

November 2007

Dear Colleague

The future of pre-registration nursing education

As NMC President and also a nurse registrant, I am delighted to have the opportunity to invite you to respond to this important consultation. The NMC is consulting on the future shape of preregistration nursing in the UK. There have been, and continue to be, significant and far-reaching changes in healthcare policy and the delivery of healthcare. As a priority we need to make sure that pre-registration nursing education enables nurses to work safely and effectively to meet the future needs of patients.

The enclosed consultation document considers the background to the consultation. We ask a number of questions including, for example, should nurses be prepared to diploma or degree level; what proportion of a pre-registration programme should be spent learning in practice; should shared learning be a requirement; should there be branch programmes, and if so, what should the branches be? Also enclosed, because we are looking towards the future of nursing, is a summary of *Nursing: towards 2015*. This provides the context for the consultation and sets out a number of scenarios about how nursing care might be provided in the future. The full document is available on the NMC website.

I would welcome your involvement in this consultation and hope that you will be able to give us your views on these important proposals. I know that your time is valuable but hope that you will appreciate that these are important issues that affect the whole of the nursing profession. To assist you we have included a pre-paid reply envelope to return your completed consultation document. Alternatively, you may wish to complete the questionnaire online. The consultation document including the questions, *Nursing: towards 2015* and a summary can all be found in the Consultations section of our website www.nmc-uk.org. To order additional copies of these documents email publications@nmc-uk.org or telephone 020 7333 6514 or fax 020 7333 2924.

Responses to this consultation will be handled by Alpha Research Ltd, an independent research company. Alpha Research will produce a report based on this consultation, which will inform our decisions about the future of pre-registration nursing education. Please may I assure you that your response will be treated in confidence. Information collected will remain anonymous and be used only in aggregated form.

Should you have any queries regarding the consultation please email consultations@nmc-uk.org

I do hope you will take this important opportunity to shape the future of nursing education by completing the attached questionnaire.



Nancy Kirkland
President

Consultation: A review of pre-registration nursing education

The Consultation

What we are consulting on

The Nursing and Midwifery Council (NMC) is the UK regulator for two professions, nursing and midwifery. The primary purpose of the NMC is protection of the public. It does this through maintaining a register of all nurses, midwives and specialist community public health nurses (referred to collectively as **registrants**) eligible to practise within the UK and by setting **standards** for their education, training and conduct. Currently the number of registrants exceeds 686,000. The Nursing and Midwifery Order 2001 (the Order) **(1)**, sets out the NMC's role and responsibilities.

The purpose of the **Review of pre-registration nursing education** (the Review) is to ensure that all those who qualify as new registrants are fit for practice. The Review is being undertaken against a backdrop of significant and far-reaching policy changes, which could have a direct influence on the way that nursing is to be delivered in the future. Some of these issues go beyond the scope of regulation to address some priorities and actions within Modernising Nursing Careers: setting the direction (DH 2006).

This consultation is about the future shape of **pre-registration** nursing education in the UK and relates to the possibility of introducing new arrangements. Pre-registration in this context refers to programmes undertaken in higher education and in practice settings that lead to an academic award and to registration on the Nurses' **part of the NMC Register**. Before any student can register, they must demonstrate proficiency in practice. We, therefore, need to ensure a rigorous and effective framework of pre-registration education that will allow the demonstration and testing of the knowledge, skills and attitudes required of nurses.

This consultation is more about looking forward than looking back and, for this reason, 2015 is our reference point. Thinking ahead urges us not be too constrained by what we do now, conversely, we do not want to lose what works well. To help your understanding of the consultation a number of possible scenarios have been developed. These have been set out in: *Nursing: towards 2015* (Longley et al 2007).**(2)**. This provides the context for the consultation, a summary of which accompanies this consultation document. The full document and the separate summary are on our website at www.nmc-uk.org. This consultation will refer you to specific sections of the main *Nursing: towards 2015* document but we also encourage you to look at the scenarios in the summary before completing the consultation questionnaire.

Looking at what we need for the future is not just about policy changes and worldwide advances in health care; it's about determining what nurses need to be able to do in the future, how they will work, with whom, how and where they will be trained and to what level. The priority is that nurses must be able to work safely and effectively with others to meet the future needs of patients and clients across the four countries of the UK and worldwide where this is appropriate. Whatever preregistration nursing education framework results from this Review, it will have to be sufficiently robust to meet these demands well into the first quarter of this century. It is not appropriate to consult on everything at this stage and some well-established principles that apply to existing programmes may well continue in the future, e.g. the importance of **partnership** between the higher education institutions, those purchasing programmes and those **providing placements**, including the concept of 'host trusts' in England that promote local ownership.

We urge you to take part in this consultation and to take the opportunity to shape the future of nursing education. The NMC is leading on this Review of pre-registration nursing education as part of Modernising Nursing Careers: setting the direction (DH, 2006) **(3)**
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138756.

The four UK chief nursing officers developed MNC in 2005/6, setting out priorities and actions relating to the changes needed to support the future careers of registered nurses. These developments are not happening in isolation and are viewed in the wider context of changing health care careers. The report emphasises the changing role of professionals engaged in health care and considers what nurses will need to meet future needs of patients and the service. It looks at how health care is changing and new ways of working, and about how careers might be structured in the future.

The aim of MNC is to secure a nursing workforce that is equipped with the **competencies** required for contemporary healthcare and professional practice with a career structure that promotes flexibility, mobility and competency transfer throughout the healthcare system. This has led to work being undertaken around four priority areas to: develop a competent and flexible workforce, update career pathways and career choices, prepare nurses to lead in a changed system, and modernise the image of nursing and nursing careers to address a range of priorities and actions.

Whilst the NMC has taken the lead in addressing some of these priorities through its Review of pre-registration nursing education, the Department of Health in England has taken the lead in developing a Framework for Post Registration Nursing Careers encompassing all stages of practice, including specialist and advanced levels. The Department of Health will be consulting separately in England on Towards A Framework for Post Registration Nursing Careers: A National Consultation, at the same time that the NMC are consulting across the UK on the Review of preregistration nursing education

Under the auspices of MNC, the CNO's Directorate in the Scottish Government are leading on developing a framework for advanced level practice, which will feed into national work and be open to wider consultation.

Any outcomes from the Review of pre-registration nursing education will therefore need to take account of the findings from the Department of Health, A Framework for Post Registration Nursing Careers: A National Consultation; the Scottish-led Advanced Practice work, and other UK MNC initiatives considering how these findings inter-relate across the four UK countries.

Why we are consulting

The past

Prior to 1989 nurse education was mainly provided through NHS hospital schools of nursing through what was known as the 'Apprenticeship Model'. Students were employees and spent most of their time in practice.

In 1989, a new type of education was developed known as **Project 2000**, which moved all nurse education into higher education. It led to a minimum award of Diploma in Higher Education and nursing registration in adult, children's, mental health or **learning disability** nursing. These four branches still remain in place.

Project 2000 was evaluated in 1999 and recommendations were made following the publication of Fitness for Practice (UKCC 1999). **(4)** New Fitness for Practice programmes were introduced from 2000. These programmes still lead to registration as a nurse today and the programme **requirements** are set out in the NMC's Standards of proficiency for pre-registration nursing education (NMC 2004) **(5)**

<http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=328>, a summary of which can be found in **Appendix 1**. Evaluation of pre-registration nursing education is referred to on page 46 of *Nursing: towards 2015*.

The *NMC code of professional conduct: standards for conduct, performance and ethics (6)* is being revised but will continue to set the standards and guidelines for professional behaviour and accountability for all new registrants, providing a continuous reference point for students undertaking pre-registration nursing programmes.

The future

Any new pre-registration nursing education framework must be aligned with the changing nature and structure of healthcare delivery and future career structures across the four countries of the UK. It must also be closely associated with the priorities and actions of *Modernising Nursing Careers*. Significant regulatory amendments such as any requirement for preceptorship linked to first renewal of registration would also require consideration in relation to the White paper and the relative positions of the devolved administrations in the four UK countries.

Looking further afield, there are changes taking place in Europe which may influence the way in which nursing programmes will be delivered in the future. Whilst the **European Directives** for nursing have changed little since the 1970s, there are proposals to better align higher education qualifications and nursing across Europe, through the **Bologna Process (7)** and the **TUNING project (8)**.

European Directive 2005/36/EC - Recognition of Professional Qualifications, **(9)** Article 31 sets out minimum requirements for what is known as 'general care' that allows the NMC registrant freedom of movement as a nurse in Europe. Currently, this is a requirement that applies to nurses who take the **adult branch** of the pre-registration nursing programmes.

