Garth Long
Education Adviser
Nursing and Midwifery Council
23 Portland Place
LONDON
W1B 1PZ

27/7/2007

Dear Garth

Re: NMC/DH pre-registration Nursing Review - Branch Review

I am writing as chair of MHNAcUK to provide some commentary and views on the most recent draft of the *'pre-consultation framework options for pre-registration nursing education'* document dated 11th July 2007. This is based on a collation of views from across a wide range of UK Academic staff and whilst views varied I have tried to represent the key points of general agreement where possible. Responses and views specifically on the 'Principles' and 'Four options' outlined in the draft are addressed from page 3 onwards.

We recognise that this is a 'pre-consultation draft' and that a fuller consultation is planned for October 2007 onwards. However, we consider that the very short time-scale for responses on the draft options presented does not provide adequate time for a more fully considered, evidence and policy informed appraisal by the necessary wide range of stakeholders, including service users and carers.

When we met in June of this year, I highlighted to you 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. This is something that I would wish to reiterate on behalf of the group. There are approximately 100,000 MHNs on the NMC register and the under-representation of MHN service and education providers potentially negates the view of the largest UK core group of mental health professionals working with mental health service users. Our position is not based on professional defensiveness or self-preservation and the general review of pre-registration nursing is indeed welcomed by the group, though it needs to be borne in mind that a very informed review of pre-registration MHN specifically has just been undertaken by the CNO. We have major concerns relating to the current review process and in particular an under-representation at this early stage of those with a commitment to and knowledge of the complex and wide ranging needs of MH service users and carers and the values and evidence based skill set necessary for working with this client group both now and in the future.

Chair: Professor John Playle
Head of Mental Health Division
School of Nursing, Midwifery & Social Work
University of Manchester
Coupland III, Oxford Road
Manchester, M13 9PL
Tel: 0161 275 7954
e-mail: *john.playle@manchester.ac.uk*

Vice-Chair: Linda Cooper
Director of Mental Health &
Learning Disabilities Directorate
Cardiff University, 6th Floor Eastgate House,
35 – 43 Newport Road,
Cardiff, CF24 0AB
Tel: 02920 917 999
e-mail: *cooperlh@cardiff.ac.uk*

We find it difficult to understand the need to explore what appear to be pre-determined options before going out to a wider consultation that is more likely to generate more representative views and carefully considered options than may be available with the approach taken here. The recent CNO review of mental health nursing in England benefited enormously from such wide consultation.

What resulted from the approach taken in that review, were credible recommendations that were both representative of a wide range of stakeholders with a strong interest in mental health nursing and based on clear evidence and policy. It was of note that as part of that consultation a number of systematic reviews of the evidence base were also commissioned, prior to proposals, to ensure that outcomes and recommendations were informed by the evidence as well as expert opinion (including service users and carers as 'experts by experience'). We know that similar reviews have been commissioned to inform this branch review, however there is a real risk that presenting models pre-wider consultation may narrow the options or indeed lead to some sense of a pre-determination of outcomes.

There has been a welcome increased focus on mental health in government policy across the UK and these policies, as well as workforce predictions must more fully inform discussions around the efficacy and effectiveness of future models of pre-registration programme preparation which seek to prepare nurses to specifically work with enhancing the experiences of (mental health) service users, patients and carers. It is imperative that options for pre-registration nursing that include mental health, be benchmarked against policy, standards and competencies and capabilities related to mental health work. There is also a host of NICE guidance relating to the delivery of mental health care across primary, secondary and in-patient care. These policies and guidelines have huge implications for informing competence to practice in mental health and service organisation and development to meet the complex needs of people with mental health problems and their carers.

It is highly unlikely that 'generalist' nursing preparation alone will be able to achieve the competencies required or indeed meet the necessary 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 be able to deliver the quality and volume of highly skilled mental health nurses necessary for future mental health service development and delivery.

Experiences from other countries that have gone down the generalist pre-qualifying nursing education route suggest that this leads to a lack of skilled MH 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. Holmes (2001; 2006), offers an Australian perspective, where 'Comprehensive' nursing education was introduced from the early 1980s onwards. Holmes suggests that this was driven forward in spite of clear objections from Australian psychiatric and mental health nurses and, consequently, 'comprehensive' nursing education has contributed to *"…an identity crisis and a complete inability to move forward on the issues of recruitment, education and role definition"* (Holmes 2001, p381). Mental health services in Australia are, in short, in danger of suffering from "demolition by neglect". 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 little apparent gain. I know that colleagues at Kings College, London have been asked by DH to collate evidence specifically

related to MHN and LDN from other countries where different models of pre-registration training are utilised and my colleague Linda Cooper (vice-chair) has agreed to send an annotated list of references of evidence by mid August.

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.

Many HEIs 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 onto *'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. This is a significant move 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 this guidance and in the review 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 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 been commissioned and will provide crucial data that should feed into any fundamental review of nursing.

Specific comments regarding the Principles and Four Options proposed.

As will be clear from the comments above, there was a general view that the range of options outlined in the pre- consultation document appear unnecessarily limited and that a wider consultation that actually involves greater representation of the various branches but specifically MH in terms of Senior staff from service, HEIs and importantly service users and carers, may produce a number of other more viable options. The strong consensus was that a MHN specific branch/programme needed to be maintained though there was an acknowledgement that the nature of the current programme and branch framework may need re-visiting with some arguing for a more MH focussed full programme and others arguing that a more flexible framework may benefit all nurses. However, in terms of the latter option the main concern related to the extent of any genericism, and that in reality this would likely mean a dilution of MH (and potentially other branches – for example child) and lead to a failure to produce nurses with adequate specific MH knowledge, skills and experience to deliver the kind of care necessary for modern mental health and social care services. In particular, there was a strong

belief that solely offering post-registration MHN education and training for a specialism would present particular problems for MH services and the workforce required to address the specific needs of a broad range of patients, clients and service users with MH problems in a variety of practice contexts.

A number of members raised objections to the use of the term 'silo working' within the document as it may be seen as giving the impression that people working in these areas, advocating the needs of vulnerable groups, are somehow doing something wrong. Whilst this may not be the intent of the use of the phrase it could be interpreted as denigrating and undermining the notions of 'specialist practice'.

In terms of general principles outlined on pages 3 and 4 of the document, the following comments/views are offered:

Exit awards

- Move towards a minimum level of award being a degree, with an exit point at Dip HE, both allowing registration, was welcomed.
- Unclear whether the links to AFC bands relate to the level of 'exit' or 'position' on the right hand side or also to 'payment during training'.
- In terms of entry to the workforce being at band 6, this may have significant cost implications for services.
- An impact evaluation of the effect of moving to a degree on the Widening Participation agenda would need to be undertaken.
- The current means-tested bursary arrangements for nursing degrees in England may significantly affect entrance by mature candidates though it is recognised that things may well have changed by 2015

Framework structure

a. *Based on full time, 3 years/4600 hours (or part time equivalent)*
    - generally okay though some questions related how this three years is structured and the eventual option for branch structure adopted.
    - Potential for a four year programme could be considered.
    - Some questioned the need to continue to base programmes on hours requirements when in some ways this may be seen to be contradictory to a knowledge, skills and competency based curriculum.

b. Common core of 50% in non-generic/generalist options with more in the initial 18 months re*ducing in the final 18 months.*
    - Depends on the model to be adopted and this 'principle' seems to favour the 'generalist' model.
    - The decision to reduce CFP to 1 year in last NMC review seems to be being overturned here – there are already major concerns with the adult/physical care orientated/dominated nature of the 1 year CFP. Many students who have chosen MH find much of the CFP irrelevant with little if any focus on MH and simply 'grit their teeth' until branch begins in year 2.
    - Agree with idea that specialism should increase over time though needs to still be a strong thread in any common core

c. *50% practice component overall with simulation*
    - Equal emphasis on practice and theory should continue – allowance for some simulation welcomed but need to be careful re: percentage of direct practice this replaces.
    - The use of the terms 'theory' and 'practice' potentially perpetuates an artificial divide – might 'campus based' and 'practice based' learning be better?

d. *50% community experience overall*
    - Seems appropriate whichever model chosen in light of increasing provision of services in non-hospital settings
    - The major challenge currently is placement capacity and in particular in Primary Care – would require a much greater engagement and commitment at pre-reg level from PCTs.

e. Specific hours, (including practice requirement) for core experiences in mental health, physical care, child care and maternal health for all students.
    - Supported – current 'exposure' model does not provide adequate knowledge/skills in these areas required for all branches

f. 12 week minimum period of consolidated practice in single setting in final six months
    - Supported

Intern Year

- General agreement that a defined and structured period of support for transition to qualification in first year of employment (if this remains as employment rather than 'rostered') is required. Whether this should be 'Internship' or a strengthened and compulsory period of Preceptorship requires further debate
- Protected study time welcomed – if model chosen retains branch specificity in some form this should be used to enhance more specialist branch skills. 30 days a year may be adequate to enable part-time top up to degree (if DipHE) or PgCert (for Hons degree). In the 'generalist' models, 1 year post registration is not considered adequate for specialist skills in for example MH and Child.
- Need to consider impact on service staffing – influences whether rostered or employed
- If rostered – source of funding would need careful consideration

Framework Options.

Option 1(generally not favoured)

- Will not meet the requirements of government policy drivers in mental health and knowledge and skills required for MHNs
- Serious implications for the MH workforce
- MH likely to be marginalised
- Potentially means only 4 weeks in total MH experience in 3 years. Will not adequately prepare nurses (as key players in the MH workforce) to meet the demands the DH is placing upon them to be key players in the delivery of the national mental health agenda, one of the Department's top three health priorities.
- Cf arguments above re: negative impact for mental health of the introduction of a generic model of nursing in other countries

Option 2(generally not favoured)

- Needs more clarification. As presented is the least workable of all the options.
- See option 1 views – similar to this model – generalist preparation problematic for delivery of competent MH workforce – 1 year PQ specialisation inadequate and late - negative effects on recruitment
- Major concerns regarding the implications for workforce and maintaining the viability of modules within programmes. A preparation programme based on student choice of modules could lead to difficulties in ensuring that all nurses are fit to practice.
- Workforce planning models are not sophisticated or responsive enough to inform the number of funded places to meet service need on such a programme. It may change on a year-to-year basis, which will inevitably lead to confusion and challenges to resourcing/skill mix for HEIs.
- Risks great variability across HEIs, lose whole sense of a 'national framework', whilst argued that can be responsive to 'local need':

- pre-reg programmes should prepare nurses for practice nationally
- Local workforce planning models are even less sophisticated and robust than regional/national ones
- Lack of clarity as to what can be expected from a nurse (seems to depend on individual pathways) – public, patients, service users, carers – difficult to regulate
- May generate numerous 'marks' on the register

Option 3(generally seen as having some potential)

- Short on detail but the notion of commencing specialisation early and for common elements to run through the whole programme appears to have some face validity.
- Early commencement of branch – positive for retention
- Significantly more detailed consideration of proposed 'major/minor' splits needed – e.g. would a MH branch student taking OP as a 'minor' focus on OPMH or OP core?
- 50% core may be too much – particularly as then only 50% for branch (including 1 major/2 minors) but if resulted in an increase in mental health, learning disability and child related learning outcomes/experiences for all maybe workable. In light of high (and growing) incidence of MH problems and this being relevant to all branches, it could be argued that this should be a substantial component of all other branches.
- Welcome defined practice experience (rather than simply 'exposure') in physical, mental health, child & YP care for all students – however, current placement capacity would mitigate against some of these.
- Not sure that 'community nursing' is a minor in light of key principles highlighted earlier in document – if 50% of experience is in 'community' then 'community nursing' is a core component rather than a 'minor'
- If possible – all branches meeting EU requirements would increase employability for all branches across Europe – but whether feasible within three year model is questionable.
- This whole model and in particular the 1 major/2 minor split is ambitious in 3 years and may work better as a full four year pre-reg programme
- Re: 'public health' branch in pre-reg - may not reflect the fact that 'public health' should be a core component with more specialist PH focus being PQ.
- 'Minors' could allow for future changes to be incorporated as needs/health agendas change and develop
- At what level would commissioning be – i.e. at the 'Major' level or even at 'minor' level – or should 'minor level' be left to student choice?
- Would all HEIs wish/be required to offer all 'Majors' and 'minors'
    - could allow for HEIs to play to research/academic/clinical strengths
    - may lead to student choice of HEI being influenced by choice of Major/minors
    - May lead to greater variation of provision across HEIs and localities (not necessarily a bad thing) but may impact on 'local' recruitment, linked to WP, and local service need – particularly where not a range of 'local' HEI providers.
    - Availability of all 'minors' would be influenced by student choice and minimum numbers viability (cost-effectiveness for HEIs) – may mean all 'minors' in theory be available but in reality not viable.
    - Also may affect transferability of students between HEIs

Option 4

- Continues to have clear potential - recognises the specialist areas of nursing practice that seem better able to meet the needs of what is currently demanded by stakeholders, at least in mental health. Has not been adequately evaluated to enable a reasoned and rational decision to be made on its future.
- Current programmes are still being developed and in relation to MHN, recent reviews are beginning to feed into curriculum developments across the UK - too early to reach conclusions on this.

The current framework could be made more robust if the NMC made the following mandatory:

- Standards, outcomes and proficiencies related MH, Child & LD in CFP (common core)
- Pre-registration Practice placements across the programme were 50% community
- Inter-professional education (definition and identified percentage in the programme to be agreed)

The meaning of IPE may be different in MH in the sense that MHN preparation may share more in common with other disciplines and professions than other nurses.

There is a fifth option that some colleagues argued should be considered - a three year Bachelors Degree in each branch, with shared modules common to each branch and specialist modules to prepare nurses in the skills, capabilities and competencies that nurses may need by 2015. In mental health, this might take the form of a Bachelors degree in Mental Health Nursing and Social Care underpinned by the principles of a recovery approach that prepares nurses to work in any MH setting.

I hope that the points above are taken on board and in particular the need to ensure wider, more representative consultation, and to base decisions on evidence, policy drivers and ultimately the needs of service users and their carers.

We look forward to discussing this further with you at our next meeting on October 19th in Brighton.

Yours Sincerely

John Playle
Professor of Mental health Nursing
Chair of MHNAcUK.