made.

Interim conditions of practice order

An interim conditions of practice order restricts a nurse, midwife or nursing associate's practice. The panel will decide what conditions are necessary to deal with any risk with the nurse, midwife or nursing associate's practice. This could mean the nurse, midwife or nursing associate is only allowed to practise under supervision, or may have to avoid particular areas of practice. Conditions of practice apply to the nurse, midwife or nursing associate's registration. This means that a nurse, midwife or nursing associate can only practise if they stick to the conditions.

Interim suspension order

An interim suspension order means that the nurse, midwife or nursing associate's registration is suspended and they must not practise as long as it is in place. For nurses, midwives or nursing associates who have more than one entry on the register (e.g. where they are registered as both a nurse, a midwife and a nursing associate), interim suspension orders will prevent them from practising as either a nurse, midwife or nursing associate.

What is the purpose of interim orders?

Interim orders protect the public from risk by restricting or suspending a nurse, midwife or nursing associate's practice while we investigate concerns about them. This means that an interim order will be imposed before a panel has considered the substance of those concerns. An interim order will be needed in cases where the concerns about a nurse, midwife or nursing associate's practice are so serious that either:

- patient safety would be put at risk, or
- there would be serious damage to the reputation of the nursing and midwifery professions if they were allowed to practise without any restrictions.

If a nurse, midwife or nursing associate deliberately breaches an interim order, this may in itself require regulatory

action. Such matters are likely to be taken seriously as they show a disregard for the steps the NMC has put in place to keep the public safe or uphold confidence in the professions[1]. We explain this in more detail in our guidance here.

Which panels can make or review interim orders?

Panels of the Investigating Committee and the Fitness to Practise Committee are able to restrict or suspend a nurse, midwife or nursing associate's right to practise. They will consider if an interim order is required after hearing about the concerns and making a risk assessment. They do not consider whether the concerns have been proven.

Making interim orders

If we've referred a concern to either practice committee, and that committee hasn't yet reached a decision about it, the committee can make an interim order to restrict or suspend the nurse, midwife or nursing associate's right to practise.[2] So for example, if we've referred a concern to the case examiners[3] while we complete our investigation, but the case examiners haven't yet decided whether there's a case to answer, the Investigating Committee can make an interim order. Or, if we've referred a case directly to the Fitness to Practise Committee, and there hasn't yet been a final decision at a hearing or meeting, the Fitness to Practise Committee can make an interim order.

The Investigating Committee has the power to make an interim order at the same time as it refers a case on to the Fitness to Practise Committee after finding a case to answer.[4] So our case examiners, who decide whether there's a case to answer on behalf of the Investigating Committee, can direct either practice committee to consider making an interim order.

The Investigating Committee can, in fact, make an interim order in a case that has already been referred to the Fitness to Practise Committee, and it can do this at any time before Fitness to Practise Committee starts considering the case at a hearing or meeting.[5]

Reviewing interim orders

Under our legislation interim orders have to be reviewed every six months, by either the committee that made the order, or (if the case has been referred to the Fitness to Practise Committee) by the Fitness to Practise Committee.[6]

We don't think this means that only the Fitness to Practise Committee can review orders in cases that have been referred to it. The Investigating Committee can also review these orders, as long as the Fitness to Practise Committee hasn't yet started considering the full case at a hearing or a meeting.

Our legislation[7] very clearly allows the Investigating Committee to make a new interim order, even in a case that has been referred to the Fitness to Practise Committee. So it's not clear why the intent behind our legislation would have been to prevent the Investigating Committee from reviewing orders in those circumstances, if it's able to make them.

It's clear from the statutory consultations about changes to our legislation that in 2014 there was a clear intent to give our Investigating Committee more flexibility to review cases that had been referred to what was then our Health Committee or Conduct and Competence Committee. When this area of our legislation changed to reflect those committees being replaced by the Fitness to Practise Committee, the consultation did not say there was any desire to restrict the Investigating Committee's role.

When can interim orders be considered?

Our legislation sets out when interim orders can be imposed. Practice committees must consider that an interim order is:

- necessary to protect the public,
- otherwise in the public interest, or
- in the interests of the nurse, midwife or nursing associate

Our practice committees (which will either be the Fitness to Practise Committee or the Investigating Committee, depending on the circumstances) are able to impose interim orders if:

- an allegation against a nurse, midwife or nursing associate has been referred to the Investigating Committee or the Fitness to Practise Committee but the Committee has not yet reached a final decision. This might be where a final hearing before either Committee adjourns part way through the case, and the panel hearing the case thinks that an interim order is necessary given what they have heard
- case examiners find a case to answer against a nurse, midwife or nursing associate and refer their case to the Fitness to Practise Committee
- the Investigating Committee directs that a nurse, midwife or nursing associate's entry on the register should be amended or removed after deciding the entry was fraudulently procured or incorrectly made
- after deciding that a nurse, midwife or nursing associate's fitness to practise is impaired, the Fitness to Practise Committee imposes a striking-off order, a suspension order, or a conditions of practice order. An interim order is imposed at this stage to cover the period before the sanction comes into effect, which is usually 28 days after the date on which the decision letter is served. The interim order can be imposed for a period up to 18 months to cover any potential appeal.

