

Responses to the NMC consultations on:

- Standards of proficiency for registered nurses
- Education framework: standards for education and training
- Prescribing and standards for medicines management

POLICY CONSULTATION RESPONSES





Royal College
of Nursing

RCN Legal Disclaimer

This publication contains information, advice and guidance to help members of the RCN. It is intended for use within the UK but readers are advised that practices may vary in each country and outside the UK.

The information in this booklet has been compiled from professional sources, but its accuracy is not guaranteed. Whilst every effort has been made to ensure the RCN provides accurate and expert information and guidance, it is impossible to predict all the circumstances in which it may be used. Accordingly, the RCN shall not be liable to any person or entity with respect to any loss or damage caused or alleged to be caused directly or indirectly by what is contained in or left out of this website information and guidance.

Published by the Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN

© 2017 Royal College of Nursing. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means electronic, mechanical, photocopying, recording or otherwise, without prior permission of the Publishers. This publication may not be lent, resold, hired out or otherwise disposed of by ways of trade in any form of binding or cover other than that in which it is published, without the prior consent of the Publishers.

1. Contents

1. Introduction – the future of nurse education	5
2. Background and overview	6
3. Consultation on standards of proficiency for registered nurses	7
Summary	7
Responses to the specific NMC consultation questions	9
4. Consultation on education framework: standards for education and training	18
Summary	18
Responses to the specific consultation questions	20
Draft learning and assessment requirements	22
Draft pre-registration nursing programme requirements	25
5. Consultation on prescribing and standards for medicines management	29
Summary	29
Responses to specific questions	31
Appendix 1: Survey results	34
Summary of results	35
Appendix 2	39
References	42

1. Introduction – the future of nurse education

The Royal College of Nursing (RCN) welcomes the opportunity to respond to the series of consultations focusing on changes to the Nursing and Midwifery Council's (NMC's) Standards to enable registered nurses to better serve the population health needs for future generations. We welcome the proposed changes and believe them to be timely and necessary.

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

To reflect the importance of the proposed changes to nursing education, and the potential impact on future delivery of care for those requiring nursing, as well as those who deliver nursing care, we have engaged widely with our members and key stakeholders. We also wanted to mitigate some of the risks associated with consultation on such a wide programme of change for the nursing profession, to increase awareness of, and engagement with, the changes proposed. The NMC Standards need to identify the signifying practices for future nurses and enable the development of curricula that constructively align the learning outcomes, content and assessment of degree level programmes to ensure future nurses are fit for practice at the point of registration. This requires debate between practitioners and academics around what knowledge and skills are needed and why. We have used a variety of means to achieve this, including planned engagement events, an online survey, social media and our formal and informal meetings; these have all contributed to influencing and informing our response.

Over 600 members shaped this response through participation at 18 workshop events across the UK. The workshops supported members to discuss and debate four key areas relating to the NMC consultation and the future of nurse

education: Practice learning environment; Assessment; Knowledge and skills; and an additional area, Preceptorship. These were derived from previous membership feedback over 2016 and 2017 that gave greatest concern to members. The debate and key recommendations were captured at each event and fed into the iterative drafting of the RCN response.

High level steering was provided by members with specific expertise and experience including the Education Forum Committee, RCN Students Committee and through our governance structures, including the Nursing Policy and Practice Committee.

Building on this wide reaching programme of engagement, we launched a survey in July 2017 to test initial findings and gather member feedback on some emerging RCN positions. The survey was promoted on RCN social media channels as well as directly mailed to a large proportion of RCN members. 7,380 members provided complete responses to this survey.

We asked our members to comment on our draft statements relating to the following:

- simulation in learning
- supervision and assessment arrangements
- pre-registration prescribing
- ability to undertake nursing/clinical assessments.

The results of this survey are reflected in the body of this response, and also available in Appendix 1.

We have also drawn on the literature and relevant available research to supplement and support our response. Where appropriate, we have integrated this into the questions but we have also offered a section (Background and Overview) to offer a more detailed exposition of current evidence and our position on the issues raised.

We recognise the substantive engagement the NMC has undertaken throughout the development of these standards and in their subsequent consultation and would like to thank Professor Dame Jill McLeod Clark in particular for her work and dedication.

2. Background and overview

As with many professions that exist to serve public need, the value and function of nursing has changed over time. Nursing has had to respond to changing health care needs, new developments and approaches to treatment and care, as well as the political context which drives priorities for funding and definitions of health care need.

This is challenging because the public and the media believe they know what nurses should be doing and yet this is often founded on historical and mythical ideals and stereotypes. These include beliefs that nursing is predominately women's work, based on simple caring interventions and so it is neither highly skilled (and thus low paid) nor does it require degree level education. Nurses themselves often struggle to define and articulate the unique contribution of nursing.¹ Frequently, this results in the public, media, politicians and even some nurses wanting to recreate the past, rather than acknowledging that nursing is evolving. This review of the NMC Standards required for entry onto the nurse register is a welcome opportunity to enable the profession to actively address nurses' contribution to the emerging challenges facing the current health and social care landscape.

This would seem to be one of the fundamental messages that must be acknowledged if the new Standards are to be successful. Health care is evolving, and so the nursing contribution must also evolve and nurses must articulate how they will nurse in the future. These Standards offer a useful platform to explain that, whilst the work of nursing is changing, it is still fundamentally concerned with the wellbeing and needs of individuals in society. We must reassure and communicate to the public, politicians and nurses that the needs of the users of services remain central to the nursing endeavour. We would wish to support the NMC in its communications plan to ensure this is achieved.

We also believe that the new Standards must achieve a balance between prescription, to ensure consistency and achievement of the right outcomes leading to nurse registration, and enabling flexibility in response to future needs and innovation for change. The Standards should be implemented to reflect the principles of "Right Touch Regulation"² and require the NMC to demonstrate a robust and transparent quality assurance framework to assess and

monitor achievement of the Standards in practice. Whilst we are supportive of the need for change in the way the NMC regulates nurses, including the changes to pre-registration proficiencies, we have concerns about the impact of the proposed changes to the draft education framework. We would caution the NMC that any changes to enable innovation and flexibility in implementation of new approaches to learning and teaching, particularly in practice settings, must be set as requirements rather than desirable. The current mandated frameworks, whilst overly prescriptive, ensure that there is a standard against which to measure performance (and this helps drive investment in resources). Currently, no other body holds a mandate to enforce these standards or requirements, and noncompliance with these represents a real risk to public protection. One of the issues that requires further development to achieve this is clarity between the use of the words competence and proficiencies; these are often used interchangeably in the text for the Standards.

Throughout the document, we are commenting on implementation as well as the proposed standards and frameworks, but do realise that the consultation itself is only on the latter.

3. Consultation on standards of proficiency for registered nurses

Summary

There is currently unwarranted variation in the pre-registration training of nurses in all four fields – adult, child, learning disability and mental health – regarding the clinical skills that students are exposed to and develop competence in during their training. The RCN therefore supports the NMC move towards standardising the student nurse experience, so that students, employers and patients and service users know what they can expect of a newly registered nurse, by clearly outlining the clinical and professional skills of all newly registered nurses. This will definitely enhance patient and service user care and increase confidence in the newly registered nurse. We further believe that all nurses, whatever their field of practice, should be able to undertake full assessments of patients and service users, including mental health, physical health and cognitive abilities and welcome this in these standards.

We also acknowledge that valid and reliable assessment of these skills is essential and we believe that this would be enhanced by a national practice assessment document.

Finally, although practice learning is vital, we believe that simulation of up to 600 hours throughout their training could provide a valuable alternative teaching strategy and would be well assessed through the use of Objective Structured Clinical Examinations (OSCEs).

Evidence on skills acquisition, competencies and assessment

The evidence base on nursing skills, competences and their acquisition and assessment has gaps and lacks standardisation in terms of what clinical/nursing-specific skills should be taught, and how these should be assessed.^{3,4,5,6,7} This is, perhaps, reflective of the diversity of nursing roles and differences in nursing education between systems and national and international countries. There is no universal consensus on the outcomes required to demonstrate competence at the point of registration, nor is there agreement on how these should be assessed.^{8,9,10} So the development of an outcomes-focused education framework is

needed and welcomed. This currently means that the knowledge, skills and competencies gained may not be transferable across different clinical settings or across different countries since there are no agreed standards of competence at an international level¹¹. At a qualitative level, assessment tools tend to prioritise human “soft skills”, personal qualities and attributes and often fail to make clear the context in which the assessment is made. On a quantitative level, assessment tools focus too much on tasks and task mastery, leaving undone the complex competences related to caring, interpersonal interactions and decision-making. The new Standards for education need to ensure the two elements are assessed and acknowledged as equally important. This will need to be tested out in the pilots throughout initial implementation.

Existing literature identifies the type of skills taught on most health care professional undergraduate programmes as a combination of general, or generic, skills, such as critical thinking, problem solving, interpersonal skills, situational awareness, reflection and leadership.^{12,13,14,15,16,17} Similarly, a systematic review¹⁸ identified 14 global and health care competences which included social justice, cultural competency, collaborative partnerships, assessment and management skills, environment, disease burden and epidemiology, ethics and professionalism, determinants of health, health systems delivery, travel and immigration, research, health promotion and illness prevention. These are reflective of the NMC skills outlined in the draft standards of proficiency, however there is a lack of inclusion of social justice, global health, immigration and sustainability. The focus on generic skills and competences in the literature, rather than specific nursing skills such as cannulation and venepuncture, may be linked to some observers’ assessment of newly graduate nurses not being seen as “practice-ready”.^{19,20}

An informal and unpublished RCN survey among nursing students and newly qualified nurses echoed this. It found that students sometimes perceived themselves as stuck between the often unrealistic expectations of mentors and wider nursing colleagues, and a perception that neither their university

education nor their clinical placement education provides them with the necessary clinical skills to be able to work effectively in clinical practice. This finding is supported by wider evidence²¹ and it may therefore be reasonable to argue that nursing students and newly qualified nurses remain subject to wide variations in how they are educated, trained, supervised and supported throughout their three years of university learning and their first year of clinical practice post-qualification. The proposed standards do address this issues, and the development of a national practice assessment document would further address this variation and ensure all students achieve an agreed level of competence by point of registration.

In our evidence gathering with members, Australia was often mentioned as a good comparator country to the UK because it has an increased focus on teaching clinical skills. Evidence from Australia²² identified over 1300 skills taught to nursing students through a documentary analysis of nursing programme curriculum documents. These were a combination of specific clinical nursing skills, in addition to a range of generic skills that could equally be applied across a range of health care professional students. The evidence further suggests that the range of skills taught remains challenging as a result of the limited time that is available to expose nursing students to these skills, as well as the time to practise them in order to achieve registration. This is why Quality Assurance (QA) is important to ensure that the level of innovation among programmes is balanced against consistency in outcomes for registration.

We believe that there is a need to identify the core skills for all registrants required at the point of registration, but it is also important to acknowledge that skills acquisition requires more than knowledge and observation – it also requires practice to become proficient. We recommend that the focus of skills and competence development should be grounded in how individuals make judgements and decisions, rather than a reliance on reproduction of behaviours.²³

We would encourage the NMC to continuously consider new emerging evidence, in particular from the pilots throughout the early implementation, given the importance of successful implementation of the new standards, and in particular, consider that proficiency cannot be fully achieved upon registration. There is evidence of the need for

a clear distinction in nurse education between the possession of general competencies and the mastering of particular nursing acts, and that such a distinction may be the source of useful discussions between stakeholders.²⁴

Simulation

It is clear that in the existing education model it is impossible to plan and ensure equal exposure to a set range of clinical issues and corresponding skills to all students. One of the key methods identified that may impact on improved skills acquisition and competency assessment has been identified as greater use of simulation strategies in nursing education programmes.^{25, 26, 27, 28, 29, 30, 32, 32, 33}

Simulation is one method in a range of technical approaches for instruction, which includes clinical patient instructors, standardised patients and computer-based simulation (low fidelity simulation) and patient-based simulators (high fidelity simulation)³⁴.

Simulation is increasingly used in nurse education programmes and there is evidence that it leads to higher student satisfaction, and greater clinical knowledge skills and behaviours when compared with no instruction³⁵.

A meta-analysis³⁶ evaluated the effects of high fidelity human simulation (HFHS) on the cognitive, affective and psychomotor outcomes of learning. High fidelity simulation is assumed to be closer to reality and it is viewed as superior to low fidelity simulation. However, high fidelity simulation is often accompanied by higher levels of complexity which may lead to reduced learning because it places too much cognitive load on the learner.³⁷ Cognitive outcomes include problem-solving, critical thinking, clinical judgement and clinical skills acquisition. Affective outcomes include self-efficacy and satisfaction, and psychomotor outcomes include clinical competency. The results reveal that the use of HFHS tended to show a beneficial effect on cognitive and psychomotor outcomes, but also revealed that the effect of HFHS on affective outcomes was inconclusive. The authors conclude that HFHS could enable nursing students to learn and practice formative skills in a less threatening and controlled environment. This is echoed in our recommendations. They suggest that a HFHS education approach, if implemented appropriately, can be used in higher education institutions as an affective learning methodology.

There is evidence that recommends that higher education institutions and provider organisations have a responsibility to adopt clinical simulation training, recognising that this involves continued investment into the appropriate level of resources.^{38,39} Therefore we have recommended that simulation hours could be increased 300 to 600 maximum, out of a total 4,600 hours, but that the Approved Education Institution (AEI) in collaboration with practice placement providers can decide how to best use them, acknowledging differences in provision. The QA framework will assess this in a robust and transparent manner to ensure quality.

Assessment of skills, knowledge and competency

There are a range of instruments for assessing a student's skills, knowledge and competency and these include Objective Structured Clinical Examinations (OSCE)^{40,41,23,43}; which are also referred to as Objective Structured Clinical Assessments (OSCA)^{44,45}; the Objective Structured Long Examination Record (OSLER)⁴⁶; and the Amalgamated Students Assessment in Practice (ASAP) model⁴⁷. These methods are ideally placed to assess learning in simulated environments.

The OSCE was developed in Scotland and has been extensively used to assess competence in medical students and nursing students. The OSCE commonly consists of a number of small tasks referred to as stations, which usually last for five minutes, and they have become increasingly used by nursing schools internationally⁴⁸. It enables the examination of what clinical and professional skills a student undertakes and it emphasises assessing components of competence in a structured way. It is also said to be superior to other forms of assessment like oral presentations, written work or the physical examination of real patients⁴⁹. There is evidence to suggest that OSCEs may be used in a formative way to improve learning, or in a summative way to assess competence, and they benefit from a partnership between mentors and nurse lecturers⁵⁰. Early introduction of OSCEs with an integrated approach to pharmacology and medications management teaching has been shown to improve student learning⁵¹.

Despite the projections from some researchers that the OSCE offers a useful mechanism for assessing the skills and competences gained and practised by student nurses, others argue that the UK Nursing and Midwifery Council has

not stipulated its mandatory use.⁵² Therefore we would welcome clarity in the proposed Standards which makes explicit how OSCE can support achievement of proficiencies.

Responses to the specific NMC consultation questions

Q1. In developing the draft standards and requirements, we aimed to:

- reflect on what people will need from nurses in the future that can be applied all fields of nursing practice (adult, children, learning disabilities and mental health)
- provide outcomes that are open to objective assessment
- reflect higher level knowledge and skills that emphasise research and evidence skills
- ensure a focus on compassion and expertise in evidence-based fundamental nursing care
- allow for flexible approaches to programme delivery
- provide entrants to nursing with an understanding of mental and physical health and care.
- contain outcomes that prepare nurses for working effectively in multi-professional and interagency teams
- include outcomes that focus on leadership and the nurse's role in managing complex care
- ensure that there is sufficient emphasis on health and wellbeing
- emphasise public health, dementia, frailty and end of life care
- ensure that the new standards of proficiency are sufficiently accessible to the public
- be unambiguous, clear and concise
- provide the building blocks for continued professional development and advanced practice across a range of contexts.

Q1a. Do you agree that these principles have been met and seek to protect the public?

These higher-level principles do appear to be reflected in the way that the standards have been written, however, this will only become apparent upon implementation and are thus reliant on the NMC, in its role as regulator, to ensure adherence is demonstrated in order to support protection of the public. It would also be helpful to have skills annexes as a separate document to allow for technological and digital changes.

There are a number of issues that would benefit from clarification and or, inclusion:

“Provide outcomes that are open to objective assessment”: It is unclear how some of the standards will be assessed; for example, standards 1.5 healthy lifestyle and 1.6 emotional intelligence and resilience. Whilst we do agree that these should be included in the standards, we do question how these will be objectively measured

“Reflect higher level knowledge and skills that emphasise research and evidence skills”: We strongly support the emphasis on research and evidence skills and think that these need to be more strongly accentuated across the standards. The ability to critically evaluate and source evidence is an essential skill for all newly registered graduate nurses, and a key component of a degree based profession. However, this is not clearly articulated across the standards. This will be particularly important in the context of new roles and routes being introduced in to the profession across the UK, such as Nursing Associates in England, as the bachelor’s degree-level education will be the main distinguishing criterion between these and registered nurses. This differentiation is important because, as a recent study has confirmed, ward-based registered nurse staffing is significantly associated with reduced mortality for medical patients.⁵³ We are aware that there have been questions raised about whether there is parity between nursing and other graduate degrees. Both Ruddy (1998)⁵⁴ and Rafferty (1998)⁵⁵ suggests that this prejudicial belief that intelligence and the capacity to care are somehow incompatible is widespread. This reflects a prejudicial view of nursing, based on stereotyping of nursing and a lack of understanding of contemporary nurses’ contribution to health outcomes.

