

Meeting of the Council

To be held from 09:30am on Wednesday 28 March 2018
at 23 Portland Place, London, W1B 1PZ

Agenda

Dame Janet Finch
Chair

Fionnuala Gill
Secretary

- | | | | |
|----------|--|-----------|--------------|
| 1 | Welcome and Chair's opening remarks | NMC/18/19 | 09:30 |
| 2 | Apologies for absence | NMC/18/20 | |
| 3 | Declarations of interest | NMC/18/21 | |
| 4 | Minutes of the previous meeting | NMC/18/22 | |
| | Chair | | |
| 5 | Summary of actions | NMC/18/23 | |
| | Secretary | | |
| 6 | Chief Executive's report | NMC/18/24 | |
| | Chief Executive and Registrar | | |

Matters for decision

- | | | | |
|----------|--|-----------|-------|
| 7 | Education | NMC/18/25 | 09:40 |
| | 7a. Standards of proficiency for registered nurses and standards for education and training | | |
| | 7b. Standards for prescribing and medicines management | | |
| | Director of Education, Standards and Policy | | |
| 8 | Education quality assurance framework | NMC/18/26 | 10:30 |
| | Director of Education, Standards and Policy | | |

Coffee **10:50–11:05**

9 Consulting on the regulation of nursing associates NMC/18/27 11:05

Director of Education, Standards and Policy

10 Council Scheme of Delegation NMC/18/28 11:50

Secretariat

11 Panel member reappointments, transfers and removal NMC/18/29

Director of Fitness to Practise

Matters for discussion

12 Midwifery update NMC/18/30 12:00

Director of Education, Standards and Policy

Corporate reporting

13 Performance and Risk report NMC/18/31 12:15

Interim Director of Resources

14 Financial monitoring report NMC/18/32

Interim Director of Resources

Comments from Observers 12:50–13:00

Lunch 13:00–13:45

Matters for decision

15 Ensuring patient safety, enabling professionalism: a new strategic direction for fitness to practise NMC/18/33 13:45

Director of Fitness to Practise

16 Corporate Plan and budget 2018–2021 NMC/18/34 14:15

Interim Director of Resources

Matters for discussion

17 Audit Committee Report

NMC/18/35 14:45

Chair of the Audit Committee

Matters for information

Matters for information will normally be taken without discussion. Members should notify the Chair or the Secretary to the Council in advance of the meeting should they wish for any item to be opened for discussion.

18 Council appointments

NMC/18/36

Secretariat

19 Chair's action taken since the last meeting

NMC/18/37

Chair of the Council

20 Questions from observers

NMC/18/38 14:55

Chair of the Council

(Oral)

Close

15:00

Meeting of the Council
Held on 31 January 2018 at 23 Portland Place, London, W1B 1PZ

Minutes

Present

Members:

Dame Janet Finch	Chair*
Sir Hugh Bayley	Member
Karen Cox	Member
Maura Devlin	Member
Maureen Morgan	Member
Robert Parry	Member
Marta Phillips	Member
Derek Pretty	Member
Stephen Thornton	Member
Lorna Tinsley	Member
Ruth Walker	Member
Anne Wright	Member

NMC Officers:

Jackie Smith	Chief Executive and Registrar
Adam Broome	Director of Resources
Emma Broadbent	Director of Registration and Revalidation
Sarah Daniels	Director of People and Organisational Development
Matthew McClelland	Director of Fitness to Practise
Geraldine Walters	Director of Education, Standards and Policy
Clare Padley	General Counsel
Alison Neyle	Strategic Adviser
Fionnuala Gill	Secretary to the Council
Pernilla White	Governance and Committee Manager

**Not present for NMC/18/11*

Minutes

NMC/18/01 Welcome and Chair's opening remarks

1. The Chair welcomed all attendees to the meeting and expressed a particular welcome to the student nurses and trainee nursing associates in attendance.
2. The Chair congratulated Jackie Smith on her appointment to the Independent Parliamentary Standards Authority. The Chair also congratulated those nurses, midwives and other partners recognised in the New Year's Honours List 2018.
3. The Council welcomed the appointment of the former Chief Nursing Officer, Dame Sarah Mullally as the new Bishop of London and endorsed the Chair's proposal to send its congratulations.

NMC/18/02 Apologies for absence

1. There were none.

NMC/18/03 Declarations of interest

1. The following declarations of interest were made.
 - a) NMC/18/07: Education quality assurance and NMC/18/13: Education consultation update – Dame Janet Finch, Karen Cox, Maureen Morgan, Robert Parry, Lorna Tinsley and Ruth Walker declared an interest given their involvement in education. This was not considered material as the individuals were not affected any more than other individuals.
 - b) NMC/18/10: Review of Council Allowances – All members declared an interest. This was not considered prejudicial as the Order (Schedule 1, Part 1 paragraph 15(2)(e)(i)) expressly gives the Council power to determine its own allowances and conflicts had been further addressed by the use of an Independent Panel.
 - c) NMC/18/11: Review of Chair's allowance 2017 – Dame Janet Finch declared an interest and would withdraw for the discussion of this item.
 - d) NMC/18/13: Midwifery Update - Lorna Tinsley, as a registered midwife and Ruth Walker, as an employer of midwives. This was not considered prejudicial as the individuals were not affected any more than other registrants.

NMC/18/04 Minutes of the previous meeting

1. The minutes of the meeting on 29 November 2017 were agreed as an accurate record.

NMC/18/05 Summary of actions

1. The Council noted progress on actions from the previous meetings.
2. Arising from NMC/17/104 – Midwifery update, the Council requested that the briefing note requested on midwifery qualification entry routes be circulated to members prior to the February 2018 seminar.
3. The Council agreed that NMC/17/80 ii: Nursing Associates had been addressed satisfactorily and could be closed. The Council had discussed the draft skills annexe the previous day in seminar. Subject to taking account of the Council's comments, this could now be shared more widely.

Action:	Provide the previously requested briefing note on routes into midwifery in advance of the Council's seminar in February 2018
For:	Director of Education Standards and Policy
By:	12 February 2018

NMC/18/06 Chief Executive's report

1. The Council considered a report from the Chief Executive and Registrar on key external developments, strategic engagement, and media activity since the previous Council meeting. The following points were noted in discussion:
 - a) The new Minister of State with responsibility for professional regulation is Stephen Barclay M.P. An early meeting is being sought.
 - b) The consultation on nursing associate fees is still open and responses to the consultation are encouraged. An update on the quality assurance of the nursing associate training would be provided to the Council's February seminar.
 - c) The Department of Health's round table had identified challenges around costs and time commitment affecting the take up of apprenticeships by health and care sector employers. The NMC was engaging with the Institute of Apprenticeships.
 - d) The Chair and a number of Council members had visited Manchester University Foundation Trust in December 2017 and had an opportunity to meet those who had cared for the victims of the Manchester Arena bombing. The Council expressed its thanks to everyone involved in the visit. It was a real privilege for the Council to spend time at the Hospital and meet such an inspirational group of colleagues.

NMC/18/07 Education quality assurance: Programme approvals for the 2018–2019 academic year

1. The Director of Education, Standards and Policy introduced the paper on the proposed approach to programme approvals for the 2018–2019 academic year only.
2. Alongside the development of new proficiency standards for the Registered Nurse degree, and new standards for the education framework which applies to Approved Educational Institutions (AEI), an independent review of the scope and shape of future quality assurance (QA) had been commissioned in 2016. The Council had discussed the main findings and options from the review during 2017 and had asked that elements of the proposals be developed further. The intention now is to implement them for programmes with a start date from September 2019. The aim was to present the full future model to the Council for approval in March 2018.
3. Meanwhile in the academic year 2018–2019, a significant number of programmes will need to be approved, including all AEIs who wish to offer the Registered Nurse degree, and all who wish to offer the Nursing Associate qualification, for which the NMC is to be the regulator. The QA proposals in this paper cover this transitional year. During this year all proposed new programmes would be subject to both documentary review and a visit.

In discussion the following points, relating to the proposals for 2018–2019 were noted:

- a) The intention to include greater focus on practice placements to ensure standards were maintained was welcome. This would be an important element of assurance, given workforce pressures and the need to find new and innovative ways of providing practice placements.
 - b) The proposal for all approvals to include a visit to aid intelligence gathering and inform a future risk based approach was welcome.
 - c) For Universities/institutions not currently holding AEI status, the proposal was for a single process that includes documentary review, and a single visit, which would cover both institution and programme approval.
 - d) In relation to delivery of programmes by non-degree awarding institutions such as further education colleges, as at present there would need to be a consortium arrangement. To provide the necessary level of assurance the NMC would approve the AEI, with the other education institution acting as a delivery partner.
 - e) The initial costs of developing QA for initial programmes for trainee nursing associates would be recoverable through the DH funding.
4. The following points were noted which relate to the development of the

new model of QA

- a) There is no power in the Order for the NMC to charge for any QA related activity. The NMC should continue to press for legislative change in this respect, given that the requirement for QA was demand led and in view of the issue of fairness around past generations having to pay for assuring the education of future registrants. It was important that the Council was careful only to spend what was necessary for patient and public safety on QA.
- b) It was important that account was taken of the differing approaches and devolved responsibilities for education in the four countries, for example in Scotland the role of NHS Education Scotland and the new Health Education and Improvement Wales (HEIW). The responsibilities of the new Office for Students in England also needed to be taken into account. Where possible, appropriately robust QA from other sources would be relied on to minimise costs and duplication and this would vary across the four countries.

5. The Council required greater clarity and certainty about proposed costs of the QA programme. This picture was complicated by the programme running across academic rather than financial years. Recognising that the demand led nature of approvals may not allow absolute predictability, planned expenditure should be framed in terms of a maximum. There should also be a clear plan to handle any shortfall throughout the year, including where any additional resources would be found, including for example through staggering approvals. This needed to be clear when the Council considered the overall budget in March 2018.