1 See GMC v Donadio [2021] EWHC 562 (Admin) in relation to the serious nature of deliberate breaches of interim orders.
2 Article 31(1)(a)(i) of the Order
3 Who carry out the functions of the Investigating Committee under article 26A(1) of the Order and rule 6C of the Rules
4 Article 26A(1) and article 26(11) of the Order and rule 6C(1) of the
5 Article 26(11) of the Order
6 Article 31(6) of the Order
7 Article 26(11) of the Order

Decision making factors for interim orders

Reference: INT-2 Last Updated: 11/12/2023

In this guide

Overview

There are two steps that the panel must follow when deciding whether an interim order may be necessary to protect the public, otherwise in the public interest, or in the nurse, midwife or nursing associate's own interests.

First of all the panel must be satisfied that, on the face of the information presented, there's sufficient evidence of a case against the nurse, midwife or nursing associate. This is sometimes referred to as finding a 'prima facie case'.

Different considerations apply at this stage if the interim order applied for has the effect of restricting freedom of expression – we deal with this separately in our guidance below.

If the panel is satisfied that there's evidence of a concern, they should then go on to consider whether or not an interim order is necessary in light of this evidence, taking into account any information put before them by the nurse, midwife or nursing associate[1].

A panel may decide that an interim order is necessary on more than one ground (for example an order may be necessary to protect patients, and may also be in the nurse, midwife or nursing associate's own interests), but each of the three interim order grounds has separate considerations, which the panel must carefully assess.

Evidence of the concerns

The first thing the panel must consider is whether there's enough evidence of a concern about the nurse, midwife or nursing associate.

The interim order panel can't make findings of fact and is not deciding whether there's a 'case to answer', which is a decision for the Case Examiners after a full investigation.

In order to take action the panel only needs to be satisfied there's sufficient evidence to support the concern, even though this may later be disproved.

The panel should consider the nature and strength of the evidence. This means looking at both the evidence that supports a particular fact or version of events, and any evidence that contradicts or undermines it.

Unlike a final substantive hearing, witnesses do not normally attend to give evidence and the panel will make a decision on the papers[2], taking into account representations from both the NMC and the nurse, midwife or nursing associate.

When assessing the overall strength of the evidence, the panel will need to consider a number of factors, including:

- The source of the evidence. Where the evidence comes from may affect whether it's reasonable for us to rely on it when deciding whether to impose an interim order.
  Evidence which comes directly from an identifiable source is likely to be more reliable than evidence from an indirect or unknown source. If the evidence is disputed, it will rarely be fair to rely on anonymous or multiple hearsay as the only basis for imposing an interim order.
  Where the police have charged someone with a criminal offence, this may be sufficient for the panel to go on to consider the need for an interim order, even where the underlying material isn't available to us.[3]
- The accuracy of the information and whether it's sufficiently clear for the registrant to understand the basis for concern. If all of the available evidence is vague or tenuous, the registrant may not be able to respond to it beyond a bare denial and so it may not be fair for us to rely on it;
- The nature of any evidence which supports / corroborates the concerns being raised. Although the panel can't make a decision on the facts of any disputed allegation, it can discount evidence that's inconsistent with objective or undisputed evidence, or which is clearly unreliable.[4]

Having considered these factors, and anything else relevant, if the panel is satisfied there's enough evidence to make out a concern, they should go on to consider whether, in light of this, one or more of the three grounds for imposing an interim order applies.

Freedom of expression and Interim Orders

As we have said above, different considerations will apply if the interim order has the effect of restricting freedom of expression directly or indirectly. It could therefore apply to interim conditions or interim suspension.

If a Panel is considering imposing an interim order which might impact a nurse, midwife or nursing associate's freedom to express themselves they must first need to be satisfied that at a full hearing the NMC is likely to succeed in establishing that a finding of impairment should be made for expressing the views that the interim order is seeking to restrict.[5]

So, what is meant by "likely to succeed"? This depends on the circumstances of the individual case, but generally a panel should be slow to make an interim order if we have not satisfied them that it is "more likely than not" that the NMC will succeed.[6]

How will an NMC Panel approach this part of an interim order application in practice? The Panel will focus on what information they have before them at the time of the Interim Order application and consider what is the most likely outcome based on what they know at that point. They are not being asked to speculate on what might happen in the future on matters which are not before them. For example, if the NMC doesn't have any evidence to indicate that the registrant has taken steps to strengthen their practise then the Panel is not being asked to consider how likely it is they will do so before a substantive hearing.

They will in practice be asking themselves "If I was hearing the case today what would be the likely outcome, on the basis of what I know today?" This would involve them considering the following:

(1) "Is it likely that the NMC would succeed in establishing the facts of the case in respect of the allegations relating to freedom of expression?" (this will usually be a higher evidential threshold than the prima facie test we apply to interim orders that don't restrict freedom of expression) and if so then;

(2) "Is it likely that the NMC would succeed in establishing that those facts amount to misconduct?" and if so then;

(3) "On the basis of what I know today would I be likely to find the professional's fitness to practise impaired?"