We will continue to work with the NMC as the Standards for Nursing Associates are developed to ensure the different contribution of these roles is explicitly addressed and articulated.

Clinical decision-making needs to be emphasised more strongly across the standards, whilst remembering that the standards of proficiency are for newly registered nurses, so they must be realistic and reflect that clinical decision-making is developed over time.

In order to address transition into the profession, a preceptorship period, or a Newly Registered Nurse (NRN) period is essential. This is supported by the English Department of Health⁵⁶ and the NHS Education Scotland Flying Start programme⁵⁷. A similar model is used in the Republic of Ireland.⁵⁸ Preceptorship has been implemented in the teaching profession through the Newly Qualified Teacher (NQT) status⁵⁹. Any such period would need to be clearly defined, ideally through a national framework or standards set.

Q2. The future nurse will work within a range of settings and therefore we have designed our draft new proficiencies to apply across all four fields of nursing (adult, children, learning disabilities, mental health). Do you feel we have achieved this approach?

We agree with the need for such a design. We do wish to draw attention to the following (potential) issues in this approach:

- To resolve any potential tension between generic and field-specific training, a sound curriculum must be written and regularly assessed for its relevance and fitness for purpose. It is vital that there is parity of esteem between fields, which was highlighted in the Raising the Bar report⁶⁰. There are concerns that core skills must have relevance across all fields and that a robust practice learning framework will enable this to happen. These should be mainly about principles that are transferable. More creativity could be adopted in utilising clinical simulation to ensure competency across all fields. This could include the use of case studies.

In pursuit of all nurses having a broader repertoire of skills that crosses different fields of nursing practice it is vital that specialist knowledge and skills are not ‘dampened down’.

Survey respondent – Nurse Educator in Higher Education

- There has to be the necessary infrastructure and capacity in place in practice with sufficient supervisors, assessors and the necessary QA processes that identify placement areas as suitable to meet agreed placement standards – especially if these become more diverse. Placements need to be safe for practitioners as well as patients. This is not addressed in the proposed education framework and there is anxiety regarding QA when the NMC Standards to Support Learning and Assessment in Practice are removed. We also need to do more to prepare students for their placements and make increasing use of coaching models and peer support.
- In line with the aspiration of the new standards to be relevant across all settings, the design of practice placements must provide access to a range of practice experiences. Community and primary care placements are particularly essential in preparing the workforce of the future and the length of the placement needs to be proportionate to the skills and proficiencies to be achieved. “Suitably experienced” should be replaced with “suitably competent”.
- As new settings are added, existing staff need to be prepared and this requires investment. We believe there must be correlation with fitness to practise and the quality of placements and the NMC should develop a QA process to ensure the education settings are appropriate – or that they are able to hold those responsible to account for this aspect of the education. With the entry into a free market for education provision and the fact that 50% of education is in practice there needs to be a line of sight between the regulator and this aspect of education. The RCN guidance^{61, 62} on mentorship attests to the importance of good practice learning environments and still apply even if terminology changes to practice supervisor and practice assessor.

Q3. Do you agree that the draft standards of proficiency provide the necessary requirements for safe and effective nursing practice at the point of entry to the register?

We would like to raise the need to be clear about the terms “proficiency” and “competency” – they are not the same, but are used interchangeably in the documents. The number of practice

hours needs to be clarified, but simulation is a safe option to practise for unusual situations. It is also important that skills are always underpinned by theory and evidence. It is essential that students are taught the skills of self-compassion and self-care, building their emotional resilience and intelligence to ensure that they are safe and effective practitioners.

Q4. Do you agree that the draft standards of proficiency underline the importance of person-centred care?

As we have set out in our work on transforming mental health services in Scotland, each person who uses health and social care services is unique and should be able to determine their own goals and outcomes for health and wellbeing. The registered nurse has a role in supporting and enabling the person to have real choices, make informed decisions, set and achieve goals, and live what they define as a meaningful life. The personal health and life outcomes the person receiving care has prioritised should inform how care is planned and provided. Working in partnership with people means nurses and other professionals need to really understand their individual life and life assets; to think about “what pre-existing skills [does the person] have? Why are they not using them? What’s going on in their life around them?”⁶³

Increasingly, health policy is focused on enabling health promotion, prevention and self-management, rather than treatment of illness alone. The integration of health and social care sets out aspirations for high quality person-centred care which is delivered at home or a homely environment, moving the focus away from health care delivered predominantly in hospitals. This is the context in which registered nurses now, and in the future, will be working and the proficiencies required need to reflect this.

It is important that the basics of Nursing are not lost in pre-registration training. Whilst it is clear that Advanced Nursing Practice is the future of nursing it is imperative that basic nursing care remains core throughout training.

Survey respondent – Registered Nurse
(Primary Care)

There needs to be a focus on skills in self-management support and prevention, particularly in supporting patients in the self-management of their long-term health conditions. This will also include skills in co-

production and a patient enablement approach. In an integrated system, registered nurses will need to use asset-based approaches to connect their patients with local services and resources. Their work, including use of all of these approaches, should be informed by the “PANEL” principles for applying a human rights based approach in practice – Participation, Accountability, Non-discrimination and Equality, Empowerment, and Legality.

Service users must be included in all aspects of curriculum development and delivery, including the assessment of skills.

Finally, there is an issue around language used in the document here – the term “disabled people” should be replaced with “people with a disability”.

Q5. Do you agree that the draft standards of proficiency confirms the role of the registered nurse in ensuring that people are encouraged and supported to self manage their care?

We do not think that this is confirmed strongly enough, but do see that it has been considered. There is a need for graduate registered nurses to be proficient in person-centred approaches that focus on co-creation, co-production and self-management support, which anticipates and responds to individual need and which ensures strong collaboration across professions and sectors.

We would like to highlight current technology and digital literacy and assessment of online resources to support promotion of self-management. The effective use of information and current technologies is a key enabler in delivering health and social care, now and in the future. The impact of technology and the potential that it has to transform care is a professional issue touching on care delivery, practice, education and research.⁶⁴ The very recent work we have done with Health Education England on defining digital literacy in nursing can serve as a helpful resource here.⁶⁵

Q6. Do you agree that the draft proficiencies state the role of the registered nurse in providing opportunities and in enabling people to have control of their own health and lifestyle decisions?

Existing, tried and tested approaches and tools that support a person-centred approach to care should be utilised to support this proficiency.

Newly registered nurses need to be able to understand the range of other disciplines who can support and be able to sign post to patients. The following frameworks will support this: the work in England on the person-centred approaches education and training framework⁶⁶; the work in England on a person-centred approaches education and training framework⁶⁷ and the realistic medicine strategy in Scotland⁶⁸ and Choosing Wisely, a global campaign to promote five key questions that patients can ask to get the best from their conversations with doctors and nurses:

1. Do I really need this test, treatment or procedure?
2. What are the risks or downsides?
3. What are the possible side effects?
4. Are there simpler, safer options?
5. What will happen if I do nothing?⁶⁹

Q7. The draft standards of proficiency place an increased emphasis on leadership skills. Do you agree that this will be achieved for the nurse at the point of entry to the register?

It is difficult to comment on whether this will be achieved for every student as there is not enough detail in the proposals, although we recognise that it is included. A stronger emphasis is required, however, on the development of clinical leadership skills through the three years, underpinned by evidence. Better preparation for leadership of groups of patients and teams also includes role modelling in the practice setting and hence will require the upskilling of some of the current workforce when implemented.

The final module of every pre-registration programme has a 12 week management placement and this is vital in terms of learning management and leadership skills. Students need to practice and develop confidence in their management and leadership skills in this final placement. It has been suggested at engagement events that this could be non-supernumerary to demonstrate the importance of this.

Assessment of leadership needs to be a continuum for the student from the first year of training onwards and they need a clear pathway throughout their studies and their career. Investment in early career nurses should support development of future ward sister

and team leaders. Strong and effective clinical leadership is one of the most influential factors in transforming organisational culture.⁷⁰

These management and leadership skills should be built on in the following preceptorship period. There needs to be a continuum for all nurses from initial training onwards throughout their careers.

It is imperative that the practical aspects of nursing are adequately covered in pre-registration training. Perhaps a probation year after the three-year degree programme could be considered so new registrants would be able to develop skills in a practice environment.

Survey respondent – Registered Nurse
(Mental Health)

Q8. The draft standards of proficiency place an increased emphasis on working in multidisciplinary teams and coordinating care across multi-agency organisations. Do you agree that this will be achieved for the nurse at the point of entry to the register?

We feel that this has been partly achieved, but could be strengthened through ensuring practice placements which better reflect multidisciplinary working. The recent joint professions' statement, of which we are a signatory, affirms our commitment to multiprofessional team working, and the importance of recognising the contribution of others whilst being clear of nursing's unique contribution. Nurses will continue to work in ever more integrated and multi-disciplinary teams with nursing care taking place across a variety of settings including NHS, independent, care home, voluntary and third sectors. This would be supported by a shared inter-regulatory standard for learning in practice. The RCN toolkit to Integrating health and social care across the UK provides the framework for this.⁷¹

We acknowledge the need for inter-professional learning, and support the proposal that all practice supervisors do not necessarily need to be NMC registrants. If practice supervisors do not need to be NMC registrants, this would also open up more placement possibilities in a wider variety of settings and better prepare for a range of settings and multidisciplinary work on registration. However, safeguards would need to be in place to ensure though that these practice supervisors have the right experience, skills and knowledge to be able to

make accurate observations of student learning and achievement. They should all be registered health care practitioners and a QA framework will ensure quality and consistency.

Q9. The draft standards of proficiency apply across all four fields of nursing practice (adult, children, learning disabilities and mental health nursing) as nurses of the future will work across a variety of settings and encounter people of all ages with varying complex needs across mental, cognitive, behavioural and physical health. Should the nursing procedures in annexe B be similarly applied across all four fields of nursing practice?

We believe these should not be similarly applied across all fields. Registrants will need a level of understanding of all the skills whatever their field, but an increased level of knowledge and skills in those applicable to their field. It is about an understanding rather than proficiency, for some skills, depending on field.

Nurses should be skilled in holistic assessments...but advanced skills should be appropriate to setting they work in, e.g. not every clinical area has the need for venepuncture therefore they will soon deskill if trained in it at point of registration but then do not remain competent in it.

Survey respondent - Registered Nurse
(Primary care, non-practice setting)

We believe that all newly registered nurses should be able to undertake mental, physical, cognitive and behavioural assessments. These skills should be applicable across all fields and included in the pre-registration programme, with a clear reference to the level of competence required.⁷² To ensure that this happens a common practice assessment document is required.

Q10. If you responded strongly disagree or disagree should there be more emphasis in the level of nursing procedures that is specific to a field of nursing? (For example we may include greater emphasis on advanced physical assessment skills in the adult nursing field and greater emphasis in advanced mental health assessment in the mental health nursing field).

Yes, and see Q9 response. See Appendix 2 where, following feedback from RCN Forums, we have outlined skill sets required for different fields.

Q11. The draft standards of proficiency provide increased clarity about the achievement of competency in nursing procedures and communication and relationship management skills (see annexes A and B). Have we omitted any core skills with this approach?

There is an increased clarity and consistency of what must be achieved, which we support.

Upskilling the current workforce will be essential for implementation. Feedback from engagement events has raised consistent concerns that supervision for current nurses undertaking clinical skills training such as cannulation, venepuncture, health assessment and prescribing is often problematic, especially in the community, so this will need to be resolved through improved CPD opportunities and offers.

There must be investment in practice learning capacity – the very people that have been identified to supervise and assess practice (as per roles outlined) are also providers of service. They will need protected time for these roles, as well as clear requirements and expectations of the quality of provision.

Core mental health/psychological skills need to be explicit across all fields, e.g. motivational interviewing. There also needs to be a stronger emphasis on professional skills, rather than just specialist and task-oriented skills. Similarly, change management skills, consent and capacity skills need to be highlighted. Reflection is key, as is the acknowledgement that clinical skills are viewed not just as procedures, but have theoretical underpinning.

Q12. Are there any nursing procedural skills stated in annex B that you think are unnecessary?

Not in terms of having an understanding of these, but as outlined above, we do not think all registrants should be proficient in every skill. Considering chest auscultation, for example: it would be useful if the registrant had a full understanding of the anatomy and physiology of the body systems and know what is normal/abnormal and when to escalate. They would not, however, be expected to carry out a full respiratory assessment and diagnose. There is a danger of confusion if this foundation level is not explicitly specified.

As discussed above, the competence of practice supervisors and assessors will also need to be considered as skills will not be equally available across the workforce.

Many of the skills are regarded as having an acute/physical focus and will not necessarily be used equally by all registrants once registered. However, an understanding of the skills is considered beneficial for all registrants. Clearly different work environments will require different skills sets.

Q13. Are there any nursing procedures contained within annex B which would be difficult to achieve in practice settings, for example due to a lack of opportunity to be exposed and practice the skill?

It will require a wide range of placements and suitably prepared practice supervisors and assessors to enable this. As above, current staff may require upskilling to teach enhanced ranges of skills, but involvement of other multi-disciplinary colleagues will aid the exposure, teaching and assessment of certain skills, for example pharmacists for medicines management. The development of skills and knowledge can also be supported through simulation as discussed above.

Q14. Should competence of certain nursing procedural skills be achieved in simulated practice settings before being assessed in practice settings?

Increased use of simulation, as discussed below, offers an opportunity for teaching and learning new skills, but not achieving proficiency. However, for simulation to be effective, there must be clear standards and quality assurance in place.⁷³

There is emerging evidence supporting the use of high fidelity simulation to provide nursing students with opportunities to learn and practise formative skills in a less threatening and controlled environment⁷³. High Fidelity Human Simulation (HFHS) can complement clinical placement experience as a way of preparing students for practice together with the potential to reduce the need for prolonged exposure to clinical placements.^{75, 76, 77} However, it requires investment (not all A&EIs have simulation facilities, for example) and should be taught by current practitioners, with support from the wider multi-professional team and service users.

There is a need for clear definitions, standards and outcomes, as well as standardised resources for simulation.

High-quality simulation is a good solution and can add real value to placements. The NMC's role in quality assuring simulation needs to be strengthened; standards need to ensure rigour in the quality assessment and clear responsibilities for AEs. However, time spent in practice with patients is however paramount.

Q15. Are there any communication and relationship management skills or nursing procedures contained within the annexes which could be fully achieved in simulation?

All skills and procedures need to be practised in the practice setting and summatively assessed as competent there. Simulation offers the opportunity for individuals to practise skills and apply principles in a safe environment. To become proficient, they must be able to transfer these principles and gain proactive experience in real life settings, where complexity and acuity will require them to be adaptable to demonstrate effective skill acquisition.

Q16. Are there any nursing procedures that cannot be fully achieved in simulated practice settings?

See Q15.

Q17. Do the proficiency annexes set out all of the necessary communication and relationship management skills needed for the future nurse to be safe and effective at the point of registration?

We have noted that there is little in the communication annexe about co-production – enabling and supporting self-care and self-management. These are important skills in supporting the wellbeing of patients and carers.

Q18. Do the proficiency annexes adequately describe the nursing procedural skills, and communication and relationship management required within each of the four fields of nursing (adult, children, learning disabilities, mental health)?

There are some omissions. For example, in a child the respiratory assessment is pivotal due to higher risk of respiratory arrest rather than cardiac arrest. Similarly, people with learning disabilities may have different health priorities.⁷⁸

Q19. Should there be some variation in the level of communication and relationship management skills and nursing procedures that is field of nursing specific? For example we may include greater emphasis on advanced physical assessment skills in the adult nursing field and greater emphasis on advanced mental health assessment in the mental health nursing field.

It is necessary to define what is meant by “advanced assessment skills” – this is not achievable at the point of registration. All nurses, however, should be able to carry out a full assessment that includes physical, mental and emotional health and wellbeing. They should know when to refer and who to refer to, recognising priorities and urgency.

Q20. In order to demonstrate that students have met the communication and relationship skills stated in annexe A to practise safely and effectively at the end of their programme, should student nurses be required to demonstrate proficiency (please select one option only):

All registrants should be proficient across all fields in terms of communication and relationship skills.

Q21. Nurses will enter the register in one or more of the four fields of nursing practice (adult, children, learning disabilities and mental health nursing). This means that nurses will be expected to achieve all the nursing procedural skills, and communication and relationship management skills stated in the annexes. Final sign off of proficiencies, communication and relationship management skills and nursing procedural skills are necessary for safe and effective practice. Should nurses be proficient:

Communication and relationship management skills are essential across the four fields, but proficiency in some procedural skills should apply in the selected field of practice only. What is generic and what is field-specific needs to be clearly defined. There are particular concerns regarding omissions from the proficiencies for learning disability nursing.⁷⁹ The RCN Guide to The Needs of People with Learning Disabilities covers what all pre-registration students should know.⁸⁰ See Appendix 2 for feedback on skills required for different fields.

Q22. Are there any aspects of nursing practice that you would expect to have seen in the draft standards of proficiencies which are missing?