Decision: The Council agreed to approve the proposed approach to programme approval for the 2018–2019 academic year.

Action:	Provide clarity around the expected maximum budget requirement for the quality assurance programme, together with a clear plan for how any shortfall will be addressed
For:	Director of Education, Standards and Policy/Interim Director of Resources
By:	28 March 2017
Action:	Ensure greater clarity and explanation of resource implications in future reports
For:	Director of Education, Standards and Policy/Interim Director of Resources
By:	28 March 2017

NMC/18/08 NMC response to Government consultation: 'Promoting professionalism, reforming regulation'

1. The Chief Executive and Registrar introduced the NMC response to

Government consultation: *'Promoting professionalism, reforming regulation'* which had been submitted in accordance with the Department's deadline. The Department would consider any additional comments the Council wished to provide following the meeting.

2. In discussion, the following points were noted:
 - a) The NMC response was well drafted with a strong and clear message.
 - b) A more flexible statutory framework would enable the NMC to be a more effective and efficient regulator able to keep up with the rapidly changing healthcare landscape.
 - c) The importance of stressing that any proposals for change should be supported with clear evidence as to why it was necessary was stressed, for example, as to why a change would be necessary in relation to professions currently regulated.
 - d) There were various models of good governance and different models were more suitable to particular organisations and contexts.
 - e) In relation to the proposals for unitary boards to replace the current Councils, members noted that again there was a lack of rationale or issue to be solved underpinning the proposals. The invaluable contribution of knowledge, insight and skills brought to the Council by the registrant members, together with their full participation in the all corporate decision-making was essential in a body with the particular role and remit of the NMC. A conflict would occur if any member of the Council were to be appointed to represent particular interests, such as an employer. As it was, the Council had the benefit of such views through the membership without any allocated place.
 - f) The opportunity costs implications of change and the accompanying disruption and distraction caused should not be underestimated with little or no evidence of any benefits that would result.
 - g) Mediation as a form of dispute resolution may be suitable in some circumstances but not for a regulator such as the NMC: FtP decisions must be based on the best interests of the public not the result of a compromise between a registrant and the NMC.

3. **Decision: The Council endorsed the response already submitted and invited the Executive to consider whether additional comments should be provided in the light of the discussions and points made.**

NMC/18/09 Gender Pay Gap Report 2017

1. The Director of People and Organisational Development introduced the draft NMC Gender Pay Report 2017 for publication. A typographical error identified in the report would be amended before publication.

2. In discussion, the following points were noted:

- a) The gender pay gap figures for the NMC were lower than those for many other organisations which was welcome.
- b) The difference between male and female median salary was driven by an out of hours allowance in payment to a small number of employees in the facilities and maintenance team who were currently all male. Should suitably qualified female applicants be appointed to such roles, in the event of a vacancy, they would receive the same allowance.
- c) The mean and median figures reflected the picture for employees as a whole. The picture in specific quartiles varied as the NMC had more female than male employees in two quartiles and vice versa for the other two quartiles.
- d) The language of the report should be gender neutral.
- e) The Council welcomed the position reflected in the report but noted that it was important not to be complacent.

3. **Decision: The Council approved the NMC Gender Pay Report 2017 for publication on the NMC website and Government portal.**

NMC/18/10 Review of Council allowances 2017

1. The Secretary to the Council introduced the paper on the review of Council allowances in 2017.
2. In 2015 the Council had agreed to set up an independent panel to review allowances, to distance the Council from decisions, given conflicts of interests.
3. As Council allowances had not been reviewed since 2009, when the Independent Panel met in August 2016, it recommended a two stage approach. As a first step the Independent Panel recommended that the equivalent daily rate for Council members be brought into line with the median across healthcare regulators and that there be a further review in 12 months.
4. The Independent Panel reconvened in October 2017 and noted that since its previous review the mean and median allowance across healthcare regulatory bodies had increased and was now higher than that for NMC members. The Independent Panel therefore recommended an increase in the Council member allowance to an equivalent daily rate of £409. The Independent Panel's view was that this should stabilise the position following the long gap since 2009 and that in future a full review of allowances be undertaken every three years.
5. In discussion, the following points were noted:
 - a) There was unease about a model based on comparisons which could potentially encourage a spiralling of allowance levels across

the sector. Other important factors related to the ability to attract and retain high calibre candidates to the Council and the time commitment involved.

- b) The value and contribution made by Council members needed to be understood, ultimately they were responsible for keeping people safe.
- c) Such factors could be built into the proposed reward philosophy or approach which the Independent Panel had suggested. The Remuneration Committee would take this forward.

6. The Council agreed that the Independent Panel's recommendations were reasonable, proportionate and evidence based.

7. **Decisions:**

- i. **The Council agreed the Independent Panel's recommendation that the annual allowance for Council members be increased to £14,724 from 1 April 2017.**
- ii. **The Council agreed that a full independent review of allowances be undertaken every three years.**
- iii. **The Council requested that the Remuneration Committee develop proposals for a 'remuneration philosophy' for consideration by the Council.**

Action:	Develop proposals for a 'remuneration philosophy' for consideration by the Council
For:	Remuneration Committee
By:	September 2018

NMC/18/11 Review of Chair's allowance 2017

- 1. Anne Wright introduced the report which related to the review of the allowance paid to the current Chair of the Council.
- 2. There had been no increase in the Chair's allowance since 2009. The Independent Panel appointed to review Council allowances had noted that the Chair's allowance was now below the median level for healthcare regulators and had recommended an increase to the median daily equivalent rate across health care regulators. The Independent Panel considered that it was for the Council to consider whether account should be taken of additional time spent.
- 3. The Chair's allowance was based on a time commitment of two days a week, however, as the Council was aware the Chair contributed considerably more than this necessitated by the increased volume of work. The increase proposed in the paper sought to go some way to recognising this and the value of the contribution made by the Chair.
- 4. In discussion, the Council confirmed that the additional time commitment by the Chair had been necessary and not optional. The

Council agreed that the proposed increase was reasonable, proportionate and evidence based.

5.

Decisions:

- i. **The Council agreed the Independent Panel's recommendation that the equivalent daily rate for the incumbent Chair be increased to £485 to take effect from 1 April 2017 to the end of the Chair's term of office (30 April 2018).**
- ii. **The Council approved an increased annual allowance for the incumbent Chair from 1 April 2017 of £63,050, on a one off basis, given the additional necessary time commitment.**

NMC/18/12 Midwifery update

1. The Director of Education, Standards and Policy introduced the update on midwifery, including the work of the Midwifery Panel.
2. Three significant reports had recently been published as detailed in the paper and these would be considered by the Midwifery Thought Leadership Group.
3. Professor Mary Renfrew had been holding a series of workshops to help gather evidence for the future midwife standards. Initial events had a broad scope with later events focussing on emerging challenges. In Cardiff, for example, the focus had been on complexity and the upcoming meeting in Glasgow would focus on normality. All of the events were being evaluated.
4. In discussion the following points were noted:
 - a) The additional verbal update was welcomed.
 - b) Early circulation of future dates would be helpful to ensure as many staff members could attend as possible. Directors of Nursing should also be informed so as to facilitate release of staff to attend.
 - c) In future reports, it would be helpful to be clear about how we are listening to and engaging with each of regulators; employers; educators; and four country governments.
 - d) So far, engagement suggested that the majority were generally in agreement with the direction of travel, although there were polarities of view. A main area of discussion focussed on 'how future midwives would be trained'. The Council would be keen to understand not just the more moderate views in the middle of the spectrum but also the polarities of view.

Action:	Ensure that future reports are clear about the views of regulators; employers; educators; and four country governments.
For:	Director of Education, Standards and Policy
By:	28 March 2018

NMC/18/13 Education and standards consultation update

1. The Director of Education, Standards and Policy introduced the update which included a high level summary of feedback from the two public consultations held during 2017 on the future nurse standards and the education framework standards. These would inform the final version of the standards, along with previous consultations and evidence collected.
2. Sufficiently high volumes of responses had been received to both consultations to rely on the results. In some specific areas the numbers were too small to break down and analyse further.
3. As anticipated, views were mixed on some of the proposals such as those relating to supervision and assessment and on the proportion of practice learning to be provided through simulation. A large majority of respondents favoured continuing to cap the maximum number of practice hours, which can be completed in simulation.
4. All evidence, including the consultation responses was being analysed by four consultation assimilation teams (CATs) made up of subject matter experts, with approximately eight to nine people per group. The CATs were almost finished with their review and the next step was for a legal review to take place. The revised standards documents were on track for submission to Council for approval at the March 2018 meeting.
5. In discussion, the following points were noted:
 - a) It would be important for the Council to know which areas were contentious. Any aspects of the final proposals which did not reflect the consultation responses should be accompanied by a clear rationale so that there was transparency for the Council.
 - b) Examples of how the CAT groups had assimilated the evidence and consultation responses and reached a view on final direction would be helpful.
 - c) Ways of strengthening equality and diversity requirements would also be considered and how this would be built into future education QA.
 - d) Although the consultation on proficiency standards had been only about nursing, the education framework standards would apply equally to midwifery, as would the consultation about prescribing and to medicines management. Therefore efforts had been made to ensure that there was a good response from midwives and others concerned principally with midwifery, to these elements of the consultation. The higher response rate from midwives to those specific issues relevant to their work was encouraging. Based on evidence gathered from the current consultation, midwifery respondents did not express different views.
 - e) In relation to midwifery programmes, with the new standards for the Future Midwife still in the process of development, it was confirmed

that aspects of the education framework could be reconsidered if necessary.