These are the requirements we must satisfy when we are applying for an interim order that has the effect of restricting freedom of expression in order to comply with section 12(3) of the Human Rights Act 1998. We have separate guidance on freedom of expression which can be found here.

As with any other interim order decision, the panel must, in addition to these matters, indicate on what grounds they are putting the interim order in place (i.e. it is necessary to protect the public, is otherwise in the public interest, or is in the nurse, midwife or nursing associate's own interests).

If the NMC is applying for interim conditions some of which restrict freedom of expression, and some of which do not (for example a requirement to undergo further training or supervision) the additional requirements of section

12(3) of the Human Rights Act 1998 will only apply to those proposed interim conditions that restrict freedom of expression.

If a Panel is considering an interim order application where s.12 of the Human Rights Act 1998 is engaged, then they must also be alive to the specific notice provisions of the Act if the person is neither present nor represented at the IO hearing. These provisions can be found at s.12(2) of the Human Rights Act 1998.

Necessary to protect the public

For an interim order to be considered necessary for the protection of the public, it is not enough for the panel to consider that an interim order is merely desirable, the panel must be satisfied that there is a real risk to patients, colleagues or other members of the public if an order is not made.

Three factors are especially important to this consideration:

- This will depend on how much harm the alleged conduct has already caused, or could have caused, to the public. Cases that involve dishonesty, sexual misconduct, or where the actions of the nurse, midwife or nursing associate may have caused the death of a patient are usually considered more serious.
- If the concerns are serious and it seems they are likely to be repeated, then this significantly increases the risk of harm to members of the public.
- There may be other relevant factors a panel needs to consider in a particular case to decide whether to make an interim order on public protection grounds.

A panel will weigh up the seriousness of the regulatory concern and the likelihood of it being repeated if an interim order were not in place.

The seriousness of the concerns and risk of repetition are then assessed with reference to the particular circumstances of each case. An assessment of the harm that was caused, or could have been caused, to the public by the alleged conduct will be vital when considering seriousness. This could include physical, mental, emotional or financial harm.

A panel must also consider how likely it is that the concerns could arise again in the future if the nurse, midwife or nursing associate's practice was not restricted. This will be crucial in assessing the level of risk the nurse, midwife or nursing associate presents to members of the public.

A panel may find the guidance on insight and strengthened practice helpful in assessing how likely it is that incidents may recur.

Otherwise in the public interest

As part of their assessment of risk, a panel will consider all the elements of what constitutes the public interest.

One element is promoting and maintaining public confidence in nurses, midwives or nursing associates. It would be relatively rare for an interim order to be made only on the grounds that an order is otherwise in the public interest, if there is no evidence of a risk of harm to patients, so the threshold for imposing an interim order solely on this ground is high.

A panel would have to be satisfied that public confidence in the profession could be seriously damaged by the nurse, midwife or nursing associate continuing to practise without restriction while their case is being investigated, and where necessary, prepared for a hearing.

In which case the panel should set out the nature and seriousness of any damage to the reputation of the professions that would result if an order was not made.

Then it would weigh the likelihood of serious damage to public confidence in the professions if the nurse, midwife or nursing associate were allowed to continue to practise, against the interests of the nurse, midwife or nursing associate; this will ensure their decision is proportionate.

Considering the interests of the nurse, midwife or nursing associate includes considering their right to practise unrestricted, damage to their own professional reputation, and their ability to address any concerns through

demonstrating safe practice (although this may be less relevant in cases that do not relate to the nurse, midwife or nursing associate's clinical ability).

In the nurse, midwife or nursing associate's own interests

In some cases there may be some evidence that the nurse, midwife or nursing associate's work is adversely affecting their health and there is potential for this to impact their ability to practise safely.

Panels need to be aware of this as where this evidence exists it may suggest that an interim order is in the interests of the individual to protect their health.

1 George v GMC [2003] EWHC 1124 Admin
2 Fairness at the interim stage doesn't require formal witness evidence to be presented. Perry v NMC [2013] EWCA Civ 145 at paragraph 33
3 A criminal charge is likely to be sufficient where we're satisfied that the decision to charge required a robust consideration of the evidence. See Fallon v Horseracing Regulatory Authority [2006] EWHC 2030 where Mr Justice Davis held that the regulatory body and the appeal board were right to proceed on the basis that the Crown Prosecution Service had concluded that there was sufficient substance in the matter to justify charges being brought. See also R (on the application of Walker) v GMC [2003] EWHC 2308 (Admin). Where we're not satisfied that the decision to charge required a robust consideration of the evidence, or where there is police involvement but no criminal offences have been charged, this is unlikely to be a sufficient basis to apply for an interim order on its own; in those cases we will consider if there is underlying evidence which satisfies the test required for an interim order.
4 Perry v NMC [2013] EWCA Civ 145 at paragraph 20
5 The root of these considerations is s.12 of the Human Rights Act 1998. See White v GMC [2021] EWHC 3286 (Admin) where the application of s.12 was specifically considered in the regulatory context of interim orders.
6 See Cream Holdings Ltd v Bannerjee [2004] UKHL 44 judgement of Lord Nicholls of Birkenhead at paragraphs 19-22 (and in particular para.22)

Interim orders and fraudulent or incorrect entry allegations

Reference: INT-2a Last Updated: 12/10/2018

In this guide

Overview

In cases of concerns about the legitimacy of the nurse, midwife or nursing associate's entry in the register, the Investigating Committee can make an interim order to restrict or suspend the nurse, midwife or nursing associate's right to practise, while the concerns are being resolved.

In these circumstances, decision makers will take into account:

- the public interest in maintaining the integrity of the register
- proportionality
- balancing the risk of serious damage to the reputation of the profession against the impact of the order on the nurse, midwife or nursing associate
- the impact on the nurse, midwife or nursing associate; for example this might include financial hardship if their practice is restricted or suspended, pending the final outcome.

If they consider that there would be serious damage to the public interest, due to the impact on the integrity of the register, the panel will identify the specific evidence of this.

Imposing interim orders during the investigation

The Investigating Committee can impose either:

- an interim suspension order or
- an interim conditions of practice order.

The decision is dependent on the circumstances.

If the allegation raises public protection concerns, it may be necessary to make an interim suspension order to protect the public from the risk of harm.

If an individual has more than one entry on the register (e.g. they are registered as both a nurse and a midwife) and concerns about fraudulent or incorrect entry relate to only of their entries in the register, an interim conditions of practice order, to restrict the person from working, may be appropriate.

Court decisions[1] have emphasised the need for Investigating Committee panels to consider if the integrity of the register could be properly maintained through sanctions imposed at the end of proceedings.

Imposing interim orders at the determination stage

If the Investigating Committee finds an allegation of fraudulent or incorrect entry is proved and makes an order for removal any interim order that's in place will lapse.

At this stage the Investigating Committee can impose another interim order to prevent the nurse, midwife or nursing associate from practising, until the order to remove their entry on the register takes effect.

This power is discretionary and should not be viewed as an automatic decision in every case. The Investigating Committee will consider the public interest in maintaining the integrity of the register in light of any order it has made.

1 See Christou v Nursing and Midwifery Council [2016] EWHC 1947 (Admin)

Interim orders and not having the necessary knowledge of English

Reference: INT-2b Last Updated: 13/01/2023

In this guide

Overview

Since the main purpose of an interim order is to protect the public while the case is being investigated, when a case involves language concerns the following factors should be considered:

- The severity of any actual or potential clinical risk or harm caused to patients, which is related to the alleged lack of knowledge of English.
- The results of any language assessment taken by the nurse, midwife or nursing associate, and
- any refusal or persistent failure to undergo an assessment.

Ensuring we are proportionate

Panels will always assess whether workable and proportionate conditions can be applied to deal with the risks presented by the nurse, midwife or nursing associate's knowledge of English.

In doing this, the panel should bear in mind the powers available to the Registrar[1] when investigating the case, one of which includes a power to direct the nurse, midwife or nursing associate to take a language test and provide us with the results by a specific date[2].

So for example a proportionate measure to protect patients could include supervision or observation by other nurses, midwives or nursing associates, whereas ordering a nurse, midwife or nursing associate to take a language test would be less proportionate in terms of protecting the public.

If an interim order is imposed, a practice committee will review it regularly.

1 The powers may be delegated to another decision maker.
2 Rule 6B(3B) of the Fitness to Practise Rules 2004.

Applications for interim orders

Reference: INT-3 Last Updated: 14/10/2022

In this guide

When will we apply for an interim order?

It is essential that when we receive information that a nurse, midwife or nursing associate's practice presents an immediate risk to the public, the case is referred to a panel for interim order consideration as early as possible.

Our screening team carries out an initial risk assessment on each referral they receive. When we receive new information that an interim order might be necessary, we will carry out a risk assessment. In conducting the risk assessment we will consider if it is likely that the panel would impose an interim order based on one or more of the three grounds, namely whether it is necessary for the protection of members of the public, is otherwise in the public interest, or is in the nurse, midwife or nursing associate's own interests.

While interim orders are generally made at the beginning of the process, they can be made at any time if new information becomes available.

Nurses, midwives or nursing associates already under conditions or suspension orders

When we receive a new referral for a nurse, midwife or nursing associate who has already had a conditions of practice or suspension order imposed on their registration following a previous final hearing, and our risk assessment suggests that we should apply for an interim order because of the new concerns, this will be dealt with at an interim order hearing, rather than at a review hearing for their existing order.

This allows any potential public protection concerns to be dealt with more quickly at an interim order hearing. A review of the existing order at a hearing would require us to give the nurse, midwife or nursing associate 28 days' notice.

An interim order will not automatically come to an end if the substantive order is revoked or allowed to lapse. However, the panel reviewing the interim order must be made aware of such a change so that it can consider its effect on the ongoing need for an interim order.

Arrangements for interim order hearings

We will normally list interim order hearings for a virtual hearing, but we will always consider requests from the nurse, midwife or nursing associate for the hearing to be held physically at a hearings centre. We'll expect such requests to be supported by clear reasons for the request. We'll be guided by the principle of fairness and will do what we can to ensure that people can engage effectively in the hearing. Before we hold a case virtually, we'll check to find out if participants have the right technology to participate effectively and are able to use it.

Where an application is made for a new Interim Order, this will often be on the grounds that there is an urgent

public protection risk. This means that it may be difficult to accommodate a request for a physical hearing, particularly if it is made close to the scheduled hearing time. As noted above, where the nurse, midwife or nursing associate has been prevented from participating in an Interim Order hearing, the panel should direct that the matter be listed for a review hearing within the next 14 days, to give the nurse, midwife or nursing associate a further opportunity to attend. The review hearing will reconsider the interim order in full.

Notice

If we are asking a panel to consider imposing an interim order on a nurse, midwife or nursing associate's registration, we need to give the nurse, midwife or nursing associate reasonable notice. For an initial interim order hearing we try to give at least seven days' notice, however this may be shorter in certain cases. For instance, if the concerns are particularly serious, or we feel there are urgent public protection needs then we can send the notice less than seven days before the hearing. If we do this, we will provide reasons for this in the notice of hearing.

When a nurse, midwife or nursing associate has told us that they are unable to attend the hearing for a particular reason, or they have asked for further time to secure or prepare representations, because of the urgent nature of the risks, the panel should consider the merits of the application for the interim order. If the panel decides that one or more of the legal grounds has been satisfied, the panel should proceed to impose an interim order, but direct that it is listed for a review hearing within the next 14 days, to give the nurse, midwife or nursing associate a further opportunity to attend. The review hearing will reconsider the interim order in full.

Information placed before panels

Due to the urgent nature of our applications for interim orders, it is not always possible for us to apply the same principles for redaction to interim order documents as those we use with substantive hearing documents. Our approach to redaction is explained in our Information handling guidance. The case material documents will be given in a form that enables the nurse, midwife or nursing associate to comment on the concerns. We will redact sensitive information out of the case material but otherwise these documents will generally be un-redacted.

Reasons for applying

Whenever we apply for an interim order the reasons for the decision must be clear. The nurse, midwife or nursing associate will be given these reasons with the documents we send to give notice of the interim order hearing. Some cases will be referred for interim order consideration more than once. In these cases, we must set out clear reasons why the case should be considered again by a panel, when one or more decisions have already been made.

Interim orders and multiple referrals

Reference: INT-4 Last Updated: 02/10/2023

In this guide

Reviewed every six months unless new evidence available

Interim orders must be reviewed by a panel every six months. Reviews must also be held if new evidence relevant to the interim order becomes available after it is made. This could include information that the nurse, midwife or nursing associate has breached the interim order. Nurses, midwives or nursing associates can request that a review should be held because new evidence is available.

We will normally list interim order review hearings for a virtual hearing, but we will always consider requests from the nurse, midwife or nursing associate for the hearing to be held physically at a hearings centre. We'll expect such requests to be supported by clear reasons for the request. We'll be guided by the principle of fairness and will do what we can to ensure that people can engage effectively in the hearing. Before we hold a case virtually, we'll check to find out if participants have the right technology to participate effectively and are able to use it.

Interim orders at final hearings

If, at the end of their final hearing, a nurse, midwife or nursing associate is made subject to a substantive conditions of practice order, suspension order or striking-off order, the order will not take effect for at least 28 days or, if the nurse, midwife or nursing associate appeals, until the appeal is withdrawn or otherwise finally disposed of. The panel may consider it necessary to impose an interim order to cover the intervening period until the order takes effect for the protection of the public or otherwise in the public interest, or in the interests of the nurse, midwife or nursing associate. The panel should first hear representations from both parties (where present) on whether or not an interim order should be made.

Duration of orders

A panel can impose an interim order for a period of up to 18 months. Interim orders must be reviewed every six months. An interim order may be reviewed earlier if new evidence relevant to the case becomes available.

Generally, we apply for interim orders lasting for the maximum period of 18 months. This makes sure that the length of each order adequately covers a case until it reaches a conclusion. This minimises the need for applications to the High Court for interim order extensions. As noted above, if a change of circumstances occurs meaning that an interim order is no longer appropriate, the professional can always apply for an interim order review hearing and ask for the interim order to be lifted.

Interim order extension applications to the courts

If it becomes necessary to extend an interim order timeframe, we may apply to the High Court in England and Wales, the Court of Session in Scotland, or the High Court of Justice in Northern Ireland, where appropriate, for an extension.

When a final hearing is not due to conclude before the expiry of the interim order, we will apply to the appropriate court for an extension. We would not apply for an extension where new information suggests that the allegation may no longer result in a finding of current impairment. Instead, we would list the matter for an early review hearing before a panel of the Investigating Committee or Fitness to Practise Committee. If the panel decides the interim order should be revoked, the matter will not be referred to the court.

Multiple referrals

If a nurse, midwife or nursing associate is the subject of two or more separate referrals, the panel considering an interim order must consider information about all of the referrals. If the panel decides that an interim order is necessary, it should not automatically impose an interim suspension order, but should first consider whether an interim conditions of practice order would be sufficient and proportionate.

If further concerns are raised in relation to a nurse, midwife or nursing associate who is already on an interim order, a panel will nearly always need to review that order at a review hearing and consider the new concerns. This is because interim orders restrict or suspend a nurse, midwife or nursing associate's registration in relation to all their practice and not just the concerns from the initial referral. Any new concerns or evidence will normally always be relevant to the order already in place.[1]

There can only ever be one interim order in place at a time, so it's important that a panel is aware of all the relevant concerns relating to a nurse, midwife or nursing associate's practice when reviewing an interim order. This is so that it can make a proper assessment of the risk of harm (whether to the public, the reputation of the profession or the nurse, midwife or nursing associate themselves), and if necessary, impose a more restrictive interim order than the one already in place.

In cases where an interim order is in place and covers more than one referral, the order doesn't automatically end once the initial, or any of the other referrals, has been dealt with. Being 'dealt with' could be that that the nurse, midwife or nursing associate has agreed undertakings with the case examiners, the case examiners have found 'no case to answer' in relation to one of the referrals, or that a panel of the Fitness to Practise Committee has made a final decision in the case.[2] The order will still be in place, but we list a review hearing as soon as possible so that a panel can assess the risk of harm following one of the cases being concluded. A panel will consider whether there needs to be a more restrictive order, no change to the order, a less restrictive order, or no order at all.

Disclosure of interim orders

Interim order hearings will generally be in held in public. Details of any interim order made will be disclosable, although hearings (or parts of hearings) that relate solely to the nurse, midwife or nursing associate's health are always held in private. Similarly, details of any part of a hearing that is held in private for reasons other than health are not disclosable to enquirers.

[1] Article 31(6)(b) of the Order requires the panel reviewing an existing order to take account of the new concerns as part of new evidence relevant to the order.

[2] For example, rule 6E(2)(c) of the Rules states that once undertakings have been agreed, any interim order in place ceases to have effect. This will require a panel to carry out a review hearing, taking into account that the order no longer has effect in respect of the concerns that led to undertakings being agreed, but it does not mean that an interim order also covering concerns in different cases about the same nurse, midwife or nursing associate, will automatically come to an end. This is because the order would not automatically come to an end if case was dealt with through any of the other possible methods identified above.

[Tier 1] Investigating at the same time as other organisations

[Tier 1 anchor link] Overview

All investigations into a nurse, midwife or nursing associate's fitness to practise should begin without delay.

We understand that our proceedings can be stressful and have an impact on all the people involved in them, so we want to resolve our cases as soon as we can.

However there can be times when our own investigations are affected by investigations that are being done, or that need to be done, by another organisation. This may mean that we have to think about limiting our own investigations, or even delaying them.

[Tier 1 anchor link] When is an investigation by another organisation likely to affect our own investigations?

The circumstances when investigations by another organisation may affect our own investigations are likely to be when:

1. There is a real and significant risk that our investigation will prejudice the other investigation

2. It is impractical for our investigation to continue at the same time

3. It is likely to be more efficient for us to wait because we can use the information the other organisation has gathered

4. The outcome of the other investigation is likely to have an impact on our decision on the fitness to practise of the person we are investigating

We talk about these circumstances in more detail in the guidance below. These circumstances should not be viewed in isolation from each other, as there may be times when there is some overlap between them or more than one of them is relevant to our own case.

Our investigation might risk prejudicing another investigation

It's most likely that our investigation can risk prejudicing an investigation by another organisation when the other investigation has criminal prosecution functions, such as the police, Serious Fraud Office (SFO) or Health and Safety Executive (HSE).

For example, there can be a risk that the evidence we've gathered could conflict with or taint the evidence being gathered by their investigation, or it could interfere with their ability to prosecute or start other proceedings.

Our investigators will always contact the other organisation to understand their view on the matter. If there's a real risk of the other investigation being prejudiced, it may still be possible for us to investigate some areas because our investigations often have a broader scope. For example, criminal proceedings might focus on an allegation of

assault while our related proceedings might include other aspects such as the quality of the care provided.

If we are actively considering continuing with our investigation into other areas of the nurse, midwife or nursing associate's practice, our investigators will always discuss with the other organisation to agree which areas we can investigate. This could include agreement on which witnesses can be contacted and what subjects we can and cannot discuss with particular witnesses.

It's unlikely that our investigation will cause prejudice in cases where the nurse, midwife or nursing associate is not being directly investigated by the other investigating organisation. This could be where the setting in which they practise is the focus of the investigation. In these cases we'll still contact the other organisation as a precaution, and because disclosure of documents or information from that party may help our investigation.

It's impractical to proceed

In some cases the nature and scope of an investigation by another organisation will mean that it's not practical for our investigation to proceed. An example of this is where the police have seized all medical records as part of an ongoing investigation and there are no other lines of inquiry for us to look into.

It's more efficient to wait

It can sometimes be significantly quicker, or otherwise more efficient, if we put our investigation on hold to allow the other organisation's investigation to conclude.

For example, if an employer is investigating a concern they may already have interviewed many of the witnesses we'd need to contact. This would have an impact on our case in terms of how much of the evidence is likely to be available.

Similarly, the nurse, midwife or nursing associate may have been able to address the problems in their practice under their employer's guidance. This might impact on whether we need to take the case any further (which ties in with the impact it has on our own fitness to practise decision - discussed below).

The other organisation may be better placed than us to carry out the investigation because of the nature or scale of the allegations. A good example of this might be a wide-ranging investigation into a serious public safety incident within a setting or healthcare organisation.

When we are considering efficiency we will need to think about the relevance of the evidence being gathered by the other organisation to our own investigations, and what benefit we think there would be to waiting for that investigation to conclude. We have separate guidance on the admissibility of such evidence in our guidance library.

It is likely to impact on our own decision on fitness to practise

There can be times when the outcome of an investigation by another organisation is important for our own decision making in respect of the fitness to practise of the professional.

For example, if the Police were investigating alleged criminal offending which was not connected to a professional context, the outcome of the criminal investigation is likely to impact on our own decision on whether we need to take regulatory action at all.

Another example of this could be where another investigation is being carried out into major systemic failings within the professional's place of employment, which is relevant to the issues in the professional's practice that we are investigating. The result of this could be that we better understand the "context" in which the issues occurred, and this in turn could impact on the view we take of the professional's fitness to practise. If this is the case we will need to carefully consider the impact that has on our own investigations, as it may be fairer for us not to conclude our investigation until the third party investigation has finished.

As we explain in our guidance on "context" there may be times when we will need to proactively share information with other organisations if we identify that systems issues caused or contributed to a situation. When we do so we will also need to ask the other organisation whether they intend to conduct their own investigations into those systems issues and consider the impact that has on us progressing our own investigations.

We have separate guidance on the admissibility of the findings of other organisations.

[Tier 1 anchor link] Deciding if we should proceed with our investigation

Where one or more of the four circumstances outlined above is met, this does not mean that we will automatically limit or stop our own investigations. What we will do is carefully consider what it means for our own investigation and then take the steps we think are appropriate in each individual case.

We will look at whether it is possible for our own investigations to continue in full, or whether we need to limit our investigations. This might mean that we only investigate certain parts of our own case which are not linked to the other investigation. Alternatively it might mean that we investigate our whole case but up to a certain point which we have agreed with the other organisation.

We may need to ultimately wait for the other investigation to conclude before we can conclude our own investigations, but there will often be things we can do so that we are in a good position to progress our own case when the other investigation has finished.

For example we may not be able to interview certain witnesses but it may be possible to make initial contact with them at an early stage to let them know that we will need to speak to them after the other investigation has been completed. Another example is that we could seek disclosure from the police about criminal offending for a prosecution that hasn't yet concluded.

As we say above, we may reach a point where we cannot progress our own case any further until the other investigation has finished. There may also be some cases where

we cannot progress our case at all until that other investigation is completed. This will mean that our own investigation will need to be paused or delayed.

When we delay an investigation, we must be clear on why we have decided this and why we consider that it's in the public interest for us to do this.

If we decide that our investigation should go ahead, we'll consider whether we should identify a later point in our own process at which we will hold our case, to allow the investigation by the other organisation to conclude, before we would then allow our case to proceed. This will most often be when the case is ready to be considered by case examiners.

[Tier 1 anchor link] What we'll do if our investigation is delayed

If our investigation is delayed this does not mean that we will be doing nothing in the meantime.

We'll need to make sure that we keep in contact with all relevant parties, and in particular the other organisation whose investigation we are waiting to conclude so that we can try and minimise the time our own case needs to be delayed. We should be proactively seeking updates from that organisation so that we can continue to assess whether we can resume our own investigations. This will help us to make sure that we resume our own investigations as soon as we can..

We will also need to consider any new information received from any of the parties, so that we make sure that we are carrying out any necessary risk assessments. This is so that we can make sure that any interim order that is in place remains appropriate, or that we can apply for an interim order if one is not in place and is now needed.

Any time we recommend that a case is closed while another organisation's investigation is ongoing, we will take care to avoid giving any party the impression that the matter has been finally dealt with.

In some cases we can reconsider allegations where new information has surfaced, including outcomes of other investigations.

Whistleblowing to the NMC

What is whistleblowing?

We recognise that nurses, midwives, students or other members of staff may identify risks or malpractice within the workplace that you wish to raise with us. This could be an issue that affects patients, the public, your colleagues or the organisation that you work for.

Whistleblowing and speaking up is important as a way of shining a light on concerns. It helps a workplace to be open, transparent and accountable, to be able to learn from events, prevent future concerns and therefore protect the public.

Healthcare has seen a particular focus on whistleblowing as a force for change. It was a whistleblower's concerns that led to the Francis inquiry and a number of changes across the healthcare sector.

Whistleblowers are afforded certain legal protections such as protection from being dismissed or penalised by their employer because of their disclosure.

Who can raise a whistleblowing concern?

A **worker** – someone who works or worked under a contract. This includes employees, agency workers, trainees, volunteers, student nurses and student midwives.

If you're a member of the public (not a nurse, midwife, nursing associate, student or employer), and you'd like to raise a concern about someone on our register, call **020 3307 6802**.

What is 'whistleblowing'?

Whistleblowing is when a worker, including a student nurse or student midwife, raises a concern about wrongdoing in the public interest. Whistleblowing can take place within an organisation or, if the worker feels they are unable to do this, to a third person known as a 'prescribed person'. The NMC is named as a prescribed person in the law.

There is a difference between raising concerns and whistleblowing. The law sets out several criteria that must be met for raising concerns to qualify as whistleblowing.

If all of the conditions set out in the law are met, the person who is blowing the whistle has legal protections to stop them suffering any disadvantage from their employer because of what they have done.

What is the law for whistleblowers?

The law sets out six criteria that have to be met for us to consider that a whistleblowing concern has been raised:

- The person raising the concern to us is a 'worker' – someone who works or worked under a contract. This extends beyond formal contracts of employment and includes employees, agency workers, trainees, volunteers, student nurses and student midwives.
- The person raising the concern must believe they are acting in the public interest. This means that a number of people stand to benefit if action is taken on the concern, and it is not solely for personal gain. Personal grievances and complaints are therefore not usually whistleblowing, unless your particular case is in the public interest. These should be reported under your employer's own grievance policy. You may also wish to seek advice from the Advisory, Conciliation and Arbitration Service about a workplace dispute.
- The person raising the concern must believe that it shows past, present or likely future wrongdoing in one or more of the following categories:
    - that a criminal offence has been committed, is being committed or is likely to be committed. This may be within or outside the UK.
    - that a person has failed, is failing or is likely to fail to comply with a legal obligation.
    - that a miscarriage of justice has occurred, is occurring or is likely to occur.
    - that the health or safety of any individual has been, is being or is likely to be endangered.
    - that the environment has been, is being or is likely to be damaged.
    - that information showing one or more of these criteria has been, is being or is likely to be deliberately concealed.
- The person raising the concern must believe that the matter falls within our regulatory remit.

- The person raising the concern must believe that the information they disclose is true.
- In raising the concern, the individual must not themselves be committing an offence.

Whistleblowing concerns that could be raised to the NMC

Examples of whistleblower concerns that could be raised to us could include, for example:

- The education of those wishing to gain a pre or post registration nursing or midwifery qualification;
- The registration or revalidation of nurses and midwives;
- The fitness to practise of nurses and midwives; or
- Non-compliance with, or concerns about our legislation, policies, standards (such as the Code), guidance or processes.

Our role is to decide whether we believe a concern raised to us constitutes whistleblowing, and to take appropriate action. Our role is not to decide whether the person blowing the whistle to us qualifies for legal protection.

It is for the individual, not the NMC, to enforce their legal protections through an employment tribunal.

How to raise a whistleblowing concern with the NMC

If you believe you have a concern that meets these criteria and you wish to raise it with us, we ask that you email us on whistleblowing@nmc-uk.org. Please set out what the concern is, and how each of the six criteria are met. If you are worried about raising concerns or wish to talk through the process and what is involved, please call us on 020 7637 7181 for advice.

You can also raise concerns through our fitness to practise referral process.

We will treat the information you provide as confidential and won't disclose it without lawful authority. However, to look into a matter properly, we will usually need to disclose some information to the organisation concerned.

You can raise your concern anonymously if you prefer. This can be done by:

- Phoning us and withholding your number.
- Communicating with us via an anonymised email address.

However, please be aware that our ability to ask follow up questions and provide feedback will be limited if you cannot be contacted. Also, if you make an anonymous disclosure it can be more difficult for you to qualify for protections as a whistleblower. This is because there would be no documentary evidence linking you to the disclosure.

What will happen to my information?

We will always acknowledge receipt of your protected disclosure.

We will assess a concern raised to us as whistleblowing against the six criteria to determine whether we reasonably believe it is a whistleblowing concern. We may need to contact the person raising the concern for further information in order to do so.

If we can, we will inform the person raising the concern with us of our decision, our reasons, and our next steps and provide an indication of timeframes.

We will take action in line with our existing approaches.

If the concern is not for us, but we believe it could be for another person or organisation, we may share the concern through our memoranda of understanding.

Where can I get advice?

If you wish to get further advice about your position, you can seek independent advice from:

- your Trade Union
- the whistleblowing charity Protect
- Freedom to Speak Up Guardian
- Independent National Whistleblowing Officer in Scotland