Yes, these are:

- literacy and numeracy, including technological (digital) literacy
- teaching skills, including coaching, supervision and assessment, particularly if newly registered nurses are expected to be practice supervisors without any further training
- developing resilience (with particular reference to systems resilience)
- quality improvement
- significant event analysis.

Additionally, we believe the following areas need strengthening significantly:

Public Health:

As all nurses and health care professional colleagues should have skills in public health practice, there needs to be a much stronger focus on population-level nursing practice, which would help future-proof these standards. There is no reference in the proposed standards to the big challenges for the public's health and wellbeing (e.g. ageing, co-morbidities, obesity, diabetes, coronary heart disease). The only real mention of the prevention agenda is when referring to infection prevention, and it is referred to as *Patient-centred care*, which does not acknowledge or recognise the distinction of the public health term.

We are also concerned that terms such as “population health” or “health inequalities” are not in the standards. They do not say that nurses are required to demonstrate understanding of the wider determinants of health (instead it says “assess the circumstances”) and health inequalities at an individual, community and population level in order to deliver evidence-based care and interventions. At best they mention health promotion, but this in itself is not sufficient to educate the future of nursing to deliver to a public health agenda.

We feel that the evidence for this emphatic inclusion can be found in the Public Health Skills and Knowledge Framework, which clearly outlines the role of all health practitioners at various stages in their careers.⁸¹

P6 gives a list of what the above framework provides. The public health functions describe areas of activity: technical, contextual and delivery. The Function level describes the groups of skills required, while the Sub-Function level of the framework describes the activity attributable to an individual and their role.

The following references will also attest to the importance of all health professionals working in a public health way.^{82a, 82b, 82c}

Sustainability:

Nurses are the largest professional group in the health care workforce and have control over the delivery of health care, health promotion and the use of resources. The International Council of Nursing⁸³ has drawn attention to the potential role of nurses in taking a lead to address the challenge of the sustainable development goals.

The delivery of health care has a negative impact on the environment. For example, data from 2015 show that the NHS carbon footprint in England is 22.8 million tonnes of carbon dioxide equivalents⁸⁴. This contributes to global warming, pollution and environmental degradation, and has serious consequences for health (for example physical and mental health consequences of flooding, exacerbation of asthma, rise in skin cancer), as well as compromising our ability to deliver health care.

The lack of any requirement for nurses to have an understanding of the impact of health care on the environment or the health consequences of climate change is a barrier to mobilising the nursing workforce on these issues. Development work has been undertaken to explore how sustainability and climate change can be embedded into nurse education.⁸⁵ However we believe that the NMC now has a clear role to ensure that this is taken up in a standardised manner across all nurse education providers, in order to address the magnitude of the challenge and the opportunity for change presented by a future workforce appropriately trained and motivated to deliver nursing care sustainably.

On that basis we recommend the work developed under the “NurSusTOOLKIT project”⁸⁶ (which has been designed to bring sustainability and climate change competences into the NMC's standards for education and training. The toolkit has been developed by a collaboration of European Universities, including Plymouth for the UK, and provides a sustainability literacy and competency framework for nurses and health care practitioners.

Human factors and ergonomics

The NMC is a signatory to the National Quality Board's Human Factors Concordat⁸⁷, which stated that the undersigned "believe that a wider understanding of Human Factors principles and practices will contribute significantly to improving the quality (effectiveness, experience and safety) of care for patients". However, "human factors" is mentioned only twice in the draft standards: once in section 5 (Leading nursing care and working in teams) and again in the glossary. The term does not appear at all in section 6 (Improving safety and quality of care).

We believe this should be addressed. Nurse registrants should have an understanding of human factors principles and be able to apply them in practical ways. Human factors in practice would include structured communication (e.g. read-back) and techniques to increase situational awareness (e.g. TeamSTEPPS)⁸⁸. In addition nurses will contribute to safety management techniques such as barrier management⁸⁹ where multidisciplinary teams review how to anticipate and monitor challenges to safety performance.

The key concerns of human factors and ergonomics are also amenable to simulation-based education. The Association for Simulated Practice in Healthcare (ASPiH) is consulting on a standards framework for simulation-based education in the UK⁹⁰.

The appearance of the word "resilience" is also of some concern. It is not defined in the glossary, which suggests its meaning, and how to teach it, are self-evident. In fact, resilience has a special meaning in the context of system safety⁹¹. In-system safety resilience concerns itself with how a system responds, monitors, learns and anticipates challenges to system performance. It is not an individual characteristic or an expectation that people can somehow adapt to poorly designed systems⁹². We believe that there should be stronger emphasis placed on the science of human factors and ergonomics.

Q23. Do you have any other comments about the future nurse standards of proficiency and annexes we are consulting upon?

We would like to see focused assessment outcomes in all settings that are relevant to all fields; at present these are acute and adult-focused, and they need to be more closely related to the settings where care is being delivered.

4. Consultation on education framework: standards for education and training

Summary

We agree that the current education framework requires review and should offer a more flexible approach, but there are real concerns that this is not currently sufficiently robust. If the NMC removes the current mandated requirements for learning and assessment in practice, the unintended consequence is likely to be a lack of investment in the infrastructure for practice-based education and support. This will impact on public protection.

The current practice-based learning model is one whereby an individual mentor has responsibility for the teaching, supervision and assessment of a student nurse⁹³. It is, as a framework, generally considered to be lacking in flexibility and overly bureaucratic⁹⁴. It also does not ensure consistency of student experience in terms of quality⁹⁵. These fundamental proposed changes to the framework are therefore welcomed.

Specific problems noted with the current framework include the difficulties experienced by students and mentors when nurses do not wish to be mentors⁹⁶. It is generally agreed that we need more of a team approach to this. Andrews and Wallis⁹⁷ suggested the development of a mentoring team, Grealish and Ranse⁹⁸ the development of a community of practice and Killam and Heerschap⁹⁹ the need for a systems approach that doesn't just rely on individuals. Generally, it would seem that the proposed new education framework could allow for such much needed changes to practice placement learning.

Another tension within the mentorship role is that of the mentor being both teacher and assessor¹⁰⁰, and so the separation of the practice supervisor and practice assessor role certainly does have some merit. The assessment element of the mentorship role is often particularly problematic, resulting in "failure to fail"¹⁰¹, and this separation may alleviate that issue.

A further tension exists in the mentorship role, between a mentor's primary responsibility to care for their patients and attending to the

learning needs of their students. This applies in particular to assessment¹⁰², which takes time to do.

Any new education framework will then need to ensure the following:

- Effective student nurse preparation for and support in placement.
 - ◊ The support that is most often required is to deal with the emotionally challenging environments that students find themselves in and practice supervisors could be well placed to provide this support, particularly as they do not assess students¹⁰³. However, the nature of this preparation and support is not clearly identified in the proposed framework, and it needs to be.
- Effective learning strategies and fair assessment strategies must be adopted by practice supervisors, practice assessors and academic assessors.
 - ◊ Students need to be self-directed learners and this requires a coaching approach rather than didactic teaching from practice supervisors, particularly as students become more senior^{104, 105}. Practice supervisors will then require support and knowledge to do this, not necessarily through a formal academic programme of study. However, this does need to be part of the pre-registration nurse training curriculum. Practice assessors and academic assessors need to be knowledgeable and confident assessors and so do require formal training for the role. The skills and knowledge required for these roles needs to be clearly articulated in the new education framework.
- Interprofessional learning is essential and should definitely feature in the new framework. We recognise the fact that practice supervisors do not always have to be NMC registrants. However, it is not well

understood how interprofessional learning should be implemented,¹⁰⁶ and this cannot be achieved by nurses alone. We need to include other professions in this discussion, and to identify and publicise examples of where this has worked well.

- Effective support for both practice supervisors and assessors is essential.
 - ◊ If the range of skills and depth of knowledge of the NRN is increased, there is a clear need to upskill the current workforce and this will require funding and protected time to do so.
 - ◊ Guidelines are also essential to clearly define the roles and responsibilities of both practice supervisors and practice assessors.
 - ◊ Valuing roles – the practice supervisor and practice assessor roles should form part of a clear career pathway, hence ensuring that only those who wish to do so take on this role and it is incorporated into their career progression.
 - ◊ It is essential to have a named person who takes responsibility for learning and assessment in the placement setting and who collaborates effectively with the AEIs. This needs to be clearly articulated in the new education framework.
- A close relationship between AEI and placement provider is essential^{107, 108}. Clarity around the academic assessor role is also essential. It needs to be made very clear in the new education framework that the AEI and placement provider have equal responsibility for the quality of placements.
- Furthermore, quality enhancement processes need to be transparent, with ultimate responsibility and accountability for the quality of all practice placements resting with Directors of Nursing and Deans¹⁰⁹.
- Flexibility within the new framework is essential to allow for a variety of different and new practice settings to be added to the placement circuit, but the preparation of new placements requires resources – both financial and time – to ensure that the areas are suitably prepared.

Overall, fundamental change is welcomed regarding practice-based learning and this new proposed education framework is a good start. One of the main criticisms of the

current framework is that there is too much inconsistency in the quality of the student experience and the proposed introduction of a national practice assessment document would certainly help to address this. However, what is missing from this draft framework is a clear sense of how it could be operationalised, whilst ensuring consistency of quality across the UK.

In order to achieve this, the following omissions need to be addressed:

- role descriptors for practice supervisors, practice assessors and academic assessors
- guidelines and proficiencies for the preparation of practice supervisors, practice assessors and academic assessors
- clearly defined education career pathways for nurses who have a particular interest in education
- proficiencies for students to achieve in their pre-registration training to ensure that they are well prepared to become practice supervisors at the point of registration
- examples of models, including inter-professional, that work well
- an acknowledgement of the need for funding CPD for the current workforce to ensure that they have the requisite skills and knowledge to support all learners in the workplace
- an acknowledgement of the need for protected time for all these roles
- an emphasis on the need for clear lines of responsibility and accountability in the practice placement setting and at executive level within both the placement provider and the AEI
- a robust evaluation strategy for early adopters of this new education framework, particularly regarding the practice supervisor/practice assessor split, preparation and support of practice supervisors and assessors, student experiences, and outcomes and effects on patient safety and care. This evaluation needs to be large-scale and longitudinal, utilising a research methodology that does not solely rely on reported experiences, for example, action learning, or ethnography
- the overarching quality assurance framework for future nurse education also needs to be clearly articulated.

Responses to the specific consultation questions

Q24. The education framework has requirements for education institutions, practice placement and work placed partners which are increasingly focused on outcome rather than describing processes and inputs. Do you agree with this approach to our education and training standards?

Some outcomes are difficult to define and assess, such as resilience, healthy lifestyle, and emotional intelligence, although this could be done through self-assessment and subsequent action planning. Furthermore, evidence-based processes are also important and must not be neglected at the expense of an outcome focus only.

Q25. The proposed programme of change for education seeks to offer more flexibility to education institutions and their practice placement and work placed partners to deliver nurse and midwifery programmes in creative and innovative ways. Is this ambition apparent in our proposals?

More clarity is needed regarding the proposed framework and the preparation and support for the practice assessors/supervisors and academic assessors. It is also currently unclear who is responsible and accountable for the quality assurance of this proposed framework. Robust quality assurance processes from the AEI, Quality Assurance Agency (QAA) and placement provider will need to be in place, with the standard for the quality of the practice assessors, practice supervisors and academic assessors and the framework, set at excellent, not adequate, or appropriate.

Standardised elements, such as common curricula, final exams, standard testing and a national practice assessment document, should be put in place to ensure effective delivery of a more flexible programme that maintains high-quality outcomes. This will also ensure that registered nurses can work across all health care sectors and all geographical areas within the UK and internationally. This document could then become the foundation of a skills passport. A good example of this approach is the work currently being undertaken by Capital Nurse in London to develop a skills passport¹¹⁰ that has currency across London, following on from a pan-London practice assessment document.¹¹¹

Regarding the practice educator role, we think the Practice Education Facilitators (PEFs) in Scotland, England, Wales and Northern Ireland could be a way forward. For example, Practice Education Facilitators and Care Home Education Facilitators (CHEFs) have been created by NHS Education Scotland (NES) as roles to support mentors. They do not directly support students as such and whilst there has been investment in growing them in the workplace there are still too few. It is a good model and one the AEIs and practice placement areas in Scotland wish to keep, but with the acknowledgement that there are limitations with this system, and not least that there are insufficient practice educators to support the model. At the very least, consistency in the role descriptors for practice-based educators should be mandatory.

In order to achieve the proposals, it is essential that existing staff are given the chance to upskill; there is anxiety in the current workforce that they will not be able to support the students to achieve the practice learning outcomes. The current workforce will require support and training to fulfil their new roles effectively. Consequently, there needs to be considerable investment in the current workforce to provide assurance of the standards of proficiency in procedures and levels of knowledge. It is essential that the current level of investment in mentorship training programmes be retained, but spent more effectively. It is also essential that current mentors, recorded on mentor registers, are supported to transition into new roles; this resource must not be lost. Organisational sign-up is also essential to support the supervising and assessing roles. There must be a minimum standard for practice assessors and this must be linked to revalidation. As practice assessors could be an independent cross-organisational role, who funds such roles would have to be clarified.

Q26. When developing the draft education framework standards and requirements, the objectives were:

- situates patient safety at the core of their function
- enhanced outcome, future-focused requirements
- being right touch – consistent, clear, proportionate and agile
- evidence-based regulatory intervention that promotes inter-professional learning and cross regulatory assurance

- a framework that is applicable to a range of learning environments
- ensuring that the education framework is measurable and assessable
- promoting equality and diversity.

Q26a. Have these objectives have been met?

These are difficult to evaluate and measure. However, we do consider a national practice assessment document, preferably digital, as useful in this context and would be happy to be involved in the development of such a document. This has worked well in Wales¹².

Q27. Do you agree that the education framework can be applied to pre and post registration education and training?

It is very generic and high-level. It lacks the detail required to ensure consistency of quality of practice placement experiences. The NMC must clearly define the standards required for the education framework.

Q28. Do you agree that the education framework can be applied to nursing and midwifery education and training?

It is very generic and high-level. It lacks the detail required to ensure consistency of quality of practice placement experiences. The NMC must clearly define the standards required for the education framework.

Q29. Do you agree that the education framework is likely to ensure effective partnership working and shared responsibilities between education institutions, practice placement and work placed learning providers?

It will not necessarily ensure it, but we do agree that it is essential to have a close relationship between AEIs, practice placement providers and associated joint QA processes. This new framework offers an opportunity, but requires more detail to ensure effectiveness, for AEIs and placement providers to work more closely together, which would enhance nurse education. A way forward would be to mirror the processes involved in the Health Education England Nursing Associate implementation project. In each region joint processes and policies have been developed locally to support the Nursing Associate training programme, which has been effective so far.¹³

Q30. Does the education framework draft standards work equally well for programmes delivered in flexible educational modes: for example full-time and part time university based, and part-time work placed?

A common curriculum and clear progression points should be implemented.

Q31. Do you agree that the education framework promotes inter-professional learning?

Yes, it could do, but this could be a stronger theme and would require further detail to implement. However, it is definitely a worthy aspiration.

Interprofessional learning requires other professions to agree to this type of learning. We support it as an aspiration, in particular as the health system moves to closer integration, but it cannot happen without the buy-in from other professions. It would be helpful if the NMC could establish consensus about this across the professions and their regulatory bodies, as we would require a shared understanding regarding issues such as information sharing and confidentiality. An example of this could be a framework which addresses the issue of professionalism in an interprofessional learning strategy¹⁴.

Q32. Do you agree that the education framework prioritises the safety of people during all education and training that takes place in academic and simulation settings?

There are improvements that could be made and are alluded to below.

Q33. Do you agree that the education framework prioritises the safety of people and patients during all education and training that takes place in practice placement and work placed settings?

We think that this aspect of the framework needs strengthening.

We would like to highlight that practice supervisors and assessors need protected time and that there needs to be a comprehensive induction for all students, mirroring what happens in Medical Education in the practice setting. Those working in the placement setting need to be in a position to support students in adopting a self-care approach, which will result in a more resilient group of nurses for the future.

A clear and genuine commitment to the health and wellbeing of all nurses must be evident in the framework.

Until there is greater detail regarding the quality assurance processes underpinning the proposed framework, the safety of people and patients cannot be guaranteed.

The RCN guidance^{115, 116} to mentorship attests to the importance of good practice learning environments and still applies even if terminology changes to practice supervisor and practice assessor.

Q34. Is there any aspect of delivery and management of education and training that you would expect to have seen in the education framework which is missing?

We strongly feel that preceptorship needs to be included in the framework. The transition period is crucial for patient safety, recruitment and retention and is essential in our view. In 2010, the Department of Health described “a period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning.”¹¹⁷ This has been supported by the NMC: “The NMC supports and strongly recommends that preceptorship be made available to nurses and midwives following initial registration.” We would certainly support this aspiration, but would wish to go further by:

- clearly defining the preceptor role
- clearly defining the responsibilities of the preceptor
- having a UK-wide preceptorship framework.

It is essential to include preceptorship into this framework as the current Health Education England RePAIR project exploring how to increase student retention has found that a clear transition plan from student to newly registered nurse is vital in order to encourage students to complete their training and then to remain in the nursing profession, and that this must be articulated in their training. This project is due to report in March 2018.

Q35. Do you have any more comments on the Draft Education Framework: standards for education and training?