- f) The paper was insufficiently clear about the costs of the work, rather than a simple statement that this had been met from the programme. Greater clarity on resource implications should be provided. Assurance was given that there were no additional costs outside those provided for in the education directorate budget and programme.

Action:	Provide a clear rationale for the content of the final version of the standards, including in contentious areas when bringing back to Council for approval
For:	Director of Education, Standards and Policy/Interim Director of Resources
By:	28 March 2017
Action:	Ensure greater clarity and explanation of resource implications in future reports
For:	Director of Education, Standards and Policy/Interim Director of Resources
By:	28 March 2017

NMC/18/14 General Nursing Council Trust Report

1. Maureen Morgan OBE introduced the report on the work of the General Nursing Council Trust (GNCT), its purpose, the contribution it makes to supporting early career nurse researchers and the benefits achieved for patients and the NHS.
2. The GNCT's income fund was static and research was funded from investment income. Between 19 to 20 research proposals were received each year. A copy of the call for proposals for 2018 had been distributed. A new website had been launched and members were encouraged to visit the site.
3. The Council welcomed the GNCT report.

NMC/18/15 Performance and Risk report

1. The Council considered the latest overview of performance and risk management across the organisation.
2. ***Registration and revalidation performance, KPIs, dashboard and customer service performance***
 - a) Performance remained on target for initial UK registrations. It would be helpful if, in future, the vertical axis on the graph started at 80 per cent to enable a clear view of variations in performance. As a result of changes to our English language requirements, volumes were

expected to increase over the coming weeks. The position was being tracked closely and the directorate should be able to cope adequately with this.

- b) Revalidation rates continued to be positive; the average rate had increased to 92%. There was no evidence that revalidation was leading to people leaving the register.
- c) It would be helpful to understand in a future report the reasons behind the 8.2 percent who were highly dissatisfied.

3.

Fitness to Practise performance, KPIs and dashboard

- a) The Interim Order (KPI 4) rolling 12 month performance remained above target.
- b) In relation to cases concluded within 15 months (KPI 5), performance continued on an upwards trajectory towards the target. There may be a case for considering a revised approach to timeliness KPIs for the future and for proposals to be brought back to the March 2018 Council.
- c) The new format of the FtP performance summary was welcome.
- d) At the end of December 2017, caseload levels were broadly on track with slightly more cases in the investigation stage and slightly less cases at the screening stage. The referral rate was 457 cases a month just below the maximum capacity of 500 cases.
- e) In relation to the timeliness pathway, on two of the three indicators the NMC was outperforming other regulators. However this was not the case in the investigation process which was the most challenging. The main causative issues included historically high staff turnover and delays in obtaining information from other parties. Steps had been taken to encourage more speedy escalation where delays were encountered, including using the employer link service. An ongoing issue for all healthcare regulators related to cases with police investigations and slow progress in agreeing a new memorandum of understanding with the National Police Chief Councils. This issue was common across the health care regulators and four countries.
- f) Latest estimates were that there would be 100 cases at the investigation stage older than 32 weeks at the end of the financial year.
- g) The proportion of cases proceeding to a full hearing was lower than anticipated, mainly due to a higher number of cases being closed at Case Examiner stage than use of the new section 60 powers. This was being taken into account in planning assumptions for 2018–2019.
- h) In addition to cases in progress, it was important for the Council to appreciate the ongoing work on cases 'concluded' but subject to substantive order reviews of which there were around 900/950 cases. It would be helpful for these cases to be highlighted to the Council on a regular basis.

4. **Staff turnover**

- a) The focus of the work on staff turnover was on leavers within the first year of service. The evidence suggested that this was due to career progression. This work would feed into the people strategy work.
- b) An updated recruitment website had been launched and included a better articulation of what it was like to work for a health care regulator. Induction arrangements were also being improved.
- c) The employee engagement survey, together with action to take the outcomes forward would be brought back to the Council in March 2018.

5. **Progress against the Corporate Plan**

Performance against the corporate plan commitments was noted. There had been little change from the report previously presented in November 2017 with most commitments on track.

6. **Corporate risk register**

The Council noted the corporate risk register update.

Action:	Provide more information on the reasons behind the 8.2 per cent who were highly dissatisfied in the customer service report
For:	Director of Registration and Revalidations
By:	23 May 2018
Action:	Consider a new approach to timeliness KPIs for 2018–2019
For:	Director of Fitness to Practise
By:	28 March 2018
Action:	Report back in more detail on cases classified as concluded but still subject to a substantive order review
For:	Director of Fitness to Practise.
By:	23 May 2018

NMC/18/16 Financial monitoring report

1. The Council considered the report on financial performance to 31 January 2018.
2. As previously reported, income from fees was expected to be £1.0 million lower than forecast which could not have been reasonably foreseen at the point when the budget was set in March 2017. This would be offset to a large degree by efforts to reduce spend in year.
3. The allocation of £2.5 million for transformation was expected to be spent in full at year end as this had either already been spent or was contractually committed when it was decided to make changes. It would

be helpful to have a clear picture of what had been delivered for the £2.5m and a breakdown of costs.

Action: Provide an analysis of deliverables including costs for the £2.5 million spent on the transformation programme
For: Interim Director of Resources
By: 28 March 2018

NMC/18/17 Chair’s action taken since the last meeting

- 1. There were no such actions to report.

NMC/18/18 Questions from observers

- 1. The Chair invited questions from observers. The following comments were made:
 - a) An observer from Unite asked about the possibility of protecting the title ‘Nurse’ similar to the way the Nursing Associate title would be protected. This required legislative change, together with an agreed definition of the scope of practice for a nurse which was no easy task, and the Government would have to be convinced that was desirable and necessary.
 - b) An observer from the RCM noted that many midwives saw the proposals around prescribing as a distraction, given the very particular nature of midwifery practice in this area.
 - c) Council member comments on the Midwifery Update report were supported. It was pleasing to see reference made to the other research reports in this area. There was a second report from MBRRACE-UK which could also usefully be considered. The Director of Education, Standards and Policy confirmed that the Thought Leadership Group would look at this additional report.

The next meeting of the Council in public will be held on Wednesday 28 March 2018 at the NMC, 23 Portland Place.

Confirmed by the Council as a correct record and signed by the Chair:

SIGNATURE:

DATE:

Council

Summary of actions

Action:	For information.
Issue:	Summarises progress on completing actions from previous Council meetings.
Core regulatory function:	Supporting functions.
Strategic priority:	Strategic priority 4: An effective organisation.
Decision required:	None.
Annexes:	None.
Further information:	If you require clarification about any point in the paper or would like further information please contact the author below.

Secretary: Fionnuala Gill
Phone: 020 7681 5842
Fionnuala.gill@nmc-uk.org

Summary of outstanding actions arising from the Council meeting on 31 January 2018

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/18/05	<p>Summary of actions</p> <p>Provide the previously requested briefing note on routes into midwifery in advance of the Council's seminar in February 2018</p>	Director of Education, Standards and Policy	16 February 2018	Completed: briefing note circulated to Council members 16 February 2018.
NMC/18/07	<p>Education quality assurance: Programme approvals for the 2018–2019 academic year</p> <p>Provide clarity around the expected maximum budget requirement for the quality assurance programme, together with a clear plan for how any shortfall will be addressed</p>	Director of Education, Standards and Policy/Interim Director of Resources	28 March 2018	This is included in the Education quality assurance report on the confidential agenda.
NMC/18/07	<p>Education quality assurance: Programme approvals for the 2018–2019 academic year</p> <p>Ensure greater clarity and explanation of resource implications in future reports</p> <p>Linked action: NMC/17/100 Education Quality Assurance</p>	Director of Education, Standards and Policy/Interim Director of Resources	28 March 2018	Noted for future reports and this is included in the Education quality assurance report on the agenda.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	<p>Annual Report 2016–2017</p> <p>i. Take account of the Council's comments in developing the new education standards and QA model</p>		i. 28 March 2018	i. Council's comments have been considered and incorporated in developing the new education standards and QA model.
NMC/18/10	<p>Review of Council allowances 2017</p> <p>Develop proposals for a 'remuneration philosophy' for consideration by the Council</p>	Secretary/Remuneration Committee	November 2018	Not yet due.
NMC/18/12	<p>Midwifery update</p> <p>Ensure that future reports are clear about the views of regulators; employers; educators; and four country governments</p>	Director of Education, Standards and Policy	28 March 2018	This is reflected in the midwifery update report on the agenda.
NMC/18/13	<p>Education and standards consultation update</p> <p>Provide a clear rationale for the content of the final version of the standards, including in contentious areas when bringing back to Council for approval</p>	Director of Education, Standards and Policy/Interim Director of Resources	28 March 2018	This is included in the report on the agenda on the Standards of proficiency for registered nurses and standards for education and training.
NMC/18/13	Education and standards	Director of Education,	28 March 2018	Noted and we will ensure this happens in

Minute	Action	Action owner	Report back to: Date:	Progress to date
	consultation update Ensure greater clarity and explanation of resource implications in future reports	Standards and Policy/Interim Director of Resources		future reports. Resource information is included in the Standards of proficiency for registered nurses and standards for education and training report on the agenda.
NMC/18/15	Performance and Risk report Provide more information on the reasons behind the 8.2 per cent who were highly dissatisfied in the customer service report	Director of Registration and Revalidations	23 May 2018	Not yet due.
NMC/18/15	Performance and Risk report Consider a new approach to timeliness KPIs for 2018-2019	Director of Fitness to Practise	28 March 2018	Details of the approach for 2018-2019 are included within the draft Corporate Plan and budget report on the agenda.
NMC/18/15	Performance and Risk report Report back in more detail on cases classified as concluded but still subject to a substantive order review	Director of Fitness to Practise	23 May 2018	Not yet due.
NMC/18/16	Financial monitoring report Provide an analysis of deliverables including costs for the £2.5 million spent on the transformation programme	Interim Director of Resources	28 March 2018	Completed: full briefing provided to Council members 27 February 2018. A summary is included in the Financial Monitoring Report on the agenda.

Summary of outstanding actions arising from the Council meeting on 29 November 2017

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/17/100	<p>Education Quality Assurance Annual Report 2016–2017</p> <p>Include trend data and information around public protection in future annual reports</p>	Director of Education, Standards and Policy	28 November 2018	Not yet due.
NMC/17/101	<p>People Strategy</p> <p>Provide more information on the key outcomes being sought; the priorities for action and the key indicators/measurements which will be used to measure progress against the key outcomes</p>	Director of People and Organisational Development	31 January 2018 Deferred to May 2018	This will be brought to the May 2018 Council meeting.
NMC/17/103	<p>Annual equality, diversity and inclusion report 2016–2017 and strategic action plan</p> <p>Provide more analysis of data in future reports and planned action to address findings</p>	Director of Education, Standards and Policy	4 July 2018	Not yet due.

Summary of outstanding actions arising from the Council meeting on 27 September 2017

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/17/80	<p>Nursing Associates</p> <p>Ensure that future consultation on the draft standards includes a specific question about whether the standards work across the four fields of practice and that the results can be broken down by responses from those working in each of the fields.</p>	Director of Education, Standards and Policy	28 March 2018	An appropriate consultation question has been included in the consultation document.
NMC/17/86	<p>Employer Link Service report one year on</p> <p>Take account of the Council's comments as set out below in future reports:</p> <ul style="list-style-type: none"> i. It would be helpful if any future ELS activity map could present a picture of the frequency with which Trusts and other employers used the service with some qualitative information about the types of issues being raised, for example, by the two most frequent and two least frequent users. 	Director of Fitness to Practise	September 2018	Not yet due.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	<ul style="list-style-type: none"> <li data-bbox="365 268 837 592">ii. Whilst the report this year was welcome and encouraging, it was focused on activity and process. For the future reports should present a cost effectiveness analysis with a focus on outcomes, costs and benefits. <li data-bbox="365 600 837 852">iii. The need to ensure the ELS engages with all relevant employers, including the independent sector, the third sector and in the other countries engagement with other professional regulators. <li data-bbox="365 860 837 1038">iv. It would be helpful to look at trends across the four countries, with discussions taken forward in the UK advisory forum. 			

Council

Chief Executive's report

Action: For information.

Issue: The Council is invited to consider the Chief Executive's report on (a) key developments in the external environment and (b) key strategic engagement activity.

Core regulatory function: All regulatory functions.

Strategic priority: Strategic priority 3: Collaboration and communication.

Decision required: None.

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Peter Pinto de Sa
Phone: 020 7681 5426
Peter.pinto@nmc-uk.org

Chief Executive: Jackie Smith
Phone: 020 7681 5871
jackie.smith@nmc-uk.org

Context: 1 This is a standing item on the Council agenda and reports on (a) key developments in the external environment; and (b) key strategic engagement activity.

Four Country Factors: 2 Not applicable to this paper.

Discussion: **A. External developments**

Nursing associates

- 3 Since the beginning of the year, we have been engaging with a range of stakeholders, experts and leaders from across the health and care sectors, including structured focus groups, which has gathered the views of representatives from community trusts, independent providers, public health organisations and primary care providers.
- 4 We have also expanded our engagement with patients and members of the public by discussing our proposed standards and requirements with representatives from leading health and social care charities, and hearing from patients on 'what good care looks like' in two workshops held in February 2018.
- 5 In January 2018, two trainee nursing associates visited the NMC and spoke to Council members about their journey into the new profession. The Director of Nursing, Therapies and Patient Partnership at Cheshire and Wirral Partnership, also attended and discussed the positive impact the new role is having on the trust.
- 6 We have also been keeping test sites and trainees regularly updated on our work and progress towards the launch of our consultation in April 2018. We have shared stories in our student newsletter and released our early working draft version of the skills annex for nursing associates, which is part of the draft standards of proficiency. This will help test sites ensure that their programmes are as closely aligned as possible to our final standards before the first students qualify in 2019.
- 7 The fees consultation for nursing associates has now closed and we received around 850 responses, 130 of these were from student nursing associates. Other responses were from Unison, Unite, RCN, NHS Employers, various NHS trusts and others (including from the Black Minority Ethnic Strategic Advisory Group). The responses are currently being analysed.

The Williams Review

- 8 The Secretary of State ordered an urgent review of medical malpractice cases after the removal of Dr Bawa Garba from the GMC's register following a successful High Court appeal by the

GMC. The review, being chaired by Professor Sir Norman Williams, a former president of the Royal College of Surgeons of England, is expected to report in the spring. We have welcomed the review and the Chief Executive gave evidence to the review on 20 March 2018.

Legislative issues

- 9 The Civil Legal Aid (Procedure) (Amendment) (No.2) Regulations 2017 came into force on 8 January 2018. They include NMC registrants within the definition of 'appropriate health professionals' (individuals who can issue letters or reports confirming that an individual has or has had injuries or a condition consistent with being a victim of domestic violence, or that the applicant was referred to a person providing specialist support or assistance for victims of domestic violence).

B: Accountability and oversight

Department of Health and Social Care (DHSC)

- 10 The Chief Executive continues to engage with senior officials at the DHSC on a range of issues. This included meetings with the Director General for Acute Care and Workforce on 14 February and 14 March 2018.

Chief Nursing Officers

- 11 The Chief Executive continues to engage with the UK Chief Nursing Officers (CNO), including discussions with:
 - 11.1 Jane Cummings, the CNO for England on 18 January 2018.
 - 11.2 Fiona McQueen, the CNO for Scotland on 25 January 2018.
 - 11.3 Charlotte McArdle, the CNO for Northern Ireland on 21 February 2018.
 - 11.4 Jean White, the CNO for Wales on 2 March 2018.

Health Select Committee

- 12 New appointments to the Health Select Committee have been made following the February 2018 recess. We have sent letters of congratulations to the Committee members and invited them to meet with us.
- 13 At the end of January 2018, the Health Select Committee published its report into the nursing workforce (the Chief Executive had given oral evidence to the Committee in November 2017). Many of the issues highlighted by the Chief Executive in her evidence were covered, including the funding of CPD and our register data showing

the increasing number of nurses leaving the profession.

Engagement with Parliamentarians

- 14 The Chief Executive has held discussions with the following parliamentarians:
 - 14.1 Baroness Finlay (22 January 2018).
 - 14.2 Lord Willis (24 January 2018).
 - 14.3 Sarah Wollaston MP (24 January and 26 February 2018).
 - 14.4 Baroness Thornton (25 January 2018).
 - 14.5 Baroness Watkins (29 January 2018).
 - 14.6 Christine Jardine MP (1 February 2018).
 - 14.7 Baroness Meacher (12 February 2018).

C: Stakeholder Engagement and Communication

Midwifery

- 15 The Chief Executive chaired the latest meeting of the Midwifery Panel on 8 February 2018. The meeting was attended by two new panellists: Lord Willis and Leigh Kendall, a prominent maternity safety campaigner.
- 16 Further detail on midwifery issues is included in the separate midwifery update paper on the agenda.

Visit to Scotland

- 17 On 23 and 24 January 2018, the Director of FtP met with senior colleagues at representative bodies and regulators and the Scottish Government in Edinburgh to discuss areas of mutual interest relating to FtP and discuss information sharing and future joint working opportunities.
- 18 We hosted the UK Directors of FtP meeting, which discussed collaboration between the professional regulators; working with patients and the public; and plans for 2018. The meeting involved, for the first time, the Northern Ireland Social Care Council and the Scottish Social Services Council.

Meet the NMC event

- 19 On 22 March 2018, we held our inaugural 'Meet the NMC' in London as part of our work to look for new ways to further develop our partnerships with key stakeholders, particularly directors across the

NHS.

- 20 The event brought together directors of nursing and heads of Midwifery and provided an opportunity to talk about our work on the new nursing and midwifery standards and the regulation of nursing associates and our developing thinking on the future strategy for FtP.

Engagement with professional bodies

- 21 The Chief Executive discussed a range of ongoing issues with the RCN Chief Executive on 15 February 2018; and the RCM Chief Executive on 7 March 2018.

Visit to Northern Ireland

- 22 On 23 January 2018, the Chief Executive met the Director of Nursing and senior colleagues at the Belfast Health and Social Care Trust; and the South Eastern Health and Social Care Trust. During the visit, the Chief Executive met a number of front-line staff who reported positively on their experiences of revalidation and the impact on their practice. The Chief Executive also received positive feedback about the NMC's employer link service.

PSA and Welsh Government seminar

- 23 The PSA and the Welsh Government jointly hosted a seminar on 15 February 2018 in Cardiff which brought together stakeholders across the healthcare system to explore some of the current developments in health and care regulatory policy in Wales and provided an update on current issues and challenges influencing Welsh Government policy in this area.
- 24 The meeting was a valuable opportunity to understand the perspectives of key stakeholders in Wales; in particular the new Health Education and Improvement Wales organisation (incorporating the Wales Deanery, the Wales Centre for Pharmacy Education and Wales Workforce, Education and Development Services). There was constructive discussion on a variety of issues including: changes in education and training; the changing health and care workforce; reflections on the duty of candour in principle and in practice, and the PSA's latest thoughts on regulatory reform. There was wide agreement that this should be the first of a regular set of meetings.

Engagement with other regulators

- 25 We continue to work with colleagues at the GMC on joint parliamentary engagement on regulatory reform and developing a shared approach to Brexit by the healthcare regulators.
- 26 The Chief Executive continues to engage regularly with the GMC's

Chief Executive, including discussions on 6 and 19 February 2018 and 19 March 2018.

Overseas Review

- 27 We have begun our programme to review the process for applicants who wish to join the register from outside the UK. The review will ensure our overseas process can assess applicants against the NMC's new standards for nursing associates, nurses and midwives, as these new standards are introduced. It will also seek to enhance and streamline the overseas registration processes reducing cost and time where possible and supporting applicants by ensuring the process is as easy to navigate as possible. The review also incorporates the next stages of our work looking at the evidence requirements for English language competence.
- 28 Engagement with stakeholders has begun and engagement activity will increase from April 2018, seeking feedback and input to potential improvements. Stakeholders are welcoming the fact that this review is underway and are keen to work with us on this programme. Where short term improvements can be identified we plan to introduce these as quickly as possible, but we anticipate other changes may require public consultation and possible changes to our legislation. Council will be kept fully up to date with progress.

Brexit

- 29 The DHSC has convened two meetings with the healthcare regulators to help explain and develop their approach in preparation for changes to MRPQ arrangements after the UK leaves the EU in relation to future 'flow' of applicants. We have submitted a detailed briefing about our position and we have also requested a face-to-face meeting with Lord O'Shaughnessy, the Parliamentary Under Secretary of State for Health and Social Care.
- 30 The Chief Executive was one of the signatories to a joint letter from the regulators to the DHSC on the issue of Brexit and legislative change.
- 31 On 22 January 2018, the Chief Executive gave an interview to the German state TV broadcaster, ZDF, on Brexit and the impact on nursing numbers.
- 32 On 15 February 2018 The Chief Executive attended the Westminster Health Forum conference on recruitment, retention and Brexit.

D: Media activity

- 33 In February 2018, there was coverage in the trade press following the release of the draft skills annex for the new nursing associate role. There was also coverage in Nursing Standard and Nursing in Practice, which focused on the ability of nursing associates to

administer medications.

- 34 There was significant national coverage of the GMC case involving Dr Bawa-Garba and the Secretary of State's decision to commission an urgent review of medical malpractice cases.
- 35 There was coverage in the professional press following the appointment of Lord Willis of Knaresborough and Leigh Kendall to our Midwifery Panel.
- 36 At the beginning of March 2018, there was coverage in the local media of the adjourned Information Commissioner's tribunal hearing in Manchester. The North West Evening Mail are appealing the decision not to release legal advice relating to the handling of Morecambe Bay FtP cases under the Freedom of Information Act.
- 37 There was coverage in the Sunday Telegraph and Telegraph online of our future approach to the use of simulation for the training of nurses and midwives. The article explained how technology is advancing in this area and how we think Universities are best placed to decide how simulation should be used in learning. The article carried a quote from the Chief Executive and supportive comments from the RCN.
- 38 There was coverage in the professional press of the appointment of the new NMC Chair with effect from 1 May 2018.

Public protection implications:

- 39 No direct public protection implications.

Resource implications:

- 40 No direct resource implications.

Equality and diversity implications:

- 41 None.

Stakeholder engagement:

- 42 Stakeholder engagement is detailed in the body of this report.

Risk implications:

- 43 No direct risk implications.

Legal implications:

- 44 No direct legal implications.

Council

Standards of proficiency for registered nurses and standards for education and training

Action	For decision.
Issue:	Seeks Council's approval of the new standards of proficiency for registered nurses and new standards for education and training.
Core regulatory function:	Education and standards.
Strategic priority:	Strategic priority 1: Effective regulation.
Decision required:	<p>Council is recommended to approve the following:</p> <ul style="list-style-type: none"> • new standards of proficiency for registered nurses, attached as annexe 1, as the standards of proficiency for entry to the nursing part of the register (as required by Article 5 (2) of the Nursing and Midwifery Order 2001 ('the Order')) with effect from 28 January 2019 (paragraph 28); • new standards framework for nursing and midwifery education (attached as annexe 2) as part of the standards for education and training that are necessary to achieve the relevant standards of proficiency for entry to all parts of the register and for additional qualifications as required by Article 15 (1) of the Order with effect from 28 January 2019 (paragraph 37); • new standards for student supervision and assessment (attached as annexe 3) as part of the standards for education and training that are necessary to achieve the relevant standards of proficiency for entry to all parts of the register and for additional qualifications as required by Article 15 (1) of the Order with effect from 28 January 2019 (paragraph 50); • new standards for pre-registration nursing programmes (attached as annexe 4) as part of the standards for education and training that are necessary to achieve the new standards of proficiency for entry to the nursing part of the register as required by Article 15 (1) of the Order with effect from 28 January 2019 (paragraph 63); and • transitional arrangements related to the above standards (paragraph 68).

Annexes: The following annexes are attached to this paper:

- Annexe 1: The Future Nurse: standards of proficiency for registered nurses.
- Annexe 2: Part 1: Standards framework for nursing and midwifery education.
- Annexe 3: Part 2: Standards for student supervision and assessment.
- Annexe 4: Part 3: Programme standards - Standards for pre-registration nursing programmes.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Anne Trotter
Phone: 020 7681 5779
anne.trotter@nmc-uk.org

Director: Prof Geraldine Walters CBE
Phone: 020 7681 5924
geraldine.walters@nmc-uk.org

Context:

- 1 The Nursing and Midwifery Council has a duty to revise the standards of proficiency it sets for registrants and standards for education and training periodically, to ensure that they are fit for purpose, to protect the public. The standards of proficiency for registered nurses were last revised in 2010.
- 2 The decision to review the pre-registration nursing standards was taken by Council in 2016. Professor Dame Jill Macleod Clark was invited to lead the work on developing the new nursing standards of proficiency. This work began with a rigorous review of evidence gained from research, the findings of national enquiries, and our own independent evaluation that sought the views of patients, the public, registrants, students and employers. We reviewed statements of policy intent from all of the four countries of the UK in order to align the new standards with the direction of travel of service delivery.
- 3 The work then entered a phase of engagement and consultation to ensure that practising nurses, the public, educationalists and policy makers were involved in defining the ambition for the new standards, and shaping their format and content.
- 4 There was universal agreement that the new standards should be ambitious in terms of the level of knowledge and skill expected of nurses at the point of registration; to enable them to be prepared to meet the increasingly complex health and social needs of people, to be more clinically autonomous, to deal with more complex models of service provision, and to prepare them for, and give them the expectation of, being the leaders of care and services in their future careers. These standards will lead to a future generation of nurses who will have the potential to work at the top of their license for public benefit.
- 5 The NMC aims to be a flexible and dynamic regulator. The new standards are a departure from previous approaches to setting regulatory standards. They are presented in a concise outcome focused format, that enables education and practice placement providers more flexibility, creativity and innovation in designing and delivering approved programmes of education to students to continue to meet the needs of the public as they change over time.
- 6 Between June and September 2017, we ran two consultations. A paper reporting on the second of these consultations is presented to Council on the March 2018 agenda.
- 7 In consultation one we sought views on:
 - 7.1 Draft standards of proficiency for registered nurses.
 - 7.2 Draft education framework, including requirements for

learning and assessment.

7.3 Draft programme requirements for pre registration nursing.

8 A number of changes have been made to the standards of proficiency and the standards for education and training as a result of the consultation feedback. These are discussed within this paper. Areas which generated the greatest amount of comment and feedback were:

8.1 The applicability of the standards of proficiency for registered nurses to:

8.1.1 The four fields of practice;

8.1.2 Public health; and

8.1.3 Prescribing readiness for new registrants.

8.2 Standards for Learning and Assessment in Practice as part of the standards for education and training.

9 Following public consultation and the assimilation of the findings of consultation, the standards are now presented for final approval by Council.

Four country factors:

10 We were assisted by UK wide subject matter experts throughout the development and refinement of the draft standards.

11 The consultation responses and activity were representative of all four countries of the UK and included the UK's four Chief Nursing Officers (CNOs) and their representatives, the Council of Deans of Health (CoDH) and patient and public representative groups. Four country consultation engagement activities were held to support this work.

12 Since the consultation we have also formed a strategic four country working group that consists of nominees from the four CNOs and CoDH to advise on the supporting information needed to aid with implementation of new standards for supervision and assessment.

Discussion: Draft standards of proficiency for registered nurses

Rationale for initial draft standards

13 We consulted on draft standards that set out the proficiencies required for the future registered nurse at the point of entry to the register. These proficiencies were seen as ambitious in articulating the enhanced knowledge and skills to ensure that nurses can meet

the needs of people of all ages across a range of settings.

- 14 The draft standards of proficiency apply to all four fields of nursing practice (adult, children's, learning disabilities and mental health nursing). This ambitious approach intends to prepare nurses to provide evidence based, compassionate care for people who may have complex mental, physical and behavioural needs, working more flexibly across different care settings whilst maintaining the ability to enter the register in one or more of the four fields.

Summary feedback from consultation and engagement

- 15 Overall the feedback on the future nurse proficiencies was positive and respondents agreed that the design principles for the proficiencies had been met¹. Responses suggested that the standards would provide for safe and effective nursing practice at the point of registration with person centred care at the core, placing sufficient emphasis on health and wellbeing, reflecting the higher levels of knowledge and skills that would be required of the future nurse and striking a suitable balance between mental and physical health and care.
- 16 There were areas where some respondents felt that the proficiencies needed strengthening or clarification. In particular a need for further clarity and detail relating to person centred care, whether there was sufficient emphasis on health prevention and protection, the applicability of the proficiencies across the four fields of nursing, and a need to further distinguish between management and leadership skills.
- 17 Respondents were positive about our intention to state the communication and relationship management skills and the nursing procedures that registered nurses can safely undertake at the point of entry to the register. Some respondents sought additional clarity about the level of proficiency that was required across each of the four fields of nursing and the additional depth of knowledge needed in certain skills and procedures for the specific field of practice the new nurse was seeking to join.

Refined draft standards of proficiency for registered nurses

- 18 Refinements focused on those areas where consultation responses were mixed or where there was an opportunity to be clearer in language and intention of the outcome proficiencies.
- 19 The structure of the new standards remains where seven platforms

¹ Defined objectives are: 1) situates patient safety at the core of their function; 2) enhanced outcome, future focussed requirements; 3) being right touch - consistent, clear, proportionate and agile; 4) evidence based regulatory intervention that promotes inter-professional learning and cross regulatory assurance; 5) providing a framework that is applicable to a range of learning environments; 6) ensuring the education framework is measureable and assessable; 7) promoting equality and diversity.

set out the key proficiency outcome standards and state the responsibilities and accountabilities of the registered nurse. The titles of the platforms have however been refined to provide a more active tone.

- 20 Platform one focuses on accountability and the professional attributes that registered nurses need to provide safe care that is evidence based. In response to particular consultation feedback, refinements include a greater emphasis on challenging discriminatory behaviour, record keeping and professional self awareness.
- 21 As a result of the consultation responses and in particular from experts in public health, platform two has been revised to ensure the proficiencies focus on preventing ill health as well as promoting and protecting the health and wellbeing of people.
- 22 In response to feedback from the four UK CNOs, platforms three and four have an enhanced emphasis on person centred care, shared decision making and partnership working with patients and the public.
- 23 Additionally, as many respondents disagreed with our proposal to include prescribing readiness in pre-registration, we have clarified our expectations in clearly stating outcomes for the inclusion of prescribing theory proficiency outcomes that enables new nurses to prescribe from a limited formulary. Nurses will register first and then be able to complete prescribing practice outcomes before they can prescribe.
- 24 In response to organisational and individual feedback, platform five now distinguishes between the managerial and leadership role of the newly registered nurse and emphasises the role of human factors in influencing health and safety in the care environment.
- 25 Platform six is largely unchanged but we have clarified some of the language used to ensure that the proficiencies focus on knowing about improvement methodologies, in managing risk and in identifying, reporting and reflecting on near misses, incidents and adverse events.
- 26 Platform seven focuses on care across and between settings and we have taken the opportunity to further emphasise the need for person centred care across different care settings.
- 27 Both annexes that accompany the standards of proficiency now clarify those communication and relationship management skills and nursing procedures where the registered nurse will demonstrate greater application of knowledge within their chosen field of nursing practice. Respondents found the annotations in the annexes confusing, instead we have clearly stated the relevant

section where new nurses must be able to demonstrate the appropriate level of proficiency for their intended field of nursing practice.

Recommendation

- 28 **We recommend that Council approve the new standards of proficiency for registered nurses, attached as annexe 1, as the standards of proficiency for entry to the nursing part of the register (as required by Article 5 (2) of the Nursing and Midwifery Order 2001 ('the Order')) with effect from 28 January 2019.**

Draft standards framework for nursing and midwifery education

Rationale for initial draft standards

- 29 Our education programme of change sought to create a single set of education and training standards that applies to pre and post registration nursing and midwifery education and are sufficiently agile to accommodate flexible routes and the introduction of new roles within professional education. We successfully collaborated with the GMC in seeking to align shared regulatory approaches to the development of our education and training standards.
- 30 We consulted on a draft education framework that sought to underpin all aspects across both theory and practice settings. Public protection and student safety was central to this framework, as was our ambition to lead and promote innovative inter-professional learning and collaboration.

Feedback from consultation and engagement

- 31 Responses to our public consultation was generally supportive of the move to a separate single set of standards for approved education institutions (AEIs) and their practice placement partners and agreed that one set of education and training standards can be applied to pre-registration, post-registration and nursing and midwifery programmes across all settings.
- 32 Overall, respondents agreed that our objectives and design principles had been met and that the outcome focused design of the framework is future proofed and offered greater flexibility for those who deliver nursing and midwifery education. There was general agreement that the requirements were applicable across a range of learning environments.

Refined draft standards framework for nursing and midwifery education

- 33 Our proposed standards for education and training have undergone some terminology and language changes for greater clarity. There

have not been any major changes to the structure of the standards or the policy intent behind them.

- 34 Engagement with hard to reach groups and representatives from the Chief Nursing Officer for England Black and Minority Ethnic Steering Group informed us there was a clear need to amplify our commitment to the voice of the service user in nursing and midwifery education and in expressing our expectations for equality and fairness for all students on all our approved programmes.
- 35 We have responded by making changes that strengthen our commitment to equality and diversity, and to ensure that this is placed at the heart of nursing and midwifery education provision. This has included providing clearer definitions and making more extensive use of the terminology used in the Care Act and equalities and human rights legislation, to embed them clearly within the standards and to highlight the direct link between the requirements set out in these standards and legislation.
- 36 We have also strengthened the outcomes to emphasise expectations of service user involvement in education and training.

Recommendation

- 37 **It is recommended that Council approves the new standards framework for nursing and midwifery education (attached as annexe 2) as part of the standards for education and training that are necessary to achieve the relevant standards of proficiency for entry to all parts of the register and for additional qualifications as required by Article 15 (1) of the Order with effect from 28 January 2019.**

Draft standards for student supervision and assessment

Rationale for initial proposals

- 38 To support the proposed new draft standards framework for nursing and midwifery education, we consulted on the introduction of new draft standards for student supervision and assessment. These would set out the mechanisms and processes for ensuring students are appropriately supervised and assessed in both academic and practice learning environments.
- 39 We sought to strike a balance in enabling innovation, while providing assurance that students are being appropriately supervised and assessed against the relevant standards of proficiency. This new draft approach to learning and assessment was initially published as an annexe to the education framework and was proposed as a replacement for our current *Standards to Support Learning and Assessment in Practice (2008)*.

Consultation responses and engagement feedback

- 40 Mixed views were received with regard to the proposals for the new learning and assessment model. A slight majority supported the proposal to separate supervision from assessment.
- 41 There was no clear majority either for or against the proposal that the practice assessor be independent of the practice supervisor. However, slightly more respondents agreed with this proposal than opposed it.
- 42 Most respondents disagreed with the proposal that we will no longer require those supporting, supervising and assessing students to complete a programme that is NMC approved. There were mixed opinions regarding the suggestion that practice supervisors can be any registered health and social care professional who is suitably prepared and does not have to be an NMC registrant.
- 43 During the engagement events there was some support for students being assigned one practice assessor and one academic assessor per part of their programme. More consultation responses agreed with these proposals than opposed them.
- 44 A small majority disagreed with the proposals that the practice assessor need not be from the same field of nursing practice as the intended field of practice for the student nurse they are to assess.

Refined draft standards for student supervision and assessment

- 45 The revised version of the draft standards for student supervision and assessment has undergone a number of changes in language, content and structure as a result of feedback during the consultation exercise. These can be summarised as follows:
- 45.1 The practice supervisor can be 'any registered health and social care professional' who is supporting and supervising learning in practice in line with their competence.
- 45.2 The practice and academic assessors for nursing students will not be required to be from the same field of practice as the student they are assessing, if they have suitable equivalent experience. Specialist Community Public Health Nursing (SCHPN) students will be assessed by a suitably experienced SCPHN regardless of field.
- 45.3 There will be no NMC approved programme for assessors or supervisors. However, assessors will be required to undergo preparation or training. Practice supervisors will be expected

to be prepared for their role, but it will not be mandated that they undergo specific training.

- 45.4 Instead, a series of high level standard outcomes for assessor preparation are now set out within the standards for supervision and assessment. This is a reversal of the previous consultation position not to set any competencies for the new assessor roles.
 - 45.5 Students will be assigned to a different academic assessor per part of the programme, and a practice assessor for a placement or a series of placements.
 - 45.6 Finally, it is proposed that the new standards will not be an annexe to the standards framework for nursing and midwifery education but will be a separate set of stand-alone standards in their own right.
- 46 The changes detailed above have been made following a consideration of the consultation result, alongside the evidence base, and input from subject matter experts. These changes indicate how we can exercise this public protection function in a proportionate way that is also capable of being quality assured. These are summarised below.
- 47 In ensuring that assessors must undergo preparation we will still require assurance that those undertaking assessment are suitably prepared for the role.
- 48 Although the response to the consultation was broadly positive to the proposal for the student to have one practice and academic assessor per part of the programme, feedback from education stakeholders suggests that one practice assessor per part of the programme may be difficult to implement in all areas. This has therefore been revised. However we expect that a nominated practice assessor will work in partnership with the academic assessor for student progression. This is to ensure that this link between practice and the academic environments remains, while allowing flexibility in implementation.
- 49 Finally, it was felt that such was the importance, the subject of supervision and assessment warranted that they become a set of standards in their own right rather than being contained in an annexe to another set of standards.

Recommendation

- 50 **It is recommended that Council approves the new standards for student supervision and assessment (attached as annexe 3) as part of the standards for education and training that are necessary to achieve the relevant standards of proficiency for entry to all parts of the register and for additional qualifications as required by Article 15 (1) of the Order with effect from 28 January 2019.**

Draft standards for pre registration nursing programmes

Rationale for initial proposals

- 51 Programme standards for pre-registration nursing programmes are currently contained within the *Standards for pre-registration nursing education (2010)*.
- 52 Within last summer's consultation (2017), we proposed information unique to pre-registration nursing degree programmes be presented as a stand-alone document, initially provisionally entitled Requirements for pre-registration nursing education.

Consultation responses and engagement feedback

- 53 Feedback from the consultation was largely positive, in particular respondents welcomed the proposals for us continuing to set limits for recognition of prior learning (RPL), for the equal split between theory and practice to be maintained and there was considerable support for a standardised national practice assessment document.
- 54 Concern was expressed in responses to questions on removing the 300 hour maximum for simulated learning, with the majority of respondents believing there should continue to be a cap on hours spent learning in simulation.
- 55 Although we did not formally direct a question towards supernumerary status there were requests to strengthen and provide additional clarity on the definition of supernumerary status.
- 56 Responses were mixed on whether AEs and the practice learning partners should be allowed to set entry criteria for literacy, numeracy and digital numeracy, or whether these should be set by the NMC.

Refined draft standards for pre-registration nursing education programmes

- 57 An assimilation of the consultation responses, feedback from engagement and input from subject matter experts led to revisions

of the draft standards for pre-registration nursing programmes.

- 58 We have refined, clarified and expanded our standards for student selection and admission.
- 59 Stating an equal split between theory and practice has been maintained in recognition of the importance of an integrated approach to professional learning to ensure students become proficient.
- 60 In recognition of the increasing evidence base and value of simulation for learning and assessment in health education we have refined our approach to standards in this area to ensure that we encourage innovation through appropriate outcome standards. Our approach recognises the growing role and importance of simulated learning, providing AEs with flexibility in determining how simulation is used for learning and assessment whilst ensuring that the amount requisite practice hours is not diminished and compliance with wider EU legislation is achieved. This flexible approach aligns with other UK regulators.
- 61 We propose that supernumerary status for students is maintained however we have refined our definition of supernumerary. We propose that decreasing levels of supervision be permissible in direct correlation with individual students' increasing proficiency and confidence. This will maintain public safety whilst providing students with opportunities to develop their practice as part of a team. This reflects the intentions of clinical practice as set out in the EU Directive. Maintaining supernumerary status whilst providing some flexibility through the new approach to student supervision should provide students with a broader range of opportunities for safely and effectively developing their practice and their confidence.
- 62 Supporting moves towards standardisation of ongoing records of achievement for students has been driven by calls for greater consistency for ensuring that students meet the new outcome proficiencies. We will offer our support through facilitation on the potential for standardising an ongoing record of achievement for students.

Recommendation

- 63 **It is recommended that Council approve the new standards for pre-registration nursing programmes (attached as annexe 4) as part of the standards for education and training that are necessary to achieve the new standards of proficiency for entry to the nursing part of the register as required by Article 15 (1) of the Order with effect from 28 January 2019.**

Transitional arrangements

- 64 Article 3(15) requires Council to publish standards that they establish. We will publish new standards documents shortly and share them with all our approved education institutions.
- 65 All new approvals after 28 January 2019 will be made against the new standards of proficiency for registered nurses and the new standards for education and training.
- 66 All nursing education providers must be approved against the new standards by September 2020. No students will be entitled to commence a programme approved against the 2010 nursing standards from September 2020.
- 67 All underpinning circulars related to existing standards in these areas will be withdrawn from the relevant transitional dates.

Recommendation

- 68 **Council is recommended to approve the transitional arrangements related to the above standards.**

Public protection implications:

- 69 Public protection is at the heart of all of our proficiency and education standards, and the proposed new draft standards have been refined with a view to ensure that person centred care, patient safety and public protection are at their core.
- 70 The future nurse proficiencies state what people can expect nurses to know and be capable of doing safely and proficiently and should enhance public confidence.
- 71 The standards framework for nursing and midwifery education and standards for student supervision and assessment provide a consistent approach to all programmes that we approve and applies to all parts of our register.

Resource implications:

- 72 Future resources necessary includes resource for design, and web based publications and further UK wide stakeholder engagement activity that will support the development and implementation of new programmes against the new standards. £74,500 has been forecast for these costs within the education programme budget.

Equality and diversity implications:

- 73 Equality and diversity considerations have been central to our standards development work at all stages. All proposals have been subject to equality impact assessments and rigorous user testing. Equality impacts and consultation responses were considered for

all refinements to the proposed final drafts of all draft standards documents to ensure that they meet all relevant legislative requirements and actively promote equality and diversity in the provision of nursing and midwifery education.

- Stakeholder engagement:**
- 74 The range and depth of our stakeholder engagement as part of the development of these standards was set out in the paper presented to Council at its January 2018 meeting.
- 75 Following Council's decision to approve these refined draft standards we will commence a programme of UK wide stakeholder engagement and quality assurance of programmes that seeks to ensure that the new standards are introduced effectively by all AEs and placement partners.
- Risk implications:**
- 76 It is essential that our education standards and nursing proficiencies remain future focused in ensuring that students receive the necessary education and training to meet the needs of people and be fit for purpose. Failure to ensure this will result in students being unable to satisfy their programme requirements and the demands of those who require their care. This would be a clear risk to patient safety and public protection.
- Legal implications:**
- 77 The legal basis for our education, standards setting and quality assurance functions are all set out in the Order.
- 78 Article 5 (2) of the Order requires Council to establish the standards of proficiency necessary to be admitted to the register. These are also deemed to be the standards that Council considers to be necessary for safe and effective practice for that part of the register. The standards of proficiency for registered nurses are the standards made under this requirement.
- 79 Article 15 (1) of the Order requires Council to establish standards for education and training necessary to achieve the standards of proficiency. The standards framework for nursing and midwifery education, the standards for student supervision and assessment and the standards for pre registration nursing programmes are made under this provision.
- 80 The standards for pre registration nursing programmes comply with the EU Directive on the recognition of professional qualifications (2005/36/EC).
- 81 Article 3 (14) of the Order requires the NMC to consult before establishing new standards. In the development of these standards extensive public consultation and engagement has taken place in

line with our legislation and the public law principles.

The Future Nurse: Standards of Proficiency for Registered Nurses

The role of the Nursing and Midwifery Council

What we do

We regulate nurses and midwives in the UK. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality care throughout their careers.

We make sure nurses and midwives keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate nurses and midwives who fall short of our standards. We maintain a register of nurses and midwives allowed to practise in the UK.

The Future Nurse: *Our Standards of proficiency for registered nurses*

These standards apply to all NMC Registered Nurses. They should be read with *Realising professionalism: Standards for education and training* which set out our expectations regarding delivery of all pre-registration and post-registration NMC approved nursing and midwifery education programmes. These standards apply to all approved education providers and are set out in three parts: Part 1: *Standards framework for nursing and midwifery education*; Part 2: *Standards for student supervision and assessment*; and Part 3: *Programme standards* which are the standards specific for each pre-registration or post-registration programme. Education institutions must comply with our standards to be approved to run any NMC approved programmes.

Together these standards aim to provide approved education institutions (AEIs) and their practice learning partners with flexibility to develop innovative approaches to education for nurses and midwives, while being accountable for the local delivery and management of approved programmes in line with our standards.

Legislative framework

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order')¹ requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The standards for nursing and midwifery education providers are established under the provision of Article 15(1) of the Order.

Article 5(2) of the Nursing and Midwifery Order 2001 requires the NMC to establish standards of proficiency necessary to be admitted to each part of the register and for safe and effective practice under that part of the register. The standards of proficiency have been established under this provision.

¹ SI 2002/253

The Future Nurse: Standards of proficiency for registered nurses

Introduction

The Nursing and Midwifery Council has a duty to review the standards of proficiency it sets for the professions it registers on a regular basis to ensure that standards remain contemporary and fit for purpose in order to protect the public. In reviewing the standards, we have taken into account the changes that are taking place in society and health care and the implications these have for registered nurses of the future in terms of their role, knowledge and skill requirements.

The proficiencies in this document therefore specify the knowledge, skills and attributes that registered nurses must demonstrate when caring for people of all ages and across all care settings. They reflect what the public can expect nurses to know and be able to do in order to deliver safe, compassionate and effective nursing care. They also provide a benchmark for nurses from the EEA, EU and overseas wishing to join the register, as well as for those who plan to return to practice after a period of absence.

The Role of the Nurse in the 21st Century

Registered nurses play a vital role in providing, leading and coordinating care that is compassionate, evidence based, and person centred. They are accountable for their own actions and must be able to work autonomously, or as an equal partner with a range of other professionals, and in interdisciplinary teams. In order to respond to the impact and demands of professional nursing practice, they must be emotionally intelligent and resilient individuals, who are able to manage their own personal health and wellbeing, and know when and how to access support.

Registered nurses make an important contribution to the promotion of health, health protection and the prevention of ill health. They do this by empowering people, communities and populations to exercise choice, take control of their own health decisions and behaviours and by supporting people to manage their own care where possible.

Registered nurses provide leadership in the delivery of care for people of all ages and from different backgrounds, cultures and beliefs. They provide nursing care for people who have complex mental, physical, cognitive and behavioural care needs, those living with dementia, the elderly and for people at the end of their life. They must be able to care for people in their own home, in the community or hospital or in any health care settings where their needs are supported and managed. They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation and rapidly evolving technologies. Increasing integration of health and social care services will require registered nurses to negotiate boundaries and play a proactive role in multidisciplinary teams. The confidence and ability to think critically, apply knowledge and skills and provide expert, evidence based, direct nursing care therefore lies at the centre of all registered nursing practice.

How the proficiencies have been structured

The proficiencies are grouped under seven platforms, followed by two annexes. Together, these reflect what we expect a newly-registered nurse to know and be capable of doing safely and proficiently at the very start of their career.

Key components of the roles, responsibilities and accountabilities of registered nurses are described under each of the seven platforms. We believe that this approach

provides clarity to the public and the professions about the core knowledge and skills that they can expect every registered nurse to demonstrate.

These proficiencies will provide new graduates into the profession with the knowledge and skills they need at the point of registration which they will build upon as they gain experience in practice and fulfil their professional responsibility to continuously update their knowledge and skills. For example, after they register with us, registered nurses will already be equipped to progress to the completion of a prescribing qualification.

The platforms are:

- 1 Be an accountable professional
- 2 Promoting health and preventing ill health
- 3 Assessing needs and planning care
- 4 Providing and evaluating care
- 5 Leading and managing nurse care and work in teams
- 6 Improving safety and quality of care
- 7 Coordinating care

The outcome statements have been designed to apply across all current fields of nursing practice (adult, children, learning disabilities, mental health) and all care settings. This is because registered nurses must be able to meet the person centred, holistic care needs of the people they encounter in their practice who may be at any stage of life and who may have a range of mental, physical, cognitive or behavioural health challenges. They must also be able to demonstrate a greater depth of knowledge and the additional, more advanced skills required to meet the specific care needs of people in their chosen field or field of nursing practice.

The annexes to these standards of proficiency are presented in two sections. The annexes provide a description of what registered nurses should be able to demonstrate that they can do at the point of registration, in order to provide safe nursing care. Annex A specifies the communication and relationship management skills required, and Annex B specifies the nursing procedures that registered nurses must demonstrate that they are able to perform safely. As with the knowledge proficiencies, the annexes also identify where more advanced skills are required by registered nurses working in a particular field or fields of nursing practice.

Platform 1 Being an accountable professional

Registered nurses act in the best interests of people, putting them first and providing nursing care that is person-centred, safe and compassionate. They act professionally at all times and use their knowledge and experience to make evidence based decisions about care. They communicate effectively, are role models for others and are accountable for their actions. Registered nurses continually reflect on their practice and keep abreast of new and emerging developments in nursing, health and care.

- 1 **Outcomes:** The outcomes set out below reflect the proficiencies for accountable professional practice that must be applied across the standards of proficiency for registered nurses, as described in platforms 2-7, in all care settings and areas of practice.

At the point of registration, the registered nurse will be able to:

- 1.1 understand and act in accordance with *The Code: Professional standards of practice and behaviour for nurses and midwives* and fulfil all registration requirements²
- 1.2 understand and apply relevant legal, regulatory and governance requirements, policies and ethical frameworks to all areas of practice, differentiating where appropriate between the devolved legislatures of the United Kingdom
- 1.3 understand and apply the principles of courage, transparency and the duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes
- 1.4 demonstrate an understanding of and the ability to challenge discriminatory behaviour
- 1.5 understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to health
- 1.6 understand and maintain the level of health, fitness and wellbeing required to meet people's needs for mental and physical care
- 1.7 demonstrate an understanding of research methods, ethics and governance in order to critically analyse, safely use, share and apply research findings to promote and inform best nursing practice
- 1.8 demonstrate the knowledge, skills and ability to think critically when applying evidence and drawing on experience to make evidence informed decisions in all situations
- 1.9 understand the need to base all decisions regarding care and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence your decisions

² *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015)

- 1.10 demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences your judgments and decisions in routine, complex and challenging situations
- 1.11 communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges
- 1.12 demonstrate the skills and abilities required to support people at all stages of life who are emotionally or physically vulnerable
- 1.13 demonstrate the skills and abilities required to develop, manage and maintain appropriate relationships with people, their families, carers and colleagues
- 1.14 provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments
- 1.15 demonstrate the numeracy, literacy, digital and technological skills required to meet the needs of people in their care to ensure safe and effective nursing practice
- 1.16 demonstrate the ability to keep complete, clear, accurate and timely records
- 1.17 take responsibility for continuous self-reflection, seeking and responding to support and feedback to develop their professional knowledge and skills
- 1.18 demonstrate the knowledge and confidence to contribute effectively and proactively in an interdisciplinary team
- 1.19 act as an ambassador, upholding the reputation of your profession and promoting public confidence in nursing, health and care services, and
- 1.20 safely demonstrate evidence based practice in all skills and procedures stated in Annexes A and B.

Platform 2 Promoting health and preventing ill health

Registered nurses play a key role in improving and maintaining the mental, physical and behavioural health and well-being of people, families, communities and populations. They support and enable people at all stages of life and in all care settings to make informed choices about how to manage health challenges in order to maximise their quality of life and improve health outcomes. They are actively involved in the prevention of and protection against disease and ill health and engage in public health, community development and global health agendas and in the reduction of health inequalities.

- 2 **Outcomes:** The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in health promotion and protection and prevention of ill health.

At the point of registration, the registered nurse will be able to:

- 2.1 understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health when engaging with people
- 2.2 demonstrate knowledge of epidemiology, demography, genomics and the wider determinants of health, illness and wellbeing and apply this to an understanding of global patterns of health and wellbeing outcomes
- 2.3 understand the factors that may lead to inequalities in health outcomes
- 2.4 identify and use all appropriate opportunities, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people's individual circumstances
- 2.5 promote and improve mental, physical, behavioural and other health related outcomes by understanding and explaining the principles, practice and evidence base for health screening programmes
- 2.6 understand the importance of early years and childhood experiences and the possible impact on life choices, mental, physical and behavioural health and wellbeing
- 2.7 understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours and lifestyle choices to mental, physical and behavioural health outcomes
- 2.8 explain and demonstrate the use of up to date approaches to behaviour change to enable people to use their strengths and expertise and make informed choices when managing their own health and making lifestyle adjustments
- 2.9 use appropriate communication skills and strength based approaches to support and enable people to make informed choices about their care to manage health challenges in order to have satisfying and fulfilling lives within the limitations caused by reduced capability, ill health and disability

- 2.10 provide information in accessible ways to help people understand and make decisions about their health, life choices, illness and care
- 2.11 promote health and prevent ill health by understanding and explaining to people the principles of pathogenesis, immunology and the evidence base for immunisation, vaccination and herd immunity, and
- 2.12 protect health through understanding and applying the principles of infection prevention and control, including communicable disease surveillance and antimicrobial stewardship and resistance.

DRAFT

Platform 3 Assessing needs and planning care

Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical, cognitive, behavioural, social and spiritual needs. They use information obtained during assessments to identify the priorities and requirements for person-centred and evidence based nursing interventions and support. They work in partnership with people to develop person-centred care plans that take into account their circumstances, characteristics and preferences.

- 3 **Outcomes:** The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in assessing and initiating person-centred plans of care.

At the point of registration, the registered nurse will be able to:

- 3.1 demonstrate and apply knowledge of human development from conception to death when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans
- 3.2 demonstrate and apply knowledge of body systems and homeostasis, human anatomy and physiology, biology, genomics, pharmacology, social and behavioural sciences when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans
- 3.3 demonstrate and apply knowledge of all commonly encountered mental, physical, behavioural and cognitive health conditions, medication usage and treatments when undertaking full and accurate assessments of nursing care needs and when developing, prioritising and reviewing person-centred care plans
- 3.4 understand and apply a person-centred approach to nursing care, demonstrating shared assessment, planning, decision making and goal setting when working with people, their families, communities and populations of all ages
- 3.5 demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person-centred evidence based plans for nursing interventions with agreed goals
- 3.6 effectively assess a person's capacity to make decisions about their own care and to give or withhold consent
- 3.7 understand and apply the principles and processes for making reasonable adjustments and best interest decisions where people do not have capacity
- 3.8 recognise and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are vulnerable
- 3.9 undertake routine investigations, interpreting and sharing findings as appropriate

- 3.10 interpret results from routine investigations, taking prompt action when required by implementing appropriate interventions, requesting additional investigations or escalating to others
- 3.11 demonstrate an understanding of co-morbidities and the demands of meeting people's complex nursing and social care needs when prioritising care plans
- 3.12 identify and assess the needs of people and families for care at the end of life, including requirements for palliative care and decision making related to their treatment and care preferences
- 3.13 demonstrate the ability to work in partnership with people, families and carers to continuously monitor, evaluate and reassess the effectiveness of all agreed nursing care plans and care, sharing decision making and readjusting agreed goals, documenting progress and decisions made, and
- 3.14 demonstrate knowledge of when and how to refer people safely to other professionals or services for clinical intervention or support.

DRAFT

Platform 4 Providing and evaluating care

Registered nurses take the lead in providing evidence based, compassionate and safe nursing interventions. They ensure that care they provide and delegate is person-centred and of a consistently high standard. They support people of all ages in a range of care settings. They work in partnership with people, families and carers to evaluate whether care is effective and the goals of care have been met in line with their wishes, preferences and desired outcomes.

- 4 **Outcomes:** The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in providing and evaluating person-centred care.

At the point of registration, the registered nurse will be able to:

- 4.1 demonstrate and apply an understanding of what is important to people and how to use this knowledge to ensure their needs for safety, dignity, privacy, comfort and sleep can be met, acting as a role model for others in providing evidence based person-centred care
- 4.2 work in partnership with people to encourage shared decision-making, in order to support individuals, their families and carers to manage their own care when appropriate
- 4.3 demonstrate the knowledge, communication and relationship management skills required to provide people, families and carers with accurate information that meets their needs before, during and after a range of interventions
- 4.4 demonstrate the knowledge and skills required to support people with commonly encountered mental health, behavioural, cognitive and learning challenges and act as role model for others in providing high quality nursing interventions to meet people's needs
- 4.5 demonstrate the knowledge and skills required to support people with commonly encountered physical health conditions, their medication usage and treatments and act as role model for others in providing high quality nursing interventions when meeting people's needs
- 4.6 demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence based nursing care to meet people's needs related to nutrition, hydration and elimination
- 4.7 demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence based, person-centred nursing care to meet people's needs related to mobility, hygiene, oral care, wound care and skin integrity
- 4.8 demonstrate the knowledge and skills required to identify and initiate appropriate interventions to support people with commonly encountered symptoms including anxiety, confusion, discomfort and pain

- 4.9 demonstrate the knowledge and skills required to prioