Qualitative research about current education programme standards

Report by Traverse

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Executive Summary

The standards for nursing and midwifery education and training in the United Kingdom (UK) are aligned with the EU Directive 2005/36/EC 'on the recognition of professional qualifications' ("the Directive") which establishes minimum EU-wide standards for the education and training of nurses responsible for general care, ("adult nurses") and midwives.

The EU requirements have been incorporated into the Nursing and Midwifery Council (NMC)'s pre-registration education standards since 2005. The requirement for the NMC to set standards that comply with the EU Directive ceased when the UK left the EU on 31 December 2020.

In that context, in November 2020, the NMC commissioned Traverse to conduct qualitative research to explore whether the requirements of the EU Directive are necessary to achieve safe and effective practice, and should therefore continue to be included in NMC standards.

Traverse heard from a sample of over 6,300 people, through a combination of in-depth interviews and an online survey. The research heard from a range of stakeholders, including nursing and midwifery professionals, students, education providers, employers, unions and professional bodies, education and improvement organisations, researchers, Chief Nursing Officers and their Midwifery Officer counterparts.

Alongside the Traverse research, Harlow Consulting were commissioned to conduct a desk review (the 'desk research'), culminating in two reports:

1) exploring the impact and effectiveness of the EU Directive (the 'Evidence Review');

2) benchmarking approaches to pre-registration education and training in other countries and for other professions (the 'Benchmarking Review').

Key findings

1. General education length and qualifications

Most key nursing partners said that the **NMC should continue to align with the EU's general education requirements**, because they help to ensure a minimum level of educational attainment and support public confidence in the profession. However, some said that, in the interests of widening accessibility, there should be pathways for applicants with atypical backgrounds who may not meet these requirements.

Most nursing stakeholders said that both the **12-year and 10-year options for entry into pre-registration courses should be retained**. Those who said they should be amended argued that this would widen access to the profession and enable candidates with strong personal qualities to become nurses. However, those who were in favour of maintaining or strengthening existing requirements said that candidates must be able to meet the academic demands of the programme and that this would protect standards of nursing

and patient safety.

A minority of key midwifery partners suggested that the requirements for entry to pre-registration midwifery programmes could be raised, in recognition of the stringent requirements of the programmes.

Meanwhile, most midwifery stakeholders supported maintaining the existing entry requirements for Route A (Direct Entry). Those who said they should be amended argued that this could help to widen access to the profession.

2. Shortened courses

Key partners were **mostly supportive of allowing all fields of nursing to access shortened midwifery programmes** – as all were thought to have transferrable learning. It was felt that widening access would make shortened programmes more sustainable as they are often undersubscribed. Some felt that non-adult nurses could bring specific skills that could improve standards of care, but others felt their skillsets were too specialised. Some would rather encourage applicants from other health professions (e.g. paramedics). It was suggested that before considering whether a shortened course would be appropriate, midwifery outcomes should be clearly mapped against other healthcare disciplines. Consideration should be given to four nations implications (e.g. the need for close alignment between Northern Ireland and the Republic of Ireland to enable midwives living and working on opposite sides of the border to easily register in their country of practice) before any changes are made.

Most midwifery stakeholders **supported retaining the current entry requirements for shortened midwifery programmes** and this was largely consistent across the four nations. Most felt that only adult nurses had skills which were transferable to midwifery and that other nurses or healthcare professionals would struggle to become competent in a shorter timeframe. A few wanted to discontinue the short course altogether, as they felt even adult nurses could not become competent within the timeframe. Those who supported changing requirements argued that learners from a wide range of disciplines would bring skills that would expand the knowledge and skills base of the profession.

3. Recognition of prior learning (RPL)

Almost all key partners **supported RPL for nursing to widen access to the profession and address staffing shortages**. Most nursing stakeholders supported aligning the approach to RPL across both professions in the interest of consistency on the part of the NMC.

Most stakeholders also supported RPL for nursing – there was little variation in this across the four UK nations. Allowing RPL was thought to widen access to the profession, leading to a more diverse workforce and more recruitment.

Among those opposing RPL for nursing, reasons were:

- Most prior learning would not be relevant to nursing given the specific demands of the profession;
- All nursing students should receive the same training in order to uphold standards;
- RPL puts all students (both with and without RPL) at a disadvantage, as those without RPL would incur greater costs in terms of student fees and maintenance loans, while those with RPL would be expected to achieve the same learning outcomes within a reduced timeframe.

Most key partners in midwifery **supported introducing RPL to facilitate the diversification of the workforce and to accelerate recruitment**. However, they said there is a need for NMC guidance on the types of prior learning appropriate for midwifery. They were largely against alignment with nursing on RPL, wanting distinct guidance specific to the profession.

Most stakeholders also supported introducing RPL for midwifery, as part of an effort to remove barriers to candidates with transferrable skills entering midwifery. However, they suggested that guidance or a cap on RPL would be necessary.

Among those opposing RPL for midwifery, reasons were:

- Any prior learning would necessarily be irrelevant to midwifery, given the uniqueness of the profession;
- All midwifery students should receive the same training in order to uphold standards;
- RPL would need to be assessed on an individual basis, and as such would be difficult for AEIs to coordinate;
- It is unnecessary given the existence of the shortened midwifery course (although the shortened course is an example of advanced standing, rather than RPL, and is limited to first level adult nurses – see section 3).

4. Knowledge and skills for nursing and midwifery

Many key nursing partners were in favour of the **skills requirements being reviewed**, in order to account for changes in how healthcare both is and will be delivered. Some said that changes might give greater scope to respond to specific regional and national needs. There were mixed views about whether to expand generalist training or to extend the field-specific requirements. Some were also keen to assess the impact of the Future Nursing Standards on the quality of graduates and safety and effectiveness of nursing practice before considering changes.

The majority of nursing stakeholders said that the **knowledge and skills specified in the EU Directive were necessary for safe and effective care**. However, there was some appetite to review and update the requirements, with several stakeholders calling for a greater emphasis on practical training and the real-life application of skills, as well as a more detailed knowledge of anatomy and physiology. Several also felt that learning disabilities should be

included in the requirements. However, it should be noted that such changes have already been integrated in the NMC's current standards of proficiency. This , suggests that some stakeholders are not as familiar with the new NMC Standards of Proficiency for nursing and midwifery.

Some key partners supported reviewing the skills and knowledge requirements for midwifery, but the question of the specified 'numbers' was acknowledged to be complex and controversial. While some felt that the numbers supported consistency and were helping to support safe and trusted services, others said they do not adequately measure the competence of student midwives or help them to support a woman in her whole journey through maternity care. Some endorsed a mixed approach, with minimum numbers set alongside an outcomes and competencies focus.

Most midwifery stakeholders agreed that the knowledge and skills specified in the EU Directive were necessary for safe and effective midwifery care and that the NMC should continue to specify the number of occasions on which skills must be performed. However, they had mixed views about the current numbers and many suggested different ways in which these might be reviewed and amended, with the most common suggestions being that they should be lowered and/or that there should be an emphasis on the quality of skills performance rather than quantity. A small number called for moving away entirely from minimum numbers in favour of taking a more holistic view where there is a greater focus on antenatal and postnatal care rather than numbers of births.

5. Practice learning hours and use of simulation

Key nursing partners were **broadly supportive of simulation**. It was seen to protect patients from harm by giving students opportunities to learn, rehearse and gain confidence and competence. However, there was concern that the use of simulation may replace practice and could be overused. Another challenge was the high cost of developing the technology, which could result in unequal access to the latest equipment.

A majority of nursing stakeholders were **supportive of simulation counting towards both practice and theory hours**. Many said that it builds confidence and competence whilst providing opportunities for group learning, feedback and reflection. However, many felt that simulation could not be a substitute for real-life practice. A small majority felt that use of simulation in assessments should be limited to certain skills and procedures, while just over a third did not feel that limits were necessary. Many supported a greater role for simulation so long as it is used in a proportionate way, which enhances real life-practice, with clear criteria and checks and balances in place.

Key midwifery partners were in **favour of simulation overall, particularly for giving students exposure to rare learning experiences, and practising repetitive tasks.** But many felt training should develop communication skills and 'hands-on' learning, and had reservations as to whether simulation could really facilitate this. Therefore, there was caution about the extent to

which simulation could replace practice hours.

Midwifery stakeholders highlighted simulation's value in confidence building, supporting women and newborn safety, allowing group learning and providing opportunities for feedback and reflection. A majority were supportive of **simulation counting towards both practice and theory hours**. However, many were concerned about the prospect of simulation replacing real-life practice, which was seen as essential for learning key skills. There were calls for robust checks and balances on its use. In the survey, a small majority felt use of simulation in assessment should be limited to certain skills and procedures, while just over a third did not feel that limits were necessary.

6. Programme length and number of hours

Key partners **strongly supported the 3-year programme length for nursing but would like a review of the hours requirement;** some focusing on total hours and others on the theory/practice split. However, any reduction in hours was seen to risk a perception of reduced safety or quality of care, and was considered a risk given the increasing complexity of patient needs.

Nursing stakeholders said the NMC should **continue to specify both a minimum programme length and number of hours**, and that the current requirements are necessary to achieve the standards of proficiency. Those who were in favour of reducing the number of hours identified a range of benefits including improved quality and availability of placements and reduced student workload. Most said that the time required to achieve the standards of proficiency should be based on competency and outcomes, rather than number of hours. Many held this view on the basis that number of hours is not a guarantee of competence.

Key midwifery partners were **strongly against any reduction in length, hours or practice hours for midwifery.** Any reduction was seen to make it difficult to cover all of the learning outcomes in the Future Midwife Standards and therefore to pose risks to safety and quality of care, especially as midwives tend to work as autonomous practitioners.

A majority of midwifery stakeholders said the NMC should **continue to specify minimum programme length and number of hours and felt that the current requirements for direct entry and short courses (2 years/18 months) are sufficient for students to achieve proficiency**, although fewer were sure of the sufficiency of the requirements for the 18-month course. A majority of survey respondents support a competency and outcomes-based approach, rather than number of hours.

7. Impact of the EU Directive

Public protection and safety

Nursing stakeholders who addressed this matter emphasised that **public protection and safety must remain the highest priority** when considering making any changes. Some suggested that any revised NMC Standards

should attempt to increase or enhance public protection and patient safety and some had a concern that diverging from the EU Directive risked undermining public protection and safety.

Midwifery stakeholders also stressed that **public protection and safety should be a paramount concern** when considering making any changes. Some again voiced concerns that diverging from the EU Directive could lead to a lowering of education standards, which had the potential to impact on the safety of services and on public protection (e.g. should the minimum programme length become shortened, or the minimum number of practice hours be significantly reduced).

Effectiveness and quality of care for people who use services

Alongside upholding patient safety, nursing stakeholders who addressed this matter stated that **effectiveness and quality of care were of paramount importance and should be driving all of the decisions to be made**.

Midwifery stakeholders also felt that **effectiveness and quality of care should be 'front and centre' when considering any changes**. While some voiced concerns that diverging from the EU Directive might have a negative impact on this area, others felt that diverging from it provided an opportunity to raise the requirements, which would have a positive impact on the effectiveness and quality of midwifery care. This could be brought about providing changes were driven by the specific and future needs of the UK, and by embracing the latest evidence base, and technological innovations in terms of learning (e.g. use of simulation, distance learning approaches).

Impact on people with different protected characteristics

Many of the nursing stakeholders who addressed this matter voiced **concerns that diverging from the EU Directive might see less consideration given to people with protected characteristics**. Many also stated that the UK needs to continue to adhere to the Equality Act and equivalent legislation for Northern Ireland, and remain committed to valuing and considering equality, diversity and inclusion, which they saw as fundamental to delivering nursing in the UK. Several stakeholders on the other hand expressed confidence that the needs of groups with protected characteristics would continue to be a priority for those at the NMC and some had the view that the rights of people with protected characteristics are already protected under UK law. Some stakeholders suggested the diverging from the EU Directive could potentially give educators greater scope and flexibility to be responsive to the needs of people with protected characteristics in terms of course design and in terms of establishing alternative pathways to entry.

In terms of midwifery stakeholders, several again emphasised the importance of **continued compliance with existing equality legislation and for the need to continue taking into account the needs of people with protected characteristics and other marginalised groups when setting education and training standards**. Several had a concern that following Brexit, the UK might

be tempted to "water down" its commitments associated with equality legislation or to fail to consider how any changes might impact on particular groups or learners or people who use services.

The experiences and perceptions of nurses, midwives, nursing associates and students

A key risk cited by nursing stakeholders was that diversion from the EU Directive would result in a **perception, amongst stakeholders and the public, that education and training standards had been lowered or diluted**, which could in turn damage confidence in the nursing profession. Some stakeholders felt that there was a need to manage how existing registrants perceive any changes and the new graduates produced following any changes.

Midwifery stakeholders also had a concern about **the potential harm to the reputation of midwifery domestically and internationally, were it perceived that the UK's education and training standards had been lowered**. Concerns also centred around changes to programmes that could impact on the preparedness of recently qualified registrants to deliver services and for the potential for changes to cause disruption or uncertainty in the profession. Others by contrast felt that the student experience stood to benefit should the NMC review and update its pre-registration standards. For example, respondents frequently focused on a shift away from "the numbers" towards achieving outcomes and competencies, which it was felt could potentially improve the quality of learning experiences and improve student's work-life balance.

The number and supply of nurses, midwives, and nursing associates

Many of the nursing respondents and interviewees who addressed this matter in the stakeholder research identified the **risk that UK registrants would no longer be able to work in the EU were the UK to diverge from the EU Directive**, which would limit their future career options. Some raised the specific concern that diverging from the EU Directive could **disrupt the movement of registrants between Northern Ireland and the Republic of Ireland.**

Some nursing stakeholders felt that the review of the programme standards was being primarily driven by a need to respond to nursing shortages, particularly in England. Here it was emphasised that the NMC must not make changes which **prioritise quantity at the expense of quality in terms of the nursing workforce**. Several also had a concern that EU registrants may be put off coming to the UK to practice, exacerbating the effect already seen as a result of Brexit. Others were hopeful that diverging from the EU Directive could help to widen access to nursing, which would help to expand and diversify the nursing workforce.

In terms of midwifery stakeholders, views were mixed. Some felt that this review provided an opportunity to **widen access and improve the inclusivity**

of midwifery programmes and in turn help to increase the size of the midwifery workforce. On the other hand, there was a concern that supply might be harmed if the UK became **less able to attract midwife students and registrants from the EU, should the Standards no longer align**. A few also voiced a concern that changes might be pursued which prioritised increasing the quantity of midwives at the expense of quality.

Effectiveness, availability, and quality of education programmes

Nursing stakeholders tended to focus on quality and effectiveness of education programmes. Many had a concern that diverging from the EU Directive could potentially lead to a **lowering in the quality of education programmes** (e.g. were practice hours to be significantly reduced), while a large proportion also felt that making changes posed an opportunity to **raise the effectiveness and quality of educational programmes.**

Midwifery stakeholders also had mixed views. While some felt this was an opportunity to **modernise and improve the quality of education programmes drawing on the latest evidence and good practice**, other respondents voiced concerns about the potential lowering of pre-registration education standards. Some suggested that the EU Directive provided a minimum "safety net" and felt that the NMC risked trying to "fix something that was not broken". Some felt that the quality of education programmes could be undermined were for instance programmes to be shortened, simulation was used to substitute practice-based learning, or where "subjective" and "less rigorous" competency assessments were employed over hours- and numbers-based requirements. A few had the view that the NMC should only add and build on the requirements of the EU Directive rather than diverging from it.

8. Sub group differences in the Phase 2 survey

Drawing on the sub group differences outlined in Appendix 2, the key trends include:

- Respondents based in Northern Ireland are frequently more likely to support status quo options compared with those based in other nations.
- Compared with other nations, respondents based in Northern Ireland are less likely to expect a positive impact as a result of changes being made to the minimum education programme standards.
- The age of respondents is likely to be the key variable driving statistically significant sub group differences in terms of differing views – with younger respondents being more likely to support change and older respondents being more likely to support status quo options[1].

[1] Where non-heterosexual and ethnic minority respondents are more likely to support changes from the status quo this is likely to be because of their younger age profile.

Introduction

The European Union (EU) Directive 2005/36/EC 'on the recognition of professional qualifications' ("the Directive")[2]establishes minimum EU wide standards for the education and training for nurses responsible for general care (adult nurses in the UK) and midwives. These requirements form the basis of recognition of qualifications for these professions between Member States. The Nursing and Midwifery Council's (NMC) standards comply with the requirements set out in the EU directive and they form part of pre-registration nursing and midwifery education standards in the UK.

Now that the UK has left the EU, the NMC is no longer required to continue to include and comply with the EU minimum requirements within its pre-registration education standards. The EU requirements cover a range of areas including: admission standards, recognition of prior learning, entry to shortened midwifery programmes, programme length and the balance between theoretical education and clinical training, including the use of simulation, and detailed curriculum content.

The NMC commissioned independent research in relation to these requirements to inform the NMC's Council to allow them to decide whether or not to undertake a programme of work to change pre-registration nursing and midwifery education standards. The research aimed to:

- Evaluate the evidence for having the EU requirements in current education standards;
- Understand whether the requirements of the EU directive are necessary to achieve the standards of proficiency to be admitted to the register, and;
- Understand whether the requirements of the EU directive have any influence upon:
    - Public protection and safety
    - Effectiveness and quality of care for people who use services
    - People with different protected characteristics (including nurses, midwives, nursing associates, students and people who use services)
    - The experiences and perceptions of nurses, midwives, nursing associates and students
    - The number and supply of nurses, midwives and nursing associates
    - Effectiveness, availability and quality of education programmes

In December 2020 the NMC commissioned, Traverse, to conduct independent research to identify and synthesise the views of relevant stakeholders and representative groups across the four countries of the UK on the topics above.

The research sought the views of registered nurses, midwives, nursing

[2] https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:02005L0036-20200424&qid=1600271014953&from=EN#tocId4

associates, students, education providers, employers, organisations representing patients or people who use nursing/midwifery services and others.

The research aimed to explore relative benefits and risks of continuing to include the EU minimum requirements within pre-registration education standards, rather than removing these or replacing them with alternative pre-registration education standards.

In parallel NMC commissioned Harlow Consulting to conduct an evidence review and international benchmarking exercise. The findings from both strands of research are to be brought together in a synthesis report, separate to this report.

Research Approach

The approach to the research aimed to ensure that data collection and analysis were at all stages independent, clearly documented, consistent, logical, traceable, with justified methodological choices and a clear description of the project limitations.

Due to the impact of Covid-19 public health restrictions and the impact of the pandemic on the professions the decision was made to stagger the research across two phases:

- **Phase 1: focussed on in-depth interviews with NMC's key partners** (which included representatives from deans and heads of schools/faculties engaged in education and research for nursing and midwives, unions and professional bodies, Lead Midwife for Education (LMO), Chief Nursing Officers (CNO), Chief Midwifery Officers (CMO) or their equivalents, and other government bodies). **Phase 1 took place in January and February 2021.**
- **Phase 2: comprised of two strands of data collection** with nurse and midwifery registrants, students, employers, educators and organisations representing people who use services and their families. Strand 1 comprised an online survey and strand 2 comprised follow up in-depth interviews with a smaller sub-sample of self-selecting survey respondents who opted in to taking part. **Phase 2 took place in April and May 2021.**

The approach for each phase of the research is described in detail below, followed by a description of the limitations of the research and guidance for reading and citing this report.

a. Phase 1: Key partner interviews

i. Achieved sample

48 interviews were completed. Table 1 below outlines who participated.

Table 1. Summary of key partner interviews completed in Phase 1

Stakeholder	Number of interviews
Chief/Deputy Nursing Officers, Chief/Deputy Midwifery Officers and members of their teams, Education and Improvement bodies[3]	5 from Wales 4 from England 4 from Northern Ireland 5 from Scotland
Unions and Professional Bodies	7
Lead Midwives for Education/Professors of Midwifer	4
Council of Deans of Health	2
Deans and Heads of Schools from across the four nations	16
Learning and simulation specialist	1
Total	**48**

[3] Education and improvement bodies refers to NHS England and Improvement, Health Education England and equivalent organisations in Wales, Scotland and Northern Ireland

ii. Sample approach

Invitations were targeted at a range of the key partners from across the four nations which were identified by the NMC and its external stakeholder reference group (comprising: CNO officers, education bodies and Governments in the four nations of the UK, plus the Council of Deans for Health). Targeted reminders were sent out to ensure that good representation was achieved from across the two professions, from different stakeholder groups, and from the four nations. Partners were consistently keen to give their views, and there were no significant gaps in terms of who participated.

iii. Data collection

Interviews were conducted remotely, via telephone and by video-call, and generally lasted between 45 mins and 1 hour. Interviewers used a pre-agreed semi-structured interview guide and took real time verbatim notes. With participant permissions, interviews were recorded in order to allow interviewers to refer to them at a later date where necessary.

iv. Analysis

Interview notes were analysed using a framework approach, structured by question and respondent sub-group to enable exploration of differences. Responses for key partners representing nursing and midwifery were analysed separately, to focus each as a distinct profession. Researchers reported and analysed by topic, and inter-researcher checks were conducted via weekly researcher analysis meetings.

b. Phase 2: Online survey

i. Achieved sample

A total of **6,266** responses were received, of which 6,169 responses were received from individuals, made up of:

- Registrants (n=5026)
- Students (1063)
- Other (64)
- Members of the public(n=16)

A further 97 responses were received from people responding on behalf of organisations (see Table 3). This was a self-selecting sample with no quotas set. The survey was live between 30 March 2021 and 11 May 2021. Table 2 below describes the registrant and student response rates.

Table 2. Survey responses from registrants and students across the four nations

Respondent type	England	Scotland	Wales	Northern Ireland	UK Wide
Registered nurses	3,389	413	282	143	92
Student nurses	467	91	90	7	13
Registered Midwives	376	45	22	18	6
Student midwives	290	72	12	10	1
Dual registrant	144	20	16	7	7
Nursing Associate registrants	75	1	-	1	3
Nursing Associate students	22	-	-	-	1
Total	4,763	642	422	186	123

See **Appendix 3** for a set of tables that provide a breakdown in terms of ethnicity, gender, gender identity, disability status, religion and sexual orientation of the individuals who responded to the survey. The proportions of sub groups is compared with the proportions in the overall NMC register. These show that the achieved sample is broadly speaking representative of the overall register in terms of demographic profile.

The research provides the views of c.1% of all registered nurses, midwives and nursing associates in the UK[4].

Table 3 below describes the response rates from all other types of respondents who completed on behalf of organisations/groups (n=97) . Respondents could tick more than one organisation category in the 'about you' section of the survey.

Table 3. Survey responses from organisations/groups against targets

Respondent type	Target	Achieved
Education provider	54[5]	48
Employer of registrants	650	36
Professional or representative organisation*	-	8
Government department or public body*	-	6
Professional organisation of trade union	-	5
Organisation or group representing people who use nursing and or midwifery services	50	3

[4] This 1% figure is based on the fact that the register was ~732,000 on 29 June 2021

[5] 54 was the target set for "schools/AEIs", whereas the 48 achieved includes both schools, AEIs as well as employers (who also provide education)

Regulatory body*	-	2
Member of the public*	-	16
Other *	-	2

Achieved responses from organisations or groups representing people who use nursing and / or midwifery services were lower than the target. This is likely to be in part due to the effect of the pandemic on organisations' time to take part in research, as well as the nature of the topic being relatively technical. It is recommended that engagement with this group is a priority for any future engagement as part of this work.

Conversely, responses were received from stakeholder groups (marked* in the table above) who were not part of the original target sample. Their organisational/professional interest in the topic is likely to have driven this motivation to contribute.

ii. Sample approach

The NMC published the survey link on their website, and also publicised the survey on their social media channels and with a press release that received coverage in the nursing and midwifery trade press. This open approach was designed to ensure that anyone with an interest in the work had an opportunity to see the survey and to reply.

In addition, Traverse worked with the NMC to target particular groups as follows:

- A random sample of 50% of the register (n=317,121) in March 2021 – this proportion was chosen as it was expected to produce enough responses to meet the target total response.
- Accredited Approved Education Institutions (AEIs)[6], who cascaded to their staff members and students. This went to all 86 AEIs.
- 691 employers, both inside and outside the NHS. This was undertaken via Directors of Nursing for whom the NMC have contact details and an additional list of NHS and non-NHS employers which NMC's Employer Link Service hold. The NMC also contacted some key employer umbrella bodies to cascade to their members.
- 124 groups representing patients, the public and people who use services who the NMC thought may have an interest in the work. This included groups representing areas such as patient safety, midwifery and maternity, and long-term conditions and disabilities.
- The NMC stakeholder reference group made up of CNO officers, education bodies and Governments in the four nations of the UK, plus the Council of Deans for Health.

[6] Education institutions which have received approval from the NMC to run nursing and/or midwifery programmes

- Other key stakeholders who the NMC regularly keep updated about our work including professional bodies, trade unions, other regulators and organisations in the voluntary sector.
- The NMC included information in its regular employer and public newsletters.

During the fieldwork period Traverse monitored responses and the NMC conducted some specific follow-up prompts with groups with lower responses. This included: employers, public groups and stakeholders in Northern Ireland.

It was agreed that the research would not specifically seek the views of the general public because the technical nature of the subject matter meant that different data collection methods and stimulus materials would have been required. Throughout the publicising of the research, it was emphasised to respondents that they would have further opportunities to give their views through a public consultation if amendments to the Standards was the recommendation emerging from the research.

iii. Data collection

An online survey was designed by Traverse and was delivered through SNAP which is an online survey platform. The survey was piloted with a small sample of nursing and midwifery registrants before being finalised and launched. The survey comprised a mix of open and closed questions with options for completion as nurses or midwives or both, for those with oversight/experience of both professions.

iv. Analysis

All survey data was uploaded into Traverse's bespoke, secure data management and analysis system, Magpie. To analyse the open text responses in a logical and consistent way, a coding framework was designed which was in the first instance guided by the survey questions. As a first step a review of a sample of the early responses to the survey was conducted in order to create the thematic structure of the framework and create new codes where themes arose in the data. Once the framework had been developed sufficiently, a team of research analysts applied the framework to open text survey responses. In order to give an indication of the weight of sentiment around particular themes, code counts were conducted.

To support quantitative data analysis, we created a series of data tables in Stata to identify how different sub groups responded to the questions. We also carried out significance testing to identify statistically significant differences in how different sub groups of the sample responded. This data was captured in an Excel file held by NMC. Where differences are significant this means we can rule out that they happened by chance alone.

c. Phase 2: Interviews

i. Achieved sample (against targets)

53 interviews were completed. Table 4 below describes the profile of the completed interviews.

Table 4. Overview of follow up interviews – achieved vs target

	England	Scotland	Wales	Northern Ireland	Total
Nurses	Target -10 Completed - 7	Target- 8 Completed - 6	Target -5 Completed - 5	Target -3 Completed - 2	**20**
Midwives	Target -8 Completed - 8	Target -3 Completed - 6	Target -2 Completed - 2	Target -2 Completed - 2	**18**
Nursing Associates	Target -4 Completed - 4	-	-	-	**4**
Student nurses	Target -3 Completed - 3	Target -2 Completed - 2	Target -2 Completed - 1	Target -1 Completed - 0	**4**
Students midwives	Target -3 Completed - 3	Target -2 Completed - 2	Target -1 Completed - 2	Target -1 Completed - 0	**7**
Total (completed)	**25**	**16**	**10**	**2**	**53**

ii. Sample approach

All respondents to the Phase 2 survey were invited to express interest in taking part in a follow up interview. Traverse were responsible for arranging and booking interviews and monitoring the spread of interviews in relation to the target sample for follow up interviews. It should be noted that all follow up interviews took place during April and May with a deadline for interviews of 17th May 2021. While every effort was made to ensure that representation was achieved from across the four nations, nursing and midwifery, students, employers and service user representative organisations, for example, via targeted follow up by the NMC, all participants were self-selecting and the final achieved sample is partial.

iii. Data collection

Interviews were conducted remotely and generally lasted between 45 mins and 1 hour. Interviewers used a semi-structured interview guide (see Appendix X) referred to respondents' individual survey responses and took detailed notes in response to closed questions and thematic notes in relation to open questions.

iv. Analysis

Interview notes were analysed using a framework approach, structured by question and respondent sub-group to enable exploration of differences. Responses for stakeholders representing nursing and midwifery were analysed separately. Researchers reported and analysed by topic, and inter-researcher checks were conducted via weekly researcher analysis meetings.

The research team has endeavoured to ensure trustworthiness[1] of the qualitative data in its approach to designing the research questions and sampling as well as data collection, management, approach to analysis and interpretation and presentation of data. The following checks have been made against key criteria for 'trustworthiness':

- **Credibility** – correct interpretation of participants' original views – Traverse inter-coder analysis checks and peer review with NMC colleagues
- **Dependability** – participants' evaluation of findings, interpretation and recommendations supported by data - peer review with NMC colleagues
- **Transferability** – degree to which results can be transferred to other contexts with other participants – peer review with NMC colleagues
- **Confirmability** – degree to which findings can be confirmed by other researchers – Traverse inter-coder analysis check and peer review with NMC colleagues
- **Reflexivity** – consideration of biases, preconceptions and the power relation between researcher and participants – Traverse researcher analysis meetings.

2. Reading and referencing this report

a. Limitations

The limitations of this research relate to both the sample, data collection methods and time when the research was conducted.

i. Sample

It should be noted that the achieved sample, while large in scale and broadly reflective of the overall population of registrants and students, is

[1] Korstjens I & Moser A (2018) Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing, European Journal of General Practice, 24:1, 120-124, DOI: 10.1080/13814788.2017.1375092 & Nowell L S et al (2017) Thematic Analysis: Striving to Meet the Trustworthiness Criteria, International Journal of Qualitative Methods, 16:1-13. DOI 10.1177/1609406917733847

limited. The research provides the views of 1% of all registered nurses and midwives in the UK. As noted previously, respondents in Phase 1 and Phase 2 data collection were self-selecting people who were willing and able to give time to complete the survey and engage in telephone interviews.

Therefore, the findings and views expressed should not be considered or reported as either representative or generalisable to the views held by all nurses, midwives, students, employers or educators.

ii. Influence of Covid-19 on the research

The research took place from February – May 2021, coinciding with a second lockdown in the UK, in response to Covid-19. The impact of the pandemic on education and training for nursing and midwifery has been significant and this context is likely to have influenced both who chose to take part in the research and their perspectives on the topics. This was particularly the case for educators and students, who had particular views on topics such as programme length, minimum hours and use of simulation due to their particular experiences of training and education during Covid-19 restrictions.

b. Reading this report

The report presents findings from each of the following topics:

1. General Education Requirements
2. Professional qualifications to shortened midwifery programmes
3. Recognition of Prior Learning
4. Knowledge and skills
5. Use of simulation
6. Programme length and minimum hours
7. Overall impacts

For each topic we begin by providing a concise summary of the findings from across each phase of the work. This is followed by:

- **Reporting of findings from Phase 1 of the research** (in-depth interviews with senior stakeholders); followed
- **Reporting of findings from Phase 2 of the research** (online survey and follow-up interviews combined – with registrants, students, employers and patient representative organisations.

The Phase 2 survey results presented throughout this report are the **overall results**[7]. The profile of those who answered each set of questions is described in Table 5 below. Respondents were able to complete one or both sets of questions, with 442 or 7% of the total sample choosing to complete both sets.

[7] Appendix 1. shows how different registrants and students answering the survey responded.

Table 5. Profile of those who answered nursing and midwifery survey questions

Nursing questions	Midwifery questions
5,373 responses in total:	**1,335** responses in total:
- 5,299 responding as individuals	- 1,294 responding as individuals
- 74 responding on behalf of organisations:	- 41 responding on behalf of organisations:
- 37 Education providers	- 20 Education providers
- 27 Employer of registrants	- 14 Employer of registrants
- 5 Prof or representative org	- 6 Prof or representative org
- 4 Government or dept. or body	- 2 Government or dept. or body
- 3 Professional org or trade union	- 2 Professional org or trade union
- 2 Regulatory body	- 2 Org/group representing service users
- 2 Org/group representing service users	- 1 Regulatory body
Individuals:	Individuals:
- 4,325 nurses (inc. SCPHNs)	- 460 midwives (inc. SCPHNs)
- 147 dual registrants (inc. SCPNs)	- 281 nurses (inc. SCPHNs)
- 79 nursing associates	- 141 dual registrants
- 34 midwives	- 1 nursing associate
- 655 nurse students	- 383 midwife students
- 25 nursing associates	- 30 nurse students
- 19 SPQ students	- 2 nursing associate students
- 3 midwives	- 1 SCPHN student
- 6 SCPHN students	- 1 SPQ student
- 14 members of the public	- 9 members of the public
- 54 'other' individuals	- 18 'other' individuals
- 4,151 England	- 1,025 England
- 536 Scotland	- 166 Scotland
- 398 Wales	- Wales 74
- 159 Northern Ireland	- 45 Northern Ireland

- 120 UK wide	- 23 UK wide
- 107 EU or non-EU	- 23 EU or non-EU

Throughout the report, after providing the overall findings, 4-nation trends are highlighted, as are demographic sub group differences of 5% or more which are statistically significant.

Appendix 2 provides a breakdown of the results by the 4-nations and also highlights statistically significant sub group differences of 5% or more.

In order to describe the weight of sentiment behind each open ended comment, relative to the other comments made in response to that question, the following quantifiers have been used. These have been used on a per-question basis and are not directly comparable between questions:

- Most
- Many
- Several
- Some
- A few
- A small number

1. General Education Requirements

1.1. Summary

Phase 1

Most key partners said that the NMC should continue to align with the EU's general education requirements rather than set new ones because they help to ensure a minimum level of educational attainment and support public confidence in the nursing and midwifery professions. However, some said that, in the interests of widening accessibility, there should be pathways for applicants with atypical backgrounds who may not meet these requirements.

Phase 2

Most nurses said that the 12 year and 10 year requirements should be retained. Those who said they should be amended argued that this would widen access to the profession and enable candidates with strong personal qualities but who currently lack the requisite education to become nurses. However, those who were in favour or maintaining or strengthening existing requirements said that candidates were able to meet the academic demands of the programme and that this would protect standards of nursing and patient safety.

Meanwhile, most midwives supported maintaining the existing entry requirements for Route A (Direct Entry). Those who said they should be amended argued that this could widen access to the profession and enable candidates with strong personal qualities but who currently lack the requisite education to become midwives.

1.2. Phase 1 Interviews

Key partners were asked to consider whether the NMC should align with the general education requirements or set new requirements for entry to pre-registration nursing and midwifery programmes. They were also asked to identify the benefits, risk and opportunities of different options.

1.2.1. Areas of consensus

Most participants said that the NMC should **continue to align with the EU's general education requirements rather than set new ones**. It was argued that the 12 year minimum requirement should remain because it helps to ensure a minimum level of educational attainment, including numeracy and literacy. It also helps to give the public confidence that applicants will be able to become confident and competent in their roles.

There was some confusion amongst key partners about the age of applicants given the 12 year requirement, but many understood that the current minimum standards aim to ensure that applicants have the necessary skills/maturity to succeed. This includes:

- Critical reasoning
- Emotional intelligence
- Independent learning
- Self-drive and motivation
- Ability to understand complex topics

Across the four nations no specific issues or differences were identified.

A few interviewees from a range of roles/organisations argued that given universities set their own entry requirements the NMC does not need to specify the general education requirements.

1.2.2. Areas of divergence

Some key partners, mainly from approved education institutions, said that whilst they agreed in most cases with the current requirements, **there should be pathways – as part of a commitment to widening access – for people with atypical backgrounds** who may not meet the 12 year or other academic requirements – for example people from abroad or for healthcare support workers. In some cases, exceptions should be made.

One midwifery focused partner felt that consideration of the entry requirements should **consider the "higher standards" of midwifery at the point of registration, rather than "matching nursing".**

1.2.3. Benefits and opportunities

The potential opportunities of diverging from the EU requirement were felt to include:

- Opening up **opportunities for more foreign students to apply**. In some countries, students are not in education for 12 years before reaching university.
- **Widening access** to people who reach university through non-standard routes. e.g. part-time education or home schooling.
- Whilst the 12 year minimum requirement makes regulation easier, an interviewee pointed out that it **does not actually measure anything** and so changing it provides an opportunity to measure something meaningful to a nursing or midwifery career.
- A **more diverse workforce** could mean better quality of service.

1.2.4. Risks and challenges

A few key partners suggested that **any reduction in general education standards risked "setting students up to fail",** leading to increased attrition from programmes. It was also suggested that reducing the requirements risked undermining the message that nursing and midwifery are graduate-level professions.

Some argued that the minimum requirements helped to **minimise risks associated with reduced quality of care or negative perceptions** of the

nursing and midwifery professions both at home and abroad.

> *"12 years - that means effectively someone has studied at A-level, and for me this provides the foundation for what it means to be a learner and developing that independence around studying." –* ***Union/professional body member, UK wide***

> *"We need to be careful [in terms of entry requirements]. Not opening midwifery up to being weakened; and being clear that it has to be a graduate profession that aligns with global standards." –* ***AEI (approved education institution), UK wide***

It was suggested that the 12 year requirement **sets a clear message about what is required and is straight forward to regulate**, whereas alternative options might be difficult to regulate.

> *"The 12 years requirement is easy to regulate for, whereas assessments about academic ability and emotional maturity are more open to interpretation and are harder to regulate." –* ***Government stakeholder, Scotland***

Additionally, it was suggested that increasing the requirement **could negatively impact on allowing a diverse range of applicants on to programmes.**

1.3. Phase 2: Survey responses and follow up interviews

Nurses were asked whether **applicants to pre-registration nursing programmes should continue to be required to have met either a 12 year or 10 year entry requirement.**

Midwives were asked whether those **applying to a pre-registration midwifery programme via Route A (Direct Entry) should continue to be required to have met a 12 year general education requirement**.

Interviewees were asked to identify the **benefits, risk and opportunities** of different options.

1.3.1. Nursing

Respondents to the online survey were asked whether the NMC should retain the EU directive on entry to pre-registration nursing programmes.

Nursing respondents were broadly in favour of keeping the 12 year requirement (81%/ n=4029), with just 10% (n=485) wanting to diverge from the directive. A small number expressed no preference (6%/ n=314) or didn't know (3%/ n=166).

Respondents answered similarly on the topic of the 10 year minimum requirement, with 79% (n=3613) in favour of keeping the requirement and 10% (n=435) opposed. A slightly larger proportion answered neither way, with 7% (n=315) expressing no preference and 5% (n=206) answering that they didn't know.

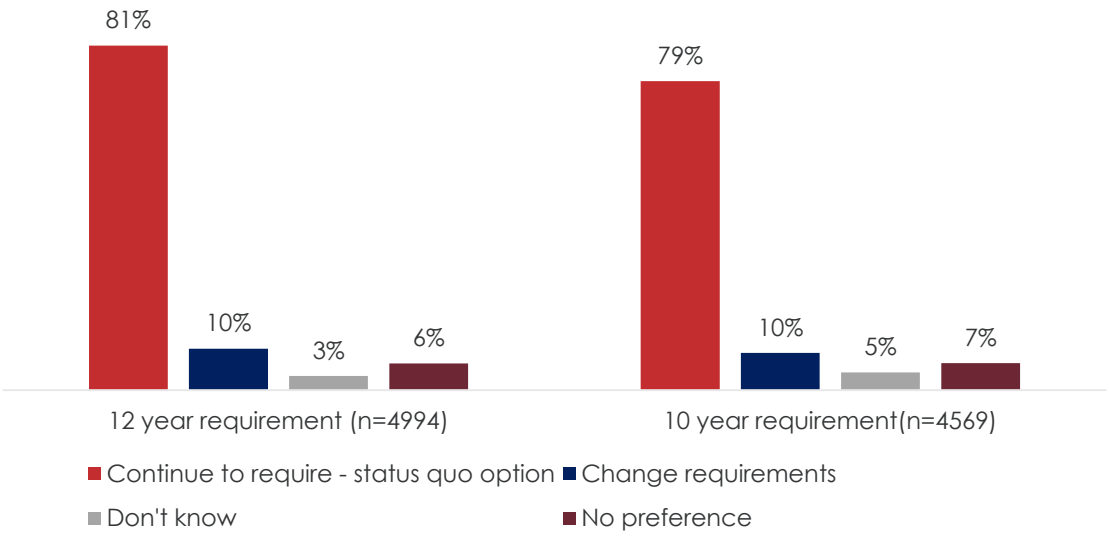

Figure 1: Question A1 - Do you think the NMC should continue to require people applying for pre-registration nursing programmes to have met one of the requirements?

This distribution of support and opposition to continuation was largely consistent across the four nations of the UK. **The greatest support for continuing with the current 12 year requirement was found in Northern Ireland (~85%/ n=123)** which also had the lowest levels of support for change (~6%, n=8).

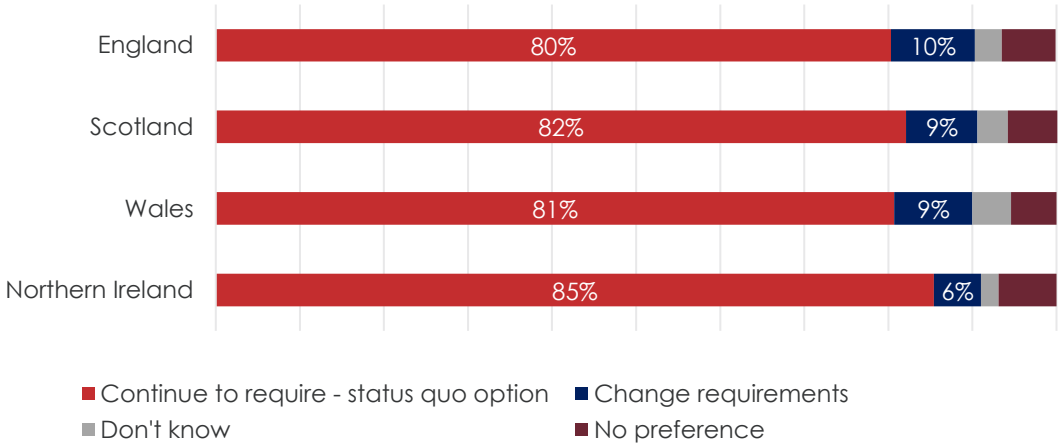

Figure 2: Question A1a - Do you think the NMC should continue to require people applying for pre-registration nursing programmes to have met one of the requirements? (Option A - Completion of a general education of 12 years) (n=4994)

Sub group differences QA1a

- Disabled respondents were more likely to support changing the requirements (90% vs 82%)

Four nation differences

In relation to the 10 year requirement, the distribution of those who support the continuation of the existing requirement and those who wish for the

requirement to be changed is broadly consistent across the four nations of the UK.

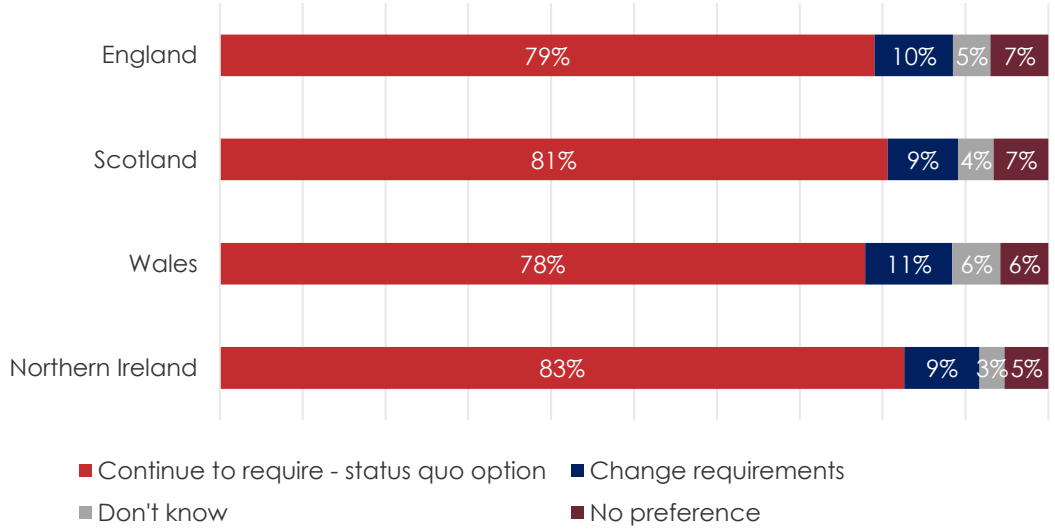

Figure 3: Question A1b - Do you think the NMC should continue to require people applying for pre-registration nursing programmes to have met one of the requirements? (B - Completion of general education of at least 10 years) (n=4569)

Many respondents who felt that the requirements should be amended said that this would help **to widen access to the profession**. They argued that mature students, students without the required grades or with alternative qualifications and individuals who had not been able to access formal education could all become good nurses, and by excluding such people the profession was missing out.

Many also argued that **personal characteristics or qualities could be as important as grades or time spent in education**. These respondents sometimes referred to the need for nurses to be empathetic, compassionate, or communicate clearly, alongside being academically able. Some respondents said that **graduates can lack the practical experience** which they feel is necessary to work effectively in the profession.

> *"The degree programme's nice and it's good not to be chucked straight into practice, but at the same time I think you learn a lot faster when thrown in at the deep end. With the uni programme a lot of it's focused on theory, when in practice it's about responding to unpredictable situations." – **Student Nurse, England***

A few respondents suggested that reducing the education requirements **could also increase workforce diversity and encourage applicants from non-EU countries**.

However, some respondents and interviewees said that existing requirements **should be maintained because of the academic demands of the programme**, and a few argued that it was necessary to maintain the graduate status of nursing. Some also argued that the standards were needed to **ensure professional standards and protect patient safety**. One

interviewee said that graduate nurses are taught to consider why they're doing something and that reducing requirements to increase accessibility would risk a situation where nurses did not feel empowered to challenge poor practice.

> *"People shouldn't be excluded from nursing, but lowering the standards isn't the answer – we need to enable them to meet those standards." –* ***Nurse, England***

Furthermore, some argued that entry requirements **should be more stringent** in order to maintain standards in the profession. They argued that reducing the requirements in order to meet demand for more nurses would have a detrimental effect on standards of nursing care.

With reference to the existing education requirements, several respondents said that the **10-year option should be removed** as 12 years is the minimum that they feel would be necessary, or because they believe those applying to study nursing should have spent enough years in education to access a university-level programme. However, some respondents argued that 10 years is sufficient and the 12-year requirement should be dispensed with.

Suggestions from respondents included:

- Offering foundation courses or entry options which are not degree-level courses
- Recognition of work experience or non-standards educational backgrounds
- Assessing applications on an individual basis
- Recognition of qualifications only (rather than years of education)
- An entrance exam for nursing courses
- A compulsory work experience requirement.

> *"There are some fantastic people who would make great nurses but wouldn't pass the course. There needs to be stepping stones that can help people succeed at the university level – i.e. access courses that give them skills to pass the requisite exams and complete the course." –* ***Student Nurse, England***

Where respondents justified their rationale or suggestion, most said they had drawn upon their experience as a nursing professional. However, a few drew upon personal experience, referred to research[8] or drew on the way in which things are currently done.

1.3.2. Midwifery

A majority of midwifery respondents (~85%/n=1134) wanted to keep the

8 For example, one respondent referred to Crawford, C., Black, P., Melby, V. and Fitzpatrick, B., An exploration of the predictive validity of selection criteria on progress outcomes for pre-registration nursing programmes – A systematic review (Journal of Clinical Nursing, published online 02/03/2021).

current 12 year or equivalent requirement while just 10% (n=131) wanted to change it. A small number of respondents had no preference either way (~3%, n=36) or said they did not know (2%, n=30).

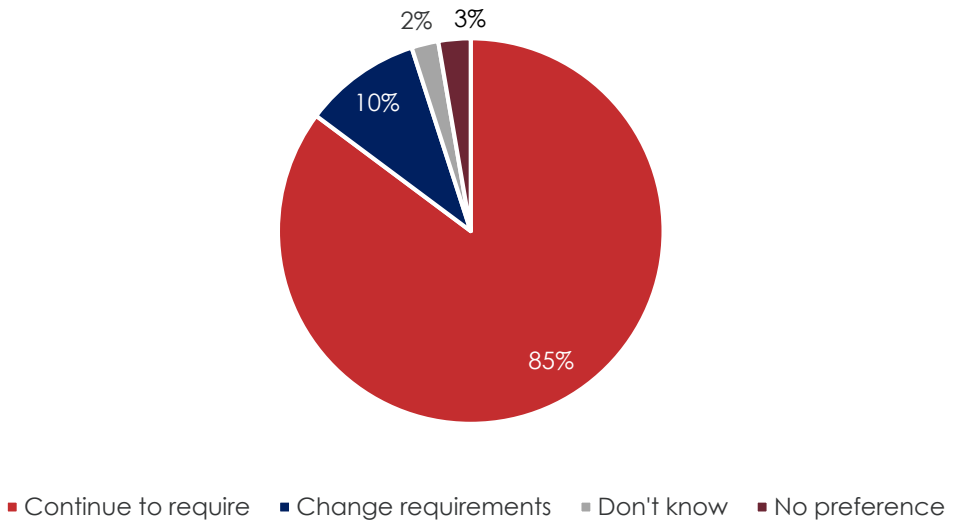

Figure 4: Question A4 - Do you think the NMC should continue to require people applying via Route A (Direct Entry) pre-registration midwifery programmes to have met 12 years of general education or exam passes? (n=1331)

Four nation differences

Across the four nations, **the proportion of respondents who wanted to maintain the status quo was higher in Northern Ireland (~89%, n=40) and England (~87%/ n=884) than in Wales (~81%/n=60) and Scotland (~78%/n=129)**. Wales had the greatest proportion of respondents supportive of changing the requirements at 16% (n=12).

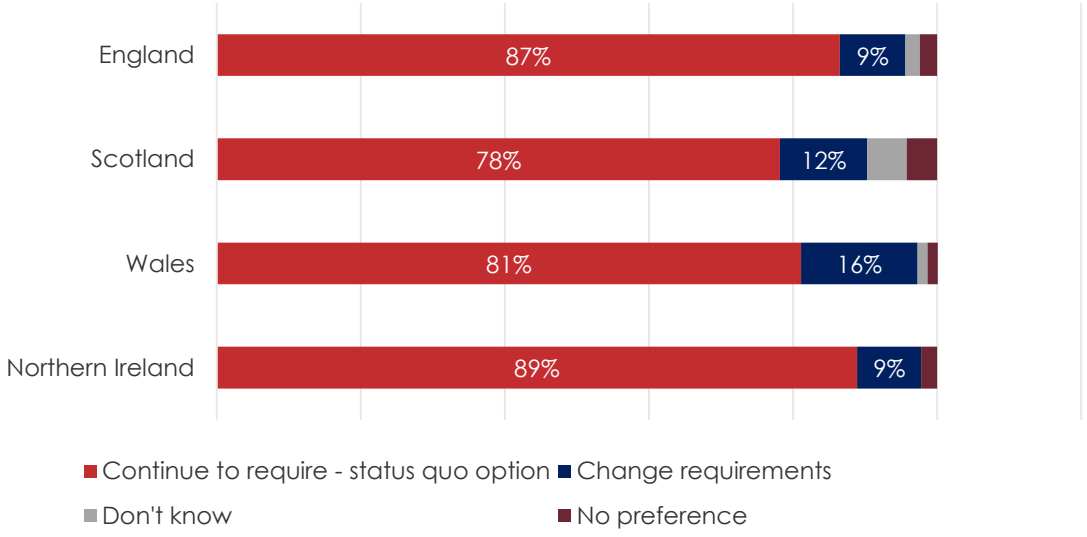

Figure 5: Question A4 - Do you think the NMC should continue to require people applying via Route A (Direct Entry) pre-registration midwifery programmes to have met 12 years of general education or exam passes? (n=1331)

Several respondents supported amending entry requirements in order to

increase access to the profession amongst those who may be unable to access education, lack the requisite grades, or are mature students with alternative experience. Some argued that **communication skills and willingness to work with people are equally as valuable as educational attainment**, whilst a few said that some current **graduates lack the requisite practical experience**.

A small number of respondents also said that amended entry requirements **could increase workforce diversity** or could **encourage applicants from non-EU countries**.

Several respondents suggested that all **midwifery applicants should be required to complete nursing training** before beginning on a midwifery programme in order to equip them for tackling medical conditions affecting adults under their care.

Other suggestions included:

- Basing entry requirements on qualifications (rather than number of years in education)
- Recognising work experience and non-standard educational backgrounds when considering applications
- Offering foundation courses or entry options which are not degree-level courses
- Aligning entry requirements with those for entry to nursing programmes
- Requiring work experience from applicants
- Assessing applications on an individual basis
- Reducing the minimum years requirements
- An entrance exam for midwifery programmes.

Several interviewees and a small number of survey respondents argued that **existing entry requirements should be retained**, typically in order **to ensure quality of care and protect women and newborn infant safety**. The interviewees argued that the entry requirements help to ensure that students have the academic and theoretical knowledge necessary to succeed throughout the course and their career. They referred to the mathematical knowledge required to calculate doses or literacy needed to write good essays and communicate with people who use services.

"You do need to have a good educational background to consider the course. Biology and science and maths are important. Basics around mental health/psychiatry. 12 years feel reasonable. Britain is a place well known for having a high standard [so] keep to this." – ***Midwife, Scotland***

Where respondents justify their answers, the vast majority refer to their own professional experience, with only a small number citing current practice, research or literature.

2. Professional qualifications to shortened midwifery programmes

2.1. Summary

Phase 1: Key partners were mostly supportive of allowing all fields of nursing to access shortened midwifery programmes – all were thought to have transferrable learning.

It was felt that widening access would make shortened midwifery programmes more sustainable as they are often undersubscribed.

Some felt that non-adult nurses' skillsets were too specialised while others thought they could bring specific skills that would improve standards of care. Some would rather encourage applicants from other health professions instead (e.g. paramedics).

Key partners feel there is a need for:

- **Midwifery learning outcomes to be clearly mapped against those of other healthcare disciplines before making any changes.**
- **Considering differing impacts across the four nations, especially regarding the need for cross-border working in NI/ROI.**

Phase 2: Survey respondents supported retaining the current entry requirements for shortened midwifery programmes this was largely consistent across the four nations.

Most felt that only adult nurses have the transferrable skills to midwifery and that other nurses/healthcare professionals would struggle to become competent in a shorter timeframe. Allowing this could lead to a potential a reduction in standards.

Suggestions for other fields/professions that could be eligible for shortened programmes in descending order are as follows: Children's nurses; Adult nurses (second level); Mental health nurses; Learning disability nurses; Nursing associates.

Those who supported changing requirements argued that learners from a wide range of disciplines would have transferrable skills that would expand the knowledge and skills base of the profession.

Some felt it was unfair to expect people with previous healthcare qualifications to complete a full-length midwifery course.

A few wanted to discontinue the short course altogether, as it was felt that even adult nurses could not become competent within the timeframe.

2.2. Phase 1: Interviews with key partners

2.2.1. Areas of consensus

Most key partners interviewed expressed **support for widening access to shortened midwifery programmes to include all fields of nursing**, rather than limiting access to adult nurses as is currently the case. It was felt that mental health nurses, children's nurses and learning disability nurses all possessed relevant prior learning that would enable them to succeed in shortened midwifery programmes.

Several interviewees highlighted that the Future Nurse standards[9] specify a number of **shared core competencies across all four fields of nursing**, many of which were seen as transferrable to midwifery. It was therefore anticipated that all qualified nurses would meet the minimum skills threshold required for success in shortened midwifery programmes, regardless of field.

> *"The position is that the restriction on shortened programmes needs to be reviewed. All types of nurses come with prior learning, and so a child and mental health nurse may well have prior learning that can allow them to do shortened programmes." –* ***Government stakeholder, Scotland***

Some key partners argued that **widening access to shortened midwifery courses would benefit the programmes themselves**, which are consistently undersubscribed. It was anticipated that changing the entry requirements for these courses would attract learners from a wider range of disciplines, thereby increasing application numbers.

2.2.2. Areas of divergence

Some key partners argued that the current entry requirements for shortened midwifery programmes should remain in place due to the **high degree of specialisation in non-adult nursing training** prior to the introduction of the Future Nurse standards in 2018. As such, these interviewees expressed concern that children's nurses, mental health nurses and learning disability nurses would not possess the skills needed to appropriately address women's physical health needs.

> *"As a country we have gone down the route of training specialists very early on, as a consequence there are gaps in [non-adult nurses'] skills and knowledge. For example, mental health nurses will have gaps in their physical health knowledge, while a children's nurse may know lots about neonatal care but not about caring for women. […] In terms of midwifery you need that broad understanding that you only get from the generalist training." –* ***Union/Professional body, UK-wide***

[9] https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/nurses/future-nurse-proficiencies.pdf

Some advocated for extending eligibility for entry to shortened midwifery programmes to **applicants with qualifications in other healthcare disciplines**, such as paramedics, whose skills may be more relevant to midwifery than those of specialist non-adult nurses. Similarly, several key partners felt that Maternity Support Workers would be suitable candidates for entry into shortened midwifery courses due to their exposure to clinical maternity environments. However, they also stressed the importance of comparing Maternity Support Worker competency frameworks across the four nations to ensure that all such frameworks are consistent with the learning outcomes of midwifery programmes.

2.2.3. Benefits and opportunities

Many key partners felt that widening entry to shortened midwifery programmes would bring significant benefits to the profession. It was widely assumed that widened entry to shortened programmes would **facilitate diversification of the workforce**, thereby expanding the range of lived experiences among midwives and increasing the knowledge base available to the profession.

On this latter point, participants highlighted specific skills possessed by nurses in each of the three non-adult fields – i.e. mental health nurses' relationship building skills, learning disability nurses' experience with complex needs, and children's nurses' neonatal care skills – that were expected to **improve the quality of care available to midwifery service users**.

> *"Specialist skills from the other fields would bring a useful mix into midwifery. It comes back to the people we serve – we serve women and families with mental health challenges and learning disabilities, and obviously children's nursing involves neonatal care – so why not?" –* ***Approved Education Institution, England***

Some key partners also argued that widening entry to shortened midwifery programmes would improve healthcare professionals' experiences of the sector by **removing barriers to transferring between professions**. It was thought that this would lead to improved retention rates by allowing professionals to pursue new interests and explore diverse opportunities for career progression.

2.2.4. Risks and challenges

Several key partners expressed concerns that widening access to shortened midwifery programmes would present **additional challenges for the regulation of midwifery education**, and argued that any changes would require extensive research into the overlap in competency outcomes between midwifery and any profession being considered for eligibility for entry to shortened programmes.

Some raised concerns relating to **differences between the four UK nations** and how these might undermine any changes to the existing entry criteria for shortened midwifery programmes. Some also stressed the need for the NMC

to consider how the competency frameworks for certain professions might differ across the four countries, and to ensure that eligible applicants from all UK nations would possess the skills required to succeed in a shortened midwifery programme.

A few key partners also felt that it was important that any change to the entry requirements for shortened midwifery programmes must not undermine regulatory alignment between Northern Ireland and the Republic of Ireland, given prevalence of cross-border working between two countries.

> *"For the proficiencies at registration, we need consistency or an agreement with the Republic of Ireland. We have quite a migrant workforce and nurses and midwives are working across both areas of the border. With any dramatic change, we would have concerns it would have an impact on our workforce." –*
> ***Government stakeholder, Northern Ireland***

2.3. Phase 2: Survey responses and follow-up interviews

2.3.1. Midwifery[10]

Survey respondents and interviewees answering the midwifery questions were asked whether they wished to **retain the current requirements for entry into shortened midwifery programmes (i.e. that applicants must have met the requirements of a formal qualification as a registered first level adult nurse), or whether there was scope for the NMC to explore options for changing these requirements.**

Most survey respondents felt that the NMC should **continue to require applicants to shortened midwifery programmes to have completed qualification as a registered first level adult nurse** (82%/n=1099). Only around 12% (n=163) of respondents felt that the current requirements should be amended, while a small number of respondents either did not know (3%/n=39), or did not express a preference (2%/n=32).

[10] Questions on shortened midwifery programmes were not asked to those who opted to answer only nursing questions in the survey, so there is no subheading for nursing in this section

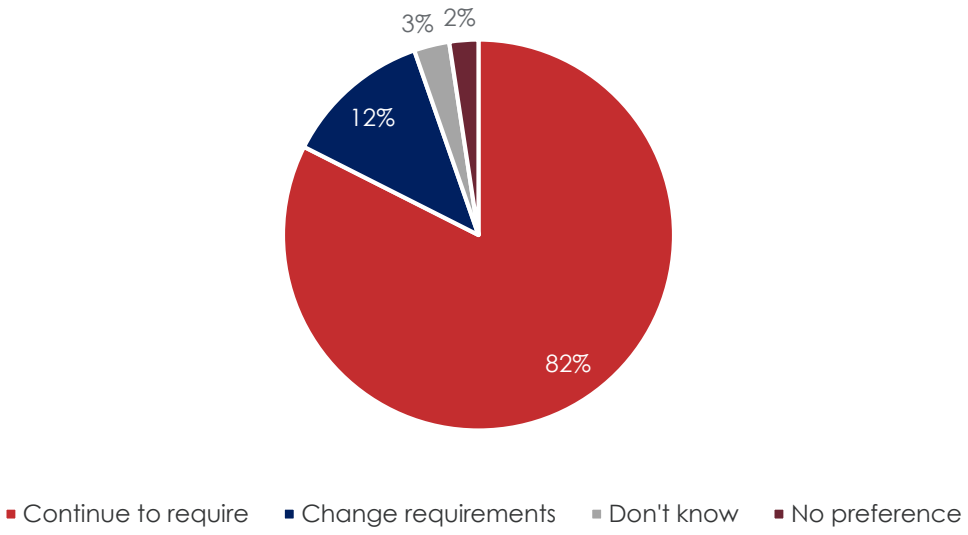

Figure 6: Question A7 - The NMC currently requires people applying via Route B (shortened midwifery programmes) to have met the requirements of a formal qualification as a registered nurse (first level) adult. Should the NMC continue to require this? (n=1333)

Four nation differences

Support for retention of the current entry requirements for shortened midwifery programmes was consistent across England, Scotland and Northern Ireland, while respondents from Wales were most in favour of keeping these requirements (87%/n=64). Similarly, **support for amending the current requirements was also consistent across England, Scotland and Wales**, with midwives from Northern Ireland most supportive of change (14%/n=6). The proportion of respondents selecting "don't know" ranged from around 1% in Wales (n=1) to approximately 5% in Northern Ireland (n=2).

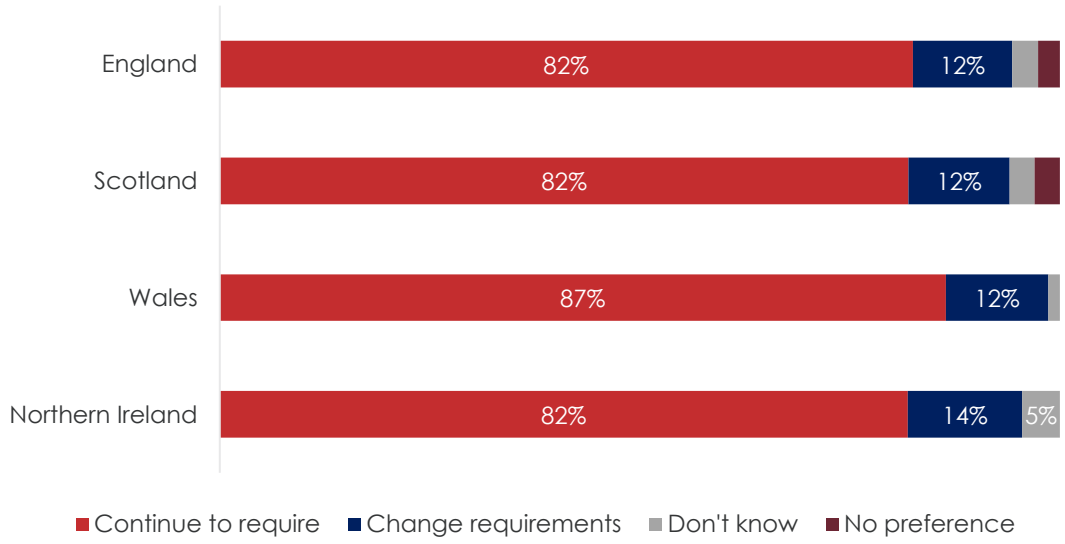

Figure 7: Question A7 – Breakdown by four nations: The NMC currently requires people applying via Route B (shortened midwifery programmes) to have met the requirements of a formal qualification as a registered nurse (first level) adult. Should the NMC continue to require this? (n=1333)

Most survey respondents and interviewees who opposed changing the existing entry requirements for shortened midwifery programmes argued that **only registered adult (first level) nurses have transferrable skills to midwifery**, and therefore that **applicants with other qualifications would struggle to meet the demands of the programme** given the shortened timeframe. This concern was exacerbated by a widespread misconception that shortened midwifery programmes would last for 18 months, as per the EU Directive, when in practice such programmes in the UK can take between 20 and 24 months.

> *The programme is very stressful even if you are an adult nurse – there are similarities but also differences. Adult nurses are the closest to midwives compared to other professions and nursing fields, and they find it stressful! If you're asking people whose skills don't overlap as much to do it in the same timeframe then that causes issues. If the entry requirements change would course content also need to change? In that case, what would be included, and how would you fit it into the 18-month timeframe? –* ***Student Midwife, England***

A few respondents expressed concern that **altering the entry requirements for shortened midwifery programmes would lead to inappropriate recruitment**, which could undermine professional standards and potentially compromise the safety of women and newborn infants. A small number echoed this point regarding the suitability of applicants, arguing that **first level adult nurses have already completed a degree-level programme and therefore possess academic skills** that may be lacking in learners with qualifications in other fields (although it should be noted that pre-registration nursing programmes are degree-level across all fields of practice).

Respondents who expressed support for changing the entry requirements for shortened midwifery programmes made a number of suggestions as to how the requirements might be amended. A majority of these respondents felt that **entry to shortened programmes should be extended to other fields of nursing**. While some wanted to admit first level nurses from all fields, others were only in favour of extending eligibility to specific fields.

As shown in Figure 8 below, **children's nurses were seen as the most suitable candidates for shortened midwifery programmes**, with around 65% of respondents supporting their eligibility (n=869), followed by mental health nurses (45%/n=581) and finally by learning disability nurses (41%/n=522). When it came to extending **eligibility for shortened midwifery programmes to non-(first level) nursing health professionals,** 55% (n=698) said it should be extended to second level adult nurses; and 30% (n=365) suggested it be extended to nursing associates.

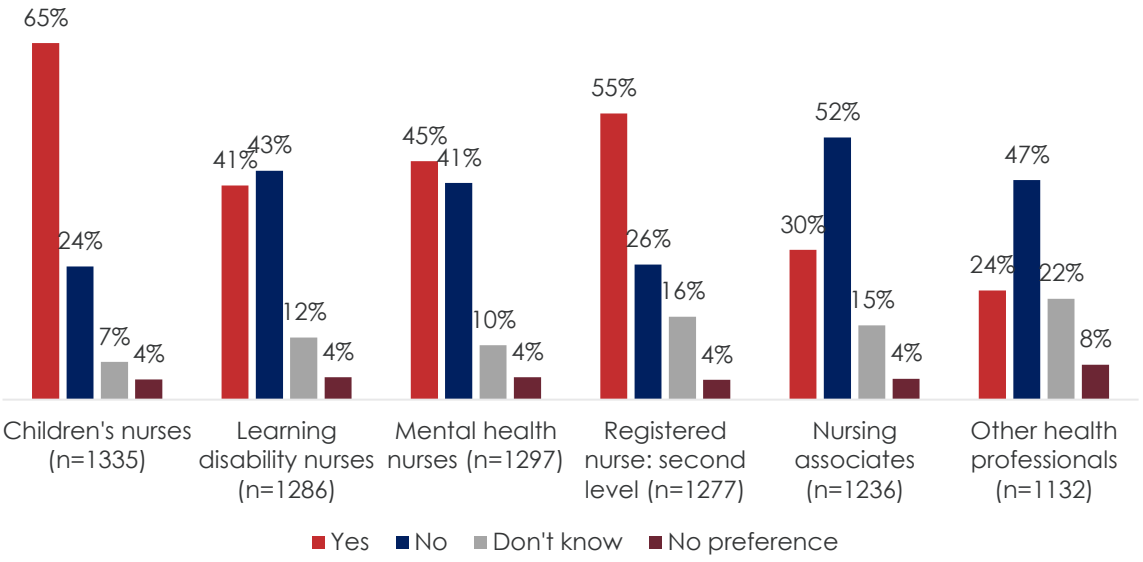

Figure 8: Question A9 - Shortened midwifery programmes are only available to first level nurses. Should the NMC stay aligned to the EU Directive or should they open access to (Route B) shortened midwifery programmes to others?

Asked to identify **other regulated health professionals who would be appropriate candidates for shortened midwifery programmes**, respondents identified:

- Paramedics (n=44)
- Physiotherapists (n=26)
- Allied health professionals (n=15)
- Doctors (n=15)
- Operating Department Practitioners (n=7)
- Health professionals who have completed a degree (n=3).

Some respondents also suggested that entry to shortened midwifery programmes should be exten**ded to unregulated health-adjacent professions, and/or to learners with partial or incomplete training, including**:

- Maternity support workers (n=7)
- Maternity Care Assistants (n=5)
- Physician Associates (n=3)
- Medical students who have partially completed (n=3).

Conversely, other respondents argued that **applicants from specific professions should be ineligible** for entry into shortened midwifery programmes. Others went further, arguing that **the short course should be discontinued altogether**, even for qualified adult nurses, due to concerns about fitting the required learning into a reduced timeframe.

Finally, a few respondents did not see the need for blanket entry criteria for specific professions, arguing instead that **applicants' suitability for shortened programmes should be assessed on an individual basis**, while a small

number felt that **shortened midwifery programmes should be available to any and all graduates**, regardless of their academic and professional backgrounds.

Sub group differences QA9

- Younger respondents were more likely to support opening access to children's nurses (76% vs 66%), second level registered nurses (79% vs 54%) and Nursing Associates (44% vs 22%).

- Ethnic minority respondents were more likely to support opening access to second level nurses (81% vs 66%) and Nursing Associates (51% vs 33%)

Among those respondents who supported changing the entry requirements for shortened midwifery programmes, a majority argued that **learners from a wide range of disciplines would possess relevant skills that could be transferred to midwifery**. Similarly, several respondents felt that **learners from disciplines other than adult nursing would bring new skills to the profession**, thereby widening the professional knowledge base and improving the quality of care for women and new born infants.

A similar point made by some respondents who favoured expanding eligibility for shortened midwifery programmes to all fields of nursing was that **nurses in all fields possess common skills**, and therefore it would be unfair to exclude non-adult nurses from shortened programmes. Further to this issue of fairness, a few respondents argued that **applicants with existing nursing and/or medical qualification could not reasonably be expected to complete a full-length course** in order to transition to midwifery.

In contrast to those who wished to widen access to shortened midwifery programmes, respondents who favoured discontinuing the shortened course entirely argued that **midwifery is a distinct profession to nursing**, and therefore that first level adult nurses do not possess the skills required to become a midwife within a shorter timeframe. Similarly, a few respondents advocated for discontinuing the shortened programme on the basis that the **timeframe is too short to become competent in midwifery**, regardless of any previous learning or experience.

> *"After discussing the shortened programme with midwives who completed it and students who are currently completing it, the overall opinion is that this training is very demanding, intense and stressful even with an adult nursing background, as the competencies that are common to both midwifery and adult nursing, while important are not the ones that are more central to midwifery. It would seem a disservice to professionals who do not even necessarily share those competencies to encourage them to complete the shortened programme." –* ***Student midwife, England***

3. Recognition of Prior Learning (RPL)

3.1. Summary

Nursing

Phase 1

Almost all key partners supported continuing to allow RPL for nursing to widen access to the profession and address staffing shortages.

Most nursing key partners supported aligning the approach to RPL across both professions in the interest of consistency.

Phase 2

Most survey respondents supported continuing to allow RPL for nursing – little variation in this across the four UK nations.

Allowing RPL was thought to widen access to the profession, leading to a more diverse workforce and more recruitment.

The main reasons for opposing RPL were that:

- **Any prior learning would be irrelevant to nursing;**
- **All nursing students should receive the same training;**
- **RPL puts all students (both with and without RPL) at a disadvantage.**

Midwifery

Phase 1

Most midwifery stakeholders supported introducing RPL for midwifery to facilitate the diversification of the workforce and to accelerate recruitment. However, there is seen to be a need for NMC guidance on the types of prior learning that would be appropriate for midwifery, given that RPL is not currently permitted for midwifery training in any EU or EU-aligned countries.

Phase 2

Most respondents supported introducing RPL for midwifery, as part of an effort to remove barriers to candidates with transferrable skills entering midwifery. However, guidance and/or a cap on RPL would be necessary.

The mains reasons for opposing RPL were as follows:

- **Any prior learning would be irrelevant to midwifery;**
- **RPL is unnecessary given the existence of shortened midwifery courses;**
- **All midwifery students should receive the same training;**
- **Difficulty in meeting all learning outcomes within a reduced timeframe;**
- **RPL would be difficult for AEIs to coordinate.**

3.2. Phase 1: Interviews with key partners

3.2.1. Areas of consensus

Key partners expressed **near universal support for continuing to allow RPL[11] for nursing programmes**. The most common justification for this position was that the use of **RPL removes potential barriers to entering the profession**, thereby improving diversity in the workforce and expanding nursing's knowledge and skills base, leading to improved quality of care for service users.

The continued allowance of RPL for nursing was also seen as **integral to addressing staffing shortages**, as allowing those with relevant prior learning to undertake shorter training programmes leads to a higher throughput of nurses into the workforce.

Most key partners were also supportive of introducing RPL for midwifery programmes, again due to the potential for increased diversification of the workforce, improved quality of care, and an acceleration of recruitment. However, several interviewees were keen to stress that midwifery and nursing are separate professions with different requirements and competency outcomes, and therefore that **the NMC should provide clear guidance** as to what prior learning would be considered suitable for entry onto midwifery programmes.

3.2.2. Areas of divergence

There was **no clear consensus among key partners as to whether the NMC should seek to align its RPL standards for nursing and midwifery**. Nurses and educators tended to favour regulatory alignment in the interests of consistency across the two professions, with several such interviewees pointing to a lack of compelling evidence for prohibiting RPL for midwifery programmes.