Draft pre-registration nursing programme requirements

Q36. As part of our proposed new requirements for learning and assessment, we propose separating the support and supervision of students from the assessment of students. Do you agree with this approach?

We can see some merit in the proposal to split the role of mentor and assessor and we believe that this has the potential to lead to more objective and consistent assessment decisions, providing the correct standards are in place for each role.¹¹⁸

I believe the system in place when I was a student needed to be changed. I think having a mentor to teach skills and an independent assessor to assess the student's skills and knowledge will ensure mentors are able to mentor students to a high standard and the students have the abilities to learn and perform to a high standard.

Survey respondent – Registered Nurse (Mental Health)

However, how this will be organised and delivered at a local level is going to be challenging, particularly if the practice assessor comes from outside of the organisation. Evidence from the engagement events attested to the real lack of supervision and support infrastructure currently in practice and this needs to be urgently addressed. There has been reduced investment in this area in nursing (unlike medical colleagues, who ring-fence this support) and this needs to be challenged.

Once selected, practice assessors need protected time and clear career pathways – for example, a clinical academic career. In addition, more joint AEI and practice roles are required. A tripartite assessment between student, mentor and clinical assessor is a model adopted in midwifery and Specialist Community Public Health Nursing education and has proved effective. Quality assurance of the practice assessor must remain, as should the recorded status of the assessors.

Q37. Do you agree with our proposal that the practice assessor role should be independent of the practice supervisor role?

This is a good opportunity for students to be supervised by the experts in their field in a non-judgemental way. There does, however, need to be clear mechanisms for the practice assessors to be able to gain feedback from supervisors to support their judgement of the students; capabilities, competence, and proficiency; remembering that the professional skills are just as vital as the clinical skills acquisition. This process needs to be undertaken including the student, practice supervisor, practice assessor and the academic assessor. All practice supervisors must be registered health care practitioners working to a professional code.

Q38. Are there any other ways we can ensure independence of the assessment outcomes of student proficiency?

Practice assessors need to be adequately trained and continuously supported, and they need to have protected time to undertake their duties.

Participants have summarised that this could be achieved through:

- personalising portfolios – recognising the different experience of different students
- simulation – can be a positive thing, we can do more with it, more e-learning and turn it into formative rather than summative
- increasing the communication element in practice and theory
- every module having a practice and theory element tailored to the placement and clinicians understanding what the theory is
- practice-based assessment of person-centred care, which we acknowledge is more difficult to assess, it does need to be assessed and this requires further development.
- practice outcomes repeated per placement and not just signed off and never assessed again
- assessment by service users
- standardised assessments across the UK such as the all Wales framework
- assessments being varied, continuous, summative and formative
- students taking more responsibility for their development – more ownership of learning

- addressing any role conflict between the practice assessor role and the university's own assessment.

Q39. We do not intend to set proficiencies for the new roles which we have proposed. Instead we will encourage locally agreed innovative and creative approaches to supervision and assessment to be in place. Do you agree with this approach?

We support the vision of enabling innovation and place-based responsiveness of, and within, the system. However, we do see real issues in this approach and feel it does need some further consideration and guidance, in particular on ensuring consistency of the student experience. Clear requirements regarding the roles and responsibilities of supervisor and assessor would be a starting point for this.

We also see a risk that this proposal could lead to real fragmentation, lack of consistency and different institutions doing different things, with the role of the NMC being very light touch in terms of their regulatory and scrutiny function.

Whilst supportive of flexibility there is a need to ensure consistency if allowing flexible educational modes, to have some standardised guidance concerning aspects such as new roles and training. A minimum standard should be set for practice assessors, such teaching and assessing modules already exist in AEIs, often as part of a degree pathway, are bound by QAA processes and would be monitored through revalidation. We need clear algorithms depicting the relationship between AEIs and practice areas for governance purposes.

Q40. We will no longer require those supporting, supervising and assessing students to complete a programme that the NMC approves. This will enable local innovation, creative and inter-professional approaches to take place. Do you agree with this approach?

As above, we are supportive of enabling innovative guidance but do think there is a requirement for underpinning guidance to ensure standards of student experience. There is a significant risk, however, if training for the roles no longer conforms to a mandatory standard. This would have an adverse effect on investment in CPD.

The mentorship preparation programme had beneficial elements, for example on how to

carry out assessments in practice, and it will be important to maintain these elements in the new framework. Further, because it was a mandatory programme, it ensured a minimum training standard for all mentors. Rather than the programme itself, issues were related to people undertaking the programme who either did not want to be mentors in the first place, or saw it as a mere part of career progression or gateway to further CPD. We would expect that all practice assessors would be doing that role because they wanted to do so.

We would also like to highlight the fact that doctors often expect payment to supervise and assess so there is a risk of a two-tier system for involving other professional groups.

Q40a. Please state any risks that you perceive in relation to this proposal.

In line with the above, we perceive there to be a real risk of inadequate, or no training for practice supervisors and assessors in the current proposal. If all registered nurses and other registered professionals are to be practice supervisors, the skills of teaching, coaching and giving feedback must be incorporated into the pre-registration training curricula. Practice assessors need to be formally trained, ideally through a framework which could culminate in the award of either PGCE/PGDE, as this role must form part of a clearly identified career pathway.

Risk factors also include lack of time to undertake the roles, lack of funding for further training and no clear standards. These can be mitigated through robust quality assurance, which we think is essential to be in place.

Q41. The proposed model allows that practice supervisors can be any registered health and social care professional who is suitably prepared and does not have to be an NMC registrant. This will enable educators to decide locally the individuals and / or groups that are best placed to supervise learners. Do you agree with this approach?

We agree that this approach would increase practice placement capacity and are in broad agreement, however, a minimum amount of supervision by NMC registrants should be put in place.

We are concerned that the term “suitably prepared” is too vague: it will need to be very

clearly defined to ensure minimum standards in supervision by non-NMC registrants. There must be shared standards for all practice supervisors.

Q41a. Please state any risks that you perceive in relation to this approach.

In line with Q41, there is a risk of lack of directly relevant and adequate supervision and lack of professional socialisation if there is excessive supervision of student nurses by professionals other than nurses. These risks can be mitigated through minimum standards for interaction with NMC registrants and well as clear guidance for supervising non-NMC registrants. The responsibility for ensuring this rests at all levels in the quality assurance process, but mainly with the placement area, as they supervise the day to day learning of all students placed there.

Q42. The proposed model states that, while a range of academic and practice-based educators will contribute to assessing a student, there will be two nominated assessors - a practice assessor and an academic assessor - who will be responsible for the assessment of a student for each part of the programme. (For example for the first year of a three-year programme or semester one of a post-registration programme.) Do you agree with this approach?

We agree with this approach in principle. However, there may be issues with implementation, in particular if the practice supervisors and practice assessors are not from the same organisation.

Q43. In the future it may not be necessary for a student nurse to be assessed by a nurse from the same field of practice. Educators from academic and practice settings would decide locally who is best placed to assess the student. Do you agree with this approach?

We can see the merit in this approach in enabling local innovative practices for the assessment of specific skills, however, an assessor from the same field of evidence is preferable and essential at progression points.

More widely, AEs and placement providers will need to work closely and with clear audit trail on these types of decisions. It could also be a route for succession planning through “buddying” for new clinical assessors.

Depending on the placement area it may be important to highlight risks attached to a nurse from a different field of practice undertaking assessments as some practitioners from other fields would not pick up on nuances underpinning safe practice.

Q44. Do you have any more comments on the Draft requirements for learning and assessment?

We would like to emphasise the following principles:

- All new roles and their responsibilities need to be clearly defined.
- Responsibilities of the AEI, placement provider and the student also need to be articulated.
- The requisite training and supervision for all roles needs to be clearly defined, costed and evaluated.
- Career pathways for educators in practice need to be identified.
- The use of language regarding “people”, “service users”, “patients” needs to be consistent.
- There needs to be greater standardisation of practice assessment documentation and a national final examination.
- Placement learning must be adequately supported through funding and training by central government.
- Robust and transparent quality assurance processes are essential for all aspects of the proposed framework; these must be carefully monitored and any changes required made in a timely fashion. The NMC must develop QA standards for practice placements.
- Principles of preceptorship needs to be included into the framework. The initial pre-registration training is only the beginning of lifelong learning and the next stages of that journey need to be clearly signposted for students and employers.
- Requirements for time spent in practice need to be clearly stipulated (whilst acknowledging that quality of experience is more important than the number of hours completed) and progression points identified.

We agree that the current standards to support learning and assessment in practice¹¹⁹ do need changing, as they are inflexible and inconsistent in terms of outputs. We also agree that the proposed framework does have the potential to unleash creative thinking and improved ways processes through allowing local issues to be solved through local solutions, but this has to be within a context of nationally agreed frameworks and standards. In order to develop this more detailed framework, we would be keen to work with the NMC and other key stakeholders to coproduce these resources and processes.

Draft pre-registration nursing programme requirements

Q45. Our new programme requirements allows approved education institutions (AEIs) and their practice placement partners to set entry criteria for literacy, numeracy and digital literacy. We will not set requirements in this area. Do you agree with this approach?

We agree that it is more important to have clear, consistent outcomes at end of programmes, rather than at the beginning, but there is also a need to monitor the continual progress of all students in all these areas. Also it is vital to remember that if students with lower levels of literacy, numeracy and digital literacy are accepted onto programmes, sufficient support must be in place to ensure that they are proficient at the end of the programme. AEIs currently set their own standards and if they continue to do so these must be transparent, based on validated assessment tools and closely monitored. There is an argument for national assessment standards, if this can be proved to lead to better student outcomes in both theory and practice and in terms of subsequent practice.

Q46. Within the existing pre-registration nursing entry criteria AEIs must have processes in place to allow recognition of prior learning to a maximum of 50% of the programme provided all the requirements are met in full. (This can be either academic and practice learning or both.) Do you agree that we should continue to set a maximum limit for recognition of prior learning?

Whilst there is currently a 50% limit on the use of accreditation of prior learning (APL) within pre-registration programmes, there is

no clear evidence base for this and there is an acknowledged lack of research related to the practice of APL in Higher Education Institutions. We believe that further consideration should be given to the use of recognition of prior learning and how this impacts on the programme outcomes leading to registration. Currently, it is often influenced by context, including the time and resources available and university regulations, rather than aligning the needs of the individual against the programme outcomes. We would want the NMC to collect data against this requirement to enable evaluation of impact of this route onto the register.

We also need to understand if the requirement of R3.5.5 in the current pre-registration nursing education standards will continue to apply – where “AEIs must have processes in place to consider unlimited APL for first and second level nurses registered with the NMC entering programmes that lead to qualification in the same or another field of practice, provided that all requirements are met in full.”

Q46a. If you answered strongly agree or agree what percentage of the programme should be the maximum available for recognition of prior learning?

Q47. In recognition of the importance of theory and practice to student learning and proficiency, we propose that we continue to require an equal amount of education to be delivered in practice and theory. Do you support this position?

We would like to emphasise some points of clarification and the wider context of practice training requirements.

“Theory” and “practice” must have very clear definitions: theory can be learnt in practice and practice can be learnt in the AEI. In recognition of the burden the organisation of practice placements places on both the AEI and the wider health system that implements them¹²¹, it is paramount that education content and outcomes are clearly defined and communicated. If this theory-practice continuum is not challenged then the perception of a “theory practice gap” will only persist.

More widely, the placement hours are mandated by an EU Directive¹²¹ and after the UK exits the European Union, there will be the opportunity to repeal directives in UK law. This could include parts or all of the EU directive on the Recognition of Professional Qualifications which contains the provision for a minimum of 4,600

hours required in the training of general care nurses split equally between theoretical and clinical.

Common EU standards for training and recognition of qualifications have enabled mobility, helped raise educational standards and put safeguards in place across Europe, which facilitated the UK to recruit from Europe to make up for its own shortfalls and included language checks on EU nurses and a duty to inform other health regulators about suspended or banned professionals.^{122, 123}

Whilst we do not advocate for a reduction of practice hours, we believe it to be essential that the NMC is prepared for this future scenario and the possibility that other stakeholders may advocate this.

Most EU member states stipulate 4,600 hours in total, but differences are apparent in the percentage allocated to clinical placement¹²⁴ as mandated by EU Directive 2013/55/EU. There are variations reported on the length of nurse programs across EU member states, and Australia¹²⁵, New Zealand¹²⁶ and the USA¹²⁷ have far fewer hours allocated both in terms of total hours and hours designated for placement.

There is no empirical evidence found that reports relationships between total length (hours) of clinical placement and specific outcomes. However benefits of longer placements (i.e. duration of individual blocks of placements) have been identified by some authors¹²⁸. While most placements appear to be offered in hospital/ward settings, there is limited reporting in the literature about the provision of placements across community, primary and mental health settings.

The benefits of longer placements have been identified as providing students with a sense of belonging and being part of a team¹²⁹ greater scope for experiencing a mutually beneficial student-mentor relationship, leading to improved clinical learning¹³⁰ and higher levels of student satisfaction.¹³¹

Finally, it is vital that the quality of the placement is evaluated by students and that quality is maintained.

Q47a. If you strongly disagree or disagree, should we leave decisions about the proportion of practice and theory to individual education institutions and their practice placement partners?

Whilst we have not disagreed, we do want to emphasise that it is essential that there is close liaison and agreement regarding learning content and location between the AEI and placement partners.

Q48. There is currently a cap that limits 300 hours of practice learning to be achieved in simulated practice learning environments. We are proposing that practice learning provided through simulation can be increased but should not exceed the number of hours spent in actual practice placement settings. This means students may spend more time in simulated practice learning environments than they do now. Do you agree with this approach?

Greater use of simulation is beneficial, as is role play with service users, as it encourages a variety of learning strategies to be used, and can expose students to skills that they have not seen in practice, but it should not be at the expense of practice hours.

There is emerging evidence supporting the use of high fidelity simulation to complement clinical placement experience as a way of preparing students for practice together with the potential to reduce the need for prolonged exposure to clinical placements.^{132, 133, 134}

As a first-year student, nothing prepares you for what you may encounter on placement, and no lecturer fully explains the realities. I feel more simulation exercises in smaller groups would be beneficial.

Survey respondent – first-year student in Adult Nursing

However, not all AEIs and trusts have the resource required and student feedback revealed an absolute requirement to learn from and to be with patients in the clinical environment.

I think there should be more hours in practice and less hours in simulated situations because the class sizes are too big so often you don't even get a chance to try the skill you are learning.

Survey respondent – Student in Adult Nursing

I believe simulation allows for a certain amount of nursing skills to be acquired, but personally the experience I have gained during my placements so far (I am half way through second year) has been invaluable. Working in a real environment with

direct patient contact has allowed for the development of communication, assessment and prioritisation skills.

Survey respondent – Student in Adult Nursing

If simulation is to remain and even have an increased role in nurse education, then the NMC's role in quality assuring simulation needs to be strengthened, standards need to be developed to assure to ensure the rigour in quality and clear responsibilities for AEIs and government agencies.

Q48a. If you answered strongly disagree or disagree do you think there should continue to be a limited number of hours that states the cap for simulation hours used for practice hours

Yes.

Q48b. If yes, how many hours should the cap limit be set at? Please state the maximum number of hours to be used as simulation for practice.

It is difficult; however, to give an exact number of hours, but we would suggest 600 hours maximum.

Q49. The draft pre-registration nursing programme requirements allow education institutions to decide what is required from a student at each progression point of their programme. Do you support this approach?

Yes, but there must be clear progression points and ease of transfer from one AEI to another must be ensured.

Q50. Throughout our pre-consultation engagement, the introduction of a UK-wide national standardised practice assessment document has been frequently proposed to improve consistency of outcome judgments on student proficiency. Do you agree with this proposal?

Yes, a national UK-wide practice assessment document is vital, preferably this would be in digital form. This has been very successful in Wales through the All Wales Initiative.

A standard national final exam has been discussed at various events but this would need further considerable discussion and research as to the most effective method.

Q51a. If you agreed or strongly agreed with the previous question, should the NMC work with others to support the development of a standardised practice assessment document?

Yes, it should and this work should include AEs, employers, professional bodies, students and service users. We would be very keen to support the development of this work in partnership, recognising the good practice already in place across the UK.

5. Consultation on prescribing and standards for medicines management

Summary

The College is supportive of the NMC's proposals regarding newly registered nurses being "prescribing-ready", in terms of an enhanced theoretical knowledge of pharmacology, pharmacokinetics and medicines management. There is clear evidence for the benefits that nurse prescribing can bring for patients, nurses, the wider health service and other health care professionals. The benefits attributed to patients include timely treatment, reduced waiting times and continuity of care,^{135, 136, 137, 138, 139, 140, 141, 142, 143, 144} with patients generally being in favour of nurse prescribing.^{145, 146, 147, 148, 149, 150, 151} There is also evidence for nurse prescribing leading to improved nurse-patient relationships, longer consultations, improved quality of care^{152, 153, 154, 155} and increased patient choice.^{156, 157, 158} Patient adherence to their medication is not, however, affected by nurse prescribing.¹⁵⁹

Nurses reported a number of benefits accruing from nurse prescribing and these included increased nursing skills and knowledge,^{160, 161, 162, 163, 164, 165, 166} greater job satisfaction,^{167, 168, 169, 170} more credibility and increased patient trust.^{171, 172} Nurse prescribers reported how their improved knowledge about medications enables them to participate in discussions about medications use, and felt it was important to ensure that nurse prescribing was not simply viewed as generating prescriptions.¹⁷³ Further evidence suggests that nurse prescribing enables nurse innovations, especially in relation to nurse-led clinics,^{174, 175} specialist nurse clinics¹⁷⁶ and critical care outreach clinics.¹⁷⁷

The benefits to the wider health service associated with nurse prescribing are evidenced as the potential for more appropriate prescribing and reduced prescribing and associated cost-effectiveness.^{178, 179, 180} In studies evaluating nurse prescribing, it was found to be as good as, or better, than medical prescribing.^{181, 182, 183}

Doctors and other health care professionals are generally positive about the value of nurse prescribing.^{184, 185} There is clear evidence showing that nurse prescribing in a community

setting improved team working because it freed doctors up to see more complex patients and less patients with minor complaints.¹⁸⁶ Similarly, HIV nurse prescribing has been shown to free up doctors and encourage skill-mix.¹⁸⁷ However, there is some evidence on the potential for role conflict and blurring the boundaries between nursing and medicine, the possibility that nurse prescribing could lead to the deskilling of junior doctors and a reduction in doctor-client consultations.^{188a, 188b, 189} The NMC must ensure that it communicates all evidence thoroughly, and seek engagement from all professions, before implementation.

The move to increasing the knowledge and understanding of newly registered nurses may in turn expand the numbers of nurses prescribing. However, its implementation will also entail challenges. A key one identified across a wide range of existing evidence is the potential of the nurse prescriber roles to be viewed as leading to the "medicalisation" of the nursing role, with the focus moving more to the curing end on the caring - curing continuum.^{190, 191a, 191b, 192, 193, 194, 195, 196, 197, 198} We are clear that the essence of the nursing role is to provide care and are confident that it is possible to extend nurse prescribing without it having a detrimental effect in this respect.

It will also be essential that nurse prescribers are adequately recognised in their extended role. This includes considering their capacity when expanding their existing duties, including adequate cover for nurse-led clinics, wider organisational enablement of nurse prescribing, such as no restrictions to hospital prescriptions only¹⁹⁹, and facilitation of required CPD and training.^{200, 201} Failure to do so may significantly jeopardise the benefits of nurse prescribing: a study of mental health nurse prescribing in Scotland, for example, found that more than half of their nurse prescriber participants were not prescribing. The reasons given included additional workload and responsibility, lack of support, and a belief that the initiative was politically motivated, without any additional role recognition.²⁰²

As these changes are rolled out, the NMC, employers, AEs and all the professional bodies will need to collaborate to raise awareness and educate others about the role of the nurse prescriber, and its impact on the role of other professions.^{203, 204} The evidence is clear that both health care organisations and higher education institutions need to work closely and jointly implement a number of changes to improve the uptake and effectiveness of nurse prescribing.

Nurse prescribing needs to be supported through the provision of mentorship and training programmes^{205, 206} support for supervisors, a buddy system²⁰⁷, a change in organisational culture and looking at improvements in the assessment of nurse prescribers²⁰⁸.

There is evidence in secondary care where the financial arrangements between trusts acted as a key barrier to the implementation of nurse prescribing.²⁰⁹ There is further evidence from general practice that while nurses with prescribing qualifications may experience enhanced career prospects, budget conscious employers may question investing in a more expensive resource when a nurse on a lower salary may produce similar outcomes.²¹⁰ There is also evidence suggesting that a lack of pay incentive may contribute to a slowing down of the development of nurse prescribing^{211, 212} – this is of particular relevance in the ongoing pay restraint nursing is undergoing.

As set out above, protected time for CPD is essential to ensure nurse prescribers can keep up to date with their pharmacology knowledge and skills^{213, 214, 215} and employers must facilitate this. Ongoing continuing education and evaluation of nurse prescribing practice is fundamental to ensure prescribing decisions remain safe and clinically appropriate.²¹⁶

Some evidence from general practice recommends that a professional lead for practice nurse prescribers should be funded by primary care trusts (PCT), GPs should ensure protected study time, and practice nurse prescribing should be brought into line with PCT employed nurses. Furthermore there should be a clear pathway for nurse prescribers working in general practice.²¹⁷

A wide range of evidence is available on the content, planning and delivery of nurse prescribing education^{218, 219, 220, 221, 222, 223, 224}, which must be considered by AEs and the NMC throughout implementation.

Responses to specific questions

Q1. Do you agree with our proposal to use the Royal Pharmaceutical Society's Single competency framework for all prescribers as the basis for our nurse and midwife prescribing proficiencies and within our post-registration prescribing programme requirements?

We agree with the proposal that a shared competency framework should be in place, and that this could be the RPS one as suggested. The current RPS framework had nursing input, is endorsed by the RCN and has been the subject of an RCN Twitter chat, so whilst the RPS hosted its creation, it is already an interprofessional document. This is not, however, a substitute for the essential development of new medicines management standards. Many of our members are concerned that the emphasis on prescribing could overshadow the need to drive improvements in medicines management.

I am concerned about the proposal to make newly qualified nurses "prescribing-ready". I would say that there is currently a huge amount of work needed to improve nurses' competence in the administration of medicine, which should be addressed before prescribing competencies are added.

Survey respondent – Registered Nurse in Adult Care (hospital)

Q2. If you answered strongly agree or agree to the question above, do you think this will promote a shared approach to prescribing competency between professional groups?

We believe this approach to be essential.

Q3. Increasingly care is taking place closer to home. In order to support the needs of people through new models of care it is important to increase nurse and midwife access to prescribing support, supervision and assessment. Do you agree with our proposal to remove the designated medical practitioner role and title and replace this with a prescribing practice supervisor and assessor roles? This could be any registered healthcare professional with a suitable prescribing qualification and relevant prescribing experience.

We strongly agree with this proposal as this has been a limiting factor. We do need, however, to clearly define "relevant prescribing experience".

When prescribing was in its infancy, medical supervisors were required to give assurance. Now that prescribing is advancing and there are many non-medical prescribers, it is essential that experienced prescribers will be able to support and supervise others.

Q4. During pre-consultation engagement potential risk areas of prescribing practice were highlighted, for example remote prescribing, cosmetic prescribing and independent prescribing practice. Do you agree that additional guidance in such areas as prescribing practice should be developed in line with the Code to ensure the public who seek access to these areas of prescribing practice are protected?

We believe this is necessary. Prescribing standards are essential for all prescribing health care professionals, including doctors, to ensure patient safety and we feel that this is the role of the regulator. This should include the principle that prescribing incorporates advanced level assessment of the patient by the prescriber. We need a framework for independent practice outside NHS and organisational services, so that nurses who practise with these skills can set up independently or in groups (perhaps similar to GP services). We also need to consider indemnity arrangements for these nurses.

Q5. Currently a nurse or midwife has to be registered for two years before being eligible to undertake a community nurse prescribing programme (known as V150). We are proposing that immediately after successful completion of their pre-registration nursing programme and following registration a registered nurse or midwife can complete the practice requirements of a community practitioner prescribing programme (known as V150). Do you agree with this approach?

We agree that in certain settings it would be beneficial to care if nurses could complete V150 immediately after registration. If this were to happen then there should be more theory in the pre-registration nursing programmes concerning pharmacology, pharmacokinetics, medicines management and patient safety related to the administration of medicines. This will prepare students for their future role and ensure they are

“prescribing-ready”. 68% of our July 2017 survey respondents either agreed or strongly agreed with this position (see Appendix 1).

V150 is a very limited formulary and only really applicable in specific service areas; this could, however, be an opportunity to extend the nurse formulary.

Despite this, we recognise that many of our members have shared concerns that the pace of becoming prescribing-ready may mean that newly qualified nurses have less time to develop and embed general competencies

I would strongly disagree with [newly qualified nurses being ready to undertake a prescribing course]. I feel that time to embed knowledge and develop competency in practice is important and will aid breadth of knowledge - especially if more time is focused on simulated learning - students need to gain experience of real world nursing before becoming prescribing-ready, especially with an increasingly aged population with complex health issues and co-morbidities.

Survey respondent – Registered nurse in Adult Care (hospital)

There should, therefore, be a nationally agreed standard/approach to this issue. Whilst preparation for prescribing is essential, we also need to ensure that organisations have clear opportunities for staff to exercise their prescribing skills if this role is going to be taken on immediately after registration.

Q6. We are consulting on the introduction of teaching and learning of prescribing theory into pre-registration nursing degree programmes. This means that newly qualified nurses in the future will be ready to commence a V150 prescribing programme following initial registration as long as they have the necessary support in place. This is intended to support proficiency of prescribing practice across a range of settings at an earlier stage of a nurse’s career. Do you agree with this approach?

We agree with this approach in principle, but we have a number of concerns. Generally, implementation will depend on the individual practitioner and the context in which they work – V150 is not applicable to all settings.

A clear definition of the proposed “necessary support” is essential.

The consultation text states:

Demonstrate the knowledge of pharmacology, inform safe prescribing from an AGREED FORMULARY recognising...

This is a description of V150 prescribing, not a preparation thereof. We would support this if it is appropriately integrated into the programme and clearly defined as a foundation level approach with a progression to V300 later, as part of advancing practice. The products and medicines covered by V150 prescribing are often currently covered using a Patient Group Direction, but this would give a standardised approach. As the curriculum content regarding medicines management in pre-registration nurse training is now being considered, it would be timely to also consider the curricula for V150 and V300 to ensure a consistent approach and avoid repetition.

Successful implementation will also depend on assessor capacity. Currently, it is difficult to get medical supervision and support in place, and if doctors are assessors, they expect payment. Until capacity is built in the workplace for other prescribing assessors from other professional groups e.g. pharmacists, there will be reliance on this support and it is unclear how these extra costs will be funded.

Ability to prescribe should always be based on service needs assessment where the registered nurse is working – it may not be necessary.

Q7. The needs of people are changing and new models of care are emerging. Nurses in the future will demonstrate evidence of enhanced theoretical knowledge that supports earlier progression towards prescribing practice. We are proposing that registrants complete one year post-registration practice (currently three years) in order to be eligible to commence a supplementary / independent prescriber (known as V300) programme. Do you agree with this approach?

As above, we agree with this in principle, but the individual practitioner and the context in which they work will need to be considered. Not all settings require nurses to have V300.

This will depend on the competence, scope of practice and readiness of individuals to progress to advanced level practice. It is essential that a formal programme of health assessment

has been obtained (degree/masters) before commencing a V300 programme; so realistically, it would be difficult to complete the training in less than two years.

Q8. Requirement 4.6.1 states that a pharmacology exam must be passed with a minimum of 80%. Do you agree?

Yes, as this is in line with the current standard for other professions.

Q9. Requirement 4.6.2 states that the numeracy assessment needs to be passed with a score of 100%. Do you agree with the pass score being 100%?

Yes, as this is in line with the current standard for other professions.

Q10. Governance and policy decisions about safe management of medicines should be made by organisations who deliver care and services to people and patients. Do you agree?

There should be national standards to guide local policy. It is essential, however, that AEs and organisations work together more closely than is often currently the case to develop relevant policies collaboratively. It is not acceptable that due to organisational policies in some areas, students are denied access to learning opportunities that are available to students in other areas.

Q11. Evidence based practice, policies and standards of management of medicines should apply to all health care professionals rather than having separate standards (set by us) that only apply to nurses and midwives. Do you agree?

Yes, we agree. There is an increasing move towards integrated care teams and all policies and standards must reflect this move.

Q12. How often do you use the current Standards for Medicines Management?

Many of our members rely on the standards in their daily work. Similarly, the RCN has historically based much of the advice it gives to members on the standards.

Q12a. If you do use the Standards for Medicines Management standards, what do you use them for?

As a professional body they form the basis of much advice and guidance given to members. It is in fact one of the NMC documents most frequently used by the RCN.

Q12b. Are there certain aspects of our current Standards for Medicines Management that you use more than others?

We refer to the whole document depending on the nature of the enquiry.

Q13. Do you agree with our proposals to withdraw our Standards for Medicines Management?

We agree that they are out of date and should be withdrawn, but there must be new standards to replace them. We would be keen to work with the NMC, RPS and other stakeholders to develop the new standards.

Q14. If you strongly disagree or disagree with our proposals to withdraw our Standards for Medicines Management, what aspect of medicines management guidance for nurses and midwives would enhance public safety and public protection?

We believe the main risk of withdrawal is the potential for inconsistency of practise and the subsequent increased risk to patient safety. Hence we believe that a robust new Standard for Medicines Management is essential to mitigate this risk.

Q15. What do you perceive to be the risks of withdrawal of our Standards for Medicines Management?

See Q14 response.

Appendix 1: Survey results



The survey was promoted on RCN social media channels and mailed directly to a large proportion of RCN members. We had 7,380 of complete responses to this survey, the results of which are presented below. The survey was launched on Wednesday 12 July 2017 and ran for two weeks.












We asked our members whether they agreed with the RCN on statements relating to the following:

- simulation in learning
- supervision and assessment arrangements
- pre-registration prescribing
- ability to undertake assessments.

We also provided an open-ended qualitative question allowing members to comment more broadly on anything they had been asked, or on other issues relating to the NMC consultation.

Summary of results

1. Are you a member of the RCN?										
							Response Percent	Response Total		
1	Yes							96.94%	7154	
2	No							3.06%	226	
Analysis	Mean:	1.03	Std. Deviation:	0.17	Satisfaction Rate:	3.06	answered	7380		
	Variance:	0.03	Std. Error:	0.04			skipped	0		

2. What is your current role?										
							Response Percent	Response Total		
1	Nursing/midwifery student							12.32%	909	
2	Health care assistant/health care support worker							0.51%	38	
3	Assistant practitioner							0.16%	12	
4	Trainee nursing associate							0.09%	7	
5	Nurse educator in a higher education setting							2.78%	205	
6	Nurse educator in a practice setting							4.38%	323	
7	Registered nurse or midwife working in a practice setting							61.61%	4547	
8	Registered nurse or midwife working in a non-practice setting							6.50%	480	
9	Nursing researcher							0.84%	62	
10	Retired nurse or midwife							1.61%	119	
11	Other:							9.19%	678	
Analysis	Mean:	6.62	Std. Deviation:	2.51	Satisfaction Rate:	56.24	answered	7380		
	Variance:	6.32	Std. Error:	0.03			skipped	0		
Other (please specify): (678)										






3. What is your main field of practice/work?									
							Response Percent	Response Total	
1	Adult care (hospital)							42.13%	3054
2	Children and young people							8.68%	629
3	Learning disability							1.92%	139
4	Management, leadership and support services							3.28%	238
5	Mental health							9.31%	675
6	Midwifery							0.33%	24
7	Nurse education							3.23%	234
8	Primary care, community/public health services							19.34%	1402
9	Other:							11.78%	854
Analysis	Mean:	4.1	Std. Deviation:	3.25	Satisfaction Rate:	38.78	answered	7249	
	Variance:	10.58	Std. Error:	0.04			skipped	131	

4. Which country do you work/study in?									
							Response Percent	Response Total	
1	England							78.94%	5826
2	Wales							6.21%	458
3	Scotland							9.95%	734
4	Northern Ireland							3.16%	233
5	Other:							1.75%	129
Analysis	Mean:	1.43	Std. Deviation:	0.92	Satisfaction Rate:	10.64	answered	7380	
	Variance:	0.84	Std. Error:	0.01			skipped	0	

The NMC says: Simulation allows students to learn or practise skills in a safe situation that imitates reality. Currently, simulation may be used for up to 300 hours of the 2,300 hours practice learning time. The NMC is proposing that this is increased to up to 50% of the 2,300 hours. This will mean that up to half of nursing students' placement hours may be achieved through simulation based learning.

The RCN says: Increased use of simulation of up to 50%, in place of practice hours, offers an opportunity for teaching and learning new skills, but not achieving proficiency. However, for simulation to be effective, there must be clear standards and quality assurance in place.






5. How far do you agree with this draft RCN statement?

						Response Percent	Response Total	
1	Agree strongly					31.84%	2350	
2	Agree					41.36%	3052	
3	Neither agree nor disagree					8.43%	622	
4	Disagree					12.95%	956	
5	Disagree strongly					5.42%	400	
Analysis	Mean:	2.19	Std. Deviation:	1.17	Satisfaction Rate:	29.69	answered	7380
	Variance:	1.37	Std. Error:	0.01			skipped	0

The NMC says: The proposed new NMC education framework suggests that the role of mentor be split into practice supervisor and practice assessor, with a different person in each role.

The RCN says: We can see some merit in this proposal and believe that this has the potential to lead to more objective and consistent assessment decisions, providing the correct standards are in place for each role.

6. How far do you agree with this draft RCN statement?

						Response Percent	Response Total	
1	Agree strongly					21.63%	1596	
2	Agree					51.21%	3779	
3	Neither agree nor disagree					13.78%	1017	
4	Disagree					10.30%	760	
5	Disagree strongly					3.09%	228	
Analysis	Mean:	2.22	Std. Deviation:	1	Satisfaction Rate:	30.5	answered	7380
	Variance:	1	Std. Error:	0.01			skipped	0

The NMC says: The NMC is proposing that newly registered nurses should be “prescribing-ready”. This means they will have learnt the theory required for the initial prescribing qualification in their pre-registration education. Nurses could then choose to take an independent non-medical prescribing course after registration.

The RCN says: We agree there should be more theory in the pre-registration nursing programmes about pharmacology and medicines management. This will prepare students for their future role and ensure they are “prescribing-ready”.

7. How far do you agree with this draft RCN statement?

							Response Percent	Response Total
1	Agree strongly						29.34%	2165
2	Agree						38.86%	2868
3	Neither agree nor disagree						10.05%	742
4	Disagree						14.82%	1094
5	Disagree strongly						6.92%	511
Analysis	Mean:	2.31	Std. Deviation:	1.23	Satisfaction Rate:	32.78	answered	7380
	Variance:	1.51	Std. Error:	0.01			skipped	0

The NMC says: All newly registered nurses should be able to demonstrate and apply knowledge of commonly encountered mental, physical, cognitive and behavioural health conditions, to inform a full nursing assessment and the development and review of person-centred nursing care plans.

The RCN says: We believe that all newly registered nurses should be able to undertake commonly encountered mental, physical, cognitive and behavioural assessments. These skills should be applicable across all fields and included in the pre-registration programme, with a clear reference to the level of competence required.

8. How far do you agree with this draft RCN statement?

							Response Percent	Response Total
1	Agree strongly						44.70%	3299
2	Agree						47.52%	3507
3	Neither agree nor disagree						5.07%	374
4	Disagree						2.20%	162
5	Disagree strongly						0.51%	38
Analysis	Mean:	1.66	Std. Deviation:	0.72	Satisfaction Rate:	16.58	answered	7380
	Variance:	0.52	Std. Error:	0.01			skipped	0

Appendix 2

Feedback from RCN Forums on skills and knowledge for different fields		
Proposed skill	RCN Learning Disability Forum	Children and Young People's Forums
Use manual techniques and electronic devices to take and record and interpret vital signs including temperature, pulse, respiration (TPR), blood pressure (BP) and pulse oximetry	KEY skill	Yes very necessary. These need to be contextualised in relation to Paediatric Early warning scores/at all levels
Undertake venepuncture and cannulation and blood sampling, interpreting routine blood profiles and venous blood gases	Yes somewhat, perhaps less so venepuncture but interpretation and analysis important	Somewhat relevant to CYP nurses as well as interpreting routine blood profiles and venous blood gases
Set up, manage routine electrocardiogram (ECG) investigations and interpret normal and commonly encountered abnormal traces	Uncommon	3 lead YES At point of entry to the register 12 lead - post registration and depending on speciality'
Manage and monitor blood component transfusions	Less likely to see	At point of entry to the register
Manage and interpret, cardiac monitors, infusion pumps, blood glucose monitors and other monitoring devices	Important to understand and use	Yes in an incremental approach and built into models of preceptorship
Accurately measure weight and height, calculate body mass index and recognise healthy range and clinical significance of low/high readings	Very important and features as a significant issue in LD care	Yes - concerned that child development missing, child health surveillance, milestones and theories
Undertake a whole body assessment including respiratory, circulatory, musculoskeletal, cardiovascular and skin status	More emphasis on this	YES - concerned that neuro is missing, very important through the age ranges
Undertake chest auscultation and interpret findings	Yes	With post registration and depending on speciality
Collect and observe sputum, urine and stool specimens, undertaking routine analysis and interpreting findings	Yes	Yes at point of entry to the register
Measure and interpret blood glucose levels	Absolutely YES	Yes at point of entry to the register
Recognise and respond to signs of mental, emotional or physical abuse	YES critical skills to have	YES and safeguarding, SEXUAL and FGM
Undertake a full cardiovascular risk assessment	In principle YES	Have knowledge and understanding - Children tend to have more respiratory problems
Undertake and interpret neurological observations and assessments	Yes and suggest capacity , consent, best interests too	Yes at point of entry to the register
Identify signs of deterioration and sepsis	YES critical skill set	Yes at point of entry to the register
Administer basic mental health first aid	YES critical skill set	Yes at point of entry to the register - could be strengthened especially motivational interviewing
Administer basic physical first aid	CRITICAL/ ESSENTIAL for ALL registrants and HCSWs	Yes
Recognise and manage seizures, choking and anaphylaxis, providing appropriate intermediate life support	Yes critical and this is a particularly key issue for people with LD	Yes

RCN Mental Health Forum response

Standards of Proficiency of Registered Nurses

- o In general, does not reflect or place enough emphasis on fields of nursing beyond adult nursing.
- o The documents do not place enough distinctiveness or emphasis on the uniqueness of each field. We would have preferred to have seen a Core Skills Framework and a separate skills framework for the each branch. In particular we would like to see more emphasis in section 2 on promoting psychological wellbeing among other things.

3. Requirements for pre-registration nurse programmes

- o We have continued concern about the wide variation of programme experiences between AEIs and wonder what the NMC are doing to ensure that this is addressed via the new framework and standards – the document continues to give considerable autonomy to AEIs, which is important, but does not necessarily go far enough to develop more consistent academic nurse training courses.
- o Generic and field specific hours again are not clear and leave it exposed to too much variation across programmes e.g. some courses may have a lot of physical health generic components for the MH branch, but others may be more limited, effectively leading to people registering with different levels of experience and understanding about the role of the mental health nurse in supporting good physical health.
- o We believe the NMC should set standards in the following areas; criteria for literacy, numeracy and literacy, practice and theory hours ratios and the ability to decide what is required from a student at each progression point. We are concerned about the wide variation in nurse training experience and believe the NMC at this point should be setting more explicit standards to achieve a more consistent standard of nurse registrants in future years.

4. Education Framework requirements for learning and assessment

- o We strongly believe that those assessing in practice (Practice Supervisors) should be registered nurses in the field of practice they are training in. From a day-to-day practice and perspective this is critical for students to develop essential skills – the practice supervisor essentially is the key role model in a placement and pivotal to the development of knowledge and skills in practice. The idea of having practice supervision from a different registered professional completely disregards the cultural distinctiveness and differences of various professional groups.
- o We think supervisor proficiencies should be set by the NMC – locally based proficiencies will leave too much variation in standard/ quality of practice-based supervisors and other new roles.

5. Standards for Education and Training

- o The five pillars are useful, but we are not sure it goes far enough to address the wide variations in course content across AEIs. In particular, variations in curricular and content require further work in these proposals. In a similar way that through revalidation the NMC has developed core materials to remain competent in practice, there is an opportunity for the NMC to identify core materials for training (which AEIs can use as the basis of its curriculum design).

RCN CYP forums also feel the following are missing:

- communicate with children and young people in an age (or developmentally) appropriate and child-centred way
- lack of listening and talking skills
- therapeutic play
- enteral feeding
- care of central line/TPN
- management of fluid therapy
- tracheostomy care
- care of the dying child and care of the child after death
- eye and mouth care
- injection techniques (diabetic child for example)
- personal hygiene
- administration of medicines
- oxygen therapy/suctioning
- caring for the ventilated child
- aseptic technique/wound care
- stoma care
- catheterisation
- no mention of skills such as motivational interviewing or advanced communication, the lack of MH skills is very disappointing
- neurovascular assessment
- clinical holding/restraint/distraction therapy
- child development, child health surveillance, milestones and theorists
- health promotion, including emotional wellbeing such as WRAP training or equivalent
- care of child with IV fluids, syringe driver, subcutaneous infusions
- pain assessment and management using appropriate tools
- feeding: breast, oral, enteral, parenteral, IV, etc.
- elimination: normal, assisted, urostomy, stoma care
- play, development and distraction
- communication skills (play, disability, non-verbal, non-English-speaking, signing, Makaton, child-centred , presentation and representation)
- negotiation, empowerment and delegation skills to include Rights of the Child evidence base
- lobbying, advocacy, diversity skills
- medication management skills including numeracy
- assessment of hydration and dehydration and developmental assessment
- involve the child, young person and family in care delivery
- recognise and care for the dying child
- deliver basic bereavement support
- break bad news

References

1. Gordon S and Nelson S (2005) An end to angels. *American Journal of Nursing*, 105 (5) pp.62-69
2. Professional Standards Authority for Health and Social Care (2015) *Right touch regulation: revised* London: Professional Standards Authority for Health and Social Care. Available at: <http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf> (Accessed 8/9/17)
3. Chen R, Gierson L E and Norman G R (2015) Evaluating the impact of high- and low-fidelity instruction in the development of auscultation skills. *Medical Education*, Mar., 49(3), pp.276-285
4. Aqel A A and Ahmad M M (2014) High fidelity simulation effects on CPR knowledge, skills, acquisition and retention in nursing students. *Worldviews Evidence Based Nursing* Dec., 11(6), pp.394-400
5. McGarry J, Baker C, Wilson C, Felton A and Banergee A (2015) Preparation for safeguarding in UK pre-registration graduate nurse education. *Journal of Adult Protection* 17(6), pp.371-379
6. Perkins C and Kisiel M. (2013) Developing the recognition and response skills of student nurses. *British Journal of Nursing*, 22(12), pp.715-724
7. Brown R A, Crookes P A, and Iverson D (2015) An audit of skills taught in registered nursing preparation programmes in Australia *BMC Nursing* 14 pp.68
8. Zasadny M F and Bull R M. (2015) Assessing competencies in undergraduate nursing students: the Amalgamated Students in Practice Model. *Nurse Education Practice* Mar., 15(2), pp.126-133
9. Bradshaw A and Merriman C (2008) Nursing competence 10 years on: fit for practice and purpose yet? *Journal Clinical Nursing* 17(10) pp.1263-1269
10. Pijl-Sieber E, Barton S, Konkin J, Awosoga O, and Caine V (2014) Competence and competency-based nursing education: finding our way through the issues. *Nurse Education Today*. 34(5) pp.676-678.
11. Zasadny M F and Bull R M. (2015) Assessing competencies in undergraduate nursing students: the Amalgamated Students in Practice Model. *Nurse Education Practice* Mar., 15(2), pp.126-133
12. Forneris S G, Neal D O, Tiffany J, Kuehn M B, Meyer H M, Blazovich L M, Holland A E, and Smerillo M (2015) Enhancing clinical reasoning through simulation debriefing: a multisite study *Nursing Education Perspectives* 36(5) pp.304-310
13. Kantar L d (2014) Assessment and instruction to promote higher order thinking in nursing students. *Nurse Education Today* 34(5) pp.789-794
14. Samawi Z, Miller T and Haras M S. (2014) Using high fidelity simulation and concept mapping to cultivate self-confidence in nursing students. *Nursing Education Perspectives* 35(6) pp.408-409
15. Heidari M, Shahbazi, S (2014) The effect of Problem Solving Training on Decision Making Skill in Nursing Students *International Journal of Nursing Education*
16. Brudvig T J, Dirkes A, Dutta P A and Rand K (2014) Critical thinking skills in health care professional students: a systematic review. *Journal of Physical Therapy Education* Fall, 27(3)
17. Pijl-Sieber E, Barton S, Konkin J, Awosoga O, and Caine V (2014) Competence and competency-based nursing education: finding our way through the issues. *Nurse Education Today*. 34(5) pp.676-678.
18. Clark M, Raffray M, Hendricks K and Gagnon A J. (2016) Global and health competencies for nursing education: a systematic review of essential competencies. *Nurse Education Today* May, 40, pp.173-180
19. Bradshaw A and Merriman C (2008) Nursing competence 10 years on: fit for practice and purpose yet? *Journal Clinical Nursing* 17(10) pp.1263-1269
20. Zasadny M F and Bull R M. (2015) Assessing competencies in undergraduate nursing students: the Amalgamated Students in Practice Model. *Nurse Education Practice* Mar., 15(2), pp.126-133
21. Morrell N and Ridgeway V (2014) Are we preparing nursing students for final practice placement? *British Journal Nursing*. 3(10) pp.518-523
22. Brown R A, Crookes P A, and Iverson D (2015) An audit of skills taught in registered nursing preparation programmes in Australia *BMC Nursing* 14 pp.68
23. Collins D., Burke, V, Martindale A., and Cruickshank A. (2015) The illusion of competency versus the desirability of expertise: Seeking a common standard for support professions in sport. *Sports Medicine*, 45 (1). pp. 17.
24. Pijl-Sieber E, Barton S, Konkin J, Awosoga O, and Caine V (2014) Competence and competency-based nursing education: finding our way through the issues. *Nurse Education Today*. 34(5) pp.676-678.
25. Chen R, Gierson L E and Norman G R (2015) Evaluating the impact of high- and low-fidelity instruction in

- the development of auscultation skills. *Medical Education*, Mar., 49(3), pp.276-285
26. Forneris S G, Neal D O, Tiffany J, Kuehn M B, Meyer H M, Blazovich L M, Holland A E, and Smerillo M (2015) Enhancing clinical reasoning through simulation debriefing: a multisite *study Nursing Education Perspectives* 36(5) pp.304-310
 27. Fourouzi A M, Heidarzadeh A, Kazemi M, Jahani Y and Afeshari M. (2015) Comparison of the combined based with the mannequin-based simulation models in self-efficacy, performance and satisfaction of nursing students' on cardiopulmonary resuscitation. *Asian Journal of Nursing Education and Research* 6(1) pp.69-73
 28. Lee J, and Oh P J. (2015) Effects of the use of high fidelity human simulation in nursing education: A meta-analysis. *Journal of Nurse Education* 54(9) pp.501-507
 29. Stayt L C, Merriman C, Ricketts B, Morton S and Simpson T. (2015) Recognising and managing a deteriorating patient: a randomised controlled trial investigating the effectiveness of clinical simulation in improving clinical performance in undergraduate nursing students. *Journal of Advanced Nursing*, Nov. 71(11), pp.2563-74
 30. Aqel A A and Ahmad M M (2014) High fidelity simulation effects on CPR knowledge, skills, acquisition and retention in nursing students. *Worldviews Evidence Based Nursing Dec.*, 11(6), pp.394-400
 31. Samawi Z, Miller T and Haras M S. (2014) Using high fidelity simulation and concept mapping to cultivate self-confidence in nursing students. *Nursing Education Perspectives* 35(6) pp.408-409
 32. Gantt L T, and Webb-Corbett R. (2010) Using simulation to teach patient safety behaviours in undergraduate nursing education. *Journal of Nurse Education*, Jan. 49(1), pp.48-51
 33. Valler-Jones (2014) The impact of peer-led simulations on nurse students *British Journal of Nursing* 23(6), pp.321-326
 34. Chen R, Gierson L E and Norman G R (2015) Evaluating the impact of high- and low-fidelity instruction in the development of auscultation skills. *Medical Education*, Mar., 49(3), pp.276-285
 35. Chen R, Gierson L E and Norman G R (2015) Evaluating the impact of high- and low-fidelity instruction in the development of auscultation skills. *Medical Education*, Mar., 49(3), pp.276-285
 36. Lee J, and Oh P J. (2015) Effects of the use of high fidelity human simulation in nursing education: A meta-analysis. *Journal of Nurse Education* 54(9) pp.501-507
 37. Lee J, and Oh P J. (2015) Effects of the use of high fidelity human simulation in nursing education: A meta-analysis. *Journal of Nurse Education* 54(9) p.276
 38. Stayt L C, Merriman C, Ricketts B, Morton S and Simpson T. (2015) Recognising and managing a deteriorating patient: a randomised controlled trial investigating the effectiveness of clinical simulation in improving clinical performance in undergraduate nursing students. *Journal of Advanced Nursing*, Nov. 71(11), pp.2563-74
 39. Aqel A A and Ahmad M M (2014) High fidelity simulation effects on CPR knowledge, skills, acquisition and retention in nursing students. *Worldviews Evidence Based Nursing Dec.*, 11(6), pp.394-400
 40. Traynor M and Galanouli D (2015) Have OSCEs come of age in nursing education? *British Journal of Nursing* 24(7), pp.388-391
 41. Meechan R, Jones H and Valler-Jones T. (2011) Do medicines OSCEs improve drugs administration ability? *British Journal of Nursing* 20(13), pp.817-822
 42. McWilliams P and Botwinski C (2009) Developing a successful nursing Objective Structured Clinical Examination *Journal of Nursing Education* 49(1) pp.36-41
 43. McWilliam P and Botwinski C (2012) Identifying strengths and weaknesses in the utilization of Objective Structured Clinical Examination (OSCE) in a nursing program *Nursing Education Perspectives* 33(1) pp.35-39
 44. East L, Peters K, Halcomb E, Raymond D and Salamonson Y. (2014) Evaluating objective structured clinical assessment (OSCA) in undergraduate nursing. *Nurse Education in Practice* 14(5) pp.461-467
 45. Rush S, Ooms A, Marks-Maran D and Firth T.(2014) Students perceptions of practice assessment in the skills laboratory: An evaluation of study of OSCAs and immediate feedback *Nurse Education in Practice* 14(6), pp627-634
 46. Traynor M, Galanouli D, Rice B, and Lynn F (2016) Evaluating the objective structured long examination record for nurse education *British Journal of Nursing* 25(12), pp.681-687
 47. Zasadny M F and Bull R M. (2015) Assessing competencies in undergraduate nursing students: the Amalgamated Students in Practice Model. *Nurse Education Practice* Mar., 15(2), pp.126-133
 48. Traynor M, Galanouli D, Rice B, and Lynn F (2016) Evaluating the objective structured long examination record for nurse education *British Journal of Nursing* 25(12), pp.681-687
 49. Traynor M and Galanouli D (2015) Have OSCEs come of age in nursing education? *British Journal of*

- Nursing* 24(7) pp.388-391
50. Traynor M and Galanouli D (2015) Have OSCEs come of age in nursing education? *British Journal of Nursing* 24(7) pp.388-391
 51. Meechan R, Jones H and Valler-Jones T (2011) Do medicines OSCEs improve drugs administration ability? *British Journal of Nursing* 20(13) pp.817-822
 52. Bradshaw A and Merriman C (2008) Nursing competence 10 years on: fit for practice and purpose yet? *Journal Clinical Nursing* 17(10) pp.1263-1269
 53. Griffiths P, Ball J, Murrells T, Jones S and Rafferty A M (2015) Registered nurse, healthcare support worker, medical staffing levels and mortality in English hospital trusts: a cross-sectional study *BMJ Open* 6(2)
 54. Ruddy, J E (1998) The nature of philosophy of science, theory and knowledge relating to nursing and professionalisation. *Journal of Advanced Nursing*, 28 (2) pp 243-250
 55. Rafferty A. (1998) Pride and prejudice. *Nursing Standard* 12(39) pp.16
 56. Department of Health (2010) Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals London: DoH
 57. NHS Education for Scotland (2017) *Flying start NHS Edinburgh: NHS Education for Scotland* Edinburgh: NHS Education for Scotland Available at: <http://www.flyingstart.scot.nhs.uk/> (Accessed 8/9/17)
 58. Nursing and Midwifery Board for Ireland (2017) *Nurse and midwife programme content and placements* Dublin: NMBI Available at: <https://www.nmbi.ie/Careers-in-Nursing-Midwifery/Becoming-a-Nurse-Midwife/Course-content-and-placements> (Accessed 8/9/17)
 59. Department for Education (2016), *Induction for Newly Qualified Teachers (NQTs)* Available at: <https://www.gov.uk/government/publications/induction-for-newly-qualified-teachers-nqts> (Accessed 8/9/17)
 60. Lord Willis (2015) *Raising the bar: Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants* Leicester: Health Education England
 61. Royal College of Nursing (2017) *RCN Guidance for Mentors of Nursing and Midwifery Students*. London: RCN Available at: www.rcn.org.uk/publications (Accessed 8/9/17)
 62. Royal College of Nursing (2017) *Helping students get the best from their practice placements*. London: RCN Available at: www.rcn.org.uk/publications (Accessed 8/9/17)
 63. Royal College of Nursing (2016) *The transformation of adult mental health care in Scotland: Learning from the past to support integration reform* London: RCN Available at: <https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-mental-health-care-transformation> (Accessed 8/9/17)
 64. Royal College of Nursing (2017) *Every nurse an eNurse: digital capabilities for 21st century nursing* London: RCN Available at: <https://www.rcn.org.uk/clinical-topics/ehealth/current-work> (Accessed 8/9/17)
 65. Royal College of Nursing and Health Education England (2017) *Improving digital literacy* London: RCN/HEE Available at: <https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/clinical-topics/improving-digital-literacy.pdf?la=en&hash=7C7B84357CCC3F1EAA3297442C6103A5519CCA3F> (Accessed 8/9/17)
 66. NHS Health Education England (2017) *Person-centred care* Available at: <https://www.hee.nhs.uk/our-work/person-centred-care> (Accessed 8/9/17)
 67. NHS Health Education England (2017) *Person-centred care* Available at: <https://www.hee.nhs.uk/our-work/person-centred-care> (Accessed 8/9/17)
 68. NHS Scotland (2017) *Chief Medical Officer for Scotland Annual Report 2015/16: Realising Realistic Medicine* Edinburgh: Scottish Government Available at: <http://www.gov.scot/Publications/2017/02/3336/downloads> (Accessed 8/9/17)
 69. Choosing Wisely UK (2017) *Choosing Wisely UK* London: Choosing Wisely UK Available at: <http://www.choosingwisely.co.uk/about-choosing-wisely-uk/> (Accessed 8/9/17)
 70. Faculty of Medical Leadership and Management, Centre for Creative Leadership and the Kings Fund (2015) *Leadership and leadership development in health care: the evidence base* London: FMLM Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf (Accessed 8/9/17)
 71. Royal College of Nursing (2017) *Integrating health and social care across the UK: toolkit for nursing leaders* London: RCN Available at: <https://www.rcn.org.uk/professional-development/publications/pub-005910> (Accessed 8/9/17)
 72. Our survey respondents overwhelmingly agreed with this position, with 92% either agreeing or strongly agreeing with the position. (See Appendix 1)
 73. A position supported by the majority of our July 2017 survey respondents (see Appendix 1)
 74. Lee J, and Oh P J. (2015) Effects of the use of high fidelity human simulation in nursing education: A meta-analysis. *Journal of Nurse Education* 54(9) pp.501-507

75. Pauly-O'Neill S and Prion S (2013) Using integrated simulation in a nursing program to improve medication administration skills in the pediatric population *Nursing Education Perspectives* 34(3) pp.148-53
76. Breymer T L, Rutherford-Hemming T, Horsley T L, Atz T, Smith L G , Badowski D and Connor K (2015) Substitution of clinical experience With simulation in prelicensure nursing programs: a national survey in the United States *Clinical simulation in Nursing* 11 (11) pp.472-478
77. Larue C, Pepin J and Allard E (2015) Simulation in preparation or substitution for clinical placement: a systematic review of the literature *Journal of Nursing Education and Practice* 5(9)
78. Royal College of Nursing (2017) *The needs of people with learning disabilities: what pre-registration students should know* London: RCN Available at: <https://www.rcn.org.uk/professional-development/publications/pub-005769> (Accessed 8/9/17)
79. Royal College of Nursing (2016) *Connect for change: an update on learning disability services in England* London: RCN Available at: <https://www.rcn.org.uk/professional-development/publications/pub-005525> (Accessed 8/9/17)
80. Royal College of Nursing (2017) *The needs of people with learning disabilities: what pre-registration students should know* London: RCN Available at: <https://www.rcn.org.uk/professional-development/publications/pub-005769> (Accessed 8/9/17)
81. Public Health England (2016) *Public Health Skills and Knowledge Framework (PHSKF)* London: PHE Available at: <https://www.gov.uk/government/publications/public-health-skills-and-knowledge-framework-phskf> (Accessed 8/9/17)
- 82a. Academy of Medical Royal Colleges (2016) *Global health capabilities for UK health professionals* London: AOMRC Available at: [Global Health Capabilities for UK Health Professionals](#) (Accessed 8/9/17)
- 82b. All-Party Parliamentary Group on Global Health (2016) *Triple impact: how developing nursing will improve health, promote gender equality and support economic growth* London: APPG Available at: [Triple Impact. How developing nursing will improve health, promote gender equality and support economic growth.](#) (Accessed 8/9/17)
- 82c. World Health Organization Regional Office for Europe (2015) *European strategic directions for strengthening nursing and midwifery towards Health 2020 goals* Copenhagen: WHO
83. International Council of Nurses (2017) Position statements Geneva: ICN Available at: <http://www.icn.ch/publications/position-statements/> (Accessed 8/9/17)
84. Sustainable Development Unit (2016) *Carbon footprint update for NHS in England 2015* Cambridge: SDU
85. Richardson J, Grose J., Bradbury M and Kelsey J. (2017) Developing awareness of sustainability in nursing and midwifery using a scenario-based approach: evidence from a pre and post educational intervention study *Nurse Education Today* 54 pp.51-55
86. NurSus (2017) *NurSus* Plymouth: NurSus Available at: <http://nursus.eu/> (Accessed 8/9/17)
87. National Quality Board (2013) *Human factors in healthcare: a concordat from the National Quality Board.* London: National Quality Board Available at: <https://tinyurl.com/o45ameq> (Accessed 8/9/17)
88. Agency for Healthcare Research and Quality (2017) *TeamSTEPPS* Rockville, Washington: AHRQ Available at: <https://tinyurl.com/yaofd8bu> (Accessed 8/9/17)
89. Chartered Institute of Ergonomics and Human Factors (2016). *Human factors in barrier management* Loughborough: Chartered institute of Ergonomics and Human Factors
90. Association for Simulated Practice in Healthcare (2017) *Standards for simulation based education in healthcare* Lichfield: Association for Simulation Practice in Healthcare Available at: <https://tinyurl.com/yldj2qs> (Accessed 8/9/17)
91. Hollnagel E (2016). *Resilience engineering* Available at: <https://tinyurl.com/ydgjydu> (Accessed 8/9/17)
92. Chartered Institute of Ergonomics and Human Factors (2017). *Human Factors (Ergonomics) in Health and Social Care. CIEHF vision for HFE integration in health and social care.* Loughborough: Chartered Institute of Ergonomics and Human Factors Available at: <https://tinyurl.com/ycbdsqmv> (Accessed 8/9/17)
93. Nursing and Midwifery Council (2008) *NMC Standards to support learning and assessment in practice* London: NMC
94. Royal College of Nursing (2015) *Mentorship Project Report From today's support in practice to tomorrow's vision for excellence* London: RCN Available at: <https://www.rcn.org.uk/professional-development/publications/pub-005454> (Accessed 8/9/17)
95. Lord Willis (2015) *Raising the bar: Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants* Leicester: Health Education England
96. Gidman J, McIntosh A, Melling K and Smith D (2011) Student perceptions of support in practice *Nurse Education in Practice* 11(6) pp.351-355
97. Andrews M and Wallis M (1999) Mentorship in nursing: a literature review *Journal of Advanced Nursing* 29

- (1) pp.201-207
98. Grealish L and Ranse K (2009) An exploratory study of first year nursing student's' learning in the clinical workplace *Contemporary Nurse* 33(1) pp.80-92
 99. Killam L and Heerschap C (2012) Challenges to student learning in the clinical setting: A qualitative descriptive study *Nurse Education Today* 33(6) pp.684-691
 100. Neary M (2000) Supporting students' learning and professional development through the process of continuous assessment and mentorship *Nurse Education Today* 20(6) pp.463-474
 101. Duffy K (2003) *Failing students: a qualitative study of factors that influence the decisions regarding assessment of students' competence in practice* London: NMC Available at www.nmc.org.uk (Accessed 8/9/17)
 102. Jokelainen M, Jamookeeah D and Turunen H. (2011) Building organizational capacity for effective mentorship of pre-registration nursing students during placement learning: Finnish and British mentors' conceptions *International Journal of Nursing Practice* 1(5) pp.509-517
 103. O'Mara L, McDonald J, Gillespie M, Brown H and Miles L. (2014) Challenging clinical environments: Experiences of undergraduate nursing students *Nurse Education in Practice* 14(2) pp.208-213
 104. Grealish I and Ranse K (2009) An exploratory study of first year nursing student's' learning in the clinical workplace *Contemporary Nurse* 33(1) pp.80-92
 105. Freshwater D (2000) *Transformatory learning in nurse education A reflexive action study* Hampshire: Nursing Praxis
 106. Roberts C and Kumar K (2015) Student learning in interprofessional practical-based environments: what does the theory say? *BMC Medical Education* 15(1) pp.211
 107. Congdon G, Baker T and Cheeseman A (2013) Enhancing the strategic management of practice learning through the introduction of the role of learning Environment Manager *Nurse Education in Practice* 13(2) pp.137-141
 108. O'Driscoll M F, Allan H T and Smith P A (2010) Still looking for leadership - who is responsible for student nurses' learning in practice? *Nurse Education Today* 3 (2) pp.212-217
 109. Royal College of Nursing (2015) *Mentorship Project Report From today's support in practice to tomorrow's vision for excellence* London: RCN Available at: <https://www.rcn.org.uk/professional-development/publications/pub-005454> (Accessed 8/9/17)
 110. My HealthLondon (2017) *My HealthLondon* Available at: www.myhealth.london.nhs.uk (Accessed 8/9/17)
 111. Health Education England (2014) *Practice Assessment Document (PLPAD) for London launched* London: HEE Available at: <https://hee.nhs.uk/hee-your-area/north-west-london/news-events/north-west-london-news/practice-assessment-document-plpad-london-launched> (Accessed 8/9/17)
 112. Workforce, Education and Development Services (2017) *Workforce, Education and Development Services* Available at: <http://www.weds.wales.nhs.uk/home> (Accessed 8/9/17)
 113. Health Education England (2017) *Nursing associate: a new support role for nursing* London: HEE Available at: <https://hee.nhs.uk/our-work/developing-our-workforce/nursing/nursing-associate-new-support-role-nursing> (Accessed 8/9/17)
 114. McNair R (2005) The case for educating health care students in professionalism as the core content of interprofessional education *Medical Education* 39(5) pp.456-464
 115. Royal College of Nursing (2017) *RCN Guidance for Mentors of Nursing and Midwifery Students* London: RCN Available at: www.rcn.org.uk/publications (Accessed 8/9/17)
 116. Royal College of Nursing (2017) *Helping students get the best from their practice placements*. London: RCN Available at: www.rcn.org.uk/publications (Accessed 8/9/17)
 117. Department of Health (2010) *Preceptorship framework for newly registered nurses, midwives and allied health professionals* London: DoH
 118. 73% of members who responded to our July 2017 survey either agreed or strongly agreed with the statement. (See Appendix 1)
 119. Nursing and Midwifery Council (2008) *Standards to support learning and assessment in practice NMC standards for mentors, practice teachers and teachers* London: NMC
 120. Royal College of Nursing (2016) *RCN response to the Department of Health Consultation on Changing How Healthcare Education is Funded* London: RCN Available at: <https://www.rcn.org.uk/professional-development/publications/pub-005689> (Accessed 8/9/17)
 121. European Parliament (2013) *Recognition of professional qualifications* Strasbourg: European Parliament Available at: <http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32013L0055> (Accessed 8/9/17)

122. <http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/internationalrecruitment/mobility-of-health-professionals-across-europe>
123. Royal College of Nursing (2016) Nursing priorities for the United Kingdom's withdrawal from the European Union London: RCN Available at: <https://www.rcn.org.uk/about-us/policy-briefings/br-1116> (Accessed 8/9/17)
124. Warne T, Johansson U B, Papastavrou E, Tichelaar E, Tomietto M, Van den Bossche K, Moreno M F and Saarikoski M (2010) An exploration of the clinical learning experience of nursing students in nine European countries. *Nurse Education Today* 30(8) pp.809-815
125. Levett-Jones T, Lathlean J, McMillan M and Higgins I (2008) The duration of clinical placements: a key influence on nursing students' experience of belongingness *Australian Journal of Advanced Nursing* 26(2) pp.8-16
126. Nursing Council of New Zealand (2015) *Education programme standards for the registered nurse: scope of practice* Wellington: Nursing Council of New Zealand Available at: www.nursingcouncil.org.nz (Accessed 8/9/17)
127. Breymer T L, Rutherford-Hemming T, Horsley T L, Atz T, Smith L G , Badowski D and Connor K (2015) Substitution of clinical experience With simulation in prelicensure nursing programs: a national survey in the United States *Clinical simulation in Nursing* 11 (11) pp.472-478
128. Warne T, Johansson U B, Papastavrou E, Tichelaar E, Tomietto M, Van den Bossche K, Moreno M F and Saarikoski M (2010) An exploration of the clinical learning experience of nursing students in nine European countries. *Nurse Education Today* 30(8) pp.809-815
129. Barry (2009) A critical analysis of theatre as a learning environment in relation to placement duration *Journal of Perioperative Practice* 19(12) pp.433-435
130. Warne T, Johansson U B, Papastavrou E, Tichelaar E, Tomietto M, Van den Bossche K, Moreno M F and Saarikoski M (2010) An exploration of the clinical learning experience of nursing students in nine European countries. *Nurse Education Today* 30(8) pp.809-815
131. Warne T, Johansson U B, Papastavrou E, Tichelaar E, Tomietto M, Van den Bossche K, Moreno M F and Saarikoski M (2010) An exploration of the clinical learning experience of nursing students in nine European countries. *Nurse Education Today* 30(8) pp.809-815
132. Pauly-O'Neill S and Prion S (2013) Using integrated simulation in a nursing program to improve medication administration skills in the pediatric population *Nursing Education Perspectives* 34(3) pp.148-53
133. Breymer T L, Rutherford-Hemming T, Horsley T L, Atz T, Smith L G , Badowski D and Connor K (2015) Substitution of clinical experience With simulation in prelicensure nursing programs: a national survey in the United States *Clinical simulation in Nursing* 11 (11) pp.472-478
134. Larue C, Pepin J and Allard E (2015) Simulation in preparation or substitution for clinical placemen: a systematic review of the literature *Journal of Nursing Education and Practice* 5(9)
135. Bradley E and Nolan P (2007) Impact of nurse prescribing: a qualitative study *Journal of Advanced Nursing* 59(2) pp.120-128.
136. Carey N, Stenner K and Courtenay M (2009) Stakeholder views on the impact of nurse prescribing on dermatology patients *Journal of Clinical Nursing* 19(3-4) pp.498-506.
137. Courtney M and Carey N (2007) Nurse independent prescribing and nurse supplementary prescribing practice: national survey *Journal of Advanced Nursing* 61(3) pp.291-299.
138. Courtenay M, Carey N, Gage H, Stenner K, and Williams P (2015) A comparison of prescribing and non-prescribing nurses in the management of people with diabetes *Journal of Advanced Nursing* 71(12) pp.2950-2964.
139. Creedon R, O'Connell E, McCarthy G, Lehane B (2009) An evaluation of nurse prescribing Part 1: A literature review. *British Journal Nursing* 18(21) pp.1322-1327
140. Creedon R, O'Connell E, McCarthy G, Lehane B (2009) An evaluation of nurse prescribing Part 2: A literature review. *British Journal Nursing* 18(22) pp.1398-1402.
141. Dhalivaal J (2011) Patients' perspectives on prescribing by nurses in general practice. *Practice Nursing* 22(1): pp.41-45.
142. Kroezen M, de Veet A, Francke A and Groenewegen P, van Dijk L (2014) Changes in nurses' views and practices concerning nurse prescribing between 2006 and 2012: results from two national surveys. *Journal of Advanced nursing* 71(11) pp.2550-2561
143. Ross J D (2015) Mental health nurse prescribing: the emerging impact. *Journal of Psychiatrist Mental Health Nursing* 22(7) pp.529-542.
144. Wikinson J, Carryer J and Adams J (2013) Evaluation of a diabetes nurse specialist prescribing project *Journal of Clinical Nursing* 23(15-16) pp.2355-2366

145. Coull A, Murray I, Turner-Halliday F and Watterson A (2010) The expansion of nurse prescribing in Scotland: an evaluation. *British Journal Community Nursing* 18(5) pp.234-242.
146. Courtenay M and Carey N (2009) Nursing prescribing by children's nurses: views of doctors and clinical leads in one specialist children's hospital. *Journal of Clinical Nursing* 18: pp.2668-2675.
147. Dawson S (2013) Evaluation of nurse prescribing in a community palliative care team. *Nurse Prescribing* 11(5): pp/246-249.
148. Earle E A, Taylor J, Peet M and Grant G (2011) Nurse prescribing in mental health (Part 2): the views and experiences of psychiatrists and health professionals. *Journal of Psychiatric Mental Health Nursing* 18: pp.281-287.
149. Ross J D (2015) Mental health nurse prescribing: the emerging impact. *Journal of Psychiatrist Mental Health Nursing* 22: pp.529-542
150. Webb W A and Gibson V (2011) Evaluating the impact of nurse independent prescribing in a weekend clinical nurse specialist service. *International Journal of Palliative Nursing* 17(11) pp.537-543
151. Wikinson J, Carryer J and Adams J (2013) Evaluation of a diabetes nurse specialist prescribing project *Journal of Clinical Nursing* 23(15-16) pp.2355-2366
152. Courtney M and Carey N (2007) Nurse independent prescribing and nurse supplementary prescribing practice: national survey. *Journal of Advanced Nursing* 61(3) pp.291-299.
153. Earle E A, Taylor J, Peet M and Grant G (2011) Nurse prescribing in mental health (Part 2): the views and experiences of psychiatrists and health professionals. *Journal of Psychiatric Mental Health Nursing* 18: pp.281-287.
154. Kroezen M, de Veet A, Francke A, Groenewegen P and van Dijk L (2014) Changes in nurses' views and practices concerning nurse prescribing between 2006 and 2012: results from two national surveys. *Journal of Advanced nursing* 71(11) pp.2550-2561.
155. Webb W A and Gibson V (2011) Evaluating the impact of nurse independent prescribing in a weekend clinical nurse specialist service. *International Journal of Palliative Nursing* 17(11) pp.537-543
156. Carey N, Stenner K and Courtenay M (2009) Stakeholder views on the impact of nurse prescribing on dermatology patients *Journal of Clinical Nursing* 19(3-4) pp.498-506.
157. Courtenay M and Carey N (2009) Nursing prescribing by children's nurses: views of doctors and clinical leads in one specialist children's hospital. *Journal of Clinical Nursing* 18: pp.2668-2675.
158. Hall J (2010) Assessing the quality of nurse prescribing. *Nurse Prescriber* 8(11) pp.547-550.
159. Creedon R, O'Connell E, McCarthy G, Lehane B (2009) An evaluation of nurse prescribing Part 2: A literature review. *British Journal Nursing* 18(22) pp.1398-1402.
160. Bradly E and Nolan P (2007) Impact of nurse prescribing: a qualitative study *Journal of Advanced Nursing* 59(2) pp.120-128.
161. Carey N, Stenner K and Courtenay M (2009) Stakeholder views on the impact of nurse prescribing on dermatology patients *Journal of Clinical Nursing* 19(3-4) pp.498-506.
162. Courtney M and Carey N (2007) Nurse independent prescribing and nurse supplementary prescribing practice: national survey. *Journal of Advanced Nursing* 61(3) pp.291-299.
163. Courtenay M and Carey N (2009) Nursing prescribing by children's nurses: views of doctors and clinical leads in one specialist children's hospital. *Journal of Clinical Nursing* 18: pp.2668-2675.
164. Creedon R, O'Connell E, McCarthy G, Lehane B (2009) An evaluation of nurse prescribing Part 1: A literature review. *British Journal Nursing* 18(21) pp.1322-1327
165. Creedon R, O'Connell E, McCarthy G, Lehane B (2009) An evaluation of nurse prescribing Part 2: A literature review. *British Journal Nursing* 18(22) pp.1398-1402.
166. Ryan-Wooley B, McHugh G and Luker K (2007) Exploring the views of nurse prescribing among Macmillan nurses. *British Journal Community Nursing* 13(4) pp.171-177.
167. Bradly E and Nolan P (2007) Impact of nurse prescribing: a qualitative study *Journal of Advanced Nursing* 59(2) pp.120-128.
168. Courtney M and Carey N (2007) Nurse independent prescribing and nurse supplementary prescribing practice: national survey. *Journal of Advanced Nursing* 61(3) pp.291-299.
169. Creedon R, O'Connell E, McCarthy G, Lehane B (2009) An evaluation of nurse prescribing Part 2: A literature review. *British Journal Nursing* 18(22) pp.1398-1402.
170. Kroezen M, de Veet A, Francke A, Groenewegen P and van Dijk L (2014) Changes in nurses' views and practices concerning nurse prescribing between 2006 and 2012: results from two national surveys. *Journal of Advanced nursing* 71(11) pp.2550-2561.
171. Hall J (2010) Assessing the quality of nurse prescribing *Nurse Prescriber* 8(11) pp.547-550.

172. Kroezen M, de Veet A, Francke A, Groenewegen P and van Dijk L (2014) Changes in nurses' views and practices concerning nurse prescribing between 2006 and 2012: results from two national surveys. *Journal of Advanced Nursing* 71(11) pp.2550-2561.
173. Bradly E and Nolan P (2007) Impact of nurse prescribing: a qualitative study *Journal of Advanced Nursing* 59(2) pp.120-128.
174. Carey N, Stenner K and Courtenay M (2009) Stakeholder views on the impact of nurse prescribing on dermatology patients *Journal of Clinical Nursing* 19(3-4) pp.498-506.
175. Ross J (2009) Researching the barriers to mental health nurse prescribing, *Nurse Prescribing* 7(6) pp.249-253
176. Creedon R, Byre S, Kennedy J and McCarthy S (2015) The impact of nurse prescribing on the clinical setting. *British Journal Nursing* 24(17) pp.878-885.
177. Ross J D and Kettles A M (2012) Mental health nurse independent prescribing: what are nurse prescribers' views of the barriers to implementation? *Journal Psychiatric Mental Health Nursing* 19(10) pp.916-932.
178. Kroezen M, de Veet A, Francke A, Groenewegen P, van Dijk L (2014) Changes in nurses' views and practices concerning nurse prescribing between 2006 and 2012: results from two national surveys. *Journal Advanced Nursing* 71(11) pp. 2550-2561.
179. Naughton C, Drennan J, Hyde A, Allen D, O'Boyle K, Felle B, Butler M (2013) An evaluation of the appropriateness and safety of nurse and midwife prescribing in Ireland. *Journal of Advanced Nursing* 69(7) pp. 1478-1488.
180. Ross J D, Kettles A M (2012) Mental health nurse independent prescribing: what are nurse prescribers' views of the barriers to implementation? *Journal of Psychiatric and Mental Health Nursing* 19(10) pp. 916-932.
181. Naughton C, Drennan J, Hyde A, Allen D, O'Boyle K, Felle B, Butler M (2013) An evaluation of the appropriateness and safety of nurse and midwife prescribing in Ireland. *Journal of Advanced Nursing* 69(7) pp. 1478-1488.
182. Ross J D, Kettles A M (2012) Mental health nurse independent prescribing: what are nurse prescribers' views of the barriers to implementation? *Journal of Psychiatric and Mental Health Nursing* 19(10) pp. 916-932.
183. Smith A, Latter S, Blenkinsopp A (2014) Safety and quality of nurse independent prescribing: a national study of experiences of education, continuing professional development clinical governance. *Journal of Advanced Nursing* 70(11) pp. 2506-2517.
184. Creedon R, O'Connell E, McCarthy G, Lehane B (2009) An evaluation of nurse prescribing Part 2: A literature review. *British Journal Nursing* 18(22) pp.1398-1402. Creedon R, Byre S, Kennedy J, McCarthy S (2015) The impact of nurse prescribing on the clinical setting. *British Journal Nursing* 24(17) pp. 878-885.
185. Wikinson J, Carryer J, Adams J (2013) Evaluation of a diabetes nurse specialist prescribing project. *Journal of Clinical Nursing* 23(15-16) pp. 2355-2366.
186. Carey N, Stenner K, Courtenay M (2009) Stakeholder views on the impact of nurse prescribing on dermatology services. *Journal Clinical Nursing* 19(3-4) pp. 498-506.
187. Ormiston K (2012) HIV nurse prescribing: a review *HIV Nursing* Autumn 4: pp.4-10
- 188a. Banicek K (2012) Attitudes of postoperative patients towards hospital nurse prescribing. *Nurse Prescribing* 10(12) pp.612-618.
- 188b. Blanchflower J, Green L, Thorp C (2013) Breaking down the barriers to nurse prescribing. *Nurse Prescribing* 11(1) pp. 44-47
189. Ross J D (2015) Mental health nurse prescribing: the emerging impact. *Journal of Psychiatric and Mental Health Nursing* 22(7) pp. 529-542.
190. Banicek K (2012) Attitudes of postoperative patients towards hospital nurse prescribing. *Nurse Prescribing* 10(12) pp.612-618.
- 191a. Creedon R, O'Connell E, McCarthy G, Lehane B (2009) An evaluation of nurse prescribing Part 1: A literature review. *British of Journal Nursing* 18(21) pp. 1322-1327.
- 191b. Creedon R, O'Connell E, McCarthy G, Lehane B (2009) An evaluation of nurse prescribing Part 2: A literature review. *British Journal of Nursing* 18(22) pp.1398-1402.
192. Dawson S (2013) Evaluation of nurse prescribing in a community palliative care team. *Nurse Prescribing* 11(5) pp. 246-249.
193. Earle E A, Taylor J, Peet M, Grant G (2011) Nurse prescribing in specialist mental health (Part 1): the views and experiences of practising and non-practising nurse prescribers and service users. *Journal Psychiatric and Mental Health Nursing* 18(3) pp. 189-197.

194. Lim A G, North N, Shaw J (2014) Nurse prescribing: The New Zealand context. *Nursing Praxis in New Zealand* 30(2): pp. 18-27.
195. Ormiston K (2012) HIV nurse prescribing: a review *HIV Nursing* Autumn 4: pp.4-10
196. Ryan-Wooley B, McHugh G, Luker K (2007) Exploring the views of nurse prescribing among Macmillan nurses. *British Journal Community Nursing* 13(4) pp.171-177.
197. Smith A, Latter S, Blenkinsopp A (2014) Safety and quality of nurse independent prescribing: a national study of experiences of education, continuing professional development clinical governance. *Journal of Advanced Nursing* 70(11) pp. 2506-2517.
198. Ross J D (2015) Mental health nurse prescribing: the emerging impact. *Journal of Psychiatric and Mental Health Nursing* 22(7) pp. 529-542.
199. Carey N, Stenner K, Courtenay M (2009) Stakeholder views on the impact of nurse prescribing on dermatology services. *Journal Clinical Nursing* 19(3-4) pp. 498-506.
200. Kelly A, Neale J, Rollings R (2010) Barriers to extended nurse prescribing among practice nurses. *Community Practitioner* 83(1) pp. 21-24.
201. Ryan-Wooley B, McHugh G, Luker K (2007) Exploring the views of nurse prescribing among Macmillan nurses. *British Journal Community Nursing* 13(4) pp.171-177.
202. Ross J (2009) Researching the barriers to mental health nurse prescribing, *Nurse Prescribing* 7(6) pp. 249-253.
203. Courtney M, Carey N (2008) Nurse independent prescribing and nurse supplementary prescribing practice: national survey. *Journal of Advanced Nursing* 61(3) pp. 291-299.
204. Bradly E, Nolan P (2007) Impact of nurse prescribing: a qualitative study. *Journal of Advanced Nursing* 59(2) pp.120-128.
205. Ryan-Wooley B, McHugh G, Luker K (2007) Exploring the views of nurse prescribing among Macmillan nurses. *British Journal Community Nursing* 13(4) pp.171-177.
206. Scrafton J, McKinnon J, Kane R Exploring nurses' experiences of prescribing in secondary care: informing future education and practice. *Journal Clinical Nursing* 21(13-14) pp. 2044-2053
207. Earle E A, Taylor J, Peet M, Grant G (2011) Nurse prescribing in specialist mental health (Part 2): the views and experiences of psychiatrists and health professionals. *Journal of Psychiatric and Mental Health Nursing* 18(4) pp.281-287.
208. Blanchflower J, Green L, Thorp C (2013) Breaking down the barriers to nurse prescribing. *Nurse Prescribing* 11(1) pp.44-47
209. Scrafton J, McKinnon J, Kane R Exploring nurses' experiences of prescribing in secondary care: informing future education and practice. *Journal of Clinical Nursing* 21(13-14) pp. 2044-2053
210. Courtenay M, Carey N, Gage H, Stenner K, Williams P (2015) A comparison of prescribing and non-prescribing nurses in the management of people with diabetes. *Journal of Advanced Nursing* 71(12) pp. 2950-2964.
211. Creedon R, Byre S, Kennedy J, McCarthy S (2015) The impact of nurse prescribing on the clinical setting. *British Journal of Nursing* 24(17) pp. 878-885.
212. Earle E A, Taylor J, Peet M, Grant G (2011) Nurse prescribing in specialist mental health (Part 1): the views and experiences of practising and non-practising nurse prescribers and service users. *Journal Psychiatric and Mental Health Nursing* 18(3) pp. 189-197.
213. Bradly E, Nolan P (2007) Impact of nurse prescribing: a qualitative study. *Journal of Advanced Nursing* 59(2) pp.120-128.
214. Carey N, Stenner K, Courtenay M (2009) Stakeholder views on the impact of nurse prescribing on dermatology services. *Journal Clinical Nursing* 19(3-4) pp. 498-506.
215. Naughton C, Drennan J, Hyde A, Allen D, O'Boyle K, Felle B, Butler M (2013) An evaluation of the appropriateness and safety of nurse and midwife prescribing in Ireland. *Journal of Advanced Nursing* 69(7) pp. 1478-1488.
216. Naughton C, Drennan J, Hyde A, Allen D, O'Boyle K, Felle B, Butler M (2013) An evaluation of the appropriateness and safety of nurse and midwife prescribing in Ireland. *Journal of Advanced Nursing* 69(7) pp. 1478-1488.
217. Kelly A, Neale J, Rollings R (2010) Barriers to extended nurse prescribing among practice nurses. *Community Practitioner* 83(1) pp. 21-24.
218. Creedon R, O'Connell E, McCarthy G, Lehane B (2009) An evaluation of nurse prescribing Part 1: A literature review. *British Journal of Nursing* 18(21): 1322-1327.
219. Scrafton J, McKinnon J, Kane R Exploring nurses' experiences of prescribing in secondary care: informing future education and practice. *Journal of Clinical Nursing* 21(13-14) pp. 2044-2053

220. Wikinson J, Carryer J, Adams J (2013) Evaluation of a diabetes nurse specialist prescribing project. *Journal of Clinical Nursing* 23(15-16) pp. 2355-2366.
221. Lim A G, North N, Shaw J (2014) Nurse prescribing: The New Zealand context. *Nursing Praxis in New Zealand* 30(2): pp. 18-27.
222. Courtenay M, Carey N (2009) Nursing prescribing by children's nurses: views of doctors and clinical leads in one specialist children's hospital. *Journal of Clinical Nursing* 18 (18) pp. 2668-2675.
223. Ross J D, Kettles A M (2012) *Mental health nurse independent prescribing: what are nurse prescribers' views of the barriers to implementation?* *Journal of Psychiatric and Mental Health Nursing* 19(10) pp. 916-932.
224. Scrafton J, McKinnon J, Kane R Exploring nurses' experiences of prescribing in secondary care: informing future education and practice. *Journal of Clinical Nursing* 21(13-14) pp. 2044-2053

The RCN represents nurses and nursing, promotes
excellence in practice and shapes health policies

RCN Online
www.rcn.org.uk

RCN Direct
www.rcn.org.uk/direct
0345 772 6100

Published by the Royal College of Nursing
20 Cavendish Square
London
W1G 0RN

020 7409 3333

September 2017
Publication code 006 447



Royal College
of Nursing