The Bologna Declaration of 1999 intends to lead to more accessible and comparable degrees as well as greater mobility, co-operation and competition, and incorporates a **European Credit Transfer System (ECTS)**.

In addition, the TUNING project intends to lead to greater harmonisation of nursing within Europe. More information is set out on pages 54 and 55 of *Nursing: towards 2015*.

Nursing: towards 2015

In taking this Review forward, we must also consider potential changes to inter-professional regulation and emerging roles in the White Paper, *Trust, Assurance and Safety - the Regulation of Health Professionals in the 21st Century (10)*. Proposals in the White Paper are intended to bring the regulation of different health professions more in line with each other and to provide more opportunities for employers to be involved in the revalidation of professional registration. There is more information on page 41 of *Nursing: towards 2015*.

It is generally agreed that whatever pre-registration nursing education framework we have for the future, it must enable nurses to have the knowledge and skills to meet needs:

- in a complex and diverse society where social inequality exists
- inside and outside hospital and across health and social care
- across public, private and voluntary health provider organisations
- of an increasing older population
- of those with long term conditions
- across the patient care pathway
- in supporting lifestyle changes
- using disease prevention and health promotional interventions
- by treating patients as partners in healthcare and maximising choice
- through the use of technological advances
- in new and emerging roles which cross professional boundaries
- as leaders and members of multidisciplinary and inter-professional teams
- as lifelong learners in an ever evolving healthcare environment.

How we are consulting

We will consult in two ways: firstly, through an extensive online and postal survey and secondly, through a number of UK-wide focus groups.

We will consult widely with the public, employers, practitioners, and those with an interest in preregistration nursing education across the four UK countries, to include patients, users, student nurses and aspirant nurses. Please remember to take a look at *Modernising Nursing Careers* and the summary of *Nursing: towards 2015* before answering the questions posed in this consultation.

We are encouraging responses from diverse communities and taking steps to reach as many people as possible.

This consultation will ask you to consider key principles around which future pre-registration nursing education might be developed. **Appendix 1** summarises the current requirements. It is important that we do not embark on change for the sake of it and we need to consider whether current arrangements might remain suitable for the future delivery of pre-registration nursing education. For this reason, the concept of 'no change' is considered in this consultation and any potential change needs to be considered in the best interests of future health care.

In shaping the consultation questions we explored a range of options with our project groups. The groups were broadly representative of key **stakeholders** in the four UK countries and the four branches of nursing. They included: employers; users of services; those who **commission**, deliver and receive nursing education; those who teach on pre-registration nursing programmes; those who mentor and assess students in clinical practice; and professional bodies and unions. We have already had some feedback, for example, through reports from DH stakeholder groups set up to discuss *Modernising Nursing Careers*, and from a 'Think Tank' established this year by NHS Education for Scotland (NES). **(11)** We have also had face-to-face discussions with some individuals and groups who asked us to meet with them.

Useful background papers that can be downloaded from the internet include:
UKCC Post Commission Development Group Fitness for Practice and Purpose (UKCC 2001)
(12) <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=629>

Modernising Nursing Careers (Department of Health 2006)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138756

Nursing: towards 2015. Longley et al. (NMC 2007)
<http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=3398>

Who we are consulting

We aim to consult with a wide range of individuals, groups and organisations that have an interest in ensuring that nurses of the future are able to deliver safe and effective healthcare.

The consultation document has been sent to a random sample of practising nurses on our register. The sample has been drawn from the four branches of nursing and the part of the register for specialist community public health nurses. Copies of the consultation, the summary of *Nursing: towards 2015*, and the main *Nursing: towards 2015* report can all be downloaded from the Consultations section of our website www.nmc-uk.org or additional copies can be requested by contacting publications@nmc-uk.org or telephone 020 7333 6514 or fax 020 7333 2924. Should you have any particular needs relating to the format, please let us know.

This consultation will run from Thursday 1 November 2007 and close at 5pm on Friday 8 February 2008

The Questionnaire - MHNAC UK – collated response – Submitted on-line 7/2/08

Section A - Overarching principles

The following section asks you to consider major issues affecting all future pre-registration nursing preparation.

Diploma or Degree

Over the years, there have been many debates over whether the minimum academic level at which a nurse qualifies should be diploma or degree level. At the moment, the NMC sets the minimum academic level for programmes leading to initial registration at Diploma of Higher Education. This is the equivalent of two thirds of a degree and we want to know if you think this should change. This must be considered within the context of public protection and we need to ask whether academic level should be important at all. There are many arguments for and against degree level preparation.

Those arguing for a degree level qualification at the point of registration say that there is a need for the future nurse to be competent at seeking out and using evidence to support and continually improve practice, safeguard patients' interests and use resources effectively. All of these skills that include the principles of research are associated with degree level preparation. It is also argued that the knowledge and skill levels needed by future nurses should be the same as those required by other health professionals, most of whom already qualify at degree level. In the future, there may be fewer registered nurses and, therefore, more support staff. More nurses are likely to be leading teams, which include other health professionals.

Therefore, should all nurses be initially educated to degree level and what would be the consequences for patients if they were not? The arguments are taken further on page 50 of *Nursing: towards 2015*. There is no doubt that the trend in the UK, Europe and across the world is towards increased degree level preparation for nurses. The NMC recently agreed that all student midwives must be required to achieve a degree for registration.

Those opposed to requiring a degree level outcome at the point of registration argue that the current diploma in HE level affords sufficient public protection. They argue that being registered is more about demonstrating an ability to practise safely and effectively, and having the right qualities, rather than about academic level. The argument is that many people who may not be capable of achieving at degree level make excellent nurses and should be encouraged rather than denied opportunities to enter the profession. This is not to say that graduate nurses are unnecessary, but that Diploma in Higher Education should be the minimum academic level for all nurses at the point of registration. There are also concerns that in the future there might be too few applicants to meet the entry requirements for degree level programmes and therefore not enough new nurses would be available to fill future posts.

Q1 Should the minimum academic level for a pre-registration nursing programme in the UK be at Diploma in Higher Education Level, or at degree level?

- | | |
|---------------------|-------------------------------------|
| Diploma in HE level | <input type="checkbox"/> |
| Degree level | <input checked="" type="checkbox"/> |
| Not sure | <input type="checkbox"/> |
| Have no opinion | <input type="checkbox"/> |

Q2 If a student is not able to achieve at degree level, but is safe and effective in practice and has achieved at diploma level, do you feel they should be:

- | | Yes | No | Not sure | Have no opinion |
|------------------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| Awarded a Diploma in HE? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Be able to apply for registration? | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Q3 Do you have any comments that you wish to add regarding your answers to the first two questions?

We believe that the minimum academic level for a pre-registration nursing programme should move towards being a degree. This would bring nursing in line with other professions allied to medicine and it could be argued that the increasing complexity of nursing requires nurses who are equipped with graduate level critical and problem solving skills. It needs to be acknowledged that in Wales and NI the level of award is already a degree though there is still a Dip HE exit point.

There were mixed views about the exit point at Dip HE allowing registration though the majority of the group considered that this should be facilitated. However, the key factor in considering a registerable qualification should be the meeting of the professional practice and theory requirements for registration. We would however, wish to avoid the scenario where different levels of academic award led to a real or perceived two tiers of qualified nurses. There was a general view that DipHE should be offered as a potential exit rather than initial entry award. If there was a continuation of DipHE and Degree programmes we would suggest that this should be time limited with a clear review point in the near future with a likely phasing out of the diploma. Allowing a DipHE as an exit award within a degree programme would need to take account of credit structures and regulations at different HEIs. Some Universities may not wish to continue to offer sub-degree level qualifications. It needs to be noted that Scotland operates a different Credit and Qualification Framework.

An Ordinary degree (with registration at this point) as an alternative exit point to DipHE could be considered.

If there was a move to all degree this would require:

A rigorous impact assessment in terms of the effects on the potential recruitment pool and the widening participation agenda, particularly for under-represented groups.

A review of the current 'means tested' bursary arrangements for students on degree nursing courses as opposed to the 'non-means tested' bursary in place for students on DipHE nursing courses. We would strongly support 'non-means tested' bursaries for all nursing students, regardless of level of award being studied.

Stepping On

It would be important that those who want to access a pre-registration nursing programme can apply to have previous learning recognised and, therefore, step on to a programme at a point that leads to completion in a shorter time. This could be attractive to health care assistants and assistant practitioners or perhaps others seeking a career change. This relies on a process of **Accreditation of Prior (Experiential) Learning or AP(E)L**, which higher education institutions have already developed for accrediting both academic and practice based learning.

The NMC currently allows a three-year pre-registration nursing programme to be shortened by up to one third for initial entrants. There are, however, arguments for permitting a larger proportion of AP(E)L than the current one third, which could create more flexibility and widen participation. A counter argument might be that there is a risk that the period of preparation is shortened by credit being given to learning, which is not directly related to the achievement of the required **proficiencies**.

Q4 Do you agree or disagree that pre-registration students should be able to complete a programme in a shorter time if some theory and/or practice requirements have already been met?

- | | | |
|-----------------|-------------------------------------|----------|
| Agree | <input checked="" type="checkbox"/> | Go to Q5 |
| Disagree | <input type="checkbox"/> | Go to Q6 |
| Not sure | <input type="checkbox"/> | Go to Q6 |
| Have no opinion | <input type="checkbox"/> | Go to Q6 |

Q5 What is the maximum amount that you think the programme could be shortened by in such instances?

- | | |
|-----------------------|-------------------------------------|
| By up to 1/3 (as now) | <input type="checkbox"/> |
| By up to 1/2 | <input checked="" type="checkbox"/> |
| By up to 2/3 | <input type="checkbox"/> |
| No limit | <input type="checkbox"/> |
| Not sure | <input type="checkbox"/> |
| Have no opinion | <input type="checkbox"/> |

Q6 Do you have any comments that you wish to make regarding Stepping On?

We believe that there should be the opportunity for students to complete a programme in a shorter time where it can be clearly established that some theory and practice requirements are already met. A maximum needs to be established and some members of the group felt that this maximum could be raised from that currently allowed. Those stepping on should clearly demonstrate both necessary academic and/or clinical experience which can be assessed through current rigorous AP(E)L systems already in place within HEIs.

We would welcome expansion of the current list of those degrees which enable existing graduates to undertake a shortened programme.

Dependent on decisions regarding the final structure of any CFP and branch years, careful consideration would need to be given to the practicalities of stepping on points for students to join programmes.

Other issues which need to be considered include ensuring the integrity of programmes, the quality of the learning experience, appropriate time for occupational socialisation, and the need for adequate periods of time working and learning together with qualified colleagues in practice settings.

The current regulatory focus on quantifying learning experiences in terms of hours required should be reviewed or at least the current high hours requirements - these can be exclusive and difficult to manage. Accelerated entry onto programmes should be based on evidence of achievement of relevant learning outcomes with equal importance being placed on experiential as well as theoretical learning

Stepping Off

'Stepping off' is about enabling those who wish to leave the programme early to have their learning recognised. Currently, students who choose to leave a programme early may be awarded a certificate confirming the amount of academic credit they have achieved but little else. This might enable a student to transfer to another programme that might be totally different from nursing. Students who leave the programme early are unlikely to be awarded a nationally recognised vocational qualification, but there is an argument that this should change. However, when we considered some of the issues about stepping off with one of our project groups, they believed it important that the pre-registration programme should primarily be for preparing registered nurses and that it would be inappropriate for this to be seen as a major route to a vocational award.

We are keen to explore whether there is support for recognising learning when students leave a programme before its completion and, if so, what qualifications might be most appropriate and at which points in the programme they might be awarded.

Q7 If a student leaves a programme early, do you think that, subject to minimum criteria being met, they should be eligible for a nationally recognised skills based qualification in care, such as a vocational award?

- | | | |
|-----------------|-------------------------------------|----------|
| Yes | <input checked="" type="checkbox"/> | Go to Q8 |
| No | <input type="checkbox"/> | Go to Q9 |
| Not sure | <input type="checkbox"/> | Go to Q9 |
| Have no opinion | <input type="checkbox"/> | Go to Q9 |

Q8 Should a vocational qualification be awarded once the following full time periods on the programme have been successfully completed?

	Yes	No	Not sure	Have no opinion
After six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After one year?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After 18 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After two years?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After two and a half years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q9 Do you have any comments that you wish to make regarding Stepping Off?

Whilst we agree that it may be useful to provide such 'sub-qualifications' for students, we believe that any such stipulations are completely outside of the public protection remit of the NMC.

If only those students completing full programmes are able to register as qualified nurses, the decision whether to offer interim awards and the nature of these awards should be left to HEIs. The cert (1 yr step off) Dip (2 yr step off – but without registration) model would better suit HEI qualification and credit frameworks.

We would argue for only two sub-award points – 1. for students completing a minimum of one year but less than two years and 2. for students completing a minimum of two years but less than three years (neither of these with registration).

NVQs are generally the domain of FE. All students exiting HEI programmes normally receive transcripts of credit and therefore recognition of equivalence to NVQs would be a decision to made by NVQ providers.

Learning in Practice

The NMC places significant importance on learning and being assessed in practice as well as the need for this to be supported through a sound knowledge base integrated with opportunities for learning through simulation. The EC Directive requires students to spend at least 50% of their programme in a practice setting learning from other nurses.

There are indications from evaluation and monitoring that most new registrants are fit for practice when they qualify. There are, however, arguments for making this 50% requirement for learning in practice longer. This is mainly related to previous concerns that some students may not have had sufficient opportunity to become both competent and confident in practice by the time they qualified; concerns that have since been addressed as part of the NMC's ongoing Review of fitness for practice at the point of registration.

Others would argue that increasing students' time in practice is no guarantee that students will gain the skills they need to become competent as this depends largely on a number of factors. These include: adequate learning opportunities, the availability and quality of supervisors, and the opportunity to work alongside effective role models. Increasing the time spent in practice might mean there are less supervisors and role models to go around. Any increase in the current proportion of 50% practice might mean that students would have less time to study what is essential for safe and effective practice.

Q10 What proportion of a pre-registration programme should be spent learning in practice?

- | | |
|-----------------------------|-------------------------------------|
| 50% (as now) | <input checked="" type="checkbox"/> |
| 55% (as now) | <input type="checkbox"/> |
| 60% (as now) | <input type="checkbox"/> |
| More (please specify below) | <input type="checkbox"/> |
| Not sure | <input type="checkbox"/> |
| Have no opinion | <input type="checkbox"/> |
| <input type="text"/> | |

Community

In the future, most health care will be provided in the '**community**'. Community in this context refers to the wider community, not just services provided by GPs and small local hospitals, but services also provided by the independent sector, voluntary and other providers, under what is becoming known as the 'third sector'. The community might include any setting outside of the district general hospital. A community approach, that includes closer links between health and social care, has already become the norm for services through which care is provided for people with mental health problems and learning disabilities. This approach is likely to be extended to most other services over the next few years.

Whilst the NMC has always required some learning to be undertaken in the community, it does not set a specific standard. With the shift to more services being provided in the community, it might seem prudent to ensure that students can learn in areas where they need to be able to practise at the point of registration. Nurses of the future need to be fit for practice and purpose and be able to practise safely and effectively in the community on registration.

The practicalities of requiring significantly more learning in the community should not be underestimated. Most students currently learn in more traditional hospital settings where there is economy of scale; there is usually a supportive infrastructure that has developed over time, which frequently provides residential accommodation, on site catering, teaching, library and internet access. Significant numbers of students can learn in practice at any one time due to the way inpatient services are managed in large hospitals.

If the NMC sets a minimum standard for the proportion of learning to be undertaken in the community, then this would have to be conditional on resources being in place to support this. There has to be access to sufficient learning opportunities, an infrastructure to support learning, and enough suitably prepared and experienced staff to support, teach, mentor and assess students.

There is already a shift towards a significant amount of the current 50% learning in practice component being spent in the community. Some universities have already acted on purchaser requirements and started to put new community learning arrangements in place and their experiences will be crucial in supporting any wider developments. As patient care changes and services are reconfigured, more learning opportunities will become available in the community, but this is likely to take time and change might not occur in a uniform way across the UK. Therefore, we are asking you whether you think any requirements to increase the proportion of time spent in the community should be introduced over time as new services come on line e.g. within five years.

Q11 How much of the learning in practice component should be in the community?

- Less than 1/3 of the learning in practice component Go to Q12
- 1/3 Go to Q12
- More than 1/3 but less than 1/2 Go to Q12
- 1/2 or more Go to Q13
- No set requirement Go to Q13
- Not sure Go to Q13
- Have no opinion Go to Q13

Q12 Should learning in practice in the community be increased to form half the total practice requirement within five years?

- Agree
- Disagree
- Not sure
- Have no opinion

EC Directives

Students registering as a nurse having followed the adult branch programme are required to fully meet the following requirements: *European Directive 2005/36/EC - Recognition of Professional Qualifications, Section 3, Article 31, Training of nurses responsible for general care and Annex V, Recognition on the basis of coordination of the minimum training conditions, 5.2.1. Training programme for nurses responsible for general care.* The Directive sets out the minimum requirements for 'general care' and provides adult nurses freedom of movement in Europe.

The ways that the EC requirements have to be met are broadly defined, leaving **programme providers** to determine what should be included and how and where this is to be experienced. This means that there is no UK standard through which the NMC can ensure that students meet the general care requirements set out in the Directive. We are, therefore, consulting on whether it would be helpful if the NMC set minimum hours and proficiencies for learning in practice, where there are EC requirements for experience in **childcare, maternity care, and mental health care**. It would not be the intention to require traditional placements in these areas. (Please note that some wording in the following descriptors is that used in the Directive).

Q13 Where the EC requires specific experience for 'general care' do you agree or disagree that proficiencies should be set for learning in practice for:

	Agree	Disagree	Not sure	Have no opinion
Child care and paediatrics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternity care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health and psychiatry	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q14 Where the EC requires specific experience for ‘general care’ what *minimum amounts of practice experience* should be set for the following, if at all?

	Child care & Paediatrics	Mental Health & psychiatry	Maternity care
Less than six weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Six weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than six weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minimum practice requirements should not be set	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Not sure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have no opinion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q15 Do you have any comments that you wish to make regarding Learning in Practice?

We strongly believe in the continued equal importance of practice based learning. Most members favoured no reduction in current requirements.

Current ‘practice’ and ‘theory’ terminology distinctions are not helpful. ‘Campus based’ and ‘practice based’ learning may better reflect the intention regarding the location of learning rather than suggesting a somewhat artificial, unhelpful divide between ‘theory’ and practice.

The recent decision by the NMC to allow 300 hours simulation to count as practice was seen as useful but this means that the current starting point for direct practice is actually <40%.

Specifically in relation to Q10, there is no clear evidence to support a change.

As in response to Q.6 above, we would argue for a re-consideration of the quantity of hours currently stipulated due to difficulties in monitoring this, the fit with HEI models and other similar professions (can limit IPL opportunities). Whilst we believe that minimum hours (or days) should be still be set it is quality rather than quantity of learning experience in an environment which is important.

We note with interest that the stem for this question states ‘There are indications from evaluation and monitoring that most new registrants are fit for practice when they qualify’. This contradicts and undermines the implicit basis of this consultation – i.e. that programmes need to fundamentally change. The clear bias in this questionnaire is towards a generalist model in numerous different guises. This is in direct contradiction to the evidence of the negative outcomes of generalist programmes from other countries which have gone down the generic route (for Mental Health care in particular). We would refer the NMC to the DH commissioned evidence review of international approaches to pre-registration educational preparation for mental health and learning disability nursing undertaken by the National Nursing Research Unit, King’s College London (NNRU 2007) which concludes that such a move would have disastrous consequences for MH care. Further summary of findings are outlined in Q.61.

Whilst we acknowledge the drive towards community based practice has increased and is likely to increase further and that curricula should respond to such changes, we believe that the NMC should confine itself more specifically to issues of public protection.

We believe that a NMC requirement that programme curricula (in terms of theory and practice experience) reflected contemporary practice would be adequate. This could be assessed at programme validation, monitoring and review where this broader requirement could be tested in terms of National changes but also the fit between curricula and local services, placements and mentors available. Standardising community experience in such a prescriptive manner fails to take into account local services models and availability and in light of currently experienced difficulties with community placements in some areas may lead to an unachievable requirement.

There is a key principle here that we would wish to emphasise: Validation of curricula should explore congruence between local service models, capacity and distribution of placements in the curriculum. Setting specific requirements at National level could be setting Education providers (HEIs & Practice partners) up to fail because of factors above. Please see response to Q12.

The current exposure to other branches is problematic. Clear proficiencies should be set rather than focussing simply on time spent in particular environments. Identifying adult, Child, LD and MH proficiencies to be achieved by the end of the program (3 years) rather than in year 1 would be better and enable more creative solutions.

We recognise the need for free exchange (mobility) and the existence of EU directives. However as we understand these they are directives rather than legislation. It is within the gift of individual countries how they respond to individuals' qualifications and programmes of study.

The quality of learning in practice in terms of knowledge and skills acquisition is a more important measure than the current 'overemphasis' on the number of hours spent in particular areas.

Placements should more appropriately reflect person centred care and the users journey through different services and care contexts. The division between 'hospital' or 'community' is increasingly outdated as nurses are and will in the future be required to provide care across traditional boundaries.

In relation to a number of issues in this section we would again emphasise the need for the NMC to confine itself to issues of public protection.

Shared Learning

Shared learning has become an important concept in health professional education. This provides opportunities for students from different disciplines to learn about each other's roles and responsibilities, sometimes through shared modules, or by engaging in learning activities in the classroom or in practice settings. A major recommendation made in 2001 by the UKCC Post Commission Development Group related to taking forward inter-professional learning. The NMC supports the principle of shared learning and wants to explore this further as part of the Review.

A number of initiatives, particularly in England, have led to pilot projects where shared learning has been fully incorporated across a range of professional programmes. Increasingly in the future, nurses will be required to work within and lead inter-professional teams. There is, therefore, an argument that shared learning with other **professional groups**, where this is possible needs to become a requirement of pre-registration nursing programmes, e.g. sharing with student social workers, medical students, physiotherapy students.

Currently there are opportunities for nursing students to learn together through a **common foundation programme (CFP)**, providing a common foundation of learning in the first part of the pre-registration nursing programme irrespective of what **branch** students may later follow. Here all nursing students can learn together most of the time to achieve common outcomes but such arrangements are flexible enough to also include other health and social care students.

Another approach is to utilise a '**common core**', where a designated proportion of time might be set aside in different parts of the programme to learn with others, unlike the common foundation programme this common core could extend throughout the programme.

We want to know whether there is support for a common foundation programme, a common core, or both.

Common foundation programme (CFP)

The concept of the common foundation programme (CFP) and nursing branch programme was first introduced in 1989 as part of Project 2000. This was based on the principle that the first part of the programme, the CFP, would be 'common' to all nursing students. The remainder of the programme would form the branch and lead to a specialist programme in one of four fields of practice: adult, children's, mental health, or learning disability nursing. This has not been without its difficulties and the length of the CFP was reduced from 18 months to 12 months following the evaluation of Project 2000 programmes. There were concerns that the needs of the majority were catered for at the expense of those in the smaller branches. This remains a concern today and yet the outcome of a *Nursing Times* survey in June 2007 indicated that existing students would like to have more exposure to content in other branches.

Common core

A 'common core' could be advantageous to those nursing students (or others) who are gaining experience with the same client group irrespective whether there is a decision to have a **generalist** or branch preparation in the future. If the principle were supported, we would look at whether this should be required in certain years or at points throughout the programme. An argument against requiring a set period for a common core is that this and other issues relating to shared learning might be best left to programme providers to determine.

Q16 Do you agree or disagree that shared learning, where students from different professional groups learn together, should be a requirement or pre-registration programmes?

- | | |
|-----------------|-------------------------------------|
| Agree | <input checked="" type="checkbox"/> |
| Disagree | <input type="checkbox"/> |
| Not sure | <input type="checkbox"/> |
| Have no opinion | <input type="checkbox"/> |

Q17 Do you agree or disagree that there should be a 'common foundation' at the beginning of the pre-registration nursing programme?

- | | | |
|-----------------|-------------------------------------|-----------|
| Agree | <input type="checkbox"/> | Go to Q18 |
| Disagree | <input type="checkbox"/> | Go to Q19 |
| Not sure | <input checked="" type="checkbox"/> | Go to Q19 |
| Have no opinion | <input type="checkbox"/> | Go to Q19 |

Q18 How much time at the beginning of the pre-registration nursing programme should be dedicated to a 'common foundation'? Please choose an option below.

- | | |
|--------------------|--------------------------|
| First three months | <input type="checkbox"/> |
| First six months | <input type="checkbox"/> |
| First nine months | <input type="checkbox"/> |
| First year | <input type="checkbox"/> |
| First 18 months | <input type="checkbox"/> |
| First two years | <input type="checkbox"/> |
| Not sure | <input type="checkbox"/> |
| Have no opinion | <input type="checkbox"/> |

Q19 Do you think that there should be a 'common core'?

- | | | |
|-----------------|-------------------------------------|-----------|
| Agree | <input checked="" type="checkbox"/> | Go to Q20 |
| Disagree | <input type="checkbox"/> | Go to Q23 |
| Not sure | <input type="checkbox"/> | Go to Q23 |
| Have no opinion | <input type="checkbox"/> | Go to Q23 |

Q20 Do you think that the 'common core' should form part of the 'common foundation'?

- Yes
- No
- Not sure
- Have no opinion

Q21 Should the required proportion of the full length programme taken up by the 'common core' form:

- 0% of the theory time
- 10% of the theory time
- 20% of the theory time
- 30% of the theory time
- 40% of the theory time
- 50% of the theory time
- More of the theory time
- Not sure if it should form part of the theory time
- Have no opinion

Q22 Should the required proportion of the full length programme taken up by the 'common core' form:

- 0% of the learning in practice time
- 10% of the learning in practice time
- 20% of the learning in practice time
- 30% of the learning in practice time
- 40% of the learning in practice time
- 50% of the learning in practice time
- More of the learning in practice time
- Not sure if it should form part of the learning in practice time
- Have no opinion

Q23 Do you have any comments that you wish to make regarding Shared Learning?

In relation to Q.16 we strongly support the principle of shared learning and believe that this should include wider professions and not solely other branches of nursing. MHNs share as much (and often more) in common with other disciplines and agencies in mental health as they do with nurses from other branches. The other professional groups with whom shared learning is appropriate may differ according to branch specialism and the networks of groups in practice. For example, MHNs may work more closely with Social Work colleagues and Children's Nurses may benefit from shared learning with educational staff. Shared learning shouldn't simply be seen in terms of shared campus based learning but needs to acknowledge and further promote IPE in practice settings in line with service models and the patient/user experience.

Learning with students from other branches has tended to be focussed in the CFP. This should be reconsidered, with opportunities for joint learning once students have established and understood the professional identity and contribution particular to their chosen branch.

Whilst there was acknowledgement of the importance of shared learning we would again question whether this is something which should be subject to regulation by the NMC.

The questions relating to CFP and common core are confusing and arbitrary given that an example or examples of potential model(s) is not provided.

Q17 assumes either current model/structure or specialisation but the answer depends on the model/structure finally adopted. If the current model/structure is retained we believe that the CFP should not be, as it is often currently, generalist dominated. In terms of the length of time of a CFP there were different views but clear agreement that were this model to continue it should be no more than 1 year in the case of a 3 year programme.

The questions in this section also provided insufficient explanation to enable clear differentiation between what was meant by a CFP versus a Common Core. However, as indicated above were the CFP + branch model to be retained the nature and focus of the CFP in terms of its current adult physical care orientation requires review.

The way in which these questions are worded could inadvertently lead to one agreeing to a one year CFP AND a one year common core leaving only one year for a specialist branch. We would strongly oppose such a model. The consequences of answering these questions in one way or another need to be made more explicit. This indicates once again the general bias of the questionnaire towards generalist preparation in one form or another.

We believe that there should be some exploration of a common core as opposed to a CFP but with the following caveats:

Learning and practice experiences during Year 1 of the programme should have a strong focus on and application to the students' chosen branch.

The balance between a common core and branch specific learning should reflect the current balance with no more than the equivalent of 1 year study devoted to common core leaning and 2 years study devoted to branch specific learning. Core learning opportunities would be better spread across all years rather than simply focused on year 1.

Any common core learning must address specific branch application of knowledge and skills.

Common Pathways and Themes

Future healthcare may be organised in a way that is characterised by broad **care pathways** and themes rather than care organised around age, care group, or clinical specialism. If the four government health departments of the UK decided to take such an approach it could significantly influence the way new nurses are prepared. If in principle they decided to do so, should such pathways and themes become a required part of future programmes, with all students needing to experience these prior to registration?

The DH in England are currently consulting on A *Framework for Post Registration Nursing Careers* which includes care pathways for: children, public and family health; first contact, access and urgent care; long term conditions; acute and critical care; mental health and psychosocial care. In addition there are cross cutting themes for; health promotion; preventative, long term conditions management or crisis monitoring; safeguarding vulnerable people, end of life care; and holistic care. This Post Registration Nursing Careers Framework would apply to all nurses in England irrespective of their branch. The Government health departments in Scotland, Wales and Northern Ireland have not yet consulted on their approaches

Q24 All programmes should be required to include care pathways and themes, if adopted by the Government health department in the respective country. Do you feel this is a good or bad idea?

- | | | |
|-----------------|-------------------------------------|-----------|
| Good idea | <input checked="" type="checkbox"/> | Go to Q25 |
| Bad idea | <input type="checkbox"/> | Go to Q26 |
| Not sure | <input type="checkbox"/> | Go to Q26 |
| Have no opinion | <input type="checkbox"/> | Go to Q26 |

Q25 Do you feel that, in principle, care pathways and themes should be explored by all students irrespective of branch or main speciality, or not?

- Should be explored by all students
- Should not be explored by all students
- Not sure
- Have no opinion

Q26 Do you have any comments that you wish to add regarding Common Pathways and Themes?

It depends on the nature of common pathways and themes. We would support pathways/themes but only if they were integrated throughout the curriculum and ensured specific branch application. Branch application of such themes/pathways is critical at an undergraduate level to enable students at the beginning of careers to work meaningfully with users in the specialist practice setting

There should be a requirement for specialist branch programmes to be mapped against Government health and social care policy (and law) and priorities. In mental health the models for the recently developed pre-registration competencies and frameworks derived from the comprehensive CNO Review in England and the Scottish Health review of MHN are good examples of this.

Again – insufficient information is provided in relation to q’s 24 – 26 to make a fully informed response.

The simultaneous DH England consultation on A Framework for Post Registration Nursing Careers is unhelpful when the future of pre registration preparation has yet to be decided. We need far more joined up consultations and policymaking. Also, the extent to which a DH England consultation should act as a driver for a UK wide consideration of pre registration preparation is questionable.

Sub-specialisation

In framing the questions for this consultation, the project groups explored a number of potential frameworks for delivering pre-registration nursing education in the future. This included looking at what flexible opportunities there might be for students to sub-specialise in an aspect of care before they qualified. Some referred to this as ‘majoring’ in a particular area, which could include: spending time exploring a specific care pathway, a cross cutting theme, a clinical speciality, or a major aspect of an existing branch programme. Alternatively, time could be spent working with older people, with populations (e.g. **public health**), or perhaps nursing in the community.

This assessed period with its own outcomes could include the development of specific skills packages attractive to both students and future employers. This would not lead directly to any new mark, or to another part of the NMC register, e.g. to specialist community public health nursing. We are consulting on the principle and the proportion of time that might be allocated to this in the final period of the programme. We are calling these sub-specialisms to differentiate them from specialist **branch programmes**. This is enabled by a proportion of time being set aside towards the end of the programme.

Q27 Towards the end of the pre-registration programme, do you think all students should be required to ‘major’ in at least one sub-specialist option? For example, this may be a care pathway, a cross cutting theme, a clinical speciality or a major aspect of an existing branch programme.

- Yes, there should be a requirement to ‘major’ in a sub-specialism
- No, a final sub-specialism should be optional
- No, I do not think there should be a final sub-specialism at all
- Not sure
- Have no opinion

Q28 How should the successful completion of a final period for sub-specialism be recognised? Please check all that apply.

- By a certificate issued by the University
- By recording on the NMC Register
- Not sure
- Have no opinion
- In some other way (please specify below)

Earlier in this consultation we have asked if the proportion of time spent learning in practice in the community should be specified for all pre-registration nursing students. We want to ask whether some students should have the additional opportunity to sub specialise in community nursing towards the end of their programme.

Nurses in the future will also be working much more closely with populations and there will be a need to consider the knowledge and skills related to public health that all students will require. We now want to ask whether some students should have the additional opportunity to sub specialise in public health nursing towards the end of their programme. The student undertaking a sub-specialism in public health nursing would major in: health inequalities; health promotion and lifestyle change, and work in partnership with other health and social care professionals to address health priorities. The sub-specialism would provide the student with baseline skills and competence in public health practice but not directly lead to registration as a specialist community public health nurse.

Q29 Should the range of possible sub-specialisms include:

- | | Community Nursing | Public Health Nursing |
|-----------------|--------------------------|--------------------------|
| Yes | <input type="checkbox"/> | <input type="checkbox"/> |
| No | <input type="checkbox"/> | <input type="checkbox"/> |
| Not sure | <input type="checkbox"/> | <input type="checkbox"/> |
| Have no opinion | <input type="checkbox"/> | <input type="checkbox"/> |

Q30 Do you have any comments that you wish to add regarding sub-specialisms?

In these questions, it is not clear whether sub-specialisms would be instead of or as well as specialist branches. Answers to this question would be different according to whether or not a specialist MH Branch continued to exist. The NMC and DH have placed respondents in an impossible position: having pre and post reg consultations simultaneously has made it very difficult to provide meaningful responses as we have no idea what the pre-reg position will be in the future.

If the current three year branch model is retained, which we strongly support, we do not believe that further sub-specialisation in pre-registration education would be useful. This could potentially be useful were a 4 year programme to be considered with the 4th year potentially being used for sub-branch specialisation.

Pre-registration programmes should focus on developing core knowledge, skills and competencies to prepare students for branch nursing practice across a relatively broad range of contexts and user groups. Sub-specialisation, assuming branches remain, should be left to post-qualification unless as indicated above, a 4 year model were to be considered.

As regards the consideration of sub-specialisms in ‘community nursing’ and ‘public health nursing’, we see these as key themes and components (rather than sub-specialisms) for all pre-registration programmes rather than sub-specialisms. The over-riding principle is that students need to have the capability to provide care for MH service users wherever they present. In order

to ensure public protection at pre-reg level the NMC must ensure that the nurse is capable of applying skills in the settings in which care is delivered. Again our view is that further such sub-specialisation should be left to post-qualification though whether community nursing should continue to be one such specialisation is debatable in light of the increasing focus on community provision.

Section B – Branch Preparation

The common foundation (CFP) and nursing branch programme were introduced in 1989 based on the principle that the first part of the programme, the CFP, would be 'common' to all students providing time for them to make their branch choice. The remainder of the programme would form the branch and lead to a specialist programme in one of four fields of practice: adult, children's, mental health, or learning disability nursing. These branches exist today and students register as a nurse with a mark denoting their **field of practice** e.g. registered nurse - mental health. The current minimum length of the branch programme is two years (or two thirds of the total programme) but, if it is determined there should be branches in the future, then these could be shorter or longer, or might make up the total programme.

The original rationale for having a branch was that a more generalist pre-registration nursing programme would be unlikely to meet the needs of specific client groups on registration. By generalist, we mean a programme that meets the general expectations of a nurse who is able to work safely and effectively in a range of settings and meet the needs of most client groups across the age spectrum at the point of registration. Although not universally accepted, there is some emerging evidence to suggest the current branches might, in fact, be fit for purpose for what is required to meet some existing service needs. However, there are views that the current branch programmes could lead to restrictive practices and that having programmes based around specific client groups is outmoded and unlikely to meet future client need. For more information see *Nursing: towards 2015* page 33.

Some argue that instead of branches there should be generalist programmes that could draw on a range of knowledge, skills and best practice from the existing branches. Others believe that such a preparation would have insufficient skills to meet current expectations of client groups, particularly in children's, mental health and learning disability nursing. Further support for this argument comes from the fact that mental health programmes are currently being revised to address the outcomes from the Chief Nursing Officers' Reviews of mental health nursing reported in 2006 in England **(12)** and Scotland. For example, in England, this required pre-registration mental health nursing programmes to be reviewed to ensure that essential competencies produced as part of the review would be gained at the point of registration, and that relationships between higher education and service providers were strengthened (DH 2006). In Scotland, this has led to a consultation on a draft national framework for pre-registration mental health nursing programmes (NES 2007) **(14)**

Our project groups looked at the models previously set out in *Fitness For practice, Fitness for Purpose* by the UKCC Post Commission Development group (UKCC 2001). In addition, some hypothetical models were considered by our two Reference groups but it was decided to consult on principles rather than on a range of different branch models. There is, however, an opportunity to comment on whether you think new or additional models should be considered at the end of this section.

For the future we have some choices: we could have new or additional branches; keep those we have now; close some that currently exist, or have no branches at all. Whichever pre-registration framework we decide on, it must address the bulleted needs as set out on page 7 under the sub heading *Nursing: towards 2015*. You may like to **look at these again** now.

Q31 Do you feel that the concept of the specialist 'branch' should remain?

- Yes Go to Q32
No Go to Q37
Not sure Go to Q33
Have no opinion Go to Q37

Q32 Which of the existing four branches should be retained?

	Retain	Don't retain	Not sure	Have no opinion
Adult	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children's	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What major structural changes are needed to ensure that those branches that continue to be offered meet future needs in the year 2015, as set out on page 7 of this consultation?

Q33 Adult

Mental health and Psychological aspects illness need to be increased.

The high prevalence of mental health issues in relation to general health care is a strong argument for increasing the mental health/psychological health component of all branches of nursing. However this does not mean that there will not continue to be a need for nurses who have undertaken mental health specific programmes of preparation at pre-registration level.

Increasing engagement with Community placements

Q34 Children's

The high prevalence of mental health issues in relation to general health care and amongst children is a strong argument for increasing the mental health/psychological care component of all branches of nursing.

Increasing engagement with Community placements

Q35 Mental Health

The comment which precedes this question 'What major structural changes are needed to ensure that those branches that continue to be offered meet future needs in the year 2015, as set out on page 7 of this consultation' assumes that programmes have been static and have failed to evolve in response to changing health care need and policy. This is a naïve and mistaken assumption.

It also fails to acknowledge 'there is some emerging evidence to suggest the current branches might, in fact, be fit for purpose for what is required to meet some existing service needs'. Indeed it is notable that since the introduction of Project 2000 programmes have been revised so frequently that the output of each new iteration of programmes at times only represents 1-2 cohorts of students. This clearly presents challenges in drawing any meaningful conclusions about the quality and outcomes of these programmes.

Mental Health Branch preparation in the UK needs to follow a national MH framework and be guided by agreed MH capabilities such as those set out by the DH (2006) and NES (2007). We believe that only a MH specific branch model will ensure that MHNs are capable of meeting MH policy, law requirements via new roles in the workplace of the future. Great progress has been made in these areas in the last 3-5 years.

In 2001 major structural changes were made to programmes including the reduction of the CFP from 18 months – 1 year. More detailed, rigorous evaluation should be undertaken before further major changes are made to relatively new and evolving curricula.

Many HEIs have recently reviewed or are currently reviewing their MHN pre-registration curricula in light of the comprehensive CNO reviews of MHN, the NMC ESCs and in particular the 'Best practice competencies and capabilities for pre-registration mental health nurses in England' (DH 2006) which resulted from the CNO Review in England and seeks to address some of the areas where improvement is needed. This guidance is benchmarked against 'The Ten Essential Shared Capabilities: A Framework for the Whole Mental Health workforce' (NIMHE 2004), National Occupational Standards for Mental Health & Drug and Alcohol (Skills for Health & DANOS 2005), NMC proficiencies for Pre-registration education (NMC 2004), the Knowledge and Skills Framework and is compatible with the NMC's recent work around Essential Skills Clusters. Similar work is ongoing in Scotland with a National Framework for the Pre Registration mental Health Nursing Programmes in Scotland soon to be launched. HEIs in Scotland are required to review and develop their programmes to respond to the national framework by the end of 2008. This and the other developments above demonstrate that significant effort has already been made to ensure that pre-registration mental health programmes will continue to evolve to meet the current and future needs of populations.

These are significant moves forward since the UKCC's (2001) report and should inform any future revision of the NMC proficiencies for pre-registration nursing. A central feature of the more recent reviews and subsequent guidance and ongoing revisions of pre-reg MHN curricula is an acknowledgement that MHNs need to enhance their physical health skills which have been neglected (as MH skills have in other branches). A number of innovative approaches to address this are being developed across the UK, including in some HEIs shared modules with adult branch students beyond the CFP. However, deficits in certain aspects of pre-registration curricula are not always solved by a total restructuring and once again suggestions of a generalist approach. Many more of the recommendations in the CNO guidance focus on the need to enhance specific MH knowledge and skills due to the increasing complexity and variety of service user needs, changing patterns of service delivery and increased user and carer involvement. It is also important to note that a DH commissioned and funded evaluation examining the implementation in Trusts and HEIs of the recommendations from the MHN Review in England (including the implementation of pre-reg guidance) has recently commenced and will provide crucial data that should feed into any fundamental review of nursing.

In Scotland, The preliminary findings of the large scale NES commissioned study into the Fitness for Practice programmes in Scotland are beginning to emerge and must be considered as part of this review as these represent the only systematic large scale evidenced-based evaluation of pre registration programmes

Q36 Learning Disability

No comments

Q37 Do you have any comments that you wish to add regarding new, additional or existing branch programmes?

We strongly believe that specialist mental health nursing preparation at pre-registration level should continue - please see response to Q42

Section C - Generalist Preparation

The aim of a generalist (or **generic**) programme would be to provide nurses with a broad range of skills sufficient to provide safe and effective care at the point of registration, irrespective of client group. This programme would also aim to meet in full the EC Directive for 'general care' enabling freedom of movement in Europe. Most countries in Europe and throughout the world prepare nurses through a generalist programme, leaving any major specialisation to be undertaken following initial registration.

This is different from what we have now in the UK. Currently the nurse who completes the adult branch will have met the EC Directive for 'general care', and achieved the minimum requirements for caring for children and people with mental health problems, as well as having had experience in maternal health. However, most of their learning will have related to the care of adults. Those following other branches may have explored these areas to varying degrees but will have not needed to have met the EC Directive.

In contrast, a generalist nurse may potentially have a more balanced opportunity to gain the breadth of knowledge and skill needed to provide safe and effective care for adults, children and young people, mothers and babies, and people with a mental health problem and a learning disability in residential settings and in the community.

Supporters of the generalist approach argue that this model is already used for preparing all other health professionals in the UK, including midwives. At registration, the generalist nurse is competent in a broad range of skills that can be applied flexibly in meeting the changing needs of future patients as services are reconfigured and new roles emerge. Delaying specialisation until later leaves options open and provides more opportunity to create post-qualifying interprofessional programmes at a higher academic level.

There are others who believe that, at the point of registration, a generalist nurse would be unable to address the needs of specific client groups at the level of proficiency of those prepared through the current branch preparation. Some would argue that this would create a hierarchy where generalist nurses would be seen as 'second best' to those nurses prepared in the branches, with insufficient knowledge and skill to meet more specialist client needs.

Q38 Do you think that there should be a new 'generalist' programme for pre-registration nursing or not?

- Yes Go to Q39
No Go to Q42
Not sure Go to Q42
Have no opinion Go to Q42

Q39 Should this generalist programme form a new branch, alongside any new or existing branches e.g. adult, child, mental health, learning disability?

- Yes
No
Not sure
Have no opinion

Q40 In which of the following would it be important for students to gain significant knowledge and expertise within a generalist preparation?

- | | Yes | No | Not sure | Have no opinion |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Maternal health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing adults and older people | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing children and young people | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing people with mental health problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing children with learning disabilities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Public health practice and nursing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

The NMC have, in the past, required broad outcomes and proficiencies to be achieved for preregistration nursing programmes. The detailed content and outcomes are determined in partnership between those: delivering the programmes, purchasing the programmes, providing the practice learning experience, and potential employers. This approach has enabled programmes to be developed locally that can respond rapidly to both **national** and **local** requirements within an overall framework. By this, we mean that, through the commissioning process, those purchasing the programmes in each country can ensure that, within the broad parameters set by the NMC, there is flexibility to ensure that the programme can adapt quickly to address changing local and national needs.

However, for some, this approach provides little opportunity to set a UK-wide standard and some argue strongly for the NMC to be much more prescriptive in what it requires, providing the profession and the public with clearer expectations and required outcomes.

Q41 If a generalist preparation were introduced, should the NMC set exacting UK-wide standards on how it should be designed, or set broad parameters so that programme design can be determined at a national or even a local level?

- NMC should set exacting UK-wide standards
- NMC should set broad parameters allowing national or local interpretation
- Not sure
- Have no opinion

Q42 Do you have any comments that you wish to add regarding a generalist preparation?

We strongly disagree with any move to ‘generalist’ nursing preparation. Such preparation will not be able to achieve the competencies required or indeed meet the necessary UK work force requirements where mental health problems are predicted to increasingly become one of the major factors in terms of UK (and Global) health burden. Indeed the high prevalence of mental health issues in relation to general health care is a strong argument for increasing the mental health component of all branches of nursing. However this does not mean that there will not continue to be a need for nurses who have undertaken mental health specific programmes of preparation at pre-registration level.

Whilst more generalist training with an increased focus on mental health may in theory have a certain appeal to some, the reality of such a model when worked out in practice is likely to be an adult, physical health dominated one with only an illusion of equal inclusion of MH. Experiences of the CFP in England suggest that whilst the intention was that this had a focus on all branches of nursing, the reality has been that exposure to other, non-adult care, branches is cursory and that the CFP does not prepare nurses with even basic skills ready for their branch programme. Equally, we are not convinced that post-registration preparation alone will attract or be able to deliver the quality and volume of highly skilled mental health nurses necessary for future UK mental health service development and delivery.

Experiences from other countries that have gone down the generalist pre-qualifying nursing education route show that this leads to a lack of skilled MHN workforce, difficulties in recruiting to post-registration MHN training and a reduction in the quality of care and service provision for those with MH problems (see the comprehensive and systematic review of International approaches to pre-registration educational preparation for mental health and learning disability nursing undertaken by the National Nursing Research Unit, King’s College London - Robinson & Griffiths NNRU 2007 – key conclusions outlined in response to Q.61). In attempting to achieve some unitary, generalist view of nursing to fit with other countries, many of whom are envious of our branch specific pre-registration model, we run the very real and significant risk of simply repeating the errors of others for no gain.

MHNs require preparation that enables them to work collaboratively with service users throughout the life span and families and carers (currently not always done well) and a range of professional and non-professional colleagues in a variety of mental health and other settings, from primary care to specialist community, day and hospital mental health services, plus numerous other statutory and voluntary organisations. In addition, they require specialist knowledge in a range of approaches related to roles, treatments, medication, legislation, ethics, research, etc specific to mental health care.

In relation to MH legislation, the impact of a generalist model on the very recent amendments - 'Approved Mental Health Professionals' and 'Responsible Clinician' need clear consideration. Whilst many surveys and studies show that MHNs are often well regarded by service users and carers, there are several areas where their attitudes and abilities are lacking. These will not be addressed by a reduction in MHN pre-registration education, practice and preparation or by solely offering post-registration education and training. Delaying major specialisation until year 4 or later will have an adverse effect on recruitment and that there would be limited placement activity in some areas, including mental health, making it difficult for all students to achieve a sufficiently broad and meaningful preparation.

Section D - Post-registration Consolidation

At the point of registration, a new registrant has to work within the *Code of professional conduct: standards for conduct performance and ethics* (NMC 2004) and take full responsibility and be accountable for their actions as a registered nurse. It has been recognised that new qualifiers require support and development within the initial post-qualifying period. This has been a challenge and various professions have taken different approaches. Some professions have used 'provisional registration' or 'internship' during this period. The NMC have, instead, issued guidelines for **preceptorship** as a means of supporting new qualifiers. Preceptorship has aimed to enable new qualifiers to be supported in the transition from student to registrant during their initial post-qualifying period. Whereas robust support systems and preceptorship have often existed amongst major employers, new qualifiers working in some parts of the service have sometimes struggled to find support.

The NMC first issued guidance on preceptorship as part of the *Standards for the preparation of teachers of nurses, midwives and specialist community public health nurses* (NMC 2004). In 2005, the NMC consulted on ways in which this guidance might be strengthened and subsequently issued *NMC Circular 21/2006 - Preceptorship Guidelines*. **(15)** The guidelines were advisory and intended to be used alongside other initiatives such as the **Knowledge and Skills Framework (KSF)**, **(16)** introduced in 2004, and **Flying Start NHS**, **(17)** now introduced in Scotland.

The KSF was introduced into the NHS across the UK in 2004 as part of **Agenda for Change**. **(18)** This provided opportunities to: identify the knowledge and skills that individuals need to apply in their post; help guide development; provide a fair and objective framework on which to base review and development; and provide the basis of pay progression in the service. *Flying Start* is a scheme within NHS Scotland that provides inter-professional learning and development opportunities for new qualifiers supported by **mentors** in practice. The model supports transition from student status to substantive employment and is being linked to the KSF gateways and academic credit mechanisms. The development of *Flying Start NHS* is being evaluated and some of the other UK countries are keen to learn more.

Whereas these initiatives might provide increasing support for new registrants, they are not universal and it might be argued that those employed in smaller organisations, or working alone, may be most at risk should they not receive the support and development they require. We, therefore, want to know whether, following initial registration, all new qualifiers should have a mandatory consolidation period of support and development, which focuses on leadership and supervision. This could require the achievement of specific NMC outcomes supported through protected learning time. The requirements might be linked to achievement of these requirements,

as a condition of first renewal of registration (currently after three years), and a minimum amount of required learning could be set to be undertaken in a stated number of months full time, or pro rata over a longer period.

Such requirements would need to integrate with existing schemes (e.g. *Flying Start NHS*) and could be linked to further professional development and academic achievement.

You may decide that setting regulatory requirements for support in the post qualifying period is not something that should concern the NMC and instead should be determined locally by the employer, or established through nationally agreed frameworks. We are keen to know your views.

Q43 Following initial registration, should there be a mandatory consolidation period set by the NMC, or not?

- | | | |
|-----------------|-------------------------------------|-----------|
| Yes | <input type="checkbox"/> | Go to Q44 |
| No | <input type="checkbox"/> | Go to Q49 |
| Not sure | <input checked="" type="checkbox"/> | Go to Q49 |
| Have no opinion | <input type="checkbox"/> | Go to Q49 |

Q44 How many full-time months (or equivalent hours) should this NMC mandatory consolidation period be?

- | | |
|------------------------|--------------------------|
| Less than three months | <input type="checkbox"/> |
| Three months | <input type="checkbox"/> |
| Six months | <input type="checkbox"/> |
| Nine months | <input type="checkbox"/> |
| More than nine months | <input type="checkbox"/> |
| Not sure | <input type="checkbox"/> |
| Have no opinion | <input type="checkbox"/> |

Q45 Should the NMC set mandatory standards for leadership and supervision to be achieved during the consolidation period?

- | | | |
|-----------------|--------------------------|-----------|
| Yes | <input type="checkbox"/> | Go to Q46 |
| No | <input type="checkbox"/> | Go to Q49 |
| Not sure | <input type="checkbox"/> | Go to Q49 |
| Have no opinion | <input type="checkbox"/> | Go to Q49 |

Q46 Who should assess the NMC mandatory standards for leadership and supervision?

- | | |
|-------------------------------------|--------------------------|
| A sign-off mentor | <input type="checkbox"/> |
| Not sure | <input type="checkbox"/> |
| Have no opinion | <input type="checkbox"/> |
| Someone else (please specify below) | <input type="checkbox"/> |

Q47 How much 'protected learning time' (full time, or pro-rata part time) should there be in the NMC mandatory consolidation period, if any?

- | | |
|--------------------------------|--------------------------|
| One day per month | <input type="checkbox"/> |
| Two days per month | <input type="checkbox"/> |
| Three days per month | <input type="checkbox"/> |
| More than three days per month | <input type="checkbox"/> |
| Not sure | <input type="checkbox"/> |
| Have no opinion | <input type="checkbox"/> |

Q48 Should this mandatory consolidation period be linked to the first renewal of registration?

- | | |
|-----------------|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |
| Not sure | <input type="checkbox"/> |
| Have no opinion | <input type="checkbox"/> |

Q49 Do you have any comments that you wish to add regarding post-registration consolidation?

As a good practice principle we agree that all new registrants should be provided with preceptorship and support, reflecting the magnitude of the transition from student to registered practitioner. Clearly such support needs to be strengthened. However, the extent to which prescription on this matter is part of the NMC's public protection brief is debatable. Setting regulatory requirements for support in the post qualifying period is not something that should concern the NMC. Whilst arguably there may be significant merit in introducing a mandatory period of post-registration consolidation, this should be determined locally by the employer and guided and informed by nationally agreed frameworks.

The resource implications and challenges of monitoring this, were it statutory, need to be considered.

NB. Questions 50 – 60 related to questions about the organisation

Q61 That is all the questions we wanted to ask. Are there any additional comments that you would like to make that have not already been covered?

Hopefully our views as a group on the issues raised are clear from our detailed responses to the questions. However, we would wish to reiterate the key points here and raise some issues related to the survey design and representativeness of various NMC committees involved in the review process.

*We strongly argue for the continuation of MHN as a pre-registration branch specialism. We believe that any other option, in particular the generalist option (which seems implicitly favoured in the consultation), will **not** meet the requirements of National and local MH policy drivers or ensure that nurses are equipped with the essential knowledge and skills required to provide high quality, evidence based, user centred care for clients/patients with MH problems. A move away from MH specific pre-registration preparation will also have serious implications for MHN and broader MH workforce and MH generally is likely to be marginalised.*

We strongly urge the NMC to take into account the reported negative experiences of other countries which have chosen to pursue the generalist option. The evidence provided in the comprehensive and systematic review of international approaches (17 countries) to pre-registration educational preparation for mental health and learning disability nursing undertaken by the National Nursing Research Unit, King's College London (Robinson & Griffiths NNRU 2007) concludes that in terms of Mental health Nursing such a move would have disastrous consequences for MH care in the UK. In the Executive Summary of the report they state that:

“The impact of the move from direct entry specialist education to generic training of either three or four years in length was perceived as having primarily negative impacts

on mental health nursing”. The key areas of impact that they identify included:

Minimal focus in the curriculum on clinical and theoretical aspects of mental health nursing knowledge and skills.

Perceptions that graduates are not adequately prepared to work in present day community and in-patient mental health settings

Difficulties in providing mental health placements for all students

The need to provide post-registration courses/support to develop basic competencies

Problems in having sufficient numbers of experienced staff to provide preceptorship and supervision during these post-registration courses

Increased difficulties over recruitment and retention”

They also highlight the fact that ‘in response to these concerns, several countries have changed, or are considering changing, the generic course to Model 3 i.e. to retain periods of common training for all students but also to include specialist options/branches’.

The report concludes:

“The view that a generic course can provide beginning level competencies in all branches of nursing appears not have been borne out by the international evidence on mental health nursing”

And

“The evidence suggests that a move to generic training would be out of keeping with the modern day realities of mental health and learning disability service delivery in the UK and the economic pressures under which such services operate. In some countries the generic model has proved unsuccessful, certainly with mental health nursing, and there have been moves to reintroduce specialist options in the form of branches and majors”.

“The international evidence suggests that the UK model of a common period of training followed by a period of branch specialisation may be the most appropriate for modern day realities of mental health and learning disability service delivery”.

This is not to say that there are not areas for improvement but recent developments and ongoing work to enhance MHN curricula based on the comprehensive reviews of MHN (CNO England review and ‘Best practice competencies and capabilities for pre-registration mental health nurses in England’ and the Scottish Executive Review and soon to be announced Scottish MHN pre-registration Framework are already showing promise. There is a need to enable these to become embedded evaluated and importantly to await the outcomes of the CNO Implementation Evaluation study in England (Callaghan et al due to report in 2009) and the emerging findings of the large scale NES commissioned study into the Fitness for Practice of programmes in Scotland.

We have already highlighted to the NMC in correspondence to Garth Long (July 2007) our concerns regarding the unrepresentative nature of the membership of the Nursing Committee, the project core and workgroups, and the two stakeholder reference groups in terms of MHN service and major education providers as well as mental health service users and carers. There are approximately 100,000 MHNs on the NMC register and we consider that the under- representation of MHN service and education providers and Service Users and Carers in the pre-consultation phase is a serious oversight.

We would specifically wish to know:

1. Which specific Mental Health Service User and Carer groups have been surveyed for this consultation? (We sent a comprehensive list of such key groups from across the UK to the NMC in October 2007 – at the request of the NMC).

2. How such representation will be assured in the process of post consultation analysis and decision-making regarding any subsequent recommendations?

We have highlighted in response to a number of questions in the consultation document areas which we believe are outside of the scope of the NMC. Whilst we recognise and appreciate the legitimate role of the NMC in professional regulation and public protection we believe that in relation to pre-registration education the NMC should only regulate on issues directly relevant to public protection and maintenance of standards.

We also wish Alpha Research and the NMC to note some key concerns regarding the survey design, assumptions and process as follows:

There was frequently insufficient information provided in the survey and accompanying notes and papers to enable properly informed responses to many of the questions. No detail regarding potential models of future options meant that the responses to many questions had to be based on numerous potential scenarios.

It was often unclear how Nursing: towards 2015 directly linked to the NMC consultation questions, again making it difficult to offer meaningful, informed responses.

The consultation document contained numerous questions that were poorly constructed and potentially leading – often towards an implicit preference for a generalist model.

The consultation was extremely England focused and failed to take account of differences across the other UK countries. The emphasis given to DH England policy did not adequately consider the different legislative, policy and service contexts in the other UK countries; a key example being the assumption that the DH England consultation on A Framework for Post Registration Nursing Careers should act as a driver for a UK wide consideration of pre registration preparation.

The presentation, complexity and lack of clarity of the consultation document and accompanying papers are likely to have acted as barriers to meaningful engagement of a wider public audience in this debate – in particular ‘non-professionals’ including service users and carers.

Lay versions of the document should have been available with explanations in more accessible language. We also note with dismay that no versions were routinely available for people who have sensory impairments or whose first language is not English.