> *"I don't see any reason for a difference here. If it's a question of safeguarding, I'd ask why mothers and children require more protection than other vulnerable groups? I understand that midwifery has taken a stance that their profession has different requirements, but I'd want to challenge that."* – ***Approved Education Institution, Scotland***

In contrast, midwifery key partners largely argued against introducing RPL for midwifery purely in the interests of regulatory alignment. While they recognised that RPL would be implemented differently across the two disciplines, there was broad opposition to making any changes to existing practice in midwifery that might **encourage a perception of midwifery as a**

[11] In line with the EU Directive, applicants for pre-registration nursing programmes can currently request that prior learning is taken into consideration. This means the NMC can allow applicants (through their education provider) partial exemptions from the approved programme if they can demonstrate previous education and training on courses that are of an equivalent level.

form of nursing, rather than a distinct profession with a unique skillset.

Some key partners expressed concerns about allowing RPL for midwifery programmes. These interviewees pointed to a **lack of clear evidence supporting any change to the current standards** regarding RPL, although some suggested that they would be supportive of further research into the topic.

> *"There's no evidence base here, so we're slightly cautious about making any changes. There are no EU countries that permit RPL for midwives – it's the same for non-EU countries with similar midwifery practice to the UK such as Canada, Australia and New Zealand. The lack of research in this area means there's space for pilot programmes addressing this." –* ***Union or Professional Body, UK-wide***

A few interviewees did not understand the need to allow RPL for full-length midwifery courses in addition to offering shortened midwifery programmes for qualified (adult) nurses, and therefore **tended to favour widening access to shortened midwifery courses, rather than introducing RPL** (see "Entry to Shortened Midwifery Programmes").

3.2.3. Benefits and opportunities

Several key partners felt that introducing RPL for midwifery programmes would help **to overcome barriers to entry into the profession and facilitate increased workforce diversity** by encouraging applications from learners who could not commit to a full-length programme due to financial constraints or caring responsibilities. Furthermore, some interviewees expected that allowing RPL would open up midwifery courses to students with relevant learning, such as biomedical sciences, biology and psychotherapy, who would not be eligible for shortened programmes even with widened access, due to a lack of clinical experience.

> *"RPL allows for shortened programmes of study that take account of prior learning, especially at postgrad level – would allow qualitatively different types of people to enter the workforce. Nursing benefits from this already, but midwifery doesn't." –* ***Approved Education Institution, England***

Some argued that non-alignment with the EU Directive with respect to RPL for midwifery would also present an **opportunity to expand international recruitment**, by encouraging applications from non-EU learners with relevant experience that is not currently recognised.

A further opportunity identified by some was that introducing RPL might **allow midwifery students to transfer between universities** during their studies without the need to repeat modules.

3.2.4. Risks and challenges

Several key partners advocated for a cautious approach to introducing RPL

for midwifery, and suggested that the NMC should carry out extensive research into the extent to which midwifery learning outcomes can be mapped onto non-midwifery qualifications in order to ascertain which disciplines might be eligible for RPL.

Another concern expressed by some was that permitting RPL for midwifery might negatively impact students' experiences of the programme. Given the stringent competency requirements laid out in the Future Midwife standards and amount of content to cover in three years, these key partners felt that **introducing RPL might "set students up to fail"**, as they would be expected to meet extensive learning outcomes in a shorter timeframe.

> *"If anything, we'd want to see midwifery training extended to 4 years. Permitting RPL runs the risk of watering down midwifery – students might struggle to achieve all the learning outcomes of the Future Midwife standards." –* ***Education and Improvement Organisation, England***

Furthermore, a few key partners felt that extending RPL to pre-registration midwifery programmes would **put pressure on the university admissions process**, as it would increase the number of applications for courses that are already over-subscribed in some places.

3.3. Phase 2: Survey responses and follow-up interviews

3.3.1. Nursing

RPL for pre-registration nursing programmes

Survey respondents and interviewees answering the nursing questions were asked whether they were in favour of **continuing to allow RPL for pre-registration nursing programmes, or if the NMC should explore options for diverging from the EU in this area.**

Most respondents to the survey supported the **continuation of RPL for pre-registration nursing programmes** (90%/n=4823). Only around 6% (n=323) of respondents wanted to diverge from the EU Directive by removing the option of RPL for nursing education, while a small minority of respondents did not know which option they preferred (2%/n=122) or expressed no opinion either way (2%/n=94).

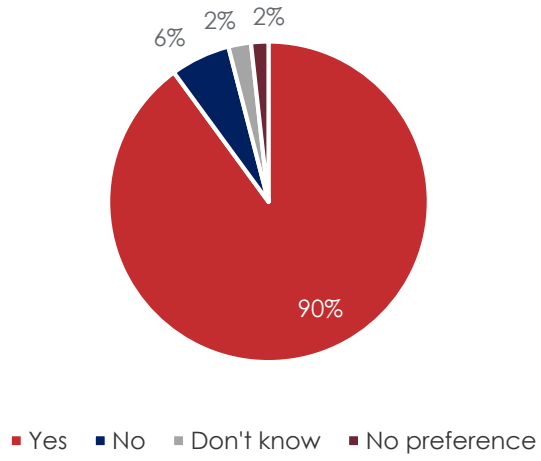

Figure 9: Question B1 - Do you think that previous learning should continue to be taken into consideration when people apply to a pre-registration nursing programme? (n=5,362)

Four nation differences

Support for continued alignment with the EU in terms of allowing RPL for pre-registration nursing programmes was largely consistent across the four UK nations, ranging from 88% in Northern Ireland (n=140) to 91% in Scotland and Wales (n= 483 and n=363 respectively).

Respondents from Northern Ireland were least in favour of continuing to allow RPL compared to respondents from the other UK nations, with 8% (n=13) not supporting the continuation of RPL. Respondents from Scotland and Wales had the lowest rate of opposition to RPL with around 5% each (n=28 and n=21 respectively).

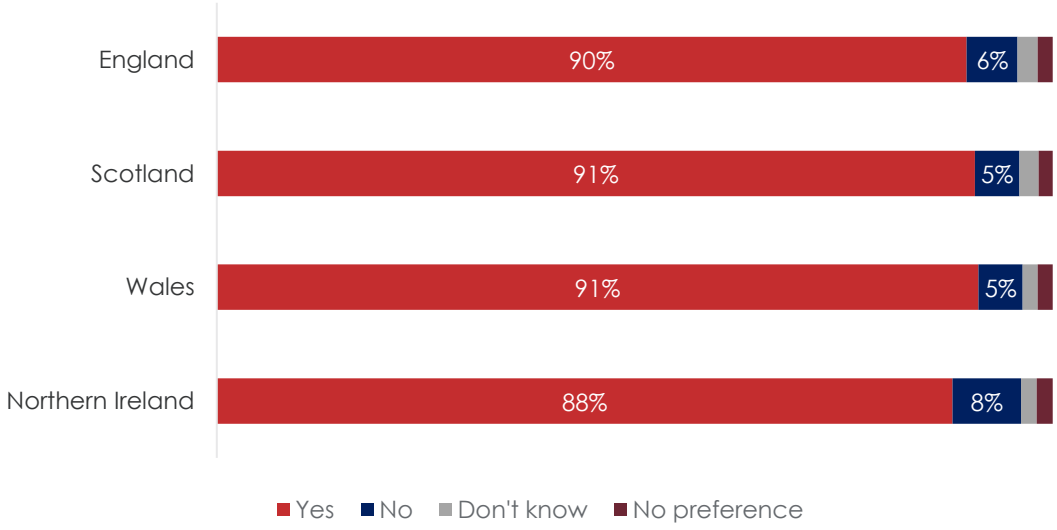

Figure 10: Question B1 – Breakdown by four nations - Do you think that previous learning should continue to be taken into consideration when people apply to a pre-registration nursing programme? (n=5362)

Those survey respondents and interviewees who wished to remain aligned to the EU Directive with regards to RPL argued that continuing to allow RPL would **widen access to the profession and enable recruitment** to address the

anticipated shortfall of nurses post-Brexit. Such arguments frequently referred to the significant time commitments of pre-registration nursing programmes, which may act as barriers to learners who have already completed some higher education and/or have responsibilities that are incompatible with long-term full-time study. Several interviewees felt that allowing learners to skip certain modules on the basis of relevant prior learning would **encourage a more diverse range of applicants** into the profession, bringing with them a range of experiences and skills that would expand the knowledge base within the profession and improve the quality of care for service users.

> *"When I was mentoring students, people came in from a variety of backgrounds with transferrable skills – it's all useful, as long as it's quantifiable and measurable. As a registrant I think [removing RPL] would be negative – it would make it harder for people from different backgrounds to get into nursing and reduce the experience pool within the profession. I've worked with students from different backgrounds and learnt a lot from them – their different perspectives make me look at things in a different way. If you narrow the profession to a more constricted group of people it disadvantages older people entering the profession later on, as their experience wouldn't be counted as part of their skillset. We need to make access as wide as we can without watering down the standards." –* ***Nurse, England***

Survey respondents and interviewees who advocated for changing the existing standards regarding RPL fell into two similarly sized camps. Such respondents argued either for **a blanket ban on RPL** for pre-registration nursing programmes, or for the introduction of **strict guidance on when and how RPL should be used**. In the latter case, respondents felt that only healthcare-specific learning should be counted towards RPL and that the NMC should set a maximum cap for theory and practice hours that could be skipped on the basis of prior learning. In some instances, respondents argued that RPL should only count towards theory hours, and that students should not be expected to complete fewer practice hours due to prior learning.

Survey respondents and interviewees who argued for a change to existing standards regarding RPL provided a range of reasons for their position. The most common justification was that any **prior learning must necessarily be irrelevant** to students' ability to navigate pre-registration nursing programmes. Interviewees who expanded on this point felt that previous experience of academia was not sufficient for students to skip certain elements of their nursing education, due to the uniqueness of the profession and the strong emphasis on practical skills.

> *"If you've got a degree there are some things that are relevant, like how to handle university, but there could be nothing in the content of your degree that helps you in nursing. There is so much to cover in the nursing programme – even people with experience can lack the theoretical knowledge about why they are doing*

what they are doing. […] Someone who has a degree might be able to navigate the library and write an essay, but with the different topics like pharmacology being introduced in year one of a nursing course it's important that time isn't deducted from this year, otherwise they would miss out." – ***Nurse, Northern Ireland***

Several respondents advocated for the removal of the RPL option to **ensure that all nursing students receive the same training**. Similarly, a small number of respondents and interviewees felt that the continuation of **RPL would put patient safety at risk,** due to a concern that students might graduate without demonstrating competence in all required skills (although in practice students with RPL would still be subject to the same sign-off procedures as their peers).

Another justification put forward by several respondents was that **students who skipped certain training due to RPL would be at a disadvantage**, as they would have a shorter timeframe in which to learn and demonstrate the same skills as their peers. However, some made the opposite point, arguing that continuing to allow RPL would **disadvantage those students without relevant prior learning** who would be expected to complete more theory and practice hours and would likely incur higher tuition and maintenance costs as a result.

3.3.2. Midwifery

RPL for pre-registration midwifery programmes

Survey respondents and interviewees were asked whether they would be in favour of allowing RPL for pre-registration midwifery programmes, or if the NMC should remain aligned with the EU in this regard.

The majority of respondents were in favour of diverging from the EU Directive to allow RPL for pre-registration midwifery programmes (71%/n=944). There was therefore less support for RPL overall than was the case for nursing programmes. This was largely due to a lack of awareness of compelling evidence in support of changing the existing standards for midwifery. Around 21% (n=280) of survey respondents opposed the introduction of RPL for pre-registration midwifery programmes, while a few respondents felt that they did not know whether RPL should be introduced (6%/n=83) and a small number did not express a preference either way (2%/n=28).

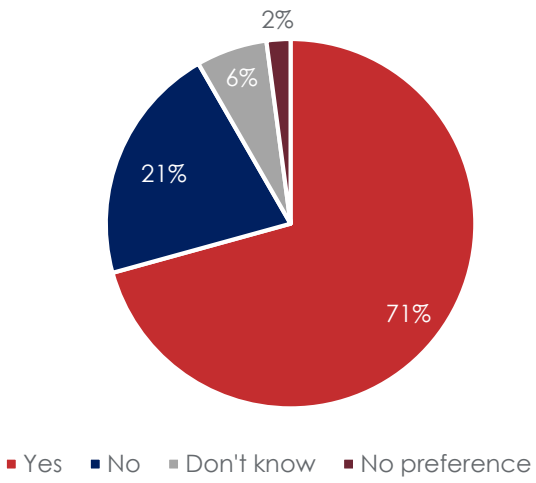

Figure 11: Question B3 - Do you think that previous learning should be taken into consideration when people apply for a pre-registration midwifery programme? (n=1335)

Four nation differences

While a majority of midwives in all four UK nations were in favour of introducing RPL for pre-registration midwifery programmes, there was **notable variation between countries**, ranging from around 80% (n=133) in Scotland to as low as approximately 62% (n=28) in Northern Ireland. England and Wales had similar levels of support for RPL, with around 70% (n=716) and 69% (n=51) respectively.

Sub group differences B3

- Younger respondents were more likely than older respondents to agree that that previous learning should be taken into consideration when people apply for a pre-registration midwifery programmes (82% vs 61%).

There was also some notable **variation in the degree of outright opposition to the introduction of RPL** for midwifery, which broadly reflected the level of support outlined above. Respondents from Northern Ireland were most opposed to RPL (27%/n=12), while Scotland had the lowest rate of opposition (17%/n=28).

It should be noted that while the data would suggest that RPL for midwifery is particularly unpopular in Northern Ireland, it may be difficult to draw any conclusions from this given the small sample size of respondents from Northern Ireland, as well as the underrepresentation of students within this sample. (See the Research Approach section for a breakdown of respondents.)

The number of respondents who did not express an opinion for or against the use of RPL for midwifery also varied across the four nations, although across the board respondents were more likely to opt for "don't know" than for "no preference". Indeed, no respondents in either Wales or Northern Ireland reported a lack of preference on this issue.

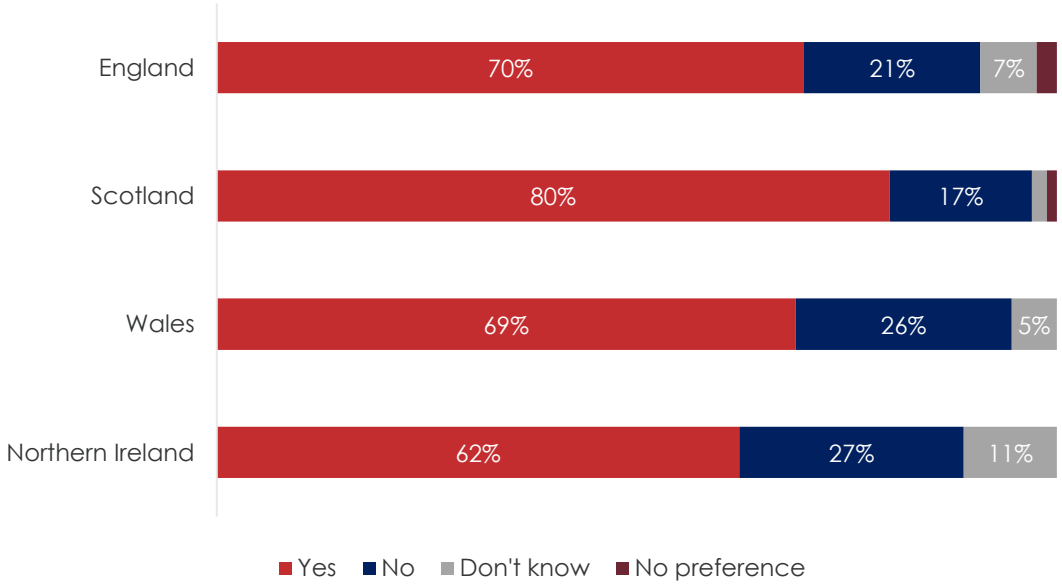

Figure 12: Question B3 – Breakdown by UK nation - Do you think that previous learning should be taken into consideration when people apply for a pre-registration midwifery programme? (n=1,335)

Of those survey respondents who made suggestions as to how RPL might be implemented for pre-registration midwifery programmes, **most did not see the need to impose limits on when and how RPL should be used**. However, a few respondents argued that there should be **strict criteria in place as to what could be deemed "relevant" prior learning** and that this should be limited to subjects and skills with direct relevance to midwifery, such as anatomy and physiology, pharmacology, and nursing skills. Furthermore, a small number of respondents advocated for the **introduction of a cap on the number of modules that could be skipped** on the basis of prior learning.

The majority of survey respondents who supported introducing RPL for pre-registration midwifery programmes felt that **applicants with previous higher education experience would be likely to possess transferrable skills** that would make them good candidates for the profession. Similarly, many respondents felt that **the current system would dissuade such candidates from joining the profession**, as they would be expected to repeat modules that they had previously covered. Some interviewees highlighted their own experiences of having to repeat previous learning during their midwifery education, despite their extensive experience.

> *"Before midwifery I was a biologist – I have a PhD – so some of what was being taught in midwifery was very basic for someone with my background. […] I went to my tutor and said, "I've done this, I've got a PhD!", but I still needed to do the assessment. Previous learning should be considered in this kind of situation." –* ***Midwife, Scotland***

Similarly, several respondents felt that introducing RPL would **enable other medical professionals to transition more easily into midwifery**, thereby

expanding the profession's knowledge base and improving care for women and newborn infants. Furthermore, a small number of respondents advocated for the introduction of RPL on the basis that they were not aware of any compelling evidence supporting the lack of alignment with nursing in this regard.

Many survey respondents who opposed the introduction of RPL for pre-registration midwifery programmes argued that **any prior learning would be irrelevant**, as the skills required for midwifery are unique to that profession. Similarly, several respondents felt that **only qualified adult nurses would have relevant prior learning** for midwifery, and therefore did not see the need to introduce RPL given the existence of the shortened programme.

Several survey respondents and interviewees felt that **all midwifery students should receive the same training**, in order to maximise consistency in graduates' level of competence. This point was echoed by a small number of respondents who expressed concern that **allowing RPL for midwifery would present a risk to the safety of women and newborn infants**, as some students would have received less training than others and therefore may be less competent.

Other respondents raised practical concerns about how RPL might impact the design and delivery of pre-registration midwifery programmes as well as the experiences of midwifery students, including:

- Students with prior learning would be at a disadvantage compared to their peers, as they would be **expected to meet the same requirements within a shorter timeframe**;
- RPL would be **too difficult for AEIs to coordinate**, as the degree and relevance of student's prior learning, and the modules that they could skip based on this, would need to be assessed on an individual basis; and
- Allowing RPL for some learners would be **unfair for those students without relevant prior learning**, who would have to complete a longer course with higher associated costs.

Need for RPL alongside shortened midwifery programmes

Survey respondents and interviewees were asked whether they would support the continued existence of shortened midwifery programmes should RPL be introduced for midwifery.

A majority of respondents (~59%/n=789) were in favour of continuing to offer shortened midwifery programmes alongside RPL, while only around 17% (n=224) advocated for the discontinuation of the shortened programme in the event of RPL being introduced for midwifery. Interestingly, these respondents were outnumbered by those survey respondents who indicated that they did not know whether there would be a need for shortened midwifery programmes should RPL be introduced (24%/n=315).

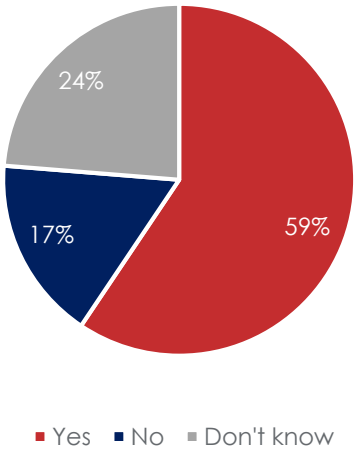

Figure 13: Question B5 - If recognition of prior learning for pre-registration midwifery programmes is introduced, would (Route B) shortened midwifery programmes for qualified registered nurses (first level) adult be required? (n=1328)

Four nation differences

Support for the continuation of shortened midwifery programmes alongside RPL was largely consistent across the four UK nations, ranging from 58% in England (n=593) to approximately 64% in Scotland (n=106). There was even less variation in opposition to retaining shortened programmes, which ranged from approximately 16% in Scotland (n=26) to around 19% in Wales (n=14).

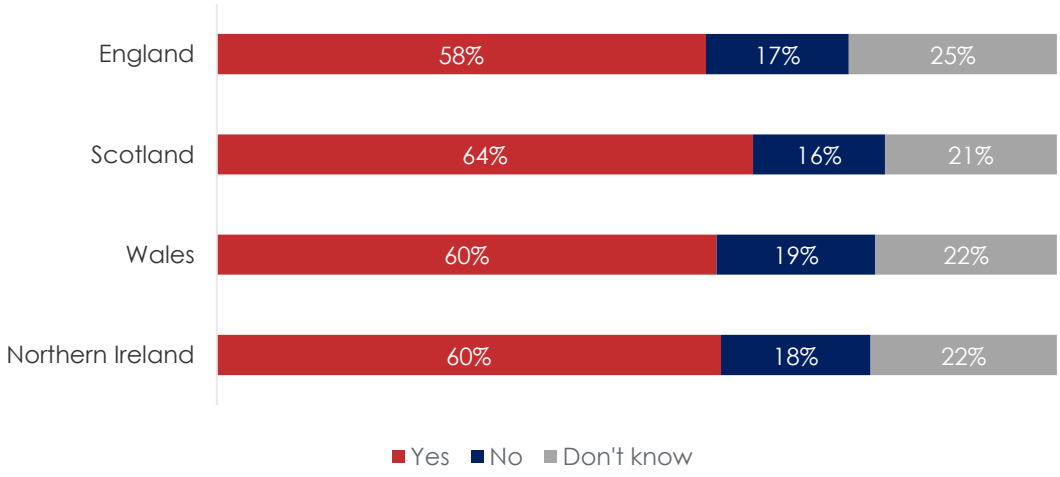

Figure 14: Question B5 – four nation breakdown - If recognition of prior learning for pre-registration midwifery programmes is introduced, would (Route B) shortened midwifery programmes for qualified registered nurses (first level) adult be required? (n=1328)

Respondents who felt that shortened midwifery programmes should continue to exist should RPL be introduced had two main justifications for their position. Some such respondents argued that **having both options in place would widen access to midwifery** and encourage applications from a wide range of disciplines, thus improving the profession's knowledge base and improving care for women and newborn infants. Others argued that it would make sense to **retain a specific pathway for adult nurses to enter midwifery**, as all

such applicants would have common learning and could undergo the same training, while **also allowing RPL for learners from other backgrounds** to be assessed on a case-by-case basis.

Several of those survey respondents and interviewees who did not see the need for shortened midwifery programmes in addition to RPL argued that the existing 2-year option is too short for students to become competent in all required skills. They therefore advocated for **introducing RPL in place of shortened programmes** on the understanding that it would only count towards theory hours and that learners would still undergo a minimum among of clinical practice.

> *"I would rather see RPL than shortened programmes – it would offer more flexibility to more people. Retaining practice hours is important unless [students] have specific clinical skills – it's easier to transfer theoretical knowledge." –* ***Student Midwife, England***

Respondents who did not indicate a preference as to whether the existing shortened course should continue in the event of RPL being introduced said they felt **unable to comment without direct experience of either pathway**.

4. Knowledge and skills

4.1. Summary

Nursing

Phase 1: Most key partners felt that the knowledge and skills requirements in the EU Directive were out of date and so were in favour of them being reviewed and updated. This would allow NMC to better account for changes in how healthcare is delivered and the future direction of travel.

There were mixed views about whether to expand generalist training applicable to all nursing fields or to extend the field-specific knowledge and skills requirements. Some wished to assess the impact of the Future Nursing Standards before considering any changes. Some felt changes to the requirements might give scope to meet regional and national needs.

Phase 2: The great majority of respondents said that the knowledge and skills specified in the EU Directive were necessary for safe and effective nursing care. However, respondents had an appetite to review and update the requirements as they felt that they were out of date or not reflective of modern nursing; with many of these respondents calling for a greater emphasis on specific nursing specialisms, on practical training and the real life application of skills, as well as on more detailed knowledge of anatomy and physiology. Several also felt that learning disabilities should be included in the requirements.

Midwifery

Phase 1: There was some support for reviewing the skills and knowledge requirements for midwifery. However, the question of the specified 'numbers' was acknowledged as complex and controversial. Some felt that the numbers aid consistency and were helping to support safe and trusted services, suggesting that a move away from the numbers could impact public attitudes to midwifery. Others felt the 'numbers' requirement does not adequately measure the competence of students and does not help them to support a women in her whole journey through maternity care. Some endorsed a mixed approach, with minimum numbers being set alongside an increased focus on outcomes and competencies.

Phase 2: Most respondents agreed the knowledge and skills specified are necessary for safe and effective care and that the NMC should continue to specify the number of occasions on which skills must be performed. However, respondents had mixed views about the appropriateness of the current numbers-based requirements and many suggested different ways in which these might be reviewed and amended. A small number called for moving away entirely from minimum numbers in favour of taking a more holistic view focused on antenatal and postnatal care. The majority of registrant and student interviewees support the continued use of numbers.

4.2. Phase 1: Interviews with key partners

4.2.1. Areas of consensus

Nursing

Many felt that the knowledge and skills requirements in the EU Directive were out of date and so were **in favour of them being reviewed and** updated (as has taken place when creating the Future Nurse Standards). This was seen to allow the NMC to better account for changes in how healthcare is currently delivered and the future direction of travel (e.g. increasing use of telemedicine).

Some noted that the EU Directive is subject-matter based rather than skills-based and is therefore not reflected in university courses which take a combined approach. A few interviewees welcomed looking to other countries such as Australia and New Zealand for guidance or comparison.

Midwifery

Whilst many were in favour of the NMC **reviewing the skills and knowledge requirements for midwifery** (as happened as part of the Future Midwife Standards), many also agreed that the issue of 'numbers' would be **divisive and controversial**. They often acknowledged the **complexity of the issue**.

4.2.2. Areas of divergence

Nursing

Some interviewees said that changes to the knowledge and skills requirements should give AEIs **greater scope to respond to specific regional and national needs** (i.e. Welsh speakers, rural nurses). However, some added that minimum standards and some level of consistency was nevertheless important.

There was disagreement about **whether to expand the generalist training applicable to all fields of nursing or to extend the nursing field-specific knowledge and skills requirements**:

- Some felt the EU Directive encouraged covering all the skills within the different fields of nursing, which wasn't practical or necessary. They wanted to prioritise the most important skillsets within each field to make the programmes more manageable.
- Others wanted a more generalist training, which included a wider skillset (i.e., digital capabilities) and exposure to a wider range of experiences and areas of nursing (e.g. community or prison nursing).

Some also felt that the NMC should **build in flexibility and make changes in the types of placements students are required to complete**, as some are harder to access. However, this was an area where many universities reported they had already worked to make alternative placements.

A few interviewees wanted to wait and see what the impact of the skills and

knowledge requirements in the **Future Nursing Standards** are through evaluation, before making further changes. Others pointed out that removing EU requirements would not make much difference if the current **NMC standards were kept, as these are higher than the Directive's skills and knowledge requirements.**

Midwifery

There were **mixed views** amongst key partners on the issue of 'numbers'. Some emphasised **the importance of competence** and suggested that the **numbers were arbitrary or based on little evidence**. They often called for the numbers to be **reviewed** or to be removed altogether and **replaced by a different mechanism for assessing competence**. A few also described difficulties in meeting the required numbers due to lack of opportunities.

> *"Specifying to this extent and in this way doesn't demonstrate competency, the descriptions and numbers don't allow students to be well rounded midwives." –* ***Education and improvement organisation, Wales***

However, **some were supportive of the existing numbers** as they said that they have been used for a number of years and **provide consistency and assurance of standards**. A few also argued that these numbers align with those adopted by different countries across the world.

> *"This is a complex area – the work I've done on this suggests that although the numbers seem arbitrary everyone seems to think it achieves the desired outcome. Consistency of this approach is attractive [and] all midwives have a minimum level of experience [which] demonstrates achievement of minimum standard." –* ***Union or professional body, UK***

Some endorsed a mixed approach, with minimum numbers set as a benchmark but an increased focus on achieving particular outcomes and competencies.

> *"I think there is a case for a combination of numbers and an outcomes-based approach, that reflects a rounded experience of the student [but this is] not an easy thing to do – hard to work this out." –* ***Government stakeholder, Scotland***

4.2.3. Benefits and opportunities

Midwifery

Several key partners saw this as an opportunity **to review the evidential basis for the existing numbers** and thereby determine whether the current levels are justified or whether changes are required.

A few also said that the numbers can pose challenges for students who struggle to meet the target level due to availability of opportunity. They suggested that **a more outcome-focussed system or a greater role for simulation may reduce this challenge for students**.

"Disproportionate impact on Scotland that has remote and rural populations. For example, for a Shetland based student 40 births is a very tall order." – ***Government stakeholder, Scotland***

4.2.4. Risks and challenges

Nursing

Some suggested that it would be a challenge to change education programmes if the NMC made a significant move away from the EU Directive on skills and knowledge, especially since the programmes are new.

Midwifery

Some felt that moving away from EU Directive **risked undermining a system that was currently producing safe and competent midwives**. Amongst key partners expressing this view the preference was to keep a numbers-focused approach or to have a combination of numbers and outcomes.

"NMC trained midwives are very sought after – we need to be mindful of that, we're clearly doing something right. Why fix what isn't broken?" ***– Government stakeholder, Northern Ireland***

Others suggested that **the repetition associated with the prescribed numbers was helping students to develop skills**, especially those that were very physical in nature like a birth.

"A birth will likely always be a significant learning experience for a [student] midwife because there is important care taking place – whereas it cannot be guaranteed there will always be significant learning experiences during hours spent in clinical practice for nursing students." ***- Union/professional body***

Some said that numbers provide **consistency about expectations and help reassure the public about midwifery standards**. It was suggested that a shift away from 'the numbers' could be the riskiest move in terms of the public attitudes towards midwifery.

4.3. Phase 2: Survey responses and follow-up interviews

4.3.1. Nursing

Skills and knowledge requirements for pre-registration nursing programmes

91% (n=4868) of respondents said that the knowledge and skills specified in the EU Directive are necessary for safe and effective nursing care, with only 8% (n=401) disagreeing with this statement.

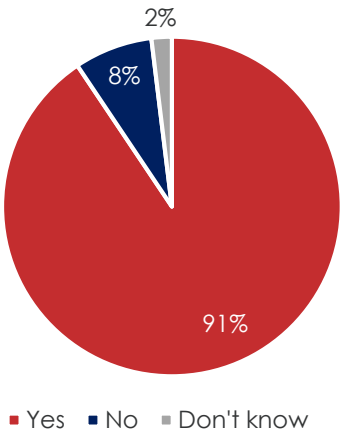

Figure 15: Question C1 - Do you think the knowledge and skills specified within the EU Directive are necessary for safe and effective nursing care? (n=5,373)

Levels of support for the knowledge and skills specified by the EU Directive were broadly consistent across the four nations of the UK.

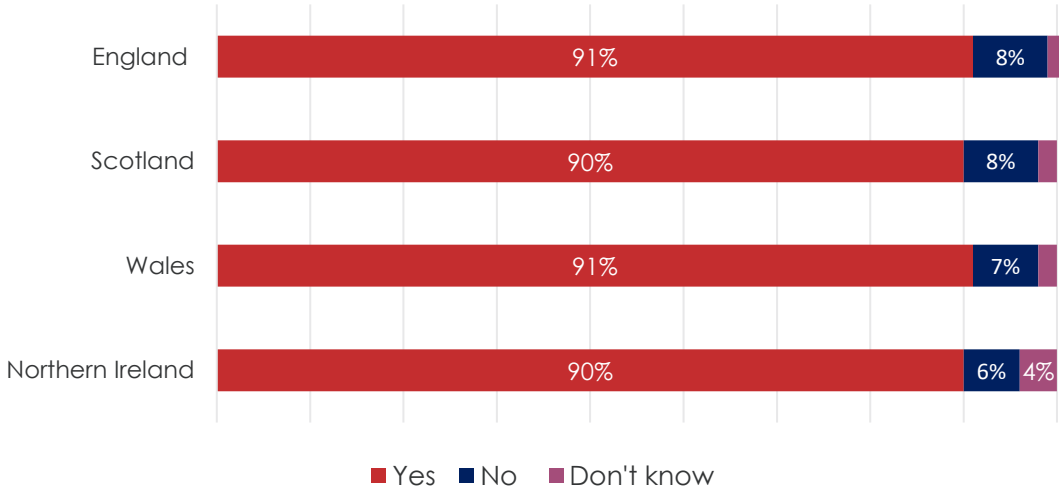

Figure 16: Question C1 – Four nation breakdown - Do you think the knowledge and skills specified in within the EU Directive are necessary for safe and effective nursing care? (n=5,373)

Many of the respondents who commented on the knowledge and skills required for safe and effective nursing care suggested elements which might be added to the requirements or be given increased emphasis.

The most common suggestion was that there should be a **greater focus on clinical or practical skills**. These respondents often said that some important aspects of nursing care cannot be learnt in theoretical settings and emphasised the need for adequate placement opportunities. They also said that **this helps build the confidence necessary for working competently and autonomously**. This point was also made in interviews by some nurses who, though they broadly support the requirements, felt that the balance could be adjusted.

"Yes, these are the right skills but I think for me it could be even

more balanced towards the more practical stuff – I remember the last several attempts at changing nurse training and in my opinion we have swung too far towards the academic portion time." –
Nurse, Scotland

Several respondents suggested the need for **greater understanding of anatomy, physiology and pharmacology**, and this was echoed by some of the nurses who participated in the depth interviews. Another common suggestion in the survey was that **learning disabilities should be included as part of the core requirements**, distinct from mental health, and that mental health itself should also have greater focus.

Meanwhile, several of those who made suggestions proposed **an increased emphasis on community care or care in primary settings** rather than an acute focus. Some tied this to a need for greater understanding of determinants of health and the role of the nurse in health promotion.

Other elements which respondents suggested should be included or given greater focus included (but were not limited to):

- Communication skills
- Palliative care
- Research and evidence-based practice
- Sustainability and environmental issue related to nursing
- Digital healthcare.

Some respondents suggested that there is **a need to focus on fundamentals and basic skills in training programmes**, and a few argued for the introduction of a compulsory preceptorship after qualification.

Conversely, several respondents suggested elements of the existing knowledge and skills requirements which could be removed or de-emphasised. These included suggestions that there was **no need to learn social sciences** (such as sociology and psychology) or history of nursing as part of the course, and that it was **unnecessary to develop skills or knowledge which would likely be covered by a more specialist professional** (e.g. children's/maternity care or radiology).

Meanwhile, several respondents suggested that the skills and knowledge requirements **should be tailored to specific nursing specialisms** so that students do not spend time learning a skill which they will not use in their careers. Some suggested the existing requirements are geared towards generalist or Adult nursing, whilst others say that paediatric and midwifery skills are not necessary for Adult nurses.

Where respondents provided a rationale for why they think the knowledge and skills requirements need to be changed, they most often said that **they are outdated.** These respondents argued that the knowledge that the requirements **do not reflect modern nursing practice**, and a few challenged whether some of the terminology was still appropriate (e.g. 'geriatrics').

Meanwhile, some said that the skills and knowledges requirements should change because **the skills necessary vary depending on your field of nursing** and the specific role you are moving into, whilst others argued that the requirements do not necessarily assess competency or proficiency and this may mean that theoretical knowledge does not translate into practical skill. Some also believe that it is **difficult to cover all of the required skills in a three year course** and therefore elements are missed or not covered in sufficient detail, whilst some suggest that the requirements are unnecessarily prescriptive.

Only a small number of respondents commented on why they supported the retention of existing standards. Those who did often simply said that the existing **requirements are important or valid**, or that they **help to ensure consistency across programmes**. However, the majority of interviewees said that the skills and knowledge listed appeared appropriate as they provide a **good baseline understanding** and equip student nurses with the **essential knowledge** that they will need in their careers.

> *"Drawing on discussions with colleagues – there was no debate, everyone is in agreement. Everyone thought everything on the list was still current and relevant. There was no debate on whether anything should be added or taken out." –* ***Nurse, Wales***

Where respondents justified their responses or suggestions, they mostly said that their responses were based on their own experiences and observations in the course of their studies or work. A small number also referenced existing standards (such as the Future Nurse Standards) or cited specific research.

4.3.2. Midwifery

Skills and knowledge requirements for pre-registration midwifery programmes

86% (n=1150) of respondents said that the knowledge and skills specified in the EU Directive are necessary for safe and effective midwifery care, with only 10% (n=131) disagreeing with this statement.

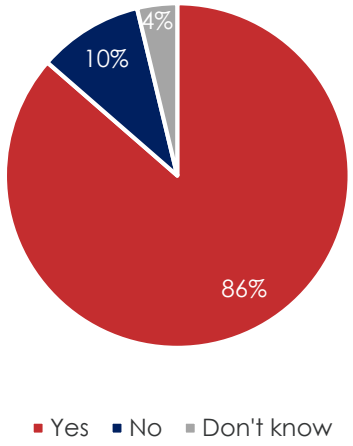

Figure 17: Question C3 - Do you think the knowledge and skills specified within the EU Directive are necessary for safe and effective midwifery care? (n=1,331)

71% (n=951) of respondents to the midwifery questions said that specifying the number of occasions on which specific skills must be performed during the pre-registration programme was necessary for safe and effective midwifery care, while. 24% (n=318) of respondents disagreed.

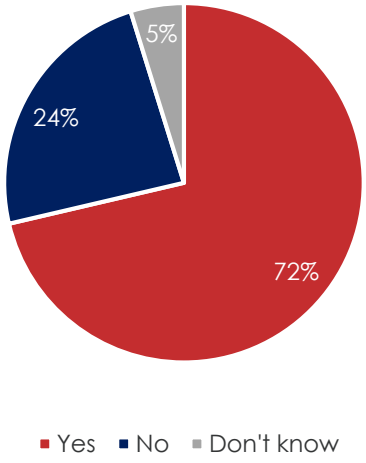

Figure 18: Question C5 - Do you think specifying the number of occasions a specific skills must be performed is necessary for safe and effective midwifery care? (n=1,333)

Similarly, 74% (n=987) of respondents to the midwifery questions said that the NMC should continue to specify the number of occasions on which skills must be performed, whilst 20% (n=260) felt that they should not.

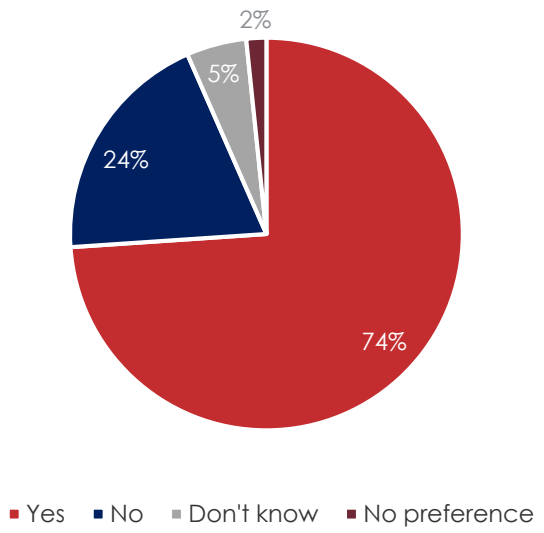

Figure 19: Question C6 - Do you think the NMC should continue to specify the number of specific occasions skills must be performed? (n=1,335)

Four nation differences

Levels of support for the knowledge and skills specified within the EU Directive were around 10% higher in Northern Ireland (n=42) than in England (n=878) or Scotland (n=141).

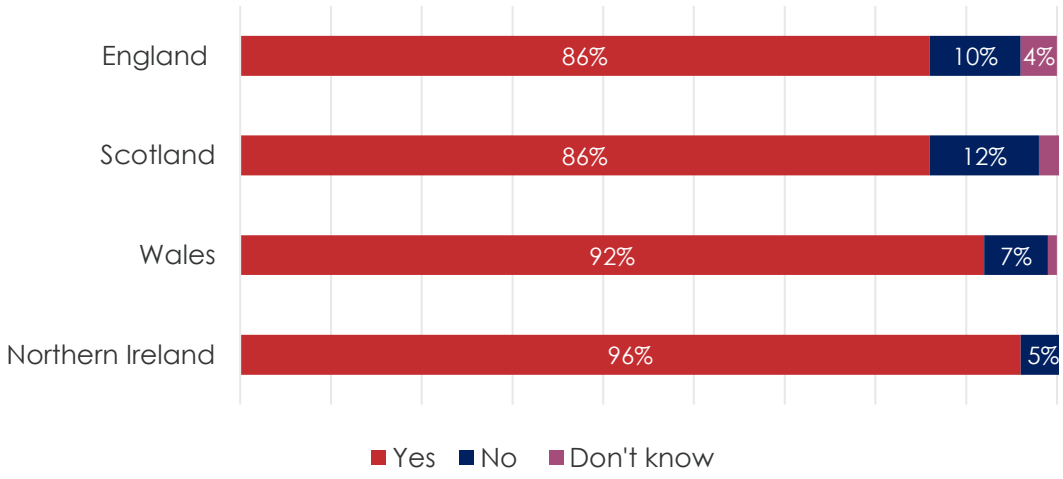

Figure 20: Question C3 - Do you think the knowledge and skill specified within the EU Directive are necessary for safe and effective midwifery care? (n=1,331)

Sub group differences C3, C5 and C6

Older respondents were more likely than younger ones to agree that:

- The knowledge and skills specified within the EU Directive is necessary for safe and effective midwifery care (94% vs 89%)
- Specifying the numbers of occasions a specific skill must be performed is necessary for safe and effective midwifery care (86% vs 70%)

- The NMC should continue to specify the number of specific occasions skills must be performed (91% vs 72%)

When asked whether it was necessary for safe and effective care to specify the number of occasions on which a skill must be performed, the number of respondents who felt this to be the case was 10% higher (n=61) in Wales than in England (n=724) or Northern Ireland (n=33) and 15% higher (n=111) than in Scotland. Similarly, the number of respondents who disagreed was significantly lower in Wales than in any of the other four nations.

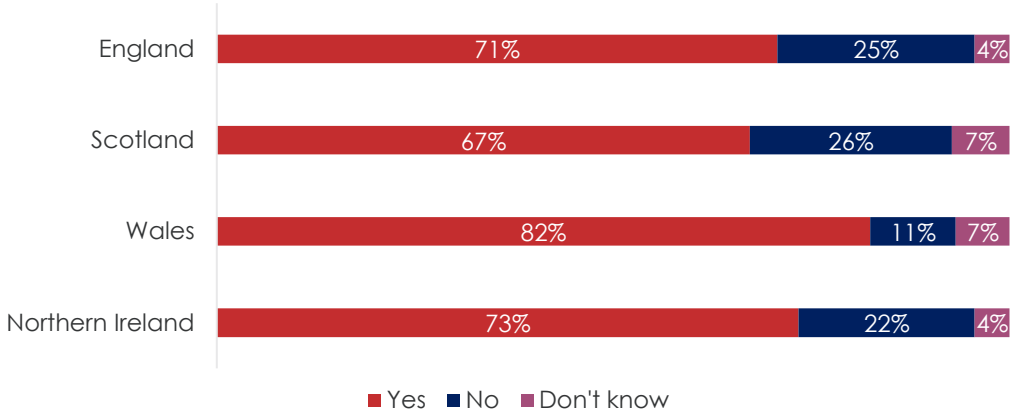

Figure 21: Question C5 - Do you think specifying the numbers of occasions a specific skill must be performed is necessary for safe and effective midwifery care? (n=1333)

The proportion of respondents who felt that the NMC should specify the number of occasions on which a skill should be performed broadly reflects the proportion who think that specifying a number is necessary for safe and effective care. Support for the NMC continuing to specify numbers was highest in Wales at 82% (n=61).

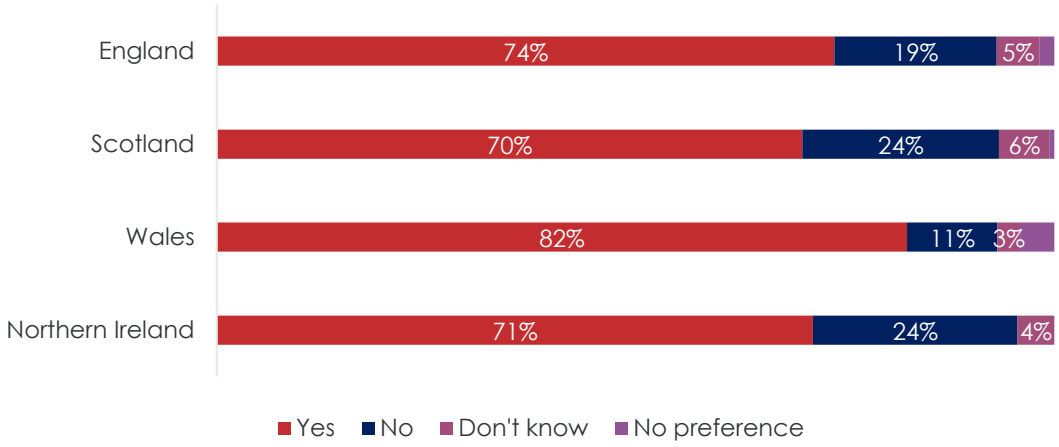

Figure 22: Question C6 - Do you think the NMC should continue to specify the number of specific occasions skills must be performed? (n=1335)

Many of the respondents who commented on the knowledge and skills required for safe and effective midwifery care suggested elements which might be added to the requirements or be given increased emphasis.

Of these respondents, many believed that the most important criterion should be **confidence and competence** and that this should be judged through **practical assessment**. Some explicitly state that this is more important than the attainment of any particular number of procedures.

Several respondents suggested skills which they felt should be added to the requirements laid out in the current EU Directive. The most common suggestion was that the requirements **should better account for intrapartum care and a holistic approach**. Some also said there is a **need for better understanding of adult health**, particularly issues such as obesity and diabetes, whilst others said that **students should have to complete an objective structured clinical examination (OSCE) before graduation** to demonstrate competency. A few suggest there is a need for a clinical focus.

Other suggested skills or areas of knowledge included (but were not limited to):

- Caesarean sections/surgical deliveries
- Forceps/instrumental deliveries
- Suturing or stitching
- Examination of newborns
- Mental health.

Meanwhile, many respondents suggested ways in which the existing numbers requirements should be changed, most commonly they suggested that they should be lowered because **it can be hard to reach the requisite number of procedures** and that students can often end up 'chasing' births. Others suggested amendments based on some of the skills listed above (e.g. broadening the number of births requirement to incorporate intrapartum care or introducing smaller, more specific target numbers for caesarean sections and forceps deliveries). A small number of respondents suggested that students should create their own records or logs to document their learning.

Many respondents said that **numeric targets should not be used at all** arguing that there is a need to take a more holistic view with a greater focus on antenatal and postnatal care rather than on numbers of births. Some argued that **quality should take precedence over quantity**. Meanwhile, some did not reject numeric targets but said that numbers should only be used for a small selection of skills with most assessed as competencies.

Some challenged the existing skills and knowledge requirements on the basis that **it is difficult to meet the requirements in the time available**, particularly the 40 births requirement. Others said that the **standards are too prescriptive** or that they are **outdated** given the increasing number of expectant women requiring interventions.

Only a small number of respondents commented on why they supported the retention of existing standards. Some said that numbers of some kind should be retained in **order to ensure that a minimum standard has been attained**

and a few felt that the requirements helps to ensure consistency.

However, interviewees typically said that the knowledge and skills listed in the Directive were **necessary and suitable**. A few suggested additional skills or areas for greater emphasis in line with those described above. In relation to the specific numbers, the vast majority **supported the continued use of numbers**, although some acknowledged that they were an imperfect measure. They felt they could be reviewed or amended in line with the suggestions given in the survey, or that there could be more flexibility, but that some form of minimum number would still be necessary.

> *"I think you do need some numbers. Whether 100 is the correct number is debatable but you need something to aim for, otherwise people come out with different levels of knowledge." –* ***Midwife, England***

Where respondents justified their rationales or suggestions, they mostly said that their responses are based on their own experiences and observations in the course of their studies or work. A small number referenced existing standards or cite research.

5. Use of simulation

5.1. Summary

Nursing

Phase 1: Key partners were on the whole supportive of the use of simulation in pre-registration nursing programmes and welcomed greater flexibility in its use. Simulation was seen as providing additional learning opportunities for students, offering a wider variety of experiences which would protect patients from harm by giving them opportunities to rehearse and gain confidence and competence.

However, there was concern that the use of simulation may replace practice hours spent working on real situations with patients and it could be overused. Another challenge was the high cost of developing technology-based simulation, which could lead inequities in access to the best and latest forms of simulation. Looking ahead, there was a keenness for the NMC to take an evidence-based approach when considering changes.

Phase 2: A majority were supportive of simulation counting towards both practice hours and theory hours; with many highlighting its important role in building confidence and competence as well as providing opportunities group learning and feedback and reflection. Although most thought simulation should count towards practice hours, it was not seen as a substitute for real life practice. Just over half felt that the use of simulation in assessment should be limited to certain skills and procedures, while over a third did not feel it should be limited. Many wanted simulation to be included in the standards, so long as it is used in a way that is proportionate, which enhances real life-practice, and where criteria and checks and balances are in place.

Midwifery

Phase 1: Midwifery focused key partners had more reservations about the role of simulation than nurses. They were overall in favour, particularly for giving students exposure to rare learning experiences and practising repetitive tasks. But many expressed the view that training should maintain a focus on working with women to develop communication skills and 'hands-on' learning. With this in mind, simulation should aim to be used for "rehearsal not substitution" within theory and practice hours.

Phase 2: A majority of respondents were supportive of simulation counting towards both practice hours and theory hours. Midwifery stakeholders highlighted its value in confidence building and in supporting patient safety and in allowing group learning and opportunities for feedback and reflection. Despite this, many had a concern were simulation to replace real-life practice which was seen as essential for learning key skills, and there were again calls for checks and balances on its use. A small majority felt that use of simulation in assessment should be limited to certain skills and procedures.

5.2. Phase 1: Interviews with key partners

5.2.1. Areas of consensus

Key partners saw **real potential in taking a more flexible approach towards the use of simulation in learning and assessment**[12]. Many felt the EU Directive did not reflect the current healthcare context and future direction of travel in terms of role of technology, especially since outbreak of Covid-19.

While support for diverging from the EU Directive on the use of simulation was high, **many key partners raised conditions**. This included:

- The importance of the NMC taking evidence-based approach when considering any changes.
- The NMC setting a clear definition of simulation, as well as clear criteria and checks and balances on how simulation is used.
- Simulation being used in a way that is proportionate and which enhances real life-practice.

5.2.2. Areas of divergence

There were **mixed views about whether simulation hours should be included in theory or practice hours across different key partners**. Some felt it was best suited to fit within practice hours, as it was a part of practice. Others, particularly those from midwifery backgrounds, felt that simulation was part of theory and should not replace contact with women and newborn infants.

> *"Midwives need that time in practice: you can't learn leadership, you can't give people bad news, going into people's houses. The reality is really hard. It's about learning to break down barriers, and you can only experience that first-hand – in practice."* – ***Approved Education Institution***

In addition, there were **mixed views about whether simulation should be used in assessment**. Some felt that simulation allowed for students to be assessed in a more focused and controlled environment, while others worried that assessment in this setting may not accurately represent a student's abilities.

Midwifery focused partners had more reservations about the role of simulation than those focused on nursing. They were overall in favour, particularly for giving exposure to rare learning experiences and practising repetitive tasks. However, many expressed the view that **training should maintain a focus on working with women to develop communication skills and 'hands-on' learning.** With this in mind, simulation should aim to be used for "**rehearsal not substitution**". Midwifery focused interviewees also

[12] Simulation is defined by the NMC as: an artificial representation of a real-world practice scenario that supports student development and assessment through experiential learning with the opportunity for repetition, feedback, evaluation and reflection

voiced more strongly that **practice hours should not be replaced with simulation.**

5.2.3. Benefits and opportunities

All key partners highlighted benefits to using simulation in education and training. Some of the main benefits identified for learners were:

- Increasing their exposure to learning opportunities and service users with different protected characteristics.
- Supporting multi-disciplinary learning.
- Providing more opportunity to practise and make mistakes, and to get feedback on their practice.
- Supporting a greater consistency and quality of learning experiences from student to student.
- Catering more flexibly to different learning styles.

Many had the view that **simulation supports service users' safety and offers an extra layer of safeguarding**. For example, it allows students to practice skills in simulation to develop confidence before they begin working with real service users.

Several felt that simulation also has a **positive impact on student experience,** with evidence that students enjoy simulation and evaluate it highly. There was a suggestion that the appropriate use of simulation could prevent students from dropping out when they start their placements by helping them to build confidence and familiarity with key elements of the role.

In addition, a few felt that simulation could **help to relieve some of the pressures on placement providers and allow universities to train more nurses and midwives**. Some also noted a lack of patients who were willing to role-play in labs and the difficulty for many students of getting enough clinical experience, which is part of the reason they need three years of education and training to fit in all of the practice hours.

5.2.4. Risks and challenges

Many key partners argued that **simulation cannot fully substitute real-world experience**, since you cannot predict how people who use services and their families will react. Some argued that simulation could not prepare students for building relationships and developing empathy in the same way real-world practice does.

There were concerns that **simulation might be overused in places where placements are difficult to access,** and that unwarranted variation could develop across the four nations without robust regulation by the NMC.

Another challenge was the **high cost** of developing technology-based simulation, which raised other issues for some:

- The potential for inequity of access to learning and student experience, since some universities, particularly prestigious or affluent ones, already

had much better simulation suites than others. This could deepen the divide between programmes and create a "postcode lottery" in terms of access to the best simulation.

- Who would pay for the cost of building and running simulation suites and how might this impact on university revenues?

A few key partners pointed out that simulation could potentially impact on students with **protected characteristics** differently, and not all will be able to access all types of simulation (e.g., IT-based simulation).

5.3. Phase 2: Survey responses and follow up interviews

5.3.1. Nursing

Use of simulation

Survey respondents were asked **whether they thought the use of different types of simulation in training would help nurses and midwives to practice safely and effectively once qualified.**

Overall, support for different types of simulation was high.

For nursing training, the **use of simulation which involves role-play using real people was most popular** (83% / n=4466), followed by simulated situations involving real service users (79% / n=4207) and simulation using mannequins or models (78% / n=4190).

Respondents were slightly **less positive about using digital approaches**: 71% were supportive of simulation involving virtual or augmented reality programmes (71% / n=3791). Simulation using digital programmes to educate and assess knowledge and decision-making was the least chosen option (68% / n=3674).

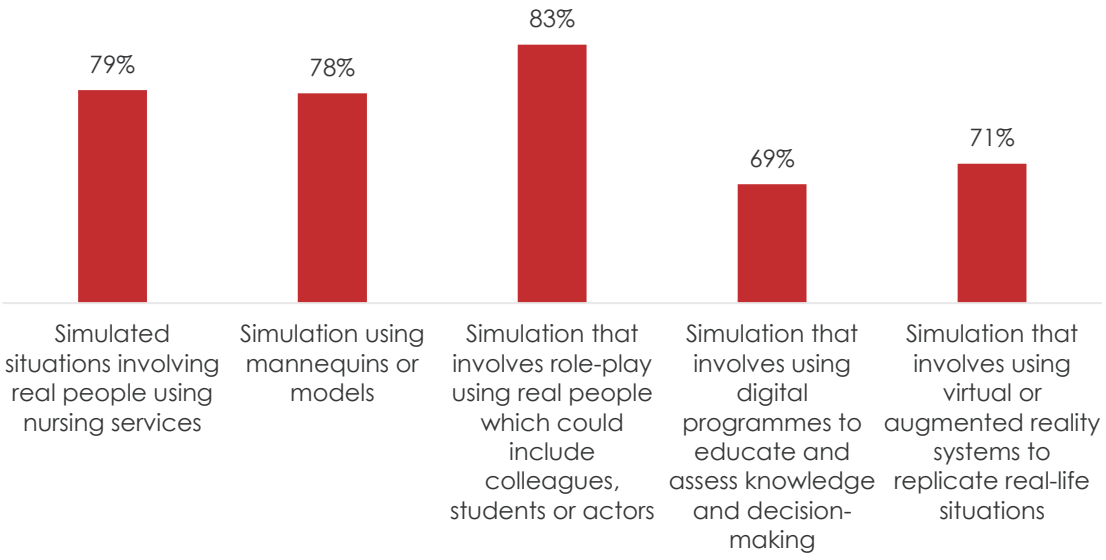

Figure 23: Question D1 - Which types of simulation-based learning can help someone to practice safely and effectively as a registered nurse? Please select all that apply (n=5,373)

Overall, survey respondents felt that simulation offered students a positive

learning experience. The biggest argument in favour of the use of simulation was its use to **build students' confidence**, before they went on placement or before they qualified. This was because simulation offered students room to practice, make mistakes and receive feedback in a lower stakes environment. This allowed them to develop basic skills before practicing on real patients on wards or in the community. Although many felt simulation was helpful to learn and repeat procedures, some also found it helpful to develop their soft skills, such as communication and time management.

Nearly all respondents who had experiences of learning through simulation found them **enjoyable and memorable**, and felt that it had enhanced their learning experience. In addition, certain types of simulation allowed students to get a feel for work on a ward and do multidisciplinary work with students studying different programmes or other professionals. A few respondents argued that this helped students understand what would be expected of them early on, and take the programme more seriously from the start.

Many also cited simulation as helpful for **students with protected characteristics** or different learning styles, as it offered a number of different methods of learning which could be accessible to more people, and more opportunity for repetition. However, some thought that some aspects of simulation may be inaccessible or harder to use for certain students and worried that they may be further excluded from courses.

Some respondents raised the **impact of simulation on patient safety**. As well as acting as an initial practice session before students practiced on real patients, simulation can help expose students to different experiences. For instance, many felt that simulation would help students practice for emergency situations, rare occurrences, or procedures they were unlikely to use in their fields of nursing. It was also seen as helpful for tasks that some students may **struggle to get patient approval to practise**. For example, one male nursing student mentioned his difficulty practising female catheterisation on patients. In such cases, simulated practice could be a backup for students who did not get the opportunity to learn in real practice.

Simulation was also seen by some as an opportunity to **expose students to a wider range of experiences**, beyond what they might encounter on their placements. A few respondents thought its use could help students understand different ways of working and work with people with protected characteristics, which they may not naturally encounter in their placements in specific fields of nursing. They felt simulation could also help level the varying quality of placements and guarantee a greater consistency of learning across the UK.

Despite widespread acknowledgement of the benefits of simulation, some respondents also raised concerns. The primary concern was that **simulation cannot substitute real-life practice**. Some respondents worried that its use would not adequately prepare students for nursing. They felt that simulation could not realistically represent all situations, particularly in terms of how

patients or service users may react. For this reason, there was strong support for a **blended approach which combined the use of simulation with real practice.**

> *"Nowadays people use simulation as something that's good enough, and it isn't. No amount of simulation can replicate a real person with pain/feelings/anxieties. All it does is enable you to learn how to do a task, or to respond to certain situations."* - ***Nurse, England***

A small number of respondents also mentioned the **high cost and the resource-intensive** nature of certain types of simulation. If the NMC included simulation in the requirements, AEIs would have to incur a high cost. There was concern that this may cause different universities to deliver simulation-based learning of varying quality, and lead to inconsistent nursing training across the country.

Despite these concerns, there was still strong support for the use of simulation, as long as it was rolled out and used appropriately. There were several conditions that respondents wanted the NMC to deliver to ensure programme quality and patient safety:

- **Specific guidance** on when and how simulation should be used, which was based on evidence. This would ensure consistency across students, programmes and AEIs.
- **Checks and balances**, with many supporting limits on the use of simulation, and emphasising the need for forms of oversight and university inspections.
- **A specific plan for how simulation is supervised**. Supervisors needed to be adequately trained so they could provide practical supervision, advice and constructive feedback.

Although many respondents discussed all aspects of simulation together, there were a number of points raised about specific types. Overall, **high fidelity approaches were preferred by many**, although low fidelity approaches were also seen to have a role in programmes. Some argued that simulated situations should be as close to reality as possible – therefore preferring simulations using real people and mannequins over IT-based methods such as digital programmes and virtual reality.

Simulation counting towards practice and theory

Respondents were asked whether simulation should count towards practice and theory hours. A majority (70% / n=3783) thought that simulation should count towards practice learning on nursing programmes, and 26% (n=1402) were opposed.

Most respondents (84% / n=4375) wanted simulation to **count towards theory hours**, with just 13% (n=654) being opposed to this.

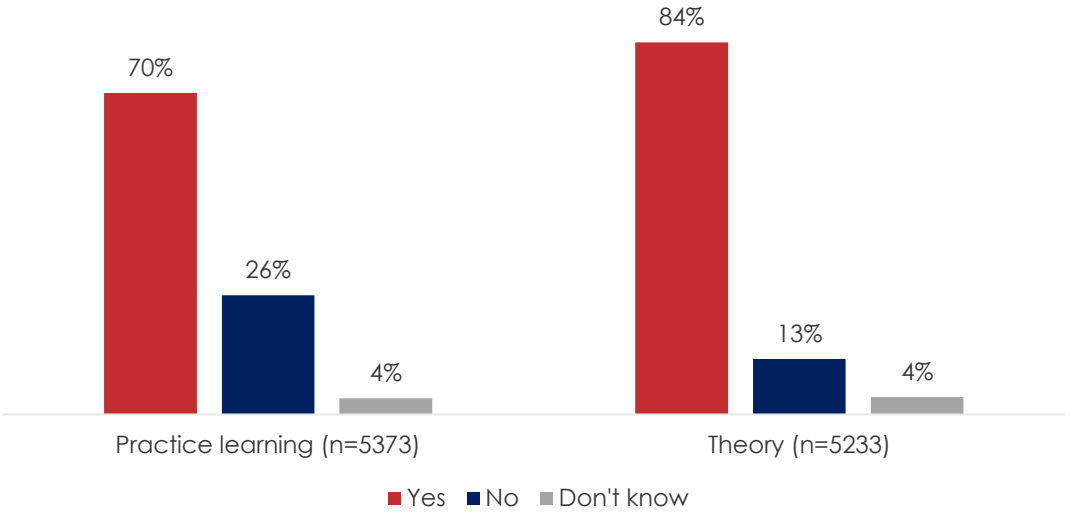

Figure 24: Question D2 - Do you think simulation should count towards practice learning and theory on pre-registration nursing programmes?

Four nation differences

Levels of support for the counting of simulation hours towards practice and theory were broadly consistent across the four nations of the UK.

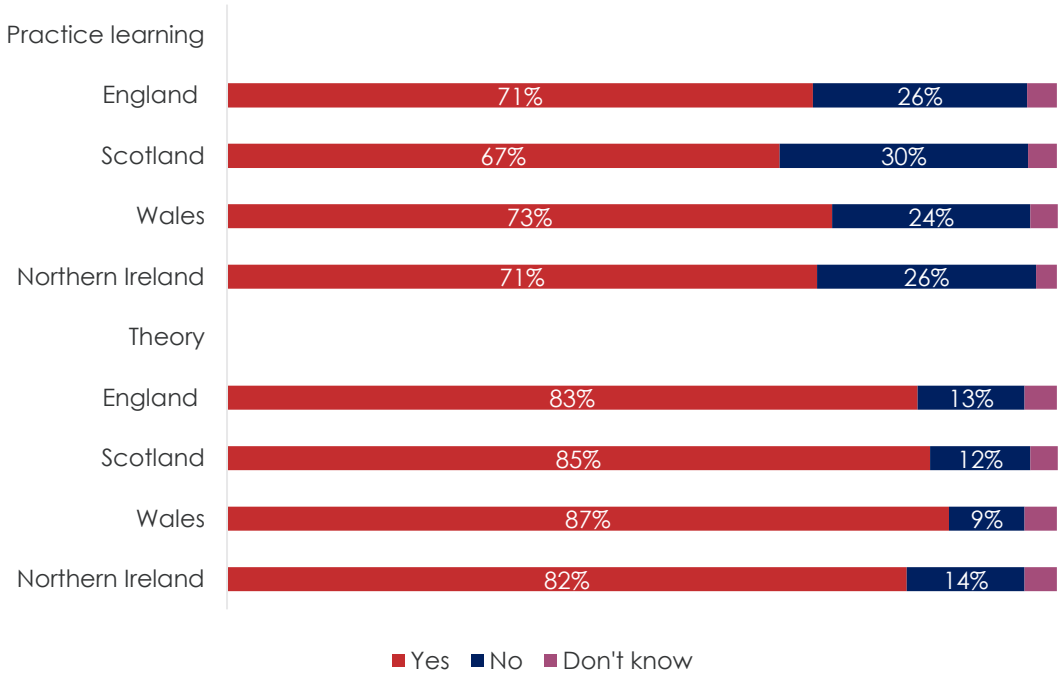

Figure 25: Question D2 – Four nation breakdown - Do you think simulation should count towards practice learning and theory on pre-registration nursing programmes? (n=5,373)

Sub group differences D2

- Ethnic minority respondents were more likely to agree that simulation should count towards practice learning on pre-registration nursing programmes (87% vs 70%).

Many survey respondents expressed **concern around simulation hours counting towards practice hours and placements**. Many felt that hours spent on wards with real people who use services should be protected and prioritised over simulation hours. Some felt that simulation could not adequately replicate real-life experiences, which were more unpredictable and unscripted than any representation in simulation. If time on placement was replaced with simulation-based hours, many worried that students would not be adequately prepared for registration.

An argument that some respondents made is that **many of the skills taught through placement cannot be learnt through simulation**, such as time management, caseload care, working under pressure, and working whilst surrounded by distractions. This was hard to replicate in simulation, and could only be properly taught in a real ward or community environment. Some highlighted that nursing is a "patient-facing" profession with a practical focus, and worried that simulation would take away from this.

> *"And if there's too much simulation then students won't have real experience, and qualifying is already such a shock that you wouldn't want to make it any more so!" -* ***Nurse, England***

Consequently, most respondents felt that **simulation-based learning should be counted towards theory** hours. Respondents typically aligned their own simulation experiences with theoretical learning, and felt that this framing would allow students to practice skills through simulation before working with patients, helping them build confidence beforehand, and keeping service users safe[13]. Some argued that this would help students make better use of their placements, as they would be better prepared and would have already started applying their theoretical knowledge to practice.

On the other hand, a small number thought this was an argument in favour of counting simulation-based learning towards practice hours, which would be used before students went on placements.

Some respondents had a different perspective on the issue, and felt that **simulation could relieve the pressure of placements,** especially in rural areas where students may struggle to find placements and fulfil all of their requirements. Counting simulation hours towards practice hours – either for all students or as a possibility some could choose – could ensure more flexibility for those struggling to find placements and ensure they could continue learning.

Counting simulation-based learning towards practice hours could also help enrich the 'lost hours' of placements. Simulation-based learning was seen as an opportunity to fill gaps in students' placements and ensure that a wider range of experiences are represented in students' training. Simulation could be an alternative to offer students a wider range of practice opportunities,

[13] As discussed in Section 1.3.1

with a few respondents mentioning the potential for virtual placements.

Some of the people we spoke to felt that simulation should count towards both theory and practice hours for some of the reasons above. They also argued that the use of simulation **offered a different type of learning** which would benefit students, and should not be limited to either part of nursing programmes.

> *"In a general sense it's helpful for the skills you won't have a chance to do in practice – I can't exactly go out and induce someone to have a seizure so I can manage it! For things that you can do easily (not necessarily on a patient), doing it in real life is more helpful than simulation. If there's an opportunity to do it in real life then simulation shouldn't count as practice."* ***Nursing student, England***

Limitations of simulation

Survey respondents were **more divided when it came to placing limitations on when simulation could or could not occur in a programme**. For nursing programmes, many (46% / n=2441) felt there should be limitations set whilst a significant minority felt there should not (31% / n=1649).

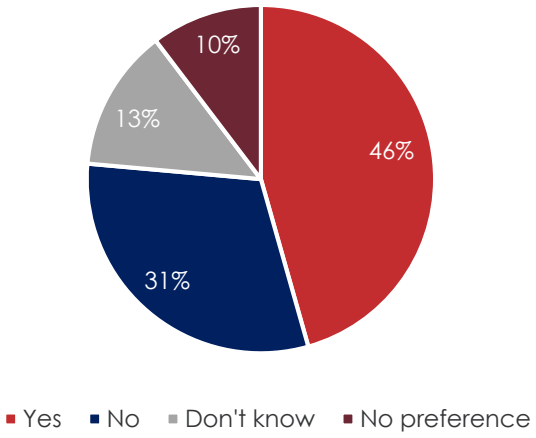

Figure 26: Question D3 - Do you think there should be any limitations set by the NMC about when simulation can/cannot occur in a programme? (e.g. in/not in a final placement) (n=5,352)

Sub group differences QD3

- Older (71% vs 47%), White (62% vs 51%), female, and heterosexual (60% vs 53%) respondents were more likely agree that there should be limitations set about when simulation can/cannot occur in a programme.

Survey respondents were asked whether there should be a maximum amount of practice learning for nursing that could be taught through simulation. Most (73% / n=3898) thought **there should be a maximum**

imposed, while 18% (n=950) thought there should be no limit. A minority (5% / n=282) of respondents didn't know and 4% (n=225) expressed no preference.

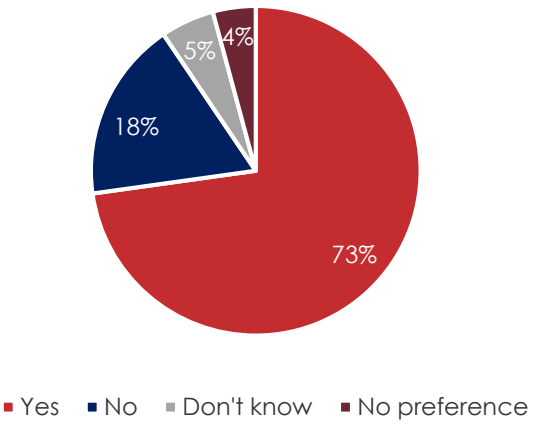

Figure 27: Question D4 - Should there be a maximum amount of practice learning that can be taught through simulation? (n=5,355)

Four nation differences

Levels of support for limitations being set on the use of simulation in programmes were broadly consistent across the four nations of the UK. However, respondents in Northern Ireland were slightly more in favour of the NMC setting limitations on when simulation can be used in a programme, whereas respondents in Scotland were slightly less supportive. Respondents in Northern Ireland were more in favour of the NMC setting maximum amounts of practice learning taught through simulation.

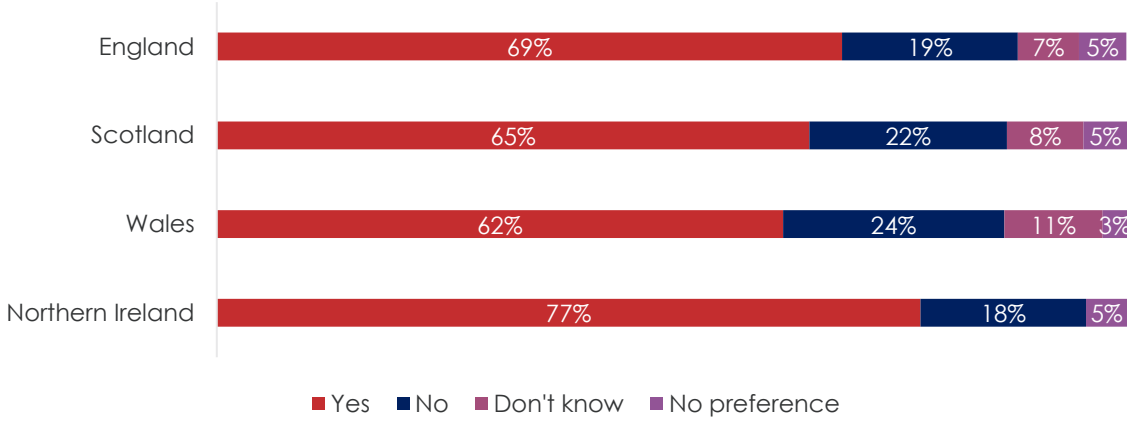

Figure 28: Question D4 - Should there be a maximum amount of practice learning that can be taught through simulation? (n=5,355)

Sub group differences QD4

- Older (87% vs 66%) and White (82% vs 71%) respondents were more likely than younger and ethnic minority respondents to agree that there should be a maximum amount of practice learning that can be taught through simulation.

Survey respondents argued that limitations on the use of simulation should (or should not) be imposed in relation to placements and to the year of study.

The main concern that was raised by respondents was the use of **simulation-based learning replacing placements**. There were concerns that simulation hours would replace practice hours, and therefore placements, which many respondents wanted to protect (as set out above). A large number of respondents did not want simulation to replace any placement hours.

Many survey respondents also expressed preferences in terms of the **years where simulation-based learning would occur**. Most who did suggested that simulation should not be used in the final year of study or in the final placement to ensure that students were "ready" to work with real service users on wards and in communities.

As simulation was identified by many as helpful to practice before having contact with real people or service users – **there was support for it being used at the beginning of a programme**. Then simulation could become less common as students move through the programme and have more exposure to practice with service users, or only be allowed in the first year of study.

However, a small number **did not want simulation to be used in the first placement, because they felt this was when it was most beneficial for students to receive direct contact with patients and service users** so they could understand expectations from the profession.

A handful of respondents only **wanted simulation to be used in the final year of study**. They felt that the use of simulation at this time could help increase students' confidence on specific skills they may not have had as much opportunity to practice.

A minority **did not want the NMC to limit when simulation could be used in a programme**. They highlighted the importance of accounting for different styles of learning and making sure that learning was accessible for all students, particularly students with protected characteristics who may experience difficulties accessing certain types of practice.

The majority of respondents wanted the NMC to **set a maximum amount of simulation hours** that could count towards the total of practice hours. In terms of practicalities, respondents were divided, but most wanted the hours to be set as a proportion of the total practice hours, and a large minority wanted there to be a simple maximum amount set out in the requirements. Some felt that the maximum amount should be set out by week or semester to ensure consistency and help set limitations on when simulation can be used in programmes.

Although many were uncertain, the maximum amounts that respondents suggested varied widely – with between **10% and 25% of total programme hours** being most regularly recommended. Some also felt that the maximum amount the NMC imposed should differ by course types and fields of nursing.

Use of simulation in assessment

The majority (59% / n=3186) of respondents **thought that the use of simulation in assessment should be limited to certain skills and procedures**. However, a large proportion (36% / n=1942) thought it should be used to assess any skill and procedure.

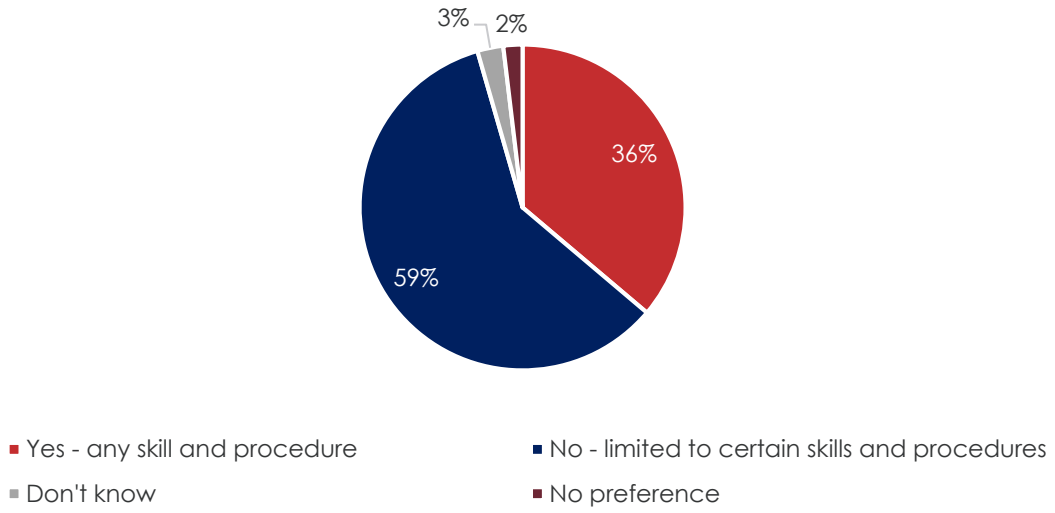

Figure 29: Question D5 - Do you think that simulation should be used to assess any nursing skills and procedures or should it be limited to certain skills and procedures? (n=5,368)

We asked respondents which types of simulation they think should be used to assess skills and procedures. Within nursing, **simulation using role-play with real people was most popular** (with 78% / n=2415), closely followed by using mannequins or models (77% / n=2377) and simulated situations involving real service users (73% / n=2250). Simulation using digital programmes and virtual or augmented reality were chosen less often (both chosen by 60% of respondents).

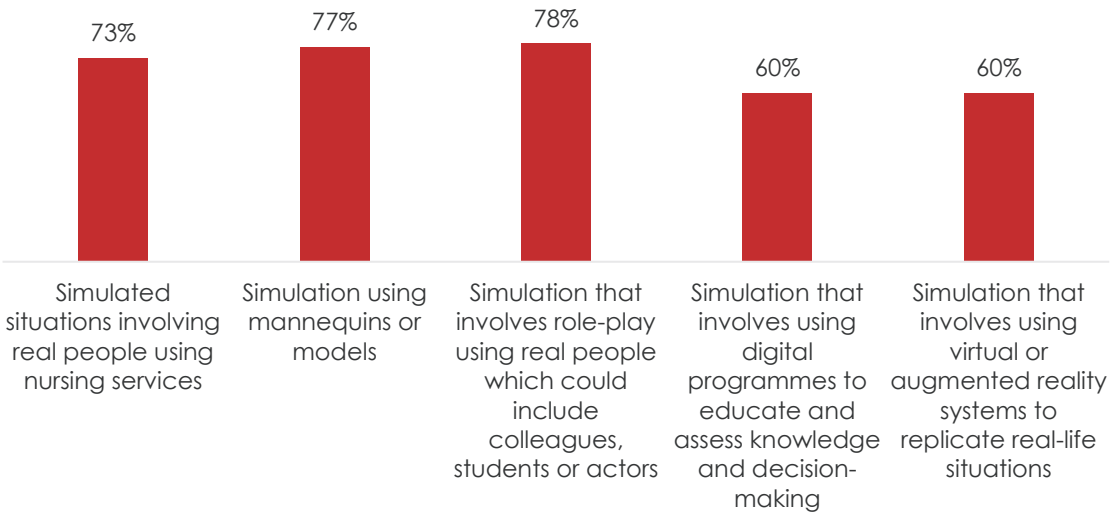

Figure 30: Question D7 - Should any of the following types of simulation be used to assess nursing/midwifery skills and procedures? (n=5,373)

Four nation differences

More respondents in Northern Ireland wanted to set limits on the use of simulation in assessment than respondents in other UK nations. Respondents in Scotland were more supportive of allowing assessment by simulation for any procedure than other nations.

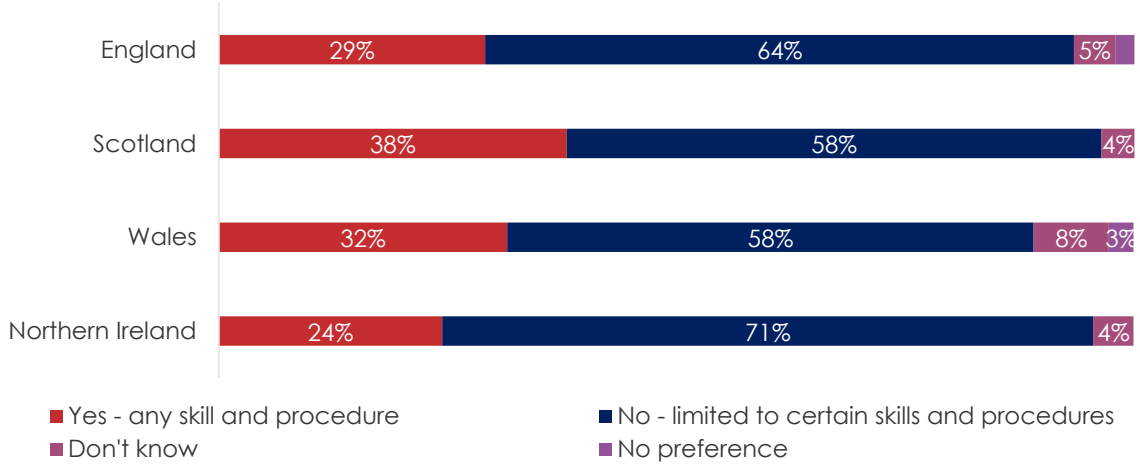

Figure 31: Question D5 - Do you think that simulation should be used to assess any nursing skills and procedures or should it be limited to certain skills and procedures? (n=5,368)

Sub group differences D5

- Younger (46% vs 28%), ethnic minority (50% vs 35%) and male (43% vs 47%) respondents were more likely than older, White and female respondents to agree that simulation can be used to assess any nursing skills and procedures.

Most wanted to **limit the use of simulation in assessment to a set of specific skills**. A few situations were seen as most useful for simulation:

- Emergency situations, where student involvement may put the patient at risk, or where it may be inappropriate to use their involvement for the purpose of assessment.
- Rare occurrences that students may not encounter in their placements, to avoid students waiting for specific situations at the end of their programmes so they can qualify.
- Procedures that nurses are unlikely to perform in their field of nursing but still need to sign off, such as catheterisation in a mental health setting.
- Procedures which students may struggle to get patient sign off.

Some felt there were other skills that could be signed off without students needing to demonstrate their abilities in 'real' practice because they could be easily simulated. Simulation could also be helpful in the assessment of participatory or multi-disciplinary scenarios if these were hard to encounter in placements.

Some of the procedures cited as acceptable to assess through simulation

include cannulation, venepuncture, catheterisation, mouth care, physical observations, CPR, administration of medicine, restraint, injection technique, basic life support (BLS), as well as communication and de-escalation.

Some respondents felt that the quality of assessors was an important consideration when it came to assessment through simulation. They wanted assessors to be independent and experienced, to ensure they were able to carry out high quality assessments.

However, there was some concern that registrants whose skills were signed off through simulation **would not have sufficiently practised the skills and knowledge** required for nursing. Respondents worried that assessments in simulation do not sufficiently replicate real situations, and assessors may sign off students who are not proficient, or fail to identify students who need additional support. A small number raised the fact that simulated situations are unlikely to replicate the environment in which a nurse would carry out a procedure, in terms of unpredictability and stress. A few respondents argued that any procedure can become complicated if there are complications or if the patient has specific needs. They felt that assessment through simulation wouldn't adequately measure student's ability to respond to such situations.

Some felt this could exacerbate other issues in the profession, in particular nurses not being practice-focused enough and having poor practical skills.

5.3.2. Midwifery

Use of simulation

Survey respondents were asked whether they thought the use of **different types of simulation in training would help nurses and midwives practice safely and effectively once qualified**.

Overall, **midwifery respondents were more supportive of the using a range of simulation compared with nursing respondents**, and preferred different methods. Simulation using mannequins or models was the most popular option (chosen by 89% of respondents / n=1162), closely followed by simulation involving role-play using real people (85% / n=1113).

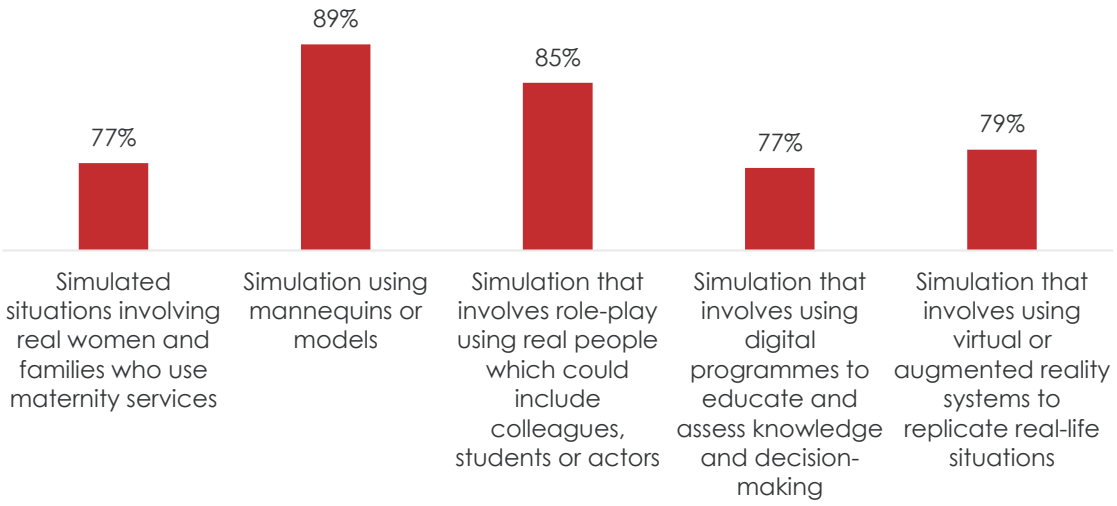

Figure 32: Question D9 - Which types of simulation-based learning can help someone to practice safely and effectively as a midwife? Please select all that apply (n=1,335)

As the use of simulation is currently allowed in theory and for hard to achieve proficiencies in midwifery programmes, many respondents mentioned their own simulation experiences and reflected positively on them. The main positive that was identified was its impact on **student confidence and learning experiences**.

Carrying out simulation-based work **often allowed students to work in groups**, **observe each other practice and reflect, discuss and debrief** on the activities they had just carried out. This opportunity for feedback was seen as important, as just as valuable as the simulation itself. As well as feedback, simulation was also seen as helpful for students to embody theoretical knowledge and repeat simple tasks in a non-stressful environment where they can make mistakes.

In addition, some respondents saw simulation as allowing for a more **diverse learning experience**, offering students new opportunities for practice and the creation of scenarios which students may be unlikely to encounter on placements. They felt it complemented other aspects of midwifery programmes. A small number of respondents also said that simulation offered room for different learning styles and allowed students with protected characteristics to have equal opportunities to practice skills.

It was felt simulation could help students who **experienced difficulties with certain parts of the programme to spend more time learning or practicing certain skills**. A few respondents felt that the use of simulation throughout programmes could also help also students develop their knowledge further if they had fulfilled most of their skills or where placements were inadequately stimulating.

The other main argument raised in favour of the use of simulation was that it can help to **improve patient safety**, by preparing students before they interact with women and newborn infants as well improving students' learning experiences.

Students can **practise handling emergencies** before they may encounter them as students or midwives – which they would not get to practise if they do not encounter any on placements. Although some respondents highlighted that handling emergencies felt very different on simulation compared to real situations, this helped students practise emergency procedures better.

Some respondents also said that **simulation allowed for students to prepare for more routine procedures**, by reinforcing their theoretical learning before or during their placements, when they can practice in real situations.

There were certain skills that were seen as **difficult or impossible** to learn through simulation. Many of these included soft skills, such as communication, compassion and time management, which were identified as essential to the midwifery profession. However, many felt that simulation would be useful for other skills, so there was **strong support for a blended approach throughout midwifery programmes.**

Simulation counting towards practice and theory

Respondents were asked whether simulation should count towards practice and theory hours. Amongst midwifery respondents, 66% (n=863) were in favour of counting simulation towards practice learning hours. A sizeable minority (28% / n=369) were opposed.

When it comes to counting simulation towards theory, most respondents were in favour (86% / n=1116), with just 9% (n=115) opposing this.

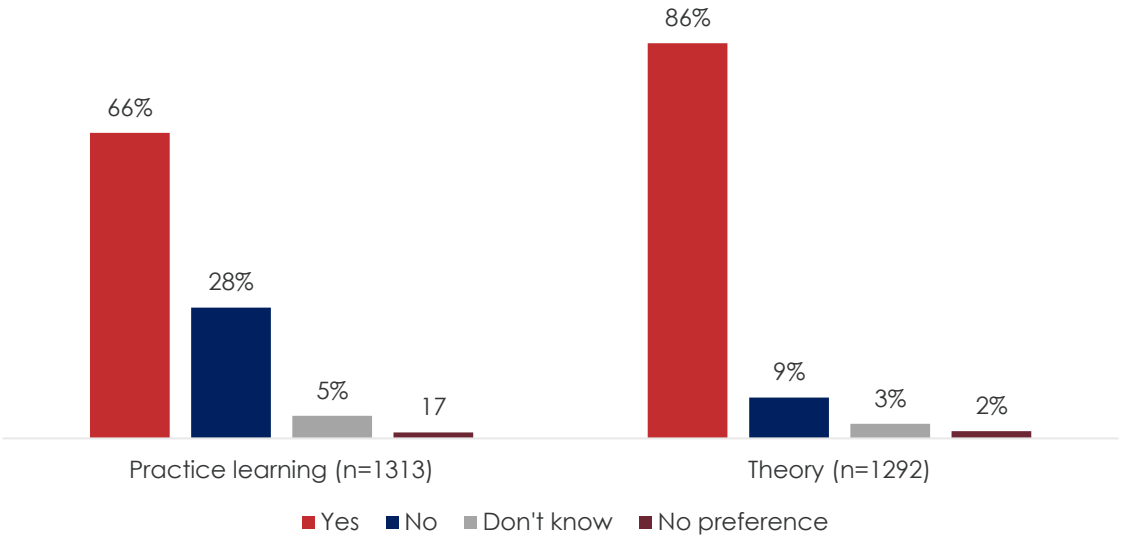

Figure 33: Question D10a & b - Do you think simulation should count towards practice learning and theory on pre-registration midwifery programmes?

Four nation differences

Levels of support for counting simulation-based learning hours towards practice hours or theory were broadly consistent across the four nations of the UK, with Northern Ireland being slightly more supportive of counting simulation towards practice hours than the national average.

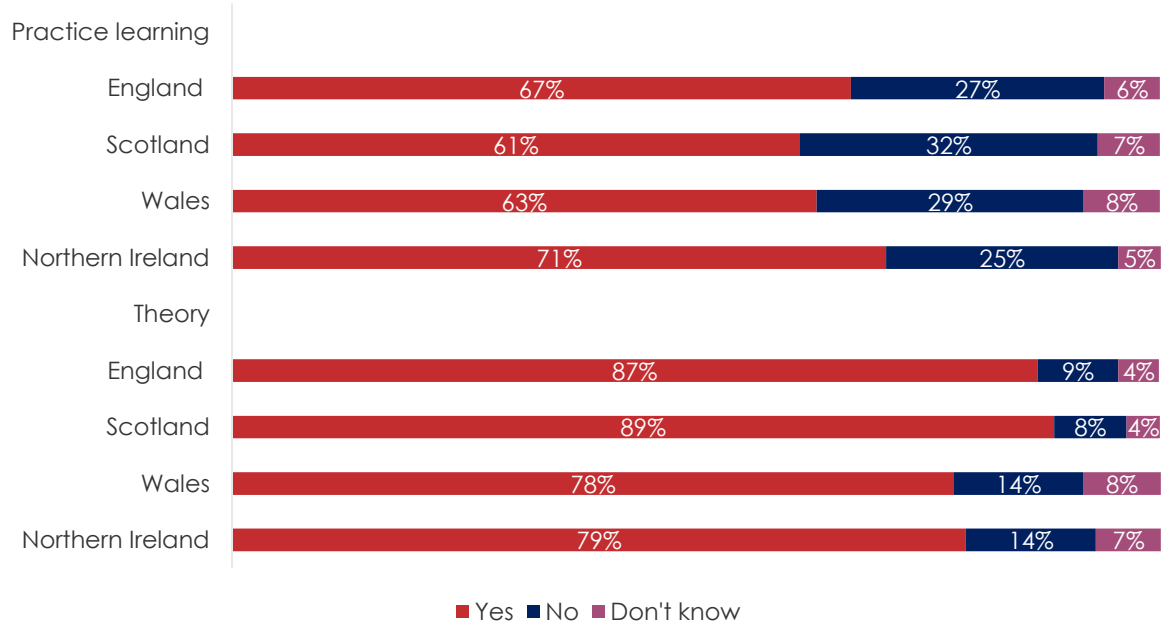

Figure 34: Question D10a & b - Four nation breakdown - Do you think simulation should count towards practice learning and theory on pre-registration midwifery programmes? (practice learning: n=1,313; theory n=1,292)

Sub group differences D10a and D10b

- Younger respondents were more likely than older respondents to agree that simulation should count towards practice learning (70% vs 59%) and theory (95% vs 86%) on pre-registration midwifery programmes.

Most respondents were **concerned about losing practice hours** and them being replaced with simulation-based learning. They felt simulation cannot substitute real world practice and prepare students in the same way.

Some highlighted the **importance of students spending time on physical placements** to understand all aspects of midwifery. This was the only way they could fully understand what was expected of them as part of the job and develop certain essential skills such as communication, compassionate care and situational awareness. Practice in simulation may also miss out some of the other aspects of the work, such as time pressures, stress and the emotional dimension of midwifery. There was concern that a loss of practice hours could lead to underprepared students qualifying, which could affect safety and job retention.

"It should count as theory because that's all it's good for. My worry is that it'll be used to get more midwives into the profession who can qualify without seeing a woman. Because it's so crammed and it's such a busy job, students won't do things in practice if they have the option to do as simulation." ***Midwife, England***

On the other hand, some felt **simulation belonged within practice hours**. This

was particularly the case when it came to practicing procedures for emergencies and rare occurrences. For some emergencies such as breech deliveries, midwifery students could already practice and be assessed through simulation. Many felt this requirement should stay, and some felt it should be extended to any rare occurrences that students may not encounter and that might hold them up from qualifying on time. This was particularly the case because students rarely have opportunities to be involved in responding to such emergencies, and it is difficult to facilitate learning in high-risk situations.

Helping **relieve pressure on placements** was another rationale for counting simulation hours with practice hours. Simulation-based learning could act as a backup if there was a shortage of placements to ensure students could complete their programmes on time, or could help allocate placements more easily. A small number also thought that simulation could help enrich placements for students who were ahead or not getting many learning opportunities on placement. Simulation hours should count towards practice hours so those students could evidence their learning.

A few respondents suggested that **students on shorter courses should have additional options to use simulation**, so they could advance faster in their programmes to ensure they covered all of the key midwifery skills needed to qualify. In addition, many of the students on the shortened midwifery course would have already demonstrated their ability to use some of the required skills (situational awareness, communication) in their previous programmes or professions.

Limitations on simulation

Midwifery respondents were divided over whether to place limitations on when simulation could occur in midwifery programmes. 47% (n=624) were in favour of placing limitations, while 32% (n=422) were opposed. Many were undecided, with 14% (n=189) answering 'don't know' and 7% (n=90) expressing no preference.

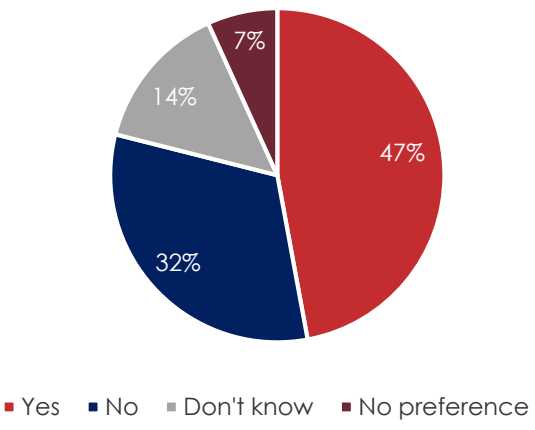

Figure 35: Question D11 - Do you think there should be any limitations set by the NMC about when simulation can/cannot occur in a programme? (e.g. in/not in a final placement) (n=1,325)

Most (68% / n=899) respondents wanted a maximum limit to the amount of practice learning taught through simulation; while 20% (n=268) did not want any limits on the amount of practice learning. A minority of respondents said they did not know (7%, n=91) and 5% (n=65) expressed no preference for either option.

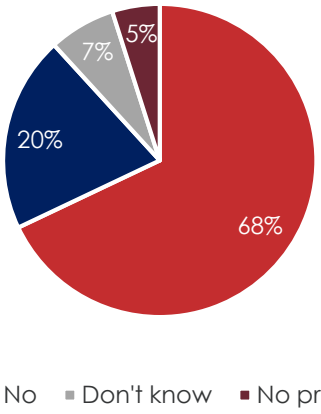

Figure 36: Question D12 - Should there be a maximum amount of practice learning that can be taught through simulation? (n=1,323)

Four nation differences

A greater proportion of respondents in Northern Ireland and Wales wanted the NMC to set limitation on when simulation can occur in programmes than in other UK nations.

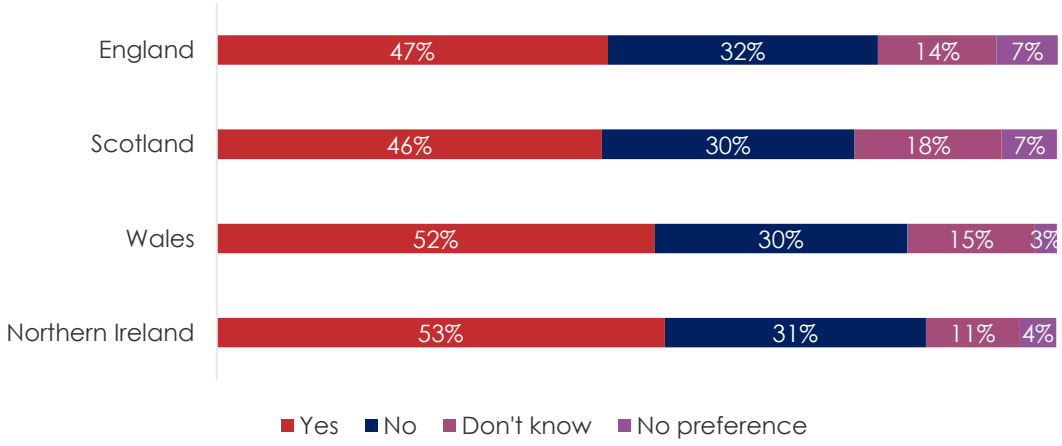

Figure 37: Question D11 - Do you think there should be any limitations set by the NMC about when simulation can/cannot occur in a programme? (e.g., in/not in a final placement) (n=1,325)

Sub group differences D11

- Older (63% vs 32%), White (46% vs 35%) and heterosexual (45% vs 35%) respondents were more likely than younger, ethnic minority and non-heterosexual respondents to say that there should be limitations set by the NMC about when simulation can/cannot occur in a programme.

Similarly, respondents in Northern Ireland were more supportive of the NMC setting a maximum amount of simulation that can count toward practice hours than in other nations, with Wales being the least supportive of the four.

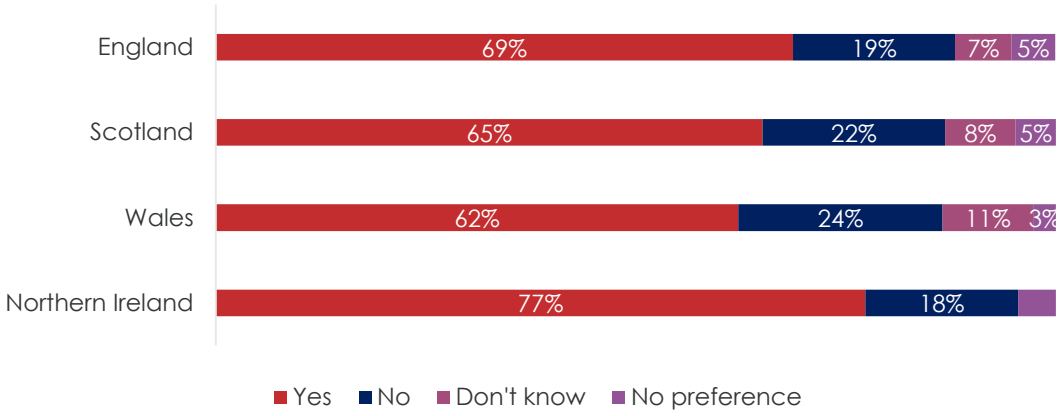

Figure 38: Question D12 - Should there be a maximum amount of practice learning that can be taught through simulation? (n=1,323)

Sub group differences D12

- Those with caring responsibilities (81% vs 76%,) older (86% vs 69%), and White (79% vs 70%) respondents were more likely than those without caring responsibilities, and younger and ethnic minority respondents to say that there should be a maximum amount of practice learning that can be taught through simulation.

Even though most were positive about the use of simulation, many wanted to see the NMC **publish guidance** and **set limitations** on how and when it could be used in programmes to ensure students were sufficiently prepared. There was concern that without limitations, AEIs may be overly liberal with their use of simulation which could impact on the safety of services. Some also emphasised:

- The **availability of support** for students when carrying out simulation, from experienced members of staff.
- **Oversight from the regulator** to check that simulation was being used appropriately and that students were learning from its use.

Many respondents wanted to **limit the use of simulation to specific skills only**, where the use of simulation could be most beneficial. The most popular choices of skills to be taught through simulation were:

- Skills that were **already taught and assessed** in midwifery programmes such as episiotomy and breech deliveries.
- Skills needed in **emergency situations**, where students were unlikely to be prepared and would be unlikely to be helping with.
- **Rare situations** which midwives needed to practice for but which students were unlikely to encounter during their placements.

"As a student you're not going to see many breech deliveries – not room for a student in high risk environments – not the safest option. In that sense it's good to count simulation as practice hours – you can talk through it and in practice you'd only be watching anyway." ***Midwife, Wales***

For other core skills, such as communication, observation, and normal deliveries, the majority of respondents preferred to **continue using real-world practice** to train and educate students and midwives. They felt that students had enough opportunities to practice these on placement, and they were skills which students would use on a regular basis and need to be adequately prepared for.

Respondents also suggested **limitations around when simulation could occur within a programme.** Most who did wanted to prevent the use of simulation-based methods in the final year and the final placement, so that students could focus more on real-life practice to develop their skills ahead of qualification. Similarly, a small number wanted simulation to only be allowed in the first year of study. A few respondents took the opposite view; preferring to avoid simulation in first year so students could get a better understanding of the role through face-to-face practice, and then using simulation at the end of programmes to learn skills required for emergencies.

In terms of the amount of time that should be dedicated to simulation in relation to practice and theory hours, respondents had mixed opinions. However, **the majority wanted to prioritise hands-on learning over simulation-based learning hours**, and set aside sufficient hours for the former. As discussed in the section above, many were keen to protect practice hours, and count simulation-learning hours towards theory hours rather than practice.

Most respondents were unsure what the appropriate amount of simulation hours might be in a programme. Of those who did make a suggestion, **10%, 20% and 25% were often cited as maximum proportions of the programme that they would like to see the NMC set** as requirement.

Use of simulation in assessment

A majority (64% / n=843) of respondents wanted **the use of simulation in assessment to be limited to certain skills and procedures**, while 30% (n=400) wanted simulation to be used to assess any skills and procedures. A small minority of respondents did not know which option they preferred or expressed no opinion either way (5% / n=61 and 2% / n=23 respectively).

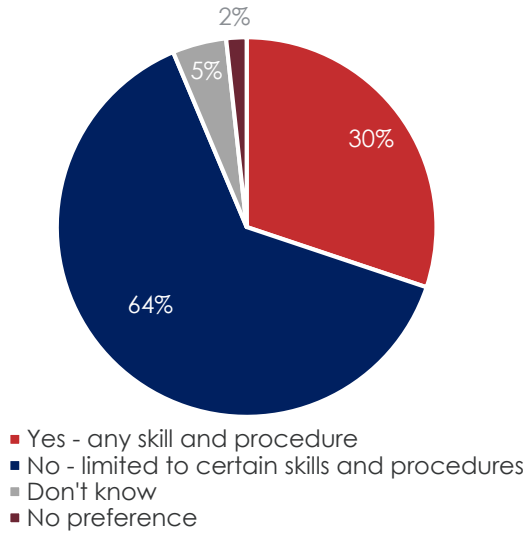

Figure 39: Question D13 - Do you think simulation should be used to assess any midwifery skills and procedures or should it be limited to certain skills and procedures? (n=1,327)

Respondents were asked which types of simulation they thought should be used to assess skills and procedures across midwifery. Simulation using mannequins or models was the most selected option (86% / n=670), followed by simulation involving role-play with real people (81% / n=633). Similar proportions of respondents were in favour of the use of simulated situations involving service users (69% / n=540), virtual or augmented reality (68% n=532) and digital programmes (67% / n=521).

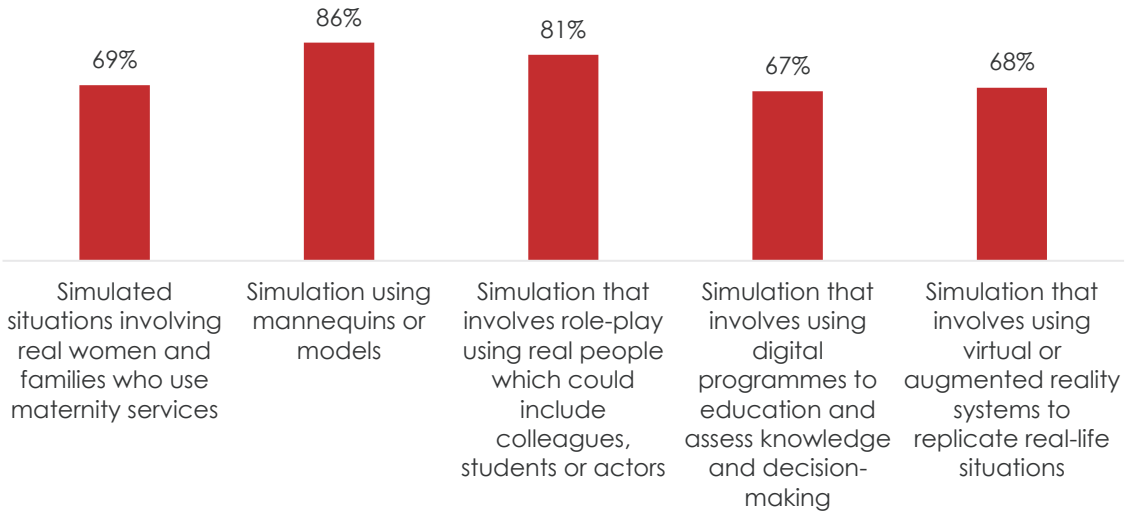

Figure 40: Question D15 - Should any of the following types of simulation be used to assess midwifery skills and procedures? Please select all that apply (n=1,335)

Four nation differences

More respondents in Northern Ireland wanted to limit the use of simulation in assessment than in other UK nations. Respondents in Scotland were slightly more supportive to opening up assessment through simulation to any skill and procedure than other nations.

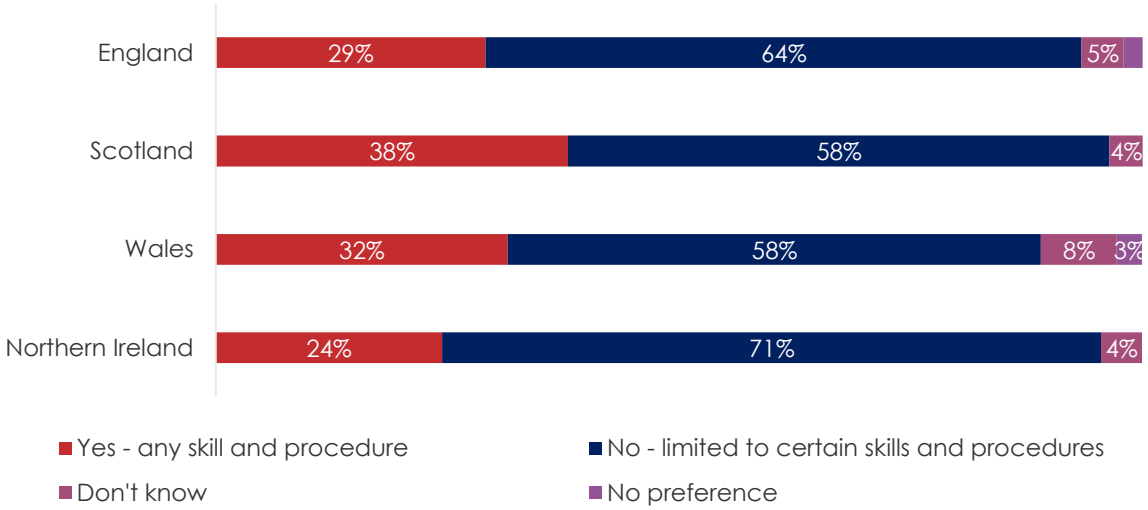

Figure 41: Question D13 - Do you think simulation should be used to assess any midwifery skills and procedures or should it be limited to certain skills and procedures? (n=1,327)

Sub group differences D13

- Younger (36% vs 23%) and ethnic minority (37% vs 30%) respondents were more likely to agree that simulation should be used to assess any midwifery skills and procedures.

Levels of support for the use of each simulation-based method for assessment were broadly consistent across the four nations of the UK,

Although many respondents **wanted the NMC to set limits** on which skills could be assessed through the use of simulation, many were in favour of simulation being used to assess particular skills.

Some argued that **simulation-based assessment could allow for better assessment** of students than face-to-face practice. They thought that simulation could be used to assess a wider range of experiences and unpredictable problems than students would encounter in the real world during their programmes – and allow for better prepared midwives.

Otherwise, there was a number of situations and skills that respondents thought could be successfully assesses through simulation-based methods:

- Most wanted simulation to be used to assess **emergency situations**, where students may not have sufficient experience to take part in the response and could put the women and newborn infants at risk if unprepared. Some of the most suggested emergencies were neonatal and adult resuscitation, breech births, cardiac arrest, shoulder dystocia, eclamptic fit and obstetric emergencies.

  "Initiation and performance of episiotomy and suturing I believe should be entirely assessed on simulated situations. As many preceptorship programmes in Wales include these skills in the programme for newly qualified midwives, I do not believe that

students are appropriately trained, experienced or knowledgeable in the performance of such procedures on the general public." ***Midwifery student, Wales***

- Many felt assessment through simulation had a place for **rare occurrences**, or any situations that students are unlikely to encounter throughout their studies or as midwives, but may have a high impact, so that their preparedness could be assessed.
- There was support for keeping simulated assessment of **suturing and episiotomy**, and other competences which are already assessed through simulation. Respondents generally reported positive experiences having been assessed on these skills through simulation and were in favour of keeping this requirement.
- A small number felt that simulation could help assess soft skills like **situational thinking**, **ward management as well as medicine management**, which would allow students more time for feedback and reflection. However, they felt that this should be done alongside assessment through real-life practice to fully understand students' abilities.
- Some thought simulation could help assess tasks where students might **struggle to get consent to perform or observe**.

"Sweeps are a good example. It's low level and all midwives can do it. As a guy I'm up against a little bit of a barrier. Most mums don't want anyone there when that's happening, especially not a student. Only one of us has been able to do a sweep so far – if this continues, few of us will have done it. Simulation is good for that sort of thing." ***Midwifery student, England***

However, some preferred to keep **current face-to-face assessment methods as these would allow for better assessment**. They argued that simulation was not necessarily close to real practice and that qualifying students this way could lead to risks to the safety of services.

"With blood taking – you can't assess that in simulation. Same with suturing. We practiced it on a sort of foam arm, but I can tell you it didn't replicate the real experience at all!" ***Midwife, England***

Respondents also clarified which types of **skills they felt should not be assessed through simulation**. There was general agreement that simulation should not be used in assessment for some of the more essential skills in midwifery. The main one that was mentioned, communication skills, was seen as difficult to replicate appropriately in simulated environments, meaning that students would not be sufficiently prepared and may struggle once they qualified.

Few wanted types of routine practices to be assessed through simulation, unless it was between the theoretical learning and practical learning phases. These routine practices included skills such as observations, abdominal palpitations or normal deliveries, which students could easily encounter on

their programmes and be assessed for in real-life situations with little difficulty. Since these were used on a regular basis, respondents also wanted to guarantee that students could perform these effectively.

6. Programme length and minimum hours

6.1. Summary

Nursing

Phase 1: There was strong support for retaining the minimum programme length at 3 years for nursing. Nearly all key partners supported reconsidering the number and mix of hours in pre-registration nursing programmes, identifying a wide range of potential benefits of doing so.

A key risk was that the public may equate reduced hours in training with reduced safety and quality in the care provided by nurses and midwives. Some also emphasised that any reduction in hours should not compromise nurses' ability to care for patients who have co-morbidities and complex needs (i.e. more challenging and complex care requirements).

Phase 2: There was high overall support for retaining the current minimum programme length and for the NMC continuing to specify both a minimum length and hours in order to ensure consistency.

A majority felt that the current programme length and minimum hours was necessary to achieve the standards of proficiency. Those in favour of reducing number of hours identified a range of benefits including quality not quantity in placement learning; improving the availability and quality of placements and reducing the considerable student workload.

Most respondents agreed that the time required to achieve the standards of proficiency should be based on competency and outcomes, rather than number of hours. Many held this view on the basis that number of hours is not a guarantee of competence.

On balance there was support for both outcomes and minimum hours to be considered in ensuring nurses can practise safely and effectively at the point of registration.

Midwifery

Phase 1: Key partners were strongly against any reduction in length, hours or practice hours for midwifery. It was felt that any reduction would make it difficult to cover all of the learning outcomes in the Future Midwife standards and would pose risks to the safety and quality of care, especially because midwives tend to work as autonomous practitioners.

Phase 2: There was high overall support for retaining the current minimum programme length and for the NMC continuing to specify a minimum length and hours in order to ensure consistency.

A majority felt that the current programme length and minimum hours for the direct entry route provides the appropriate amount of time for students to achieve the standards of proficiency. A majority felt that the length and hours requirements for the 2 year and 18 month shortened courses were

appropriate, although fewer felt that the 18 month option is sufficient.

A majority support a competency and outcomes-based approach, rather than number of hours (although this majority is lower compared to nursing).

On balance there was support for both outcomes and minimum hours to be considered to ensure that midwives can practise safely and effectively at the point of registration.

6.2. Phase 1: Interviews with key partners

6.2.1. Areas of consensus

Most key partners **supported retaining the minimum programme length at 3 years for nursing**. It was seen as an appropriate length for covering a lot of content and learning and allowing students to have enough time for self-reflection and development of critical thinking skills. Some also noted that it was an advantage for programmes to align in terms of length with that of other undergraduate programmes, including those of related health care professions (so that some modules could be taught across different disciplines).

There was near universal **support for reconsidering the number and mix of hours in pre-registration nursing programmes**. This included support for taking an outcomes-based approach, with many of the key partners interviewed feeling that number of hours is not an accurate indicator of competency. Many cited the fewer practice hours undertaken by nurses training in Australia and New Zealand in support of reducing the number of practice hours required in the UK. Many key partners said that the international evidence base should be reviewed and drawn upon in order to determine the right number and balance of hours, including what number should be set as the minimum number of hours.

> *"Many students have met outcome competencies well before their final placement, learning becomes doing the hours not achieving competencies."* - ***Education and improvement organisation, Wales***

While many key partners felt the same in principle about midwifery programme length and hours as they did for nursing - that is, supportive of the 3 year programme, and believing that outcomes and competencies are more important than number of hours - it should be noted that most of these key partners had a nursing background or focus in their work, and many acknowledged that midwifery was not their key area of expertise.

Many of the **key partners with a midwifery focus were strongly against any reduction in length, hours or practice hours for midwifery**. They noted that during the recent development of the Future Midwife standards, there was significant debate about this, with many having argued for the programme length to be 4 years, due to the amount of content to cover within the programme. Amongst those who had advocated for a 4 year programme,

there was no appetite to reduce length or hours. Many also noted that because the Future Midwife standards have only recently been implemented, no changes should be considered until the impact of the new standards has been evaluated.

> *"Do not reduce length. This has to be about safety and quality at the point of registration and about what the public and families and newborns need. It can't be about workforce issues;, you can't just shorten length of programme – it will have long term safety consequences." –* ***Lead Midwife for Education***

6.2.2. *Benefits and opportunities*

Key partners from nursing and midwifery who thought the NMC should consider reducing the number of hours identified a range of potential benefits to this. Many felt that shifting to a more competency-based approach would recognise that students are individuals and as such, **learn at different paces**. It would therefore stop students having to do 'additional hours for no benefit', when they are already competent.

Fewer hours overall would **reduce workload and pressure** on students, which would have benefits for students' experience and wellbeing, and thereby potentially **impact positively on retention**. It might also **widen access** by encouraging applicants who are currently put off by the number of hours. Here, some key partners interviewed noted that the 45 weeks a year typically undertaken by nursing students is much greater than the 30 weeks for other healthcare professions.

Having fewer practice hours specifically would **free-up placements**, with many key partners recognising the current pressure on placement capacity.

> *"I feel increasingly we are trying to put a square peg into a round hole in terms of the availability and quality of placements, and we are not doing it because it's the best thing for the students. We're doing it for the NMC/EU directives." –* ***Approved Education Institution, Scotland***

As illustrated by the quote above, key partners cautioned that while placement capacity is a driver, it would not be sufficient in itself to justify change. It was emphasised that if hours were to be reduced, it should be in the context of a **broader and more holistic review of the quality of learning**, to ensure that all practice hours provide genuine learning. 'Quality not quantity' was a phrase used by some interviewees. Some also identified an opportunity to redefine or flex what counts as practice hours to incorporate virtual/remote healthcare delivery, building on what has worked well during the pandemic.

> *"There's a need for a more flexible competency based system – some people can become competent in fewer hours, while others will take longer […] There might need to be a minimum number of hours, but then there needs to be some flex beyond that. It should*

be tailored towards competence rather than repetition." –
Approved Education Institution, England

6.2.3. Risks and challenges

Midwifery key partners often voiced concerns about reducing programme length or hours. These centred on the feasibility of covering all of the learning outcomes in the Future Midwife standards in less time, and risks to **safety and quality of care**, that is, that students may not have enough time to develop the confidence and sound clinical judgement that they need to practice safely after registration. This was particularly a concern for midwives, highlighting their role as autonomous practitioners. However, nursing key partners also flagged this risk particularly in relation to the care of people with complex needs and comorbidities, who are seen as an increasing proportion of those receiving care.

Many key partners were concerned about **negative public perceptions**, believing that the public may equate reduced hours in training with reduced safety and quality in the care provided by nurses and midwives.

Some suggested possible **ways of mitigating the risks and challenges** they identified:

- Well planned placements could help ensure that each practice hour is used well. It was noted that this would have implications for practice learning partners, as it may mean providing more intensive support and there would be a need for quality assurance of learning environments.
- In nursing, many felt that competency-based assessments should ensure students are competent (regardless of number of hours).
- Better support for newly qualified registrants could help them transition into practice (preceptorship), potentially compensating for fewer hours during training.
- Clear public messaging would help avoid negative public perceptions that might arise from a reduction in hours.
- As noted already, key partners felt that any reduction in hours should only take place in the context of broader consideration of the type and quality of learning.

One key partner in Scotland noted that students receive a bursary which may be reduced if the hours were to be reduced; they were uncertain as to the likely impact of this on students.

6.3. Phase 2: Survey and follow up interviews

6.3.1. Nursing

Programme length and minimum hours for pre-registration nursing programmes

Retain or amend the current requirements for length and hours, for nursing

Survey respondents and interviewees were asked **whether the current requirement for education and training to consist of at least three years made up of 4,600 hours (of which at least a third is theoretical study and at least half is clinical study) is the minimum necessary for someone to practise safely and effectively as a registered nurse at the point of registration**.

The majority of respondents to the online survey felt that the current requirements on length and hours are necessary for safe and effective practice (70%); while around a fifth felt that it was not the minimum necessary (21%).

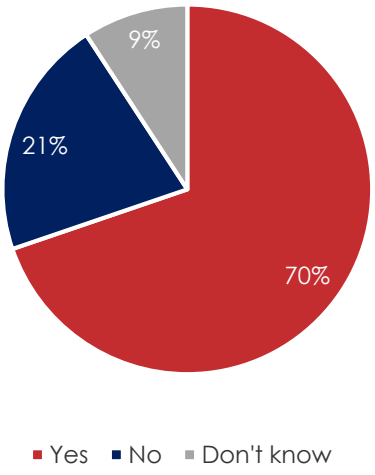

Figure 42: Question E1 - Currently nursing education and training must consist of at least three years made up of 4,600 hours (of which at least a third is theoretical study and at least half is clinical study). Is this the minimum necessary for someone to practice safely and effectively as a registered nurse at the point of registration? (n=5,362)

Four nation differences

The proportion of respondents who feel that the current three years made up of 4,600 hours requirement is the minimum necessary for someone to practice safely and effectively is 10% higher in Northern Ireland than in England, Scotland and Wales.

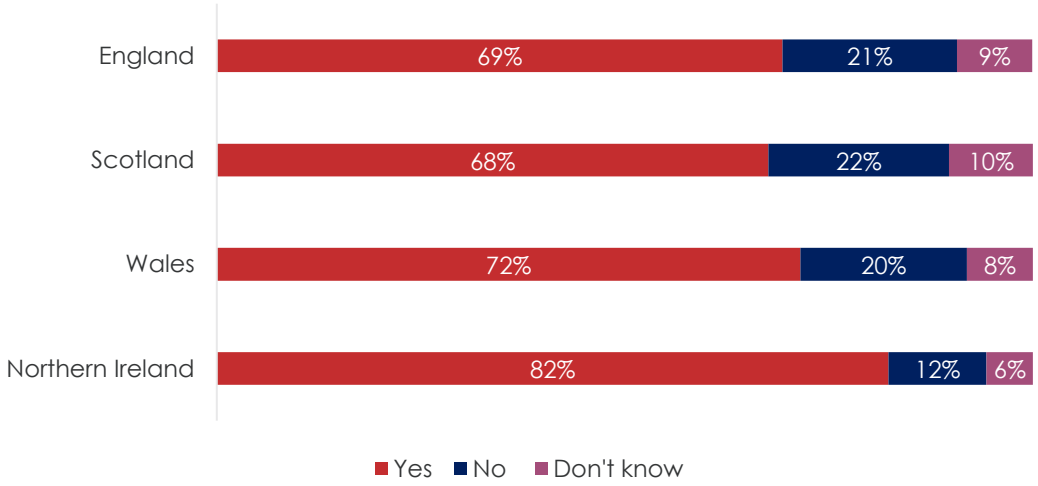

Figure 43. Question E1 Four nation breakdown - Currently nursing education and training must consist of at least three years made up of 4,600 hours (of which at least a third is theoretical study and at least half is clinical study). Is this the minimum necessary for someone to practice safely and effectively as a registered nurse at the point of registration? (n=5,362)

Sub group differences E1

- Those who do not identify as disabled (78% vs 71%) and heterosexual (78% vs 70%) respondents were more likely to say that three years made up of 4,600 hours is the minimum necessary for someone to practice safely and effectively as a registered nurse at the point of registration.

Survey respondents and interviewees **who said that programme length and minimum hours should continue to align** with the requirements of the EU Directive largely felt that the current length and hours provide the appropriate amount of time for students to cover the course content required to achieve the necessary standards of proficiency. Specific reasons for this included:

- There is **a lot of content to cover within pre-registration nursing programme**s and a reduction in length or hours would present a challenge to achieving this. Indeed, some noted that it was already a challenge to cover everything within the existing timeframe and hours.
- Achieving proficiency is not only a case of covering course content, but also having time for a) **reflecting on and digesting** what is being learned and b) **the repetition of skills** to ensure they are embedded and experienced in a variety of patients and settings.
- Requiring an equal number of hours for all students creates a '**level playing field**' within which for students to learn, taking into account the variation in individuals' pace of learning.

> *"I think three years is a good length. It gives you time to develop your practice and get the basics. But after registration, there is still enormous amounts to learn, so preceptorships are vital." –* ***Nurse, Northern Ireland***

With regards to the split between theory and practice hours, those who commented on the current split of 50/50 felt that this proportion of time spent in practice is essential to ensuring competence, and that it allows students to gain **exposure to a range of clinical settings**, which not only develops a broader skillset but helps students to identify which settings or areas they may wish to work in once they become qualified.

Survey respondents and interviewees **who felt that there was scope to reconsider the current requirements** had a range of reasons for this. By far the most commonly mentioned was the '**quality not quantity**' argument, that is, that a student having undertaken the current number of hours required does not necessarily indicate their competence. The quality of learning was seen to have a far greater impact on competency than quantity of time spent.

Lack of **availability and quality of placements** was identified as a reason for reconsidering the number of practice hours required, with the current requirement being seen as difficult to achieve in a number of ways, including:

- Placements generally being **oversubscribed** and acting as a **bottleneck** to increasing student numbers.
- **Supervisors being too busy** to provide meaningful learning experiences for students on placement; students being used as 'an extra pair of hands' on placements instead of learning.
- **Students being off sick or for other reasons,** and then having to make up the lost placement hours – which was seen as too inflexible
- Students being **unable to go on placement due to Covid-19.**

Some respondents compared the pre-registration nursing programme to other degree level programmes, noting that the hours for nursing students exceed those required of many other students, and that this places a **burden on students in terms of workload** and is particularly difficult for those with family commitments. Reducing the number of hours may have a positive impact on students in terms of reducing 'burn out' and increasing retention.

Survey respondents and interviewees had an opportunity to say **what they considered to be the appropriate length of time to achieve proficiency for safe and effective nursing practice at the point of registration** using a free-text question. Some wanted a reduction, others an increase, with most of the comments focusing on hours rather than overall length.

Amongst those proposing to reduce overall hours, there was no consensus as to what number of hours would be appropriate. Many did not specify a number but simply felt that a reduction would be desirable, and feasible; of those suggesting an appropriate figure it was most commonly in the 3000-4000 hours bracket (some noting that 3600 hours would represent parity with other degrees). Slightly fewer suggested 1000-2000 hours, or 2000-3000 hours. Some suggested that there should be a 2-year option for pre-registration nursing, however, within this there was a range of opinions and proposals as to how this might work, and no clear consensus on rationale.

Many respondents talked about **reducing practice hours**, for the reasons discussed above in relation to quality and availability of placements, and students' heavy workload. It was suggested that reducing hours could drive an improvement in quality of practice learning, because placement capacity would be less pressured. Of the small number who suggested an appropriate number of hours for practice, the figures were in either the 1500-2000 hours bracket, or 1000-1500.

A smaller cohort of respondents suggested **reducing theory hours**, mostly on the basis that it was not as important as practical experience, and difficult to manage writing assignments while also undertaking a placement.

Of respondents arguing for an **overall increase in the number of hours** to

accommodate the amount of learning required and to enable sufficient time to develop competence, some felt that the course should be 4 years, with smaller numbers suggesting 3.5 years, and 5000 hours. Again, more respondents focused their comments on the number of **practice hours**; those in favour of increasing practice hours believed this would allow students to better rehearse clinical skills, increase patient-facing skills such as communication, build students' confidence and increase the variety of clinical experience gained.

> *"I think you need more practice. We were too theory-based. And the practice needs to be more structured – we need to have specific courses for cannulation etc. Maybe the theory needs to cover more practical aspects of nursing too. You never stop learning as a nurse and we lacked a foundation in the basics – but that might be because I work on an acute ward – perhaps I might not need that working elsewhere." –* ***Nurse, Scotland***

Many respondents acknowledged in response to this topic that the amount of time that is required for someone to practise safely and effectively as a nurse at the point of registration is **highly varied by individual**, noting a range of factors that influence this, such as previous experience, ability, learning style, and opportunities provided on placements. However, while some felt this was an argument for a more individual, outcomes- based assessment approach, others thought the opposite: arguing for a standard and consistent number of hours for everyone (the level playing field argument). This is explored further by the question on outcomes vs hours- based approach later in this section.

Several respondents noted that they would like to see decisions about programme length and hours being informed by **evidence and best practice from other countries**.

Should the NMC specify minimum length and/or hours, for nursing

Survey respondents and interviewees were asked **whether the NMC should continue to specify a minimum length and/or hours for pre-registration nursing programmes**. There was broad support for the NMC continuing to specify both a minimum length (86% of survey respondents in favour; 8% against) and number of hours (81% in favour; 11% against) for pre-registration nursing programmes.

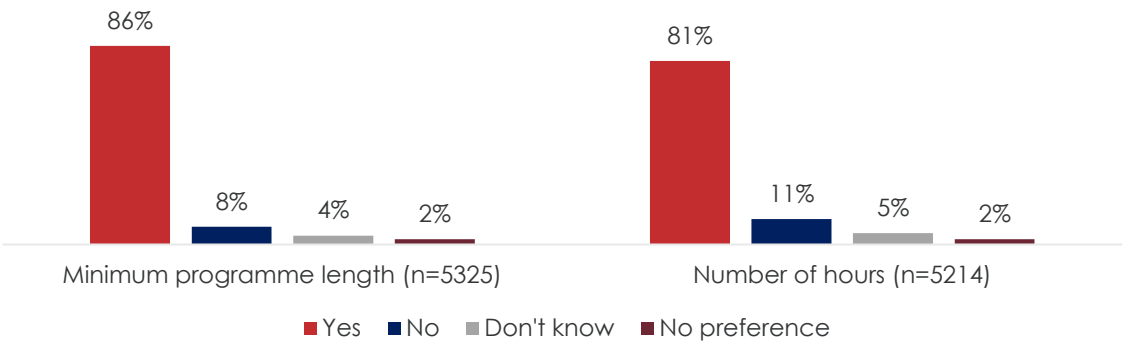

Figure 44: Question E3 – Do you think the NMC should continue to specify a minimum length and/or hours for pre-registration nursing programmes?

Four nation differences

Higher proportions of respondents based in Northern Ireland agree that the NMC should continue to specify a minimum programme length and minimum number of hours compared with those based in England, Scotland and Wales. This is particularly the case when it comes to number of hours.

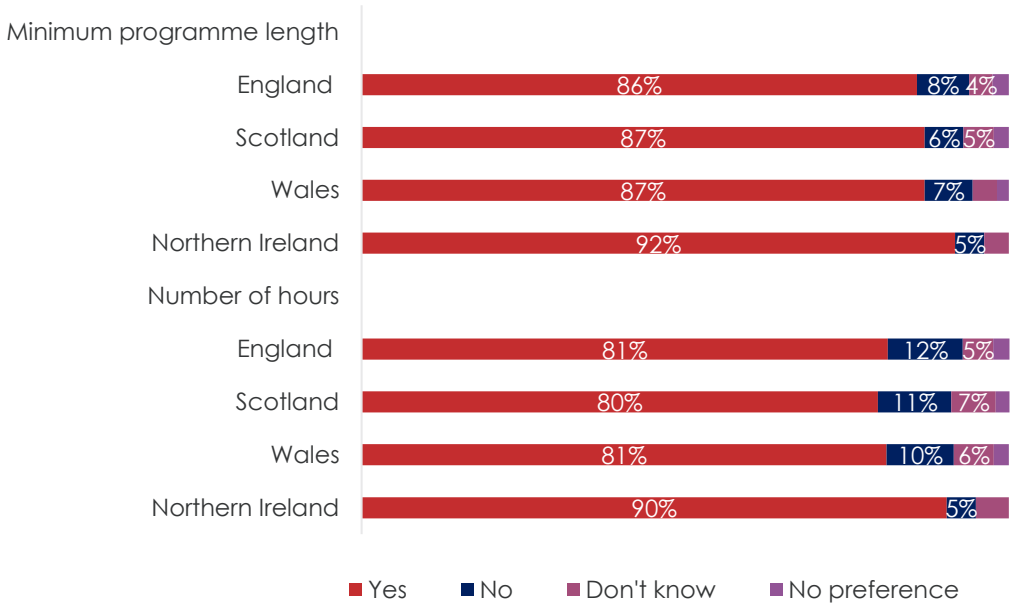

Figure 45: Question E3 - Four nation breakdown: Do you think the NMC should continue to specify a minimum length and/or hours for pre-registration nursing programmes? (Minimum programme length: n=5325; No. of hours: n=5214)

Sub group differences E3

- Older (94% vs 88%) respondents were more likely to say that the NMC should continue to specify minimum length for pre-registration programmes.

- Older (92% vs 82%) and heterosexual (89% vs 82%) respondents were more likely to agree that the NMC should continue to specify a minimum number of hours for pre-registration programmes.

For those who believed that the NMC should continue to specify a minimum

number of hours, many felt that this was **essential to producing competent nurses** and that having no minimum hours specified by the NMC would create too much disparity in experience and potentially present a risk to patient safety. A key reason was that it helps to encourage **consistency across different courses** and institutions providing pre-registration nursing programmes, with many citing the importance of standardisation and equitable provision, giving all students a fair opportunity to achieve the standards of proficiency. Many emphasised the importance of the NMC's role in ensuring this.

A clear point in favour of a minimum number of hours being set by the NMC mentioned by a few was that having a fixed number of hours enables students to **plan their time and set clear goals** around what needs to be achieved.

Outcomes vs hours, for nursing

Survey respondents and interviewees were asked **whether, in line with the NMC's outcome focused standards, the time required to achieve the standards of proficiency should be based on competency and outcomes rather than on number of hours**.

Two thirds of survey respondents agreed that the time required to achieve the standards of proficiency should be based on competency and outcomes, rather than number of hours (67%), while a fifth disagreed with this (20%).

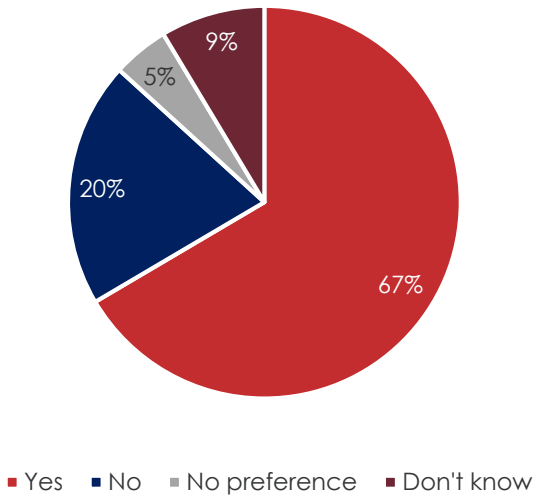

Figure 46: Question E4 - In line with the NMC's outcome focused standards, should the time required to achieve the standards of proficiency be based on competency and outcomes rather than on number of hours? (n=5,341)

Four nation differences

A slightly smaller proportion of respondents in Northern Ireland support a competency and outcomes focused approach to achieving the standards of proficiency, compared with those in England, Scotland and Wales.

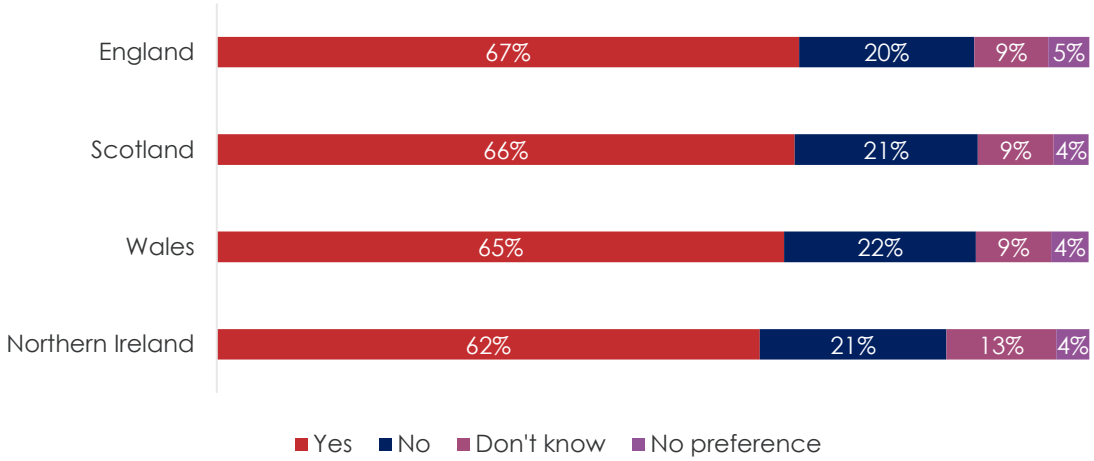

Figure 47: Question E4 – Four nation breakdown - In line with the NMC's outcome focused standards, should the time required to achieve the standards of proficiency be based on competency and outcomes rather than on number of hours? (n=5,341)

Sub group differences E4

- Ethnic minority (82% vs 76%) respondents were more likely to agree that the time required to achieve the standards of proficiency should be based on competency and outcomes.

Survey respondents and interviewees shared their rationale for **supporting a competency and outcomes- based approach**, rather than number of hours. The most frequent comment was that number of **hours is not a guarantee of competence**, with many emphasising that different students will need different amounts of time to reach competence.

> *"Some people can hit the proficiencies (e.g. venepuncture) really quickly and some need longer to get it right. I had already been with the Trust six years so lots of things could be signed off – I was already doing ECGs. Somebody new to the course won't have that and would need that time. So, it should be based on the student's skills. Minimums might not apply if someone already has proficiency, or if they pick things up really quickly. However, you would be relying on the mentor or nurse to be honest." –* ***Nursing Associate, England***

The key advantages of allowing students to become qualified based on competence rather than on having achieved the minimum number of hours were as follows:

1) If students could stop accruing hours once they have been deemed competent, they would not have to undertake **'unnecessary' placement hours**, thereby saving their own time and making placements available for other students who need them
2) An outcomes- based approach would encourage a clear **focus on specific and measurable learning outcomes**, that is, setting clear

expectations for learners and encouraging a clear focus on the learning needed to achieve the proficiencies. For example, clarity on what needs to be achieved in each clinical setting and how it will be evaluated.

Some respondents noted that in order for an outcomes-based approach to ensure safe and effective practice, there needs to be **effective assessment** of competency, and felt that the NMC would have an important role in providing clear guidance for effective and consistent assessment.

Those with a **preference for number of hours being the key requirement** (as opposed to a competency and outcomes basis) gave the following reasons:

- Time is needed for students to gain the necessary skills, range of experience and confidence to practise safely and effectively. Simply demonstrating the ability to undertake a task does not mean that a student will necessarily perform it well under pressure. Some spoke of the need for **time to embed, not merely achieve, competence**.
- Having a minimum number of hours provides (to some degree) a safety net, **mitigating the risk of a student being signed off too early** or incorrectly by a practice assessor.
- Having a fixed number of hours enables **exposure to varied settings** and situations, helping to broaden a student's experience.
- The same number of hours for all students provides **consistency and fairness** for all students.
- Some had concerns about the **difficulty of assessing competence**, and felt that number of hours has value as an objective measure.

There was wide support for using **both competency assessments and number of hours to ensure safe and effective practice at the point of registration**. Many respondents felt that a combination of competency- based assessment and achievement of a minimum number of hours represented the best option for ensuring nurses can practise safely and effectively at the point of registration. However, many acknowledged this may be complex, and some offered suggestions to help make it work, including:

- There should be flexibility to allow students to undertake additional hours if they need to in order to demonstrate competence.
- Set a maximum, as well as a minimum, hours within which to demonstrate competence.

6.3.2. *Midwifery*

Programme length and minimum hours for pre-registration midwifery programmes: direct entry and shortened programmes

Retain or amend the current requirements for length and hours, for midwifery

Survey respondents and interviewees were asked **whether the current requirement for education and training to consist of at least three years made up of 4,600 hours (of which at least a third is practice learning) is the minimum necessary for someone to practise safely and effectively as a midwife at the point of registration** (for **direct entry** programmes).

The majority of respondents to the online survey felt that the current requirements on length and hours for direct entry midwifery programmes are necessary for safe and effective practice (71%). Around a fifth felt that it was not the minimum necessary (19%), with the remainder selecting 'don't know' (10%).

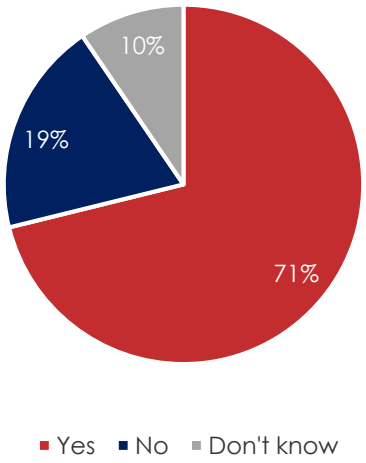

Figure 48: Question E6 - Currently direct entry and training must consist of at least three years made up of 4,600 hours (of which at least a third is practice learning). Is this the minimum necessary for someone to practice safely and effectively as a midwife at the point of registration? (n=1,324)

Four nation differences

A larger proportion of respondents based Northern Ireland think that three year made up of a minimum of 4,600 hours is necessary for someone to practice safely and effectively compared with respondents in England, Scotland and Wales.

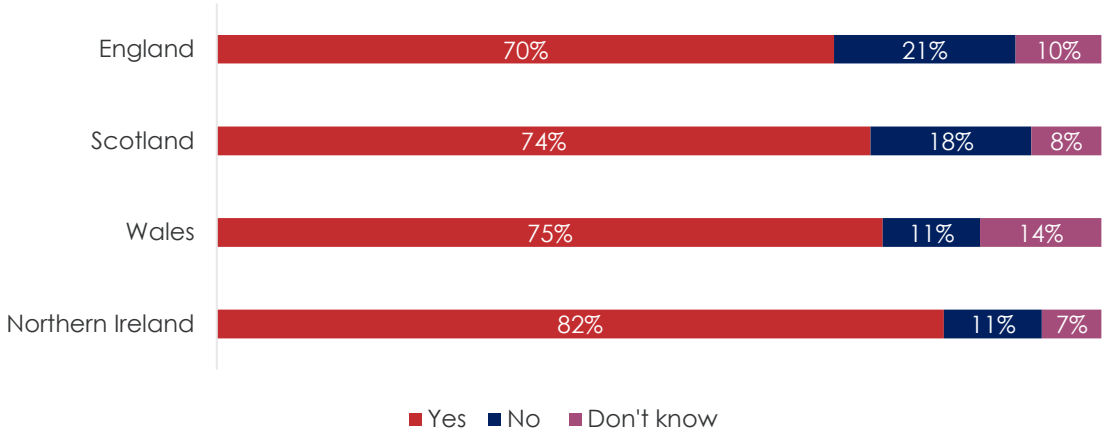

Figure 49: Four nation breakdown - Question E6 - Currently direct entry and training must consist of at least three years made up of 4,600 hours (of which at least a third is practice learning). Is this the minimum necessary for someone to practice safely and effectively as a midwife at the point of registration? (n=1,324)

Sub group differences E6

- Older (86% vs 73%) and White (81% vs 70%) respondents were more likely to agree that three years made up of 4,600 hours is this the minimum necessary for someone to practice safely and effectively as a midwife at the point of registration.

Shortened midwifery programmes are only available to first level adult nurses, with the following two options for shortened programmes:

- **Option 1**: full-time shortened programme, which must be at least two years and 3,600 hours
- **Option 2**: full-time shortened programme, which must be at least 18 months and 3,000 hours, and in order for the qualification to be recognised in EU member states it must be followed by a year of professional midwifery practice.

Survey respondents and interviewees were asked **whether the minimum length and hours for shortened midwifery programmes in options 1 or 2 are sufficient for someone to practise safely and effectively as a midwife at the point of registration**.

For option 1 (2 years, 3600 hours), the majority of respondents to the online survey felt that the current requirements on length and hours for shortened programmes are necessary for safe and effective practice (69% - similar to the proportion in relation to direct entry programmes). Only 12% felt that it was not sufficient. A greater proportion of respondents selected 'don't know' (16%) for this question than other questions, likely because many do not have experience of the shortened programme.

For option 2 (18 months, 3000 hours), fewer respondents thought the length and hours are sufficient than for option 1 (60% for option 2, compared to 69% for option 1) and more felt it was not sufficient (19% for option 2, compared

to 12% for option 1). Again, 'don't know' was high at 17%.

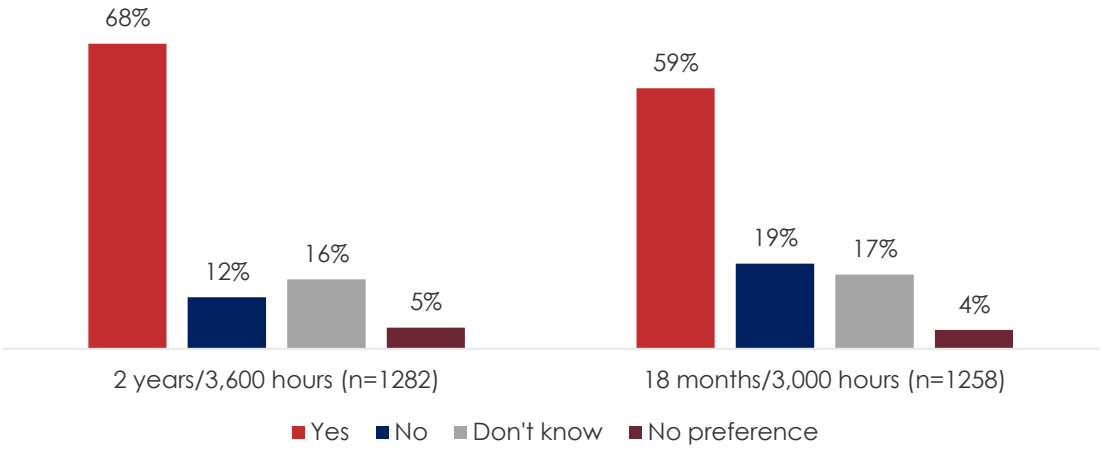

Figure 50: Question E12 - Do you think the current minimum length and hours of shortened midwifery programmes is sufficient for safe and effective midwifery practice at the point of registration?

Four nation differences

When it comes to the two year/ 3,600 hours minimum length and hours, a larger proportion of respondents based in England and Wales felt that this was sufficient compared with those based in Scotland and Northern Ireland. Reflecting on the 18 month/ 3,000 hours minimum length and hours, the proportions across the four nations who thought this was sufficient are broadly similar.

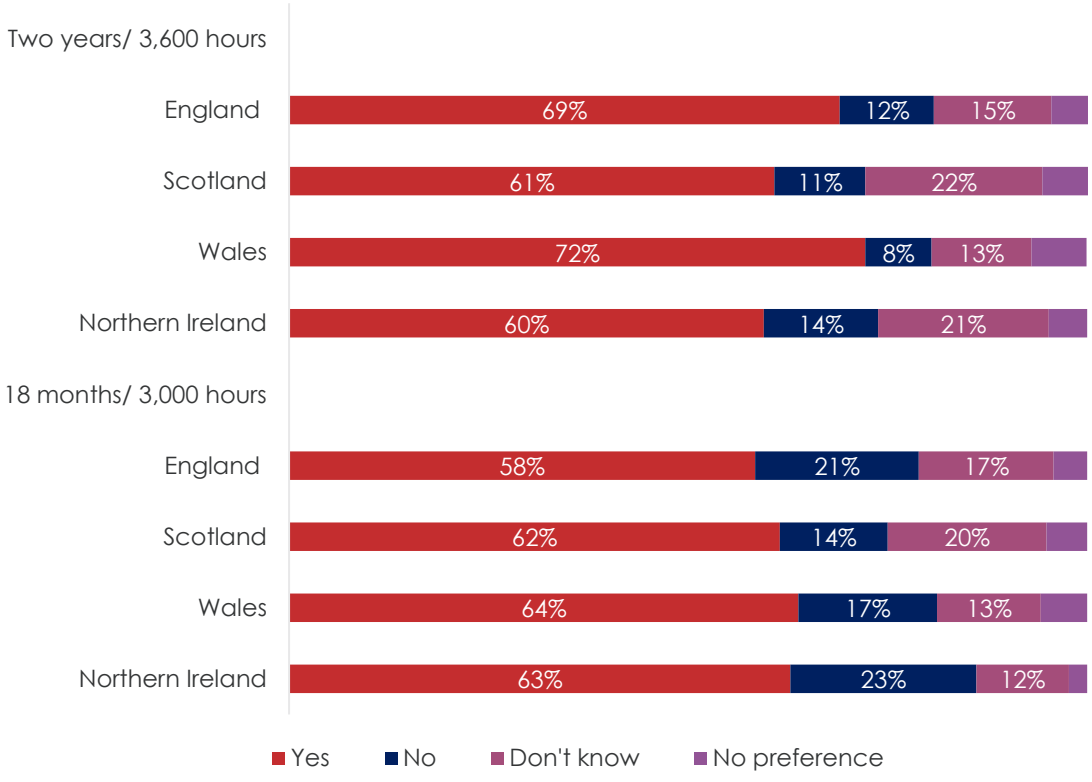

Figure 51: Question E12 – Four nation breakdown - Do you think the current minimum length

and hours of shortened midwifery programmes is sufficient for safe and effective midwifery practice at the point of registration? (2 years n=1282; 18 months n=1258)

Survey respondents and interviewees **who said that programme length and minimum hours should continue to align** with the requirements of the EU Directive for midwifery programmes largely felt that any less than the current length and hours would not allow students enough time to achieve the necessary standards of proficiency. Respondents highlighted:

- The demands of the course in terms of **volume of learning**
- The need for time to enable students to encounter a wide **range of clinical scenarios**
- Allowing time for learning to be consolidated, through **reflection and repeated practising of skills**
- The importance of **'soft skills' such as communication**, in midwifery, and how these are improved over time
- The role of the midwife as an **accountable professional** and the responsibilities that go with this
- The risk that a reduction in hours would **negatively affect the reputation of midwives** as safe, effective and accountable

The key reasons for survey respondents and interviewees view that there was **scope to reconsider the current requirements** for number of hours related to the impact on **students' wellbeing, work-life balance and mental and physical health**. Here burn-out, stress and exhaustion were frequently mentioned, with students feeling overwhelmed by the number of hours they are expected to complete, particularly when:

- Students have to complete academic work alongside practice hours
- Students have family or other commitments
- Students attend placement even when they are sick, because they will have to make up hours missed - risking becoming even more unwell.

> *"I know people who have done the 18 months programme and they felt it was very crammed. They felt quite overwhelmed within the 18-month course, trying to fit everything in. Even though they have had the 3 years of their adult nursing training before, it's still a lot to learn." –* ***Midwife, England***

Some respondents also noted that the hours exceed those expected of students on other degree programmes, so addressing this would bring more parity.

A similar number of respondents cited the view that **quality of learning is more important than number of hours**, with the latter not being an accurate measure of whether a student can practise safely and effectively.

Lack of **availability of placements** was mentioned by fewer respondents, and several of these noted the particular challenge during the pandemic.

There were few comments on the **theory/practice split**, but those who

commented on this tended to be in favour of more emphasis on practice.

Survey respondents and interviewees had an opportunity to say **what they considered to be the appropriate length of time** to practise safely and effectively as a midwife at the point of registration in a free text question.

Amongst those proposing to reduce overall hours for direct entry programmes many did not specify by how much but merely felt the current requirement was too much. Of those suggesting an appropriate figure this was most commonly in the 3000-4000 hours bracket, with a very few suggesting 2000-3000 hours or a 2 year option. A few proposed a reduction in terms of hours per week (e.g. 30 hours) or weeks per year (e.g. 30 weeks). Several focused on reducing number of placement hours rather than overall hours, but very few specified by how much; and an even smaller number suggested reducing theory hours.

Of respondents arguing for an **overall increase in length/hours** to cover all of the competencies and develop confidence, the most common suggestion for direct entry programmes was 4 years. Some suggested that the extra year should be focused on practice; while a few thought that a 4 year programme without an increase in hours would allow students a better work-life balance.

Of respondents who talked about increasing the number or proportion of **practice hours,** some noted that while the EU Directive requires a third of hours to be in clinical placement, a 50/50 split is preferred. A few felt that the proportion spent on practice should be higher, such as 60%, because they believed that more valuable learning is gained in practice compared to theory.

For **shortened programmes**, there were few comments on length and hours amongst survey respondents and it was not always clear whether these related to option 1 (2 years) or option 2 (18 months), however a handful of respondents did suggest that a reduction would be possible, with some mentioning the need for preceptorship to support this.

Several respondents called for more flexibility in hours, for example **tailoring requirements to individuals** based on their prior experience and learning style and learning pace. It was noted that different people take different amounts of time to reach proficiency. A few thought that there should be flexibility in relation to **sick leave**, allowing students to take a number or percentage of days off if they are sick, without having to make up the hours.

A few respondents felt that the NMC should draw on **examples from other countries and from related healthcare professions** to inform guidance on programme length and hours for midwifery programmes.

Should the NMC specify minimum length and hours, for midwifery

Survey respondents and interviewees were asked **whether the NMC should continue to specify a minimum length and/or hours for direct entry pre-**

registration midwifery programmes.

There was broad support for the NMC continuing to specify both a minimum length (86% of survey respondents in favour; 7% against) and hours (79% in favour; 13% against) for direct entry pre-registration midwifery programmes.

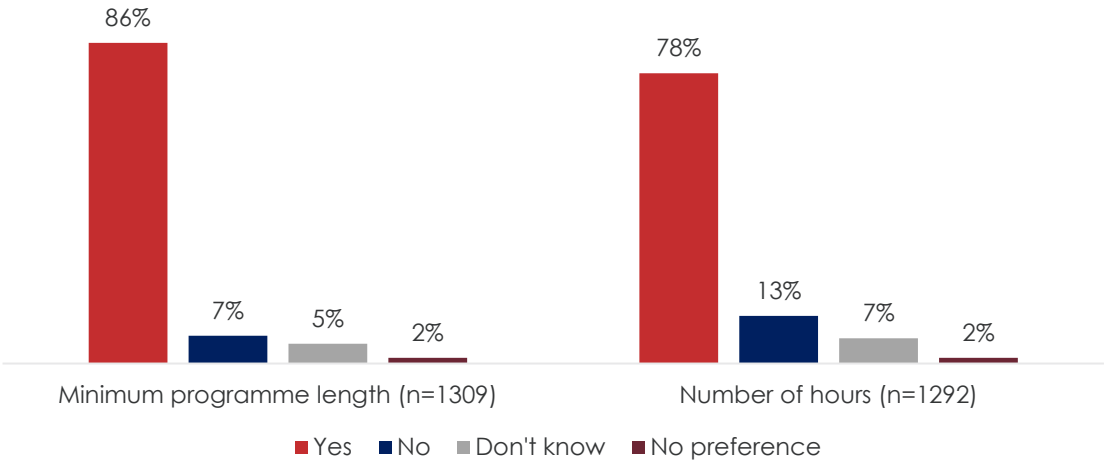

Figure 52: Question E9 - Do you think the NMC should continue to specify a maximum length and/or hours for direct entry pre-registration midwifery programmes?

Four nation differences

A slightly smaller proportions of respondents based in Northern Ireland agree that the NMC should continue to specify the minimum programme length compared with England, Scotland and Wales. The reverse is true for number of hours, where a slightly higher proportion of respondents based in Northern Ireland think that the NMC should continue to specify number of hours, compared with England, Scotland and Wales.

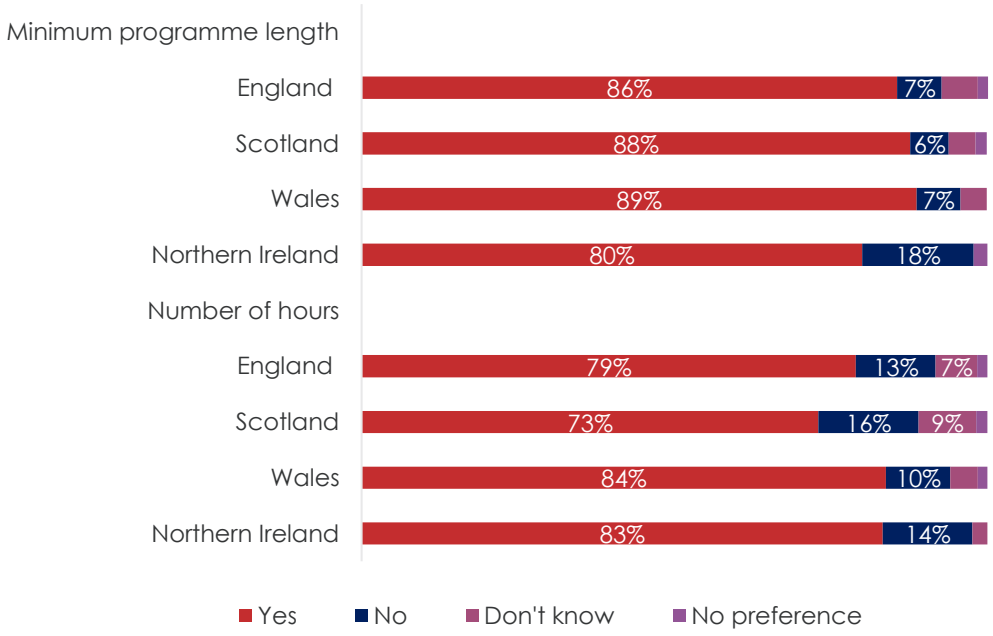

Figure 53: Question E9 - Four nation breakdown: Do you think the NMC should continue to specify a minimum length and/or hours for direct entry pre-registration midwifery programmes? (min programme length n=1309; no. of hours n=1292)

Sub group differences E9

- Older respondents (92% vs 80%) were more likely than younger respondents to agree that the NMC should continue to specify a minimum programme length for direct entry pre-registration midwifery programmes.

- Older respondents (77% vs 63%) were more likely than younger respondents to agree that the NMC should continue to specify a minimum number of hours for direct entry pre-registration midwifery programmes.

Survey respondents and interviewees were asked **whether the NMC should continue to specify a minimum length and/or hours for shortened pre-registration midwifery programmes**.

There was broad support for the NMC continuing to specify both a minimum length (81% of survey respondents in favour; 7% against) and hours (77% in favour; 11% against) for shortened pre-registration midwifery programmes.

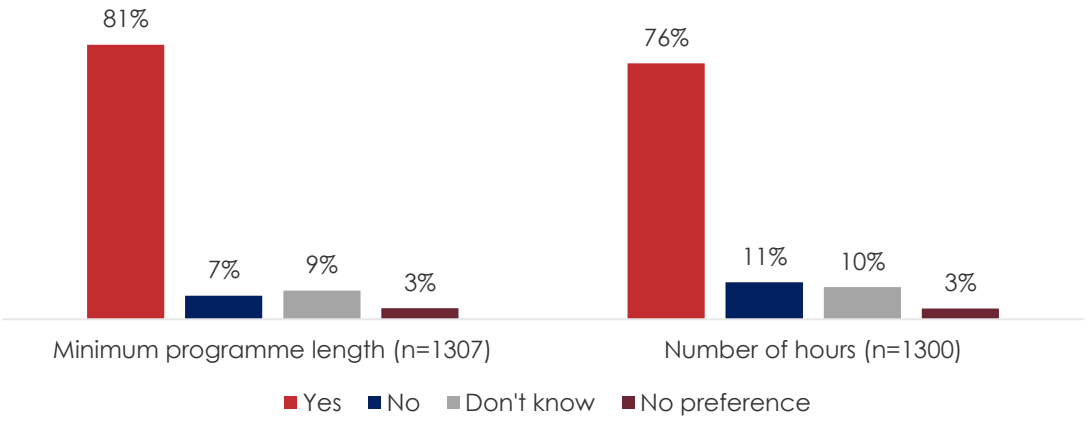

Figure 54: Question E15 - Do you think the NMC should continue to specify a minimum length and/or hours and length for shortened pre-registration midwifery programmes?

Four nation differences

A smaller proportion of respondents based in Northern Ireland support the NMC continuing to specify a minimum programme length, compared with those based in England, Scotland and Wales. When it comes to numbers of hours, however, the reverse is true; with a larger proportion of those based in Northern Ireland supporting the NMC setting a minimum number of hours compared with those based in England, Scotland and Wales.

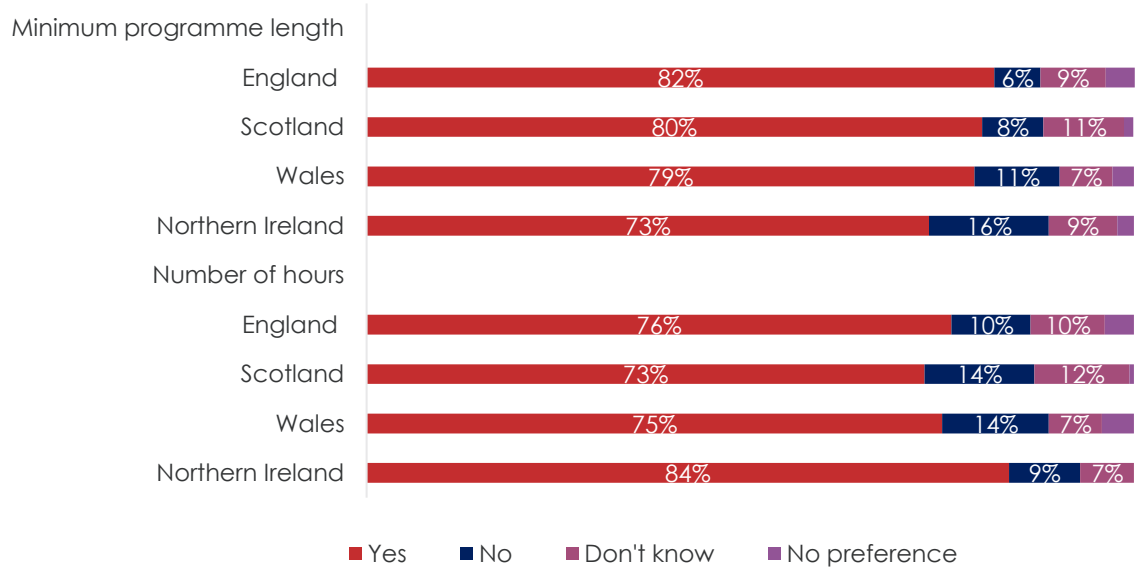

Figure 55: Question E15 – Four nation breakdown - Do you think the NMC should continue to specify a minimum length and/or hours and length for shortened pre-registration midwifery programmes? (programme length: n=1,307; no. of hours: n=1,300)

Sub group differences E15

- Those who do not identify as disabled (90% vs 81%), older (93% vs 86%) and heterosexual (90% vs 79%) respondents were more likely than disabled, younger and non-heterosexual respondents to agree that the NMC should continue to specify a minimum number of hours for shortened pre-registration midwifery programmes.

Reasons for agreeing that the NMC should continue to specify a minimum length and hours for pre-registration midwifery programmes (shared by a small number of respondents) centred around the need to, and NMC's role in, ensuring consistency across different courses/institutions, with the word 'standardisation' coming up frequently.

> *"We should keep going with these numbers – it's good to have consistency from the governing body. It ensures consistent standards; it's a good vehicle to doing that. We need to know what we are getting is up to the right standard. It's right that the regulator sets these standards."* – ***Midwife, Scotland***

Outcomes vs hours, midwifery

Survey respondents and interviewees were asked **whether, in line with the NMC's outcome focused standards, the time required to achieve the standards of proficiency should be based on competency and outcomes rather than on number of hours, for pre-registration midwifery programmes**.

Just under two thirds of survey respondents agreed that the time required to achieve the standards of proficiency should be based on competency and

outcomes, rather than number of hours (60%,), while a fifth disagreed with this (25%). The rest selected don't know (11%) or no preference (4%) for this question.

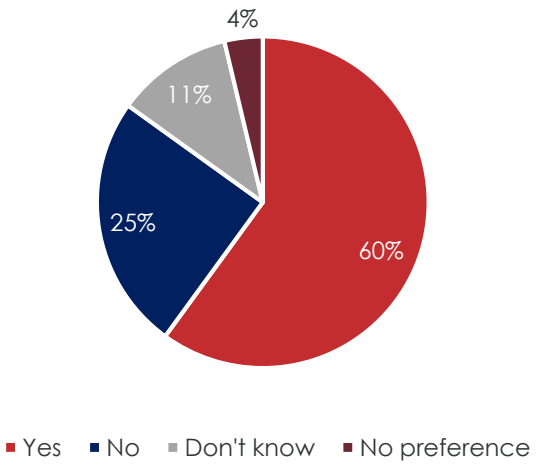

Figure 56: Question E10 - In line with the NMC's outcome focused standards, should the time required to achieve the standards of proficiency be based on competency and outcomes rather than on hours? (n=1,313)

Four nation differences

Just over 10% fewer respondents based in Northern Ireland support a competency and outcomes focused approach to achieving the standards of proficiency, compared with those based in England, Scotland and Wales.

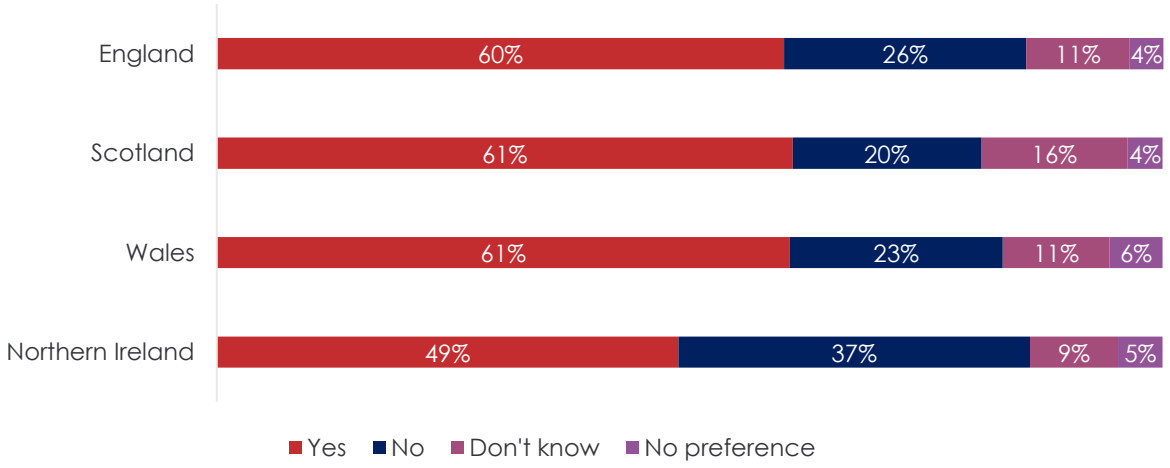

Figure 57: Question E10 – Four nation breakdown - In line with the NMC's outcome focused standards, should the time required to achieve the standards of proficiency be based on competency and outcomes rather than on hours? (n=1,313)

Sub group differences E10

- Younger (77% vs 63%), ethnic minority (81% vs 69%) and non-heterosexual respondents (83% vs 70%) were more likely than older, White and heterosexual respondents to agree that the time required to achieve the standards of proficiency should be based on competency and outcomes.

Those **in favour of an outcomes based approach** for pre-registration midwifery programmes stated that number of hours is not a reliable indicator of competence, noting that students learn at different paces and will require different amounts of time to develop the proficiencies. Moving away from a system that requires students to continue to **'clock up' hours**, when they are already competent or when additional hours do not expose the student to opportunities to learn or consolidate learning, made sense to many respondents.

> *"Some people will make excellent midwives but it takes them a bit longer. There should be some flexibility to lengthen courses if the learner needs it. On the other side: practice supervisors: they can tell very quickly if a student can meet competencies or not, after a while, they know what you can do and trust you, you get to the point where you are still practicing but you don't need to." –* ***Midwife, England***

They also noted that missing hours due to factors such as having to take time off for ill health, or spending hours 'waiting' for a learning opportunity such as a birth, is outside of the student's control and they should not be penalised by having to **make up missed hours** (if they are assessed as being competent).

Some respondents believed that a greater focus on outcomes, without the burden or distraction of counting hours, would encourage a **clearer focus on developing skills and knowledge**, amongst both learners and placement providers. In this way **placement hours would be more targeted** to learning, incorporating theory into practice - and less likely to be wasted (e.g. 'doing the tea trolley').

It was however noted that this would only work if there was **clear guidance for, and quality assurance of, assessment**, to ensure that assessment of competency is accurate and consistent across assessors and institutions.

Many survey respondents felt that **retaining a minimum number of hours** was essential, as opposed to shifting towards a competency and outcomes based approach. Many saw it as an **essential safeguard** helping to deliver minimum standards and a consistent experience and level of opportunity for students. Many respondents identified a **risk to safe and effective practice** in moving away from requiring minimum hours, citing the potential for subjective and inconsistent assessment by assessors, students projecting 'overconfidence' in their demonstration of skills, and lack of exposure to a sufficiently wide variety of experiences.

The midwife's role as an **autonomous practitioner** who has responsibility for the care of women and families – was highlighted as a key factor in respondents' reluctance to remove hours as a requirement. If students were able to qualify based only on competency, then they might miss out on having the time to develop skills such as observation, understanding, active participation that are important in obstetric emergencies – which could

create a risk to the safety of services.

Many respondents felt that it was not an either/or issue and emphasised rather that **students both achieve a minimum number of hours *and* demonstrate competency in assessments**. Many of these comments associated this approach with the best chance of producing midwives who can practise safely and effectively at the point of registration. It was proposed that while setting a minimum number of hours, students should be able to undertake more hours if needed to become proficient. In addition, there should be a maximum number of hours to ensure momentum and to identify students who will ultimately not achieve proficiency.

> *"I think actually that the numbers are only the starting point to learning something; the outcomes/competency approach is important as well. You need to have minimum numbers of hours but need to continue to hone your skills." –* ***Midwife, Scotland***

7. Overall impacts

7.1. Summary

Nursing

Phase 1: It was felt that consistency of standards across the four nations would be important to retain to support the mobility of the workforce. Many were also keen to avoid creating any 'bureaucratic' barriers to the movement of registrants between the EU and UK. This was also seen as important in the context of supporting the cross-border movement of students and registrants between Northern Ireland and the Republic of Ireland. In Scotland divergency with the EU Directive was seen as a potential challenge in terms of the cross-transfer registrants and in terms of an independent Scotland's future aspirations to re-join the EU.

Phase 2: When asked about the overall impact of the NMC potentially changing requirements, up to a fifth of respondents expect an overall positive impact, with greater levels of optimism about the impact on England. Around 1 in 10 respondents expect the impact on each nation to be negative. Many emphasised the importance of the NMC maintaining consistency of standards across the UK, and changing the requirements were often seen as an opportunity to raise and tailor standards to the UK context. On the other hand, some suggested that changes could lead to the lowering of standards and to poorer outcomes and there was a concern that UK qualifications may be less well recognised internationally.

Midwifery

Phase 1: Consistency of standards across the four nations would be important to retain and there was again a keenness to avoid creating 'bureaucratic' barriers to the movement of registrants between the EU and UK. Midwifery key partners had a particular concern about any real or perceived "dilution" of midwifery standards as a result of divergence from the EU Directive, which could harm the strong global reputation of UK midwifery and its ability to influence others. With these concerns in mind, it was felt to be important to highlight that any changes were evidence-based and driven by safety and quality considerations and to consider alignment with global midwifery standards.

Phase 2: Compared with nursing, slightly higher proportions expected a positive impact on the four nations, with England again being the nation that it was felt would most likely experience a positive impact. Respondents saw opportunities to raise and tailor standards to the UK context. Potential risks included lowered standards harming the reputation of UK midwifery and UK midwifery qualifications becoming less recognised and valued internationally, which could restrict the movement of registrants and reduce interest in studying in the UK.

7.2. Phase 1: Interviews with key partners

Key partners were asked to explore their views about the **overall impact of any move away from the EU Directive, specifically with respect to the recognition of qualifications and potential impact on recruitment to and from the EU and other countries** that have adopted the EU standards.

7.2.1. Areas of consensus

Most felt that consistency of standards across the four nations would be important to retain, as it gives UK registrants the flexibility to work and study where they choose.

Key partners were keen to avoid creating any 'bureaucratic' barriers to the movement of registrants between the EU and UK. This was felt to be particularly important in England, which relies on EU workers to a greater degree than the other four nations.

> *"We believe it is important that any change to the standards still enables the NMC to recognise equivalent training programmes in other countries to therefore enable nurses and midwives of equivalent standards to work in the UK with the minimum of bureaucracy and barriers." –* ***Union/Professional body***

In the Northern Ireland and Scotland contexts there was support for continuing to enable the cross-border movement of registrants between the EU and the UK. In Northern Ireland, the focus was on supporting the ongoing movement of registrants over the border with the Republic of Ireland. Here it would be important to ensure that the UK was not wildly divergent in their education/training from their nearest EU neighbours for the purposes of getting onto the register of another country.

In Scotland, alongside concerns about creating to barriers to the cross-transfer of registrants between the EU and UK, divergence with the EU Directive was seen as a potential challenge in terms of any future aspirations to re-join the EU should they become independent.

> *"Part of this is about our standards and whether these are up-to-date, but the other is about cross-Scotland-EU transfer of students and staff." –* ***Government stakeholder, Scotland***

> *"That is the biggest detrimental impact of divergency; it could make it harder for a future independent Scotland to re-join the EU." –* ***Government stakeholder, Scotland***

7.2.2. Areas of divergence

Midwifery focused key partners voiced a concern about any real or perceived "dilution" of midwifery standards as a result of divergence from the EU Directive which could harm the strong global reputation of UK midwifery education and training. It was felt that any 'dilution' of standards had the potential to reduce interest in studying in the UK from overseas

students and could undermine UK midwifery's ability to influence others and set standards globally.

Reflecting on the potential to harm UK midwifery's reputation, key partners felt that it would be important to highlight that any changes were evidence-based and driven by safety and quality considerations. Others emphasised that the process of reaching decisions and implementing changes needed to involve close-working and dialogue with the EU and with international partners, rather than being solely led by the research evidence base.

7.2.3. Opportunities, risks and challenges

Some key partners suggested that divergence from the EU minimum standards presented opportunities for the UK to:

- Establish "**new reciprocal relationships**" with other countries both in and outside of the EU to support movement of the workforce.
- **Make recruitment of nurses from other countries easier**, for example New Zealand and Australia, were the UK to become more closely aligned with their training and education standards.
- Place an emphasis on **alignment with global midwifery standards** (e.g. via the ICM). This could help to maintain or increase the global reputation of UK midwifery, ensuring continued ability to attract students and registrants.

When considering impacts on recruitment to and from the EU, there was a view that it would be helpful to **assess the scale of movement in both directions to date and expected**, to better understand the potential issues.

In terms of reducing the barriers to the movement of registrants between the UK and EU, some key partners suggested that:

- Approved Education Institutions could offer students an **additional opportunity to achieve EU alignment** (e.g. topping-up practice hours if the UK requirement were to be reduced) to support transferability. This could be particularly beneficial in Northern Ireland and Scotland.
- Northern Ireland in particular might want to seek **mutual recognition of EU/non-EU standards** to support movement over its border with the Republic of Ireland. There was also a view that Approved Education Institutions in Northern Ireland should be free to continue to align with EU standards should they want to, in order to avoid the loss of students from the Republic of Ireland. One interviewee suggested extending these options to Scotland and Wales.
- The standards could be revised in such a way that the NMC were largely **adding to rather than reducing or changing** what is in the EU Directive. This might be particularly relevant in areas such as the knowledge and skills requirements.

There was a view that the risks and challenges associated with divergence from the EU Directive could be reduced by **pausing consideration of any UK changes and waiting to see how the EU updates the minimum education and**

training standards (which it was suggested may happen in the next two years)[14]. If the NMC does not pause this work, it would be sensible to be a part of the European conversations taking place in relation to the updating of the Directive which are taking place.

7.3. Phase 2: Survey and follow up interviews

Both nursing and midwifery respondents were asked to indicate **whether they thought there would be positive and or negative impacts on each of the four nations from the NMC changing their requirements from the EU Directive**. Respondents were also asked to explain their responses in an open- ended question.

7.3.1. Nursing

Impact of changing requirements on four nations

Respondents were most likely to say that they did not know whether the impact would be positive or negative (37-48%) with a majority explaining that they selected this option because at this stage it was not clear what changes might be taken forward. Around a quarter (23-27%) felt that it would be both positive and negative. A larger proportion of respondents expected a positive impact for England compared with the other three nations.

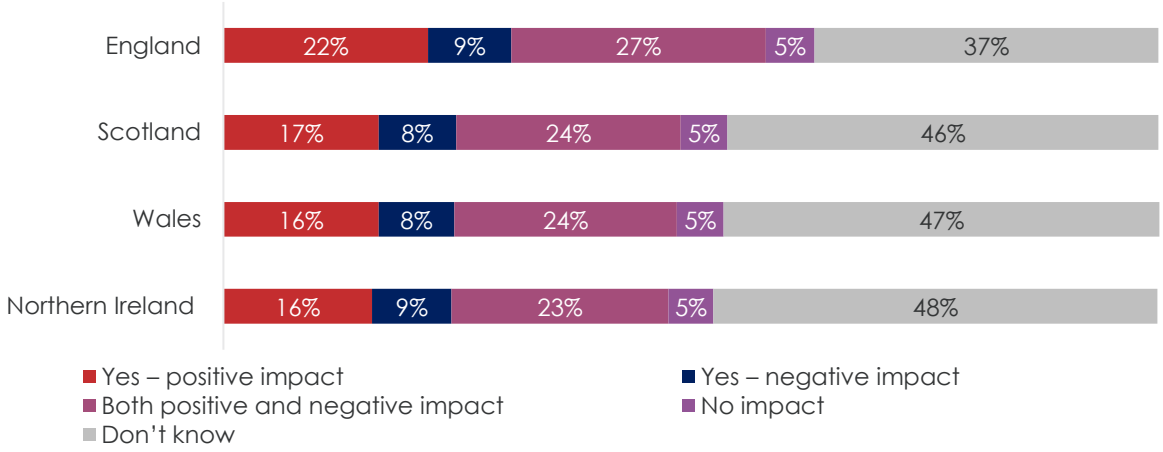

Figure 58: Overall results. Question F1 – Do you think there will be any impacts from the NMC changing their requirements from the EU Directive on nursing in any of the four countries of the UK? (All respondents who answered nursing questions, n=5,142)

Sub group differences F1

- Younger respondents and those from ethnic minority backgrounds were more likely than older and White respondents to expect a positive impact on each of the four nations (see Appendix 2 for percentages).

[14] Currently the EU has made no suggestion that they will be reviewing the minimum number of programme hours and practice learning definition.

Four nation differences

In terms of how respondents rated the impact on the nation where they were based, those in England were most likely to expect a positive impact, while those in Northern Ireland were the least likely of the four nations to expect a positive impact and the most likely expect a negative impact.

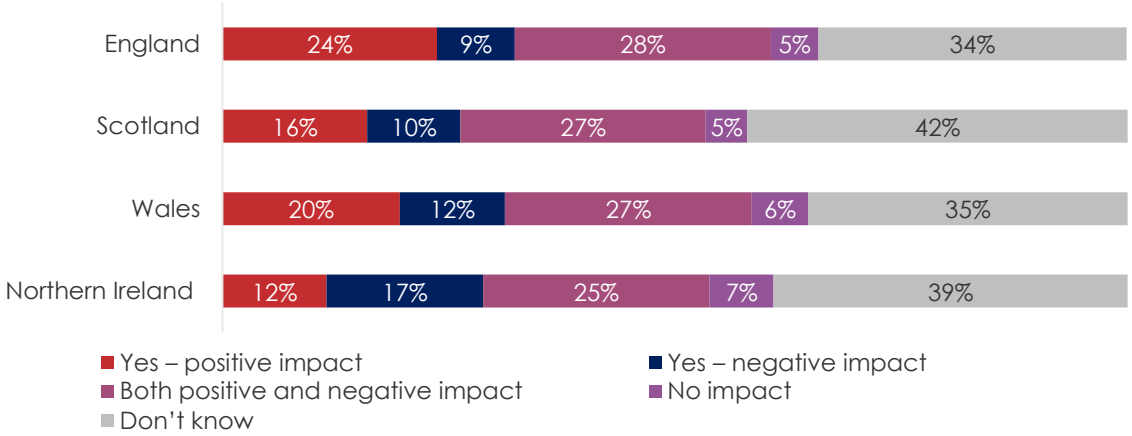

Figure 59: Respondents rate impact on the nation where they are based. Question F1 – Do you think there will be any impacts from the NMC changing their requirements from the EU Directive on nursing in any of the four countries of the UK? (England: n=4,118; Scotland; 524; Wales: n=388; Northern Ireland: n=156)

Overall impact

Reflections about overall impacts have been grouped into three categories: opportunities, risks, and suggestions.

Opportunities – Nursing

A majority of respondents felt that this was an opportunity for the UK to **raise its minimum education and training standards** to enhance the quality and effectiveness of services and of the nursing profession. Some suggested that changes should be based on a review of what is working well and less well under the current requirement.

*UK should seek to benchmark its standards against other countries and Federations - **Nurse, England***

Without the constraints of the EU Directive, a majority of respondents felt that the revised standards presented an opportunity to **tailor them to the UK health system and to meeting the population's needs**. It should be noted that most respondents who cited this opportunity did not specify what potential changes might bring this about and respondents did not acknowledge in their responses that the NMC's standards are already tailored to the UK context.

Some respondents were also keen to give the individual nations and even regions of the UK greater scope to flex their approaches in terms of the design and delivery of training and education.

"Having UK standards should be more bespoke to the UK's health

care system and demographics compared to the EU. The EU ranges from Ireland to Romania, Finland to Malta and tries to accommodate 27 different health care systems and national demographics. Let the UK develop what it needs. I believe there will be a lot of similarity but the UK directives for nursing would reflect the UK's situation. ***- Nurse, England***

It was common to see the review of standards as an opportunity to **modernise nursing programmes**, with several respondents suggesting that the current EU standards were outdated and did not reflect the current digital age and the changes that have taken place in how health care is delivered, especially since the outbreak of Covid. Respondents also made a wide range of **specific suggestions about how nursing programmes might be improved** which included a stronger focus on clinical competencies/hands-on skills/vocational learning).

Several respondents hoped that revised standards might help to **widen access to pre-registration nursing programmes and therefore increase the numbers and diversity of the nursing workforce**. This could be achieved through for example:

- The use of **alternative learning** methods suited to different types of learners;
- Shifting the emphasis towards **practice-based learning** and away from academic components; and
- Increasing how prior **learning and experience is recognised** by Approved Education Institutions.

Others hoped that any changes might help to improve the **workplace wellbeing and retention of nurses.**

Risks

Many answering the question identified the risk that UK registrants would **no longer be able to work in the EU** were the UK to diverge from the EU Directive, which in turn would limit their future career options. A few suggested that because the EU Directive standards are recognised globally it could potentially hinder their impact to practise in non-EU countries as well.

More specifically, some respondents raised concerns that diverging from the Directive could create additional barriers to the **movement of registrants between Northern Ireland and the Republic of Ireland**.

"The shared border with movement of nurses across the island of Ireland is an issue – change may have a negative impact for staff movement. This could be overcome with flexibility in terms of the requirements." – ***Nurse, Northern Ireland***

It was also felt that divergence in standards could make it **more difficult for Northern Ireland-based AEIs to attract Irish students**.

"[move away from the EU Directives] will affect the attractiveness of our programme [to students] from the south of Ireland. We have come a long way to make two sides integrated. To create a difference in the standard of training would detrimental to the healthcare workforce." – ***Approved Education Institution***

Another risk identified by a majority of respondents was that diverging from the EU Directive could make it more **difficult and off-putting for EU registrants to enter and practise in the UK**, for example were it to require timely additional training or increased "paperwork". There was a concern also that the changes could make the UK a **less attractive destination to study nursing**. This could exacerbate the current shortage of nurses, especially in England. Around this theme, some noted that Brexit had already resulted in some EU registrants leaving the UK or in deciding not to study or practise in the UK.

While many saw the review of the Directive as an opportunity to raise standards, some had a concern that changes had the potential to lead to a **lowering of the education and training standards,** resulting in nurses who were underprepared to do the role and risks to the safety and quality of services. Some noted that high standards were more important than ever given that patients have increasingly complex needs.

"A reduction in hours may deplete the skills and knowledge of the future nursing workforce; students will not be prepared for practice. Heavy reliance on simulation may impact on the delivery on other theoretical components in programmes, may be rushed and not delivered with care (simulation can detrimentally reduce learner confidence if not delivered with care and diligence by skilled facilitators)." – ***Nurse, England***

It was suggested that the lowering of standards could be driven by a desire to cut costs or in an effort to **expand the nursing workforce rapidly potentially at the expense of quality**, with some noting that this was more of an England-specific driver. Some respondents identified specific changes that might lower standards and quality. This included, a reduction in the minimum amount of practice hours or overall length of programmes or reduced exposure to different clinical settings during pre-registration programmes.

"I feel there is a pressure on the NMC to change as nurse shortages are acute and are likely to get worse in the short term." – ***Nurse, England***

Another risk identified by many respondents was the potential for **different standards in each nation**, which could make it more difficult for UK registrants to work where they choose.

Several respondents voiced concerns about the **potential for disruption and confusion for nurses, employers and educators** if and when any changes were made. Respondents emphasised the need for a smooth and well managed transition period and clear guidance and communications (e.g.

for practice supervisors and assessors) and to be mindful that many staff in the NHS are already overburdened.

Suggestions – Nursing

A majority of respondents called for **setting consistent standards across the UK** which would ensure that across each nation the same outputs/outcomes and standards are being achieved/maintained. This would also support workforce mobility and ensure that AEIs are still able to attract students from other UK nations. Some called for providing overall consistency whilst also providing space for accommodating the devolution agenda/local tailoring.

Many respondents answering the question suggested **full alignment with the EU Directive** to support the transferability of the workforce; with several suggesting that the UK should only add to or extend rather than diverge from the EU. A few suggested changing the standards but taking the best from the current approach as the starting point.

Several registrant respondents called for **specific changes,** such as enhanced field-specific training, a reduction in practice hour requirements; greater focus on the quality of learning experiences were placement hours to be reduced; deepening or extending the knowledge and skills requirements in particular areas; and greater innovation and flexibility in terms of the role played by simulation.

A few registrant respondents called for **alignment with non-EU countries.** It was suggested that this could be an opportunity to learn from and or align with the education and training standards set by countries outside of the EU, such as Australia, New Zealand, the United States and the Philippines. Some suggested this might also give UK registrants greater opportunities to work abroad.

Other responses

- **Don't know:** Reflecting the high proportion of don't know responses, many explained that they could not comment on impact because they did not know what changes the NMC would take forward.
- **No impact:** Those who selected 'no impact' explained in most cases that they anticipated that the changes were likely to be minimal and that they felt confident that the NMC would be committed to maintaining standards.
- **Restating key messages:** Many respondents used this question to reiterate points made in previous sections of the survey.

Overall impacts relating to key prompts

Respondents were asked to give their views about the overall impact of any potential move away from alignment with the EU Directive, specifically with respect a set of prompts outlined below.

People who share a protected characteristic

Many respondents voiced concerns that diverging from the EU Directive might see less consideration given to people with protected characteristics. Many stated that the UK needs to continue to adhere to the Equality Act and remain committed to valuing and considering equality, diversity and inclusion, which they saw as fundamental to delivering nursing in the UK. Several respondents on the other hand suggested that protected characteristics felt more confident that the needs of groups with protected characteristics would continue to be a priority by those at the NMC while some also had the view that the rights of people with protected characteristics are already protected under UK law.

Some respondents suggested the changes to the Standards could give potentially give educators greater scope and flexibility to be responsive to the needs of people with protected characteristics in terms of course design and in terms of establishing alternative pathways to entry. A number of respondents wondered whether the creation of a more inclusive culture in terms of nursing training and education could help to attract more diverse applicants to nursing. A few respondents talked about the need to consider the accessibility of nursing programmes for disabled people, who it was felt are not always well accommodated by universities.

Public protection and safety

Respondents emphasised that public protection and safety must remain the highest priority when considering making any changes. Some suggested that any new Standards should attempt to increase or enhance public protection and patient safety and some had a concern that diverging from the EU standard risked undermining public protection and safety. A few made the point that the greater use of simulation could enhance safety by giving learners more chance to build confidence and competence before working with real people who use services. Others stressed the value in learning from other countries who were achieving similar or better outcomes whilst doing things in different ways (e.g. reduced minimum practice hours).

Effectiveness and quality of care

Alongside upholding patient safety, respondents stated that effectiveness and quality of care were of paramount importance and should be driving all of the decisions to be made. A range of specific suggestions were provided as to how effectiveness and quality of care could be maintained or improved. This included: through a commitment to modernising and updating the Standards; greater tailoring of Standards to the needs and context of the UK; and shifting towards a less task focused curriculum or to one where learners' individual needs are better addressed.

Experience and perceptions of registrants and students:

A key risk cited by respondents was a perception amongst stakeholders and the public that standards could be lowered or diluted, which could damage

confidence in the nursing profession. Some respondents felt that there was a need to manage how existing registrants perceive any changes made and also the new graduates produced following any changes. It was noted that many registrants are attached to the current way of doing things (e.g. number of practice hours) and may struggle to accept significant changes. Some noted that the risk of negative perceptions would be greater and harder to manage were the NMC to make more significant changes.

Number and supply of registrants

Some respondents had the view that the review of Standards was being primarily driven by a need to meet shortages of nurses. Here many emphasised that the NMC must not make changes which prioritise quantity at the expense of quality in terms of the nursing workforce. Respondents also highlighted that there are already bottlenecks in the education and training system which could undermine expansion (e.g. placement capacity, capacity of supervisors and lecturers).

Several also had a concern that EU registrants may be put off coming to the UK to practice, with Brexit having already led to this challenge. Others talked about considering how any changes could boost the morale and working conditions to help maintain and grow numbers, and there was support for any changes that could help to reduce people leaving the profession.

Others felt that the NMC must continue to ensure that nursing students continue to have positive learning experiences during their programmes – to reduce student attrition and some warned that entry requirements should not be lowered as this risked higher attrition. Others were hopeful that diverging from the EU standard could help to widen access to nursing, which would help to expand and diversify the nursing workforce.

Effectiveness, availability and quality of education programmes

Respondents tended to focus on quality and effectiveness of education programmes. Many had a concern that diverging from the EU Standard could lead to a lowering in the quality of education programmes (e.g. were practice hours to be significantly reduced), while large proportion also felt that the changes might allow for increased educational standards. For example, some thought that the new standards might allow programme providers to shift their approach towards outcomes and competencies rather than time/hours and some again noted that educators may have greater scope to tailor learning to individual learners' needs. Others suggested that quality and effectiveness could potentially improve if the new Standards allowed education providers to explore and implement new ways of working and innovations, for example, based on what has worked well since the outbreak of Covid-19. A few respondents noted that it would be important for the NMC to work closely and collaboratively with AEIs to agree and implement any changes, while a few other emphasised the importance of the NMC continuing to regulate AEIs in a robust manner, especially as new providers emerge, ensuring that for example programmes

offer appropriate levels of academic support and supervision for learners.

7.3.2. Midwifery

Impact of changing requirements on four nations

Respondents were most likely to say that they did not know whether the impact would be positive or negative (33%-43%) with most explaining that at this stage it was not clear what changes might be taken forward. Around a quarter of respondents felt that it would be both positive and negative. A larger proportion of respondents expected a positive impact for England compared with the other three nations, while the proportions who expected a solely negative impact were similar for each nation (10-11%).

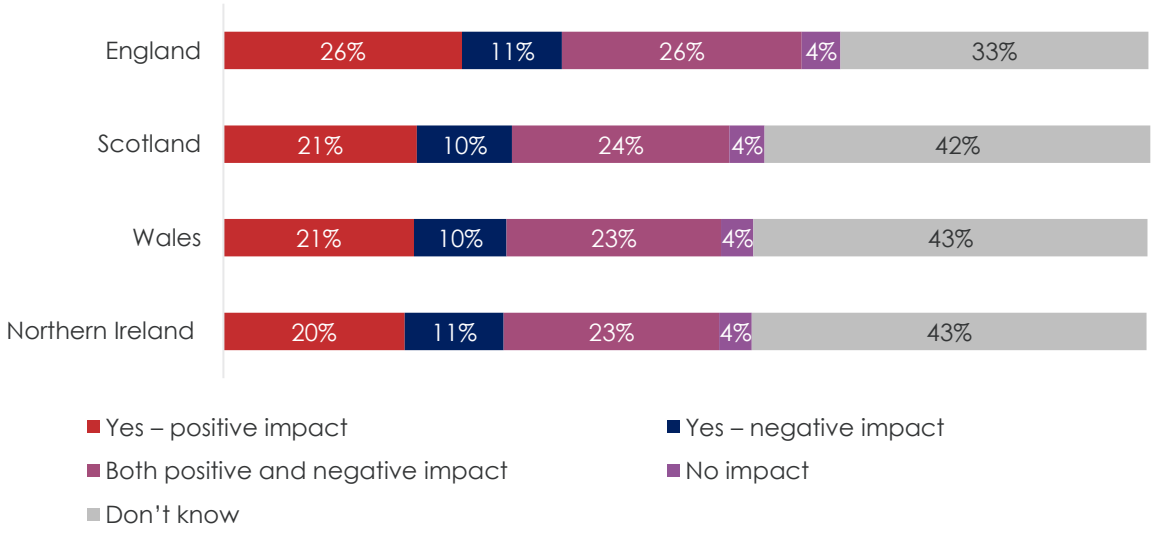

Figure 60: Overall results. Question F4 – Do you think there will be any impacts from the NMC changing their requirements from the EU Directive on midwifery in any of the four countries of the UK? (n=1,256)

Sub group differences

- Younger respondents and those with caring responsibilities were more likely than older respondents and those without caring responsibilities to expect a positive impact in each of the four nations (see **Appendix 2** for percentages).

Four nation differences

In terms of how respondents rated the impact on the nation where they were based, those based in Northern Ireland were most likely to expect a negative impact while those based England were most likely to expect a positive impact.

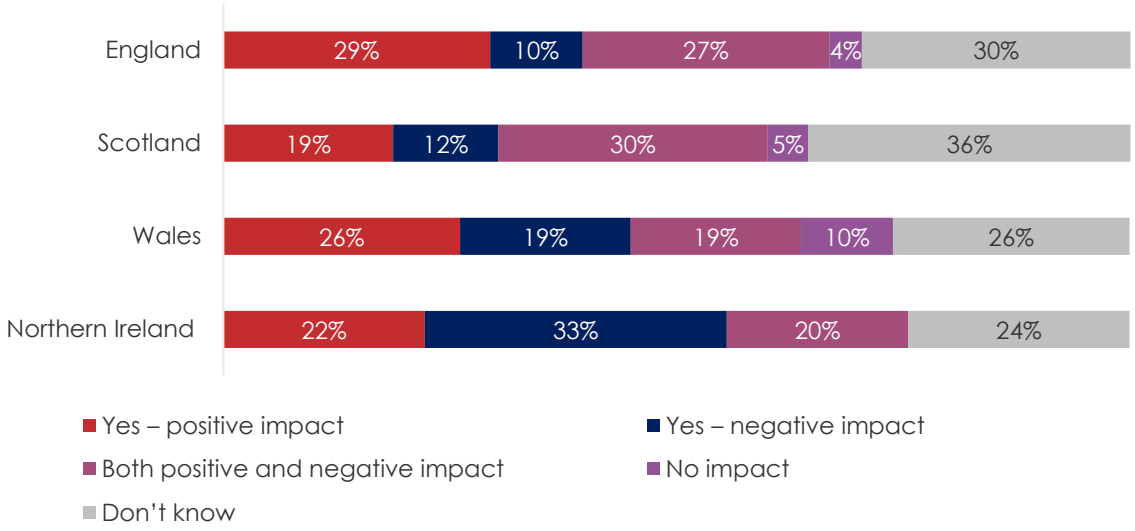

Figure 61: Respondents rate impact on the nation where they are based. Question F4 – Do you think there will be any impacts from the NMC changing their requirements from the EU Directive on nursing in any of the four countries of the UK? (England: n=982; Scotland; 155; Wales: n=69; Northern Ireland: n=45)

Respondents were asked to explain their response to the question about the impact of any change on the four nations. Responses have been grouped into opportunities, risks and suggestions.

Opportunities – midwifery

Many respondents suggested that this was an opportunity for the **UK to set its own standards and to raise rather than lower them.** Many also suggested that the standards could be better tailored to the needs of the UK population and midwifery workforce and updated to reflect a "changing world".

Several respondents suggested that changes to the requirements could support the **expansion of midwifery university places**, brought about by increasing placement capacity and by widening access to midwifery programmes to the other fields of nursing. A few also felt that a reduction in the minimum hours and numbers could also make the course more appealing and manageable for different learners and could reduce student attrition.

Several stakeholders felt that this was an opportunity to **improve the quality of midwifery graduates and the student experience** by placing a greater focus on the quality of the learning experience; becoming more skills and competency-focused and giving educators more scope to make judgements about whether students have had the right level of experience/exposure to practice to become competent and confident.

Risks – Midwifery

Many identified a risk that **UK qualifications may not be recognised or valued internationally** which could undermine the ability of UK midwives to practice in other countries, in the Ireland-Northern Ireland context, the EU and beyond

(e.g. Australia and New Zealand).

Respondents suggested that diverging from the requirements could mean that UK midwives may need to do additional courses or need to 'requalify'. In turn this could **put people off studying in the UK** with ambitious midwives potentially choosing to study elsewhere. Some also had concerns that diverging from the requirements could **negatively affect how UK midwifery is viewed both in the UK and internationally** should the requirements be lowered.

Some respondents had a concern that were programmes to be shortened, in order to expand the workforce, this could **reduce graduate's confidence and competence and their ability to practice safely**.

Others had a concern about **allowing variation in the standards and expectations across the four nations** which could lead to variable outcomes and quality of graduates.

Suggestions - Midwifery

Many respondents felt that the requirements should **be the same across the whole of the UK** to support ability of UK registrants to work where they choose and the consistency of standards and outcomes.

Several stakeholders felt that the NMC should aim to **remain as closely aligned as possible to the EU minimum standards** in order to protect the transferability of students and registrants between the UK and the EU and to maintain the strong reputation of UK midwifery. A few respondents instead made the case for **aligning with global standards**, such as the ICM Global Standards for Midwifery Education, which could help to raise standards and outcomes in the UK.

A number of respondents made suggestions relating to the process of reviewing and changing the minimum standard. Respondents underlined the importance of **recognising midwifery as a distinct profession** separate to nursing and the importance of carrying out **in-depth and robust ongoing consultation** with midwifery registrants, students and educators in the next stages of the review.

Other responses:

- **Don't know (n=1053):** Those who selected don't know, explained that they did so because they were not sure at this stage what changes would be taken forward by NMC.
- **No impact (n=244):** Those who selected 'no impact' explained in most cases that they anticipated that the changes were likely to be minimal and that they felt confident that the NMC would be committed to maintaining standards.
- **Restating key messages:** A large proportion of respondents used this question to reiterate points made in previous sections of the survey.

Overall impacts relating to key prompts

Respondents were asked to give their views about the overall impact of any potential move away from alignment with the EU Directive, specifically with respect to a set of prompts outlined below.

People who share a protected characteristic

Several emphasised the importance of continued compliance with the 2010 Equality Act and for the need to continue taking into account the needs of people with protected characteristics and other marginalised groups when setting education and training standards. Several had a concern that following Brexit, the UK might be tempted to "water down" its commitments associated with equality legislation or to fail to consider how any changes might impact on particular groups or learners or people who use services.

Public protection and safety

Respondents emphasised that patient safety should be a paramount concern for the NMC, with some voicing concerns about public safety being put at risk by the lowering of educational standards (e.g. if practice hours were reduced, or a situation where unwanted variation in terms of what AEIs offer was to increase).

Effectiveness and quality of care

Many felt that diverging from the standards provided an opportunity to set new and potentially higher standards which would have a positive impact on the effectiveness and quality of midwifery care. Respondents hoped that any proposed changes placed safety and quality front and centre, were driven by the specific and future needs of the UK, embraced the latest evidence base, and embraced technological innovations in terms of simulation and distance learning. Related to this, several also hoped that changes could improve the quality of midwifery graduates being produced. This could be brought about providing the focus is on prioritising quality of learning experience and achieving outcomes and competencies over hours, and shaping any revised standards through robust consultation with registrant and student midwives.

Experience and perceptions of registrants and students:

Several respondents felt that student experience stood to benefit should the NMC review and update the standards. Respondents frequently focused on a shift away from "the numbers" towards achieving outcomes and competencies, which it was felt could potentially improve the quality of learning experiences and improve student's work-life balance. Other pointed out that the increased use of simulation and digital technology in courses could give students greater exposure to different settings/skills and greater scope to complete a range of placements. Some also hoped that AEIs might have greater scope to tailor programmes to individual learners and to co-produce programmes with learners.

On the other hand, a few respondents voiced a concern that changes to standards could potentially harm the domestic and international reputation of UK midwifery profession. Any lowering of standards could also mean that qualifying midwives were less prepared for the role, who would attract more complaints from people who use services. A few stated that making any changes could potentially cause disruption for learners and registrants further lowering morale. A few others anticipated that there would be some general reluctance or anxiety about moving from the status quo position, which the NMC would need to be ready to manage.

Number and supply of registrants

Several respondents felt that this review provided an opportunity to make widen access to midwifery programmes in turn helping to increase the midwifery workforce. This could be achieved by making courses more inclusive (e.g. by attracting more mature learners, more use of online learning for rural learners) and by allowing nurses from other fields to access shortened midwifery programmes.

Conversely, there was a frequent concern that supply might be harmed if the UK became less able to attract midwife students and registrants from the EU, should the standards no longer align. Here some noted that this had the potential to worsen current midwife shortages and place greater pressure on practicing midwives. A few also voiced a concern that changes could be pursued which prioritised quantity of midwives at the expense of quality.

Effectiveness, availability and quality of education programmes

Whilst some felt this was an opportunity to modernise and improve quality, many respondents voiced concerns about the potential lowering of education standards. Some valued the EU standard as providing a minimum "safety net" and stated that the NMC risked trying to "fix something that was not broken". Some felt that quality of education could be undermined were for instance programmes were shortened, simulation was used to substitute practice-based learning, and in cases where "subjective" and "less rigorous" competency assessments were favoured over hours- and numbers-based requirements. Several suggested that the NMC should only add and build on the EU Standards rather than diverge from them.

Appendix 1 – Phase 2 survey results by type of registrant

The following table shows how different stakeholder groups responded to the survey questions. The percentages / numbers are the proportions who answered 'yes' to the questions outlined in the 'Question' column.

Nursing responses

Q no.	Question	OVERALL RESULTS	Nurse registrants	Nurse students	Nursing Associate registrants and students
A1a	Continue to require completion of general education of 12 years...	81% / 4029	82% / 3,477	70% / 456	55% / 53
A1b	Continue to require completion of general education of at least 10 years...	79% / 3613	81% / 3,061	70% / 439	65% / 61
B1	Previous learning should be taken into consideration when people apply to a pre-registration nursing programme	90% / 4823	90% / 4,067	90% / 607	91% / 95
C1	Knowledge and skills specified within the EU Directive are necessary for safe	91% / 4868	91% / 4127	90% / 611	89% / 93

Q no.	Question	OVERALL RESULTS	Nurse registrants	Nurse students	Nursing Associate registrants and students
	and effective nursing care				
D1	Which types of simulation-based learning can help someone to practise safely and effectively as a registered nurse:				
D1:1	Simulated situations involving real people using nursing services	79% / 4,207	78% / 3,512	82% / 557	77% / 80
D1:2	Simulation using mannequins or models	78% / 4,190	77% / 3,474	84% / 571	
D1:3	Simulation that involves role-play using real people which could include colleagues, students or actors	83% / 4,466	84% / 3783	79% / 534	80% / 83
D1:4	Simulation that involves using digital programmes to educate and assess knowledge and decision-making	69% / 3,674	68% / 3,070	69% / 468	75% / 78

Q no.	Question	OVERALL RESULTS	Nurse registrants	Nurse students	Nursing Associate registrants and students
D1:5	Simulation that involves using virtual or augmented reality systems to replicate real-life situations	71% / 3,791	70% / 3,171	72% / 488	69% / 72
D2a	Simulation should count towards practice learning	70% / 3,783	69% / 3,105	82% / 555	81% / 84
D2b	Simulation should count towards theory	84% / 4,375	83% / 3,680	84% / 559	80% / 79
D3	Any limitations set by the NMC about when simulation can/cannot occur in a programme	46% / 2,441	49% / 2,188	27% / 181	24% / 25
D4	A maximum amount of practice learning that can be taught through simulation	73% / 3,898	76% / 3,424	52% / 353	59 / 61
D5	Simulation should be used to assess any nursing skills and procedures	36% / 1,942	34% / 1,528	50% / 338	44% / 46
D7	Should simulation be used to assess nursing skills and procedures				

Q no.	Question	OVERALL RESULTS	Nurse registrants	Nurse students	Nursing Associate registrants and students
D7:1	Simulated situations involving real people using nursing services	73% / 2,250	72% / 1,964	77% / 224	69% / 34
D7:2	Simulation using mannequins or models	77% / 2,377	76% / 2,066	85% / 246	84% / 41
D7:3	Simulation that involves role-play using real people which could include colleagues, students or actors	78% / 2,415	78% / 2,138	74% / 214	78% / 38
D7:4	Simulation that involves using digital programmes to educate and assess knowledge and decision-making	60% / 1,863	60% / 1,636	61% / 177	63% / 31
D7:5	Simulation that involves using virtual or augmented reality systems to replicate real-life situations	60% / 1863	60% / 1,638	59% / 171	61% / 30
E1	3 years/4,600 hours is the minimum necessary to	70% / 3741	73% / 3,283	54% / 365	59% / 61

Q no.	Question	OVERALL RESULTS	Nurse registrants	Nurse students	Nursing Associate registrants and students
	practise safely and effectively as a registered nurse at the point of registration				
E3a	NMC should continue to specify for pre-registration nursing programmes: minimum programme length	86% / 4,595	88% / 3,944	77% / 519	66% / 69
E3b	NMC should continue to specify for pre-registration nursing programmes: number of hours	81% / 4,246	85% / 3,738	59% / 388	67% / 67
E4	The time required to achieve the standards of proficiency be based on competency and outcomes	67% / 3,553	65% / 2,923	78% / 526	81% / 84
F1a	Positive impact expected from the NMC changing their requirements from the EU	22% / 1,124	21% / 892	28% / 184	28% / 28

Q no.	Question	OVERALL RESULTS	Nurse registrants	Nurse students	Nursing Associate registrants and students
	Directive on nursing: England				
F1b	Positive impact expected from the NMC changing their requirements from the EU Directive on nursing: Scotland	17% / 753	15% / 588	22% / 132	19% / 17
F1c	Positive impact expected from the NMC changing their requirements from the EU Directive on nursing: Wales	17% / 745	15% / 580	21% / 129	21% / 18
F1d	Any impacts from the NMC changing their requirements from the EU Directive on nursing: Northern Ireland	16% / 713	15% / 560	20% / 121	19% / 17

Midwifery responses

Q no.	Question	OVERALL RESPONSE	Midwife registrants	Midwife student
A4	Continue to require completion of general education of 12 years for Direct Entry...	85% / 1134	89% / 526	83% / 319
A7	Continue to require formal qualification as a registered nurse adult for Shortened Programme…	82% / 1099	86% / 505	80% / 308
A9 a	Open access to Shortened midwifery programmes to Children's nurses	65% / 869	60% / 354	67% / 256
A9 c	Open access to shortened midwifery programmes to Learning disabilities nurses	41% / 522	36% / 200	42% / 160
A9 d	Open access to shortened midwifery programmes to Mental health nurses	45% / 581	44% / 249	46% / 173
A9 e	Open access to shortened midwifery programmes to	55% / 698	46% / 261	62% / 234

Q no.	Question	OVERALL RESPONSE	Midwife registrants	Midwife student
	Registered nurse: second level			
A9f	Open access to shortened midwifery programmes to Nursing Associates	30% / 365	23% / 122	35% / 128
A9 g	Open access to shortened midwifery programmes to Other health professional/s	24% / 266	22% / 108	21% / 68
B3	Previous learning should be taken into consideration when people apply for a pre-registration midwifery programme	71% / 944	63% / 374	76% / 290
B5	If RPL is introduced would Shortened Programmes for qualified registered nurses (first level) adult still be required	59% /789	63% / 368	52% / 198
C3	Knowledge and skills specified within the EU Directive are necessary for safe and effective midwifery care	86% / 1150	92% / 546	84% / 320

Q no.	Question	OVERALL RESPONSE	Midwife registrants	Midwife student
C5	Specifying the no. occasions a specific skill must be performed is necessary for safe and effective midwifery care	71% / 951	81% / 477	61% / 232
C6	The NMC should continue to specify the number of specific occasions skills must be performed	74% / 987	85% / 503	60% / 228
D9	Which types of simulation-based learning can help someone to practise safely and effectively as a midwife:			
D9: 1	Simulated situations involving real women and families who use maternity services	77% / 1,011	77% / 453	76% / 291
D9: 2	Simulation using mannequins or models	89% / 1,162	87% / 516	88% / 338
D9: 3	Simulation that involves role-play using real people which could include colleagues , students or actors	85% / 1,113	88% / 518	78% / 298

Q no.	Question	OVERALL RESPONSE	Midwife registrants	Midwife student
D9: 4	Simulation that involves using digital programmes to educate and assess knowledge and decision-making	77% / 1005	75% / 445	74% / 282
D9: 5	Simulation that involves using virtual or augmented reality systems to replicate real-life situations	79% / 1,028	78% / 460	73% / 280
D10 a	Simulation should count towards practice learning	66% / 863	59% / 346	74% / 278
D10 b	Simulation should count towards theory	86% / 1116	87% / 504	90% / 334
D11	Any limitations set by the NMC about when simulation can/cannot occur in a programme?	47% / 624	54% / 319	31% / 117
D12 a	Maximum amount of practice learning that can be taught through simulation?	68% / 899	78% / 458	56% / 216
D13	Simulation should be used to assess any midwifery skills and procedures	30% / 400	24% / 144	37% / 141

Q no.	Question	OVERALL RESPONSE	Midwife registrants	Midwife student
D15	Should simulation be used to assess the following midwifery skills and procedures:			
D15 :1	Simulated situations involving real women and families who use maternity services	69% / 540	64% / 256	74% / 145
D15 :2	Simulation using mannequins or models	86% / 670	85% / 343	83% / 163
D15 :3	Simulation that involves role-play using real people which could include colleagues, students or actors	81% / 633	83% / 333	75% / 147
D15 :4	Simulation that involves using digital programmes to education and assess knowledge and decision-making	67% / 521	65% / 263	63% / 123
D15 :5	Simulation that involves using virtual or augmented reality systems to replicate real-life situations	68% / 532	66% / 267	63% / 123

Q no.	Question	OVERALL RESPONSE	Midwife registrants	Midwife student
E6	3 years/4,600 hours is the minimum necessary to practise safely and effectively as a midwife at the point of registration	71% / 942	62% / 475	62% / 236
E9a	NMC should continue to specify minimum programme length for pre-registration midwifery programmes	86% / 1123	89% / 518	84% / 317
E9b	NMC should continue to specify number of hours for pre-registration midwifery programmes	79% / 1,017	86% / 495	68% / 256
E10	The time required to achieve the standards of proficiency should be based on competency and outcomes	60% / 788	54% / 318	68% / 260
E12 a	Current minimum length and hours is sufficient for safe and effective midwifery practice: 2 year/3,600 hours shortened programme	68% / 874	75% / 425	57% / 210

Q no.	Question	OVERALL RESPONSE	Midwife registrants	Midwife student
E12 b	Current minimum length and hours is sufficient for safe and effective midwifery practice: 18 month/3,000 hours shortened programme	59% / 747	62% / 345	48% / 179
E15 a	NMC should continue to specify for pre-registration midwifery programmes: Minimum programme length	81% / 1,062	87% / 508	74% / 279
E15 b	NMC should continue to specify for pre-registration midwifery programmes: Number of hours	76% / 990	86% / 496	62% / 233
F4a	Positive impact expected from the NMC changing their requirements on midwifery: England	22% / 1124	19% / 107	31% / 113
F4b	Positive impact expected from the NMC changing their requirements on midwifery: Scotland	17% / 753	14% / 73	25% / 89
F4c	Positive impact expected from the NMC changing	17% / 745	14% / 72	24% / 87

Q no.	Question	OVERALL RESPONSE	Midwife registrants	Midwife student
	their requirements on midwifery: Wales			
F4d	Positive impact expected from the NMC changing their requirements on midwifery: Northern Ireland	16% / 713	13% / 66	24% / 86

Appendix 2 – Summary of significant results

The following table highlights:

a) 4-nation trends: A breakdown of how nursing registrants and students and midwifery registrants and students based in the four nations respondents to the questions.

b) Significant .5% sub group trends: Highlights where there are differences of 5% or more which are also statistically significant between different demographic sub groups of nurse registrants and students and midwife registrants and students. Where age-based percentage differences are provided, this compares respondents aged 30 or under with those aged 50 and over.

Nursing question responses are in blue text and midwifery question responses are in lilac text.

Theme	4-nation trends	Significant >5% sub groups trends
A1a 12-year general education requirement – nurses	The range who support for status quo is 80% - 85%. Highest in Northern Ireland and lowest in England.	Disabled respondents were more likely to support changing the requirements (90% vs 82%)
A4 12-year general education requirement – midwives	The range who support the status quo option is 81% - 90%. Highest in Northern Ireland and lowest in Scotland.	-
A7 People applying via Route B to have met the requirements of a formal qualification as a registered nurse adult.	The range who support the status quo option is 80% - 86%. Highest in Wales and lowest in Northern Ireland.	-
A9 Open access to shortened midwifery programmes other fields of nursing / roles	-	Younger respondents were more likely to support opening access to children's (76% vs 66%), second level adult (79% vs 54%) and Nursing Associates (44% vs 22%). Ethnic minority respondents were more likely

Theme	4-nation trends	Significant >5% sub groups trends
		to support opening access to second level nurses (81% vs 66%) and Nursing Associates (51% vs 33%)
B1 RPL continuing in nursing	The range who support continuing to allow RPL is 88% - 91%.	-
B3 RPL introduced to midwifery	The range who support allowing RPL is 55% - 79%. Highest in Scotland and lowest in Northern Ireland.	Younger respondents were more likely to support the introduction of RPL (82% vs 61%)
C1 The knowledge and skills specified within the EU Directive is necessary for safe and effective nursing care	The range who answered 'yes' is 90% - 92%.	-
C3 The knowledge and skills specified within the EU Directive is necessary for safe and effective midwifery care	The range who answered 'yes' is 88% -97%. Highest in Northern Ireland and lowest in England.	Older respondents were more likely to answer 'yes' (94% vs 89%)
C5 Specifying the numbers of occasions a specific skill must be performed is necessary for safe and effective midwifery care	The range who answered 'yes' is 70% - 86%. Highest in Wales and lowest in Scotland.	Older respondents were more likely to answer 'yes' (86% vs 70%)
C6 The NMC should continue to specify the number of specific occasions skills must be performed	The range who answered 'yes' is 68% - 84%. Highest in Wales and lowest in Northern Ireland.	Older respondents were more likely to answer 'yes' (91% vs 72%)
D2a Simulation should count towards practice learning on pre-registration nursing programmes	The range who answered 'yes' is 66% - 73%. Highest in Wales and lowest in Scotland.	Ethnic minority respondents were more likely to answer 'yes' (87% vs. 70%)

Theme	4-nation trends	Significant >5% sub groups trends
D2b Simulation should count towards theory on pre-registration nursing programmes	The range who answered 'yes' is 82% - 87%. Highest in Wales and lowest in Northern Ireland.	-
D3 There should be limitations set by the NMC about when simulation can/cannot occur in a programme	The range who answered 'yes' is 45% - 49%. Highest in Wales and lowest in Scotland.	Older (71% vs 47%), White (62% vs 51%), female, and heterosexual (60% vs 53%) respondents were more likely to answer 'yes'
D4 There should be a maximum amount of practice learning that can be taught through simulation	The range who answered 'yes' is 73% - 77%. Highest in Northern Ireland.	Older (87% vs 66%) and White (82% vs 71%) respondents were more likely to answer 'yes'
D5 Simulation can be used to assess any nursing skills and procedures	The range who answered 'yes' is 27% - 37%. Highest in Wales and lowest in Northern Ireland.	Younger (46% vs 28%), ethnic minority (50% vs 35%) and male (43% vs 47%) respondents were more likely to answer 'yes'
D10a Simulation should count towards practice learning on pre-registration midwifery programmes	The range who answered 'yes' is 58% - 71%. Highest in England and lowest in Scotland.	Younger (70% vs 59%) and ethnic minority (75% vs 64%) respondents were more likely to answer 'yes'
D10b Simulation should count towards theory on pre-registration midwifery programmes	The range who answered 'yes' is 85% - 93%. Highest in England and lowest in Wales.	Younger (95% vs 86%) respondents were more likely to answer 'yes'
D11 There should be limitations set by the NMC about when simulation can/cannot occur in a programme?	The range who answered 'yes' is 40% - 46%. Highest in Scotland and lowest in Wales.	Older (63% vs 32%), White (46% vs 35%) and heterosexual (45% vs 35%) respondents were more likely to say 'yes'
D12 There should be a maximum amount of practice learning that can	The range who answered 'yes' is 57% - 71%. Highest in Northern Ireland and lowest in Wales.	Older (86% vs 69%), those with caring responsibilities (81% vs 76%) and White (79%

Theme	4-nation trends	Significant >5% sub groups trends
be taught through simulation		vs 70%) respondents were more likely to answer 'yes'
D13 Simulation should be used to assess any midwifery skills and procedures	The range who answered 'yes' is 28% - 39%. Highest in Scotland and lowest in England.	Younger (36% vs 23%) and ethnic minority (37% vs 30%) respondents were more likely to answer 'yes'
E1 Is 3 years made up 4,600 hours the minimum necessary to practise safely and effectively as a nurse at the point of registration?	The range who answered yes is 68% - 82%. Highest in Northern Ireland and lowest in Scotland.	Those who do not identify as disabled (78% vs 71%) and heterosexual (78% vs 70%) respondents were more likely to answer 'yes'
E3a NMC should continue to specify for pre-registration nursing programmes: Minimum programme length	The range who answered 'yes' is 86% - 92 %. Highest in Northern Ireland and lowest in England.	Older (94% vs 88%) respondents were more likely to answer 'yes'
E3b NMC should continue to specify for pre-registration nursing programmes: Number of hours	The range of who answered 'yes' is 80% - 91%. Highest in Northern Ireland and lowest in Scotland.	Older (92% vs 82%) and heterosexual sexual(89% vs 82%) respondents were more likely to answer 'yes'
E4 The time required to achieve the standards of proficiency should be based on competency and outcomes	The range who answered yes is 62% - 67%. Highest in England and lowest in Northern Ireland.	Ethnic minority (82% vs 76%) respondents were more likely to answer 'yes'
E6 Is 3 years made up 4,600 hours the minimum necessary to practise safely and effectively as a midwife at the point of registration?	The range who answered 'yes' is 72% - 84%. Highest in Northern Ireland and lowest in England.	Older (86% vs 73%) and White (81% vs 70%) respondents were more likely to answer 'yes'
E9a The NMC should continue to specify for direct entry pre-registration	The range who answered 'yes' is 77% - 90%. Highest in Scotland and Lowest in Northern	Older (92% vs 80%) respondents were more

Theme	4-nation trends	Significant >5% sub groups trends
midwifery programmes: Minimum programme length	Ireland.	likely to answer 'yes'
E9b The NMC should continue to specify for direct entry pre-registration midwifery programmes: Number of hours	The range who answered 'yes' is 79% - 85%. Highest in Wales and lowest in England.	Older (77% vs 63%) respondents were more likely to answer 'yes'
E10 The time required to achieve the standards of proficiency should be based on competency and outcomes	The range who answered 'yes' is 48% - 64%. Highest in Wales and lowest in Northern Ireland.	Younger (77% vs 63%), ethnic minority (81% vs 69%) and non-heterosexual respondents (83% vs 70%) were more likely to answer 'yes'
E15a NMC should continue to specify for shortened pre-registration midwifery programmes: Minimum programme length	The range who answered 'yes' is 68% - 83%. Highest in Scotland and lowest in Northern Ireland.	-
E15b NMC should continue to specify for shortened pre-registration midwifery programmes: Number of hours	The range who answered 'yes' is 74% - 80%. Highest in Northern Ireland and lowest in Wales.	Older (93% vs 86%), those who do not identify as disabled (90% vs 81%) and heterosexual (90% vs 79%) respondents were more likely to answer 'yes'
F1a Any impacts from the NMC changing their requirements on nursing: England	The range who expect positive impact is 18% - 36%. Highest in England lowest in Northern Ireland.	Younger (38% vs 33%) and ethnic minority (44% vs 32%) respondents were more likely to expect positive impact
F1b Any impacts from the NMC changing their requirements on nursing: Scotland	The range who expect positive impact is 20 – 32%. Highest in England and lowest in Northern Ireland.	Younger (36% vs 26%) and ethnic minority (43% vs 32%) respondents were more likely to expect positive impact

Theme	4-nation trends	Significant >5% sub groups trends
F1c Any impacts from the NMC changing their requirements on nursing: Wales	The range who expect positive impact is 19% - and 32%. Highest in England and lowest in Northern Ireland.	Younger (35% vs 27%) and ethnic minority (40% vs 28%) respondents were more likely to expect positive impact
F1d Any impacts from the NMC changing their requirements on nursing: Northern Ireland	The range who expect positive impact is 18% - 32%. Highest in England and lowest in Northern Ireland.	Younger (35% vs 28%) and ethnic minority (40% vs 27%) were more likely to expect positive impact
F4a Any impacts from the NMC changing their requirements on midwifery: England	The range who expect positive impact is 19% and 39%. Highest in England and lowest in Wales.	Younger respondents (40% vs 30%) and those with caring responsibilities (41% vs 33%) were more likely to expect positive impact
F4b Any impacts from the NMC changing their requirements on midwifery: Scotland	The range who expect positive impact is 19% - 35%. Highest in England and lowest in Wales.	Younger respondents (38% vs 23%) and those with caring responsibilities (37% vs 29%) were more likely to expect positive impact
F4c Any impacts from the NMC changing their requirements on midwifery: Wales	The range who expect positive impact is 35% - 20%. Highest in England and lowest in Scotland.	Younger respondents (38% vs 29%) and those with caring responsibilities (37% vs 29%) were more likely to expect positive impact
F4d Any impacts from the NMC changing their requirements on midwifery: Northern Ireland	The range who expect positive impact is 19% - 34%. Highest in England and lowest in Scotland.	Younger (37% vs 20%) and those with caring responsibilities (35% vs 28%) were more likely to expect positive impact

Appendix 3 – Demographic profile of Phase 2 survey respondents

The following tables provide a demographic breakdown of the individuals who responded to the survey, alongside the proportions found in the profile of the register (nursing and midwifery populations combined). Rounding has been applied to the percentages. The source for the overall registrant population is NMC's 2019-20 EDI annual data tables, which can be found here.

Table 1. Breakdown of survey responses from individuals – midwife registrants – what is your ethnic group?

	White	Asian	Black	Mixed	Other
Survey Ns	522	16	13	30	7
Survey %	89%	3%	2%	5%	1%
Overall registrant population	79%	2%	3%	2%	0%

Table 2. Breakdown of survey responses from individuals – nurse registrants – what is your ethnic group?

	White	Asian	Black	Mixed	Other
Survey Ns	3376	302	129	253	7
Survey %	83%	7%	3%	6%	0%
Overall registrant population	67%	7%	7%	2%	1%

Table 3. Breakdown of survey responses from all registrants – what is your gender?

	Female	Male
Survey Ns	5242	741
Survey %	88%	12%
Overall registrant population	89%	11%

Table 4. Breakdown of survey responses from all registrants – does your gender identity match your sex registered at birth?

	Same	Different	Prefer not to say / unknown
Survey Ns	5,852	41	151
Survey %	97%	1%	3%
Overall registrant population	86%	1%	13%

Table 4. Breakdown of survey responses from all registrants – do you have a disability?

	Yes	No	Unknown/prefer not to say
Survey Ns	625	5007	166
Survey %	11%	86%	3%
Overall registrant population	5%	77%	18%

Table 5. Breakdown of survey responses from all registrants – what is your religion or belief?

	Christian	No religion	Muslim	Hindu	Buddhist	Jewish	Sikh	Prefer not to say	Any other
Survey Ns	3,145	2,393	104	46	37	12	10	220	107
Survey %	52%	39%	2%	1%	1%	0%	0%	4%	2%
Overall registrant population	54%	20%	2%	1%	1%	0%	0%	6%	2%

Table 6. Breakdown of survey responses from all registrants – which best describes your sexual orientation?

	Heterosexual	Gay or lesbian	Bisexual	Prefer not to say	Other/unknown
Survey Ns	5,138	246	240	393	40
Survey %	85%	4%	4%	7%	1%
Overall registrant population	77%	1%	1%	6%	15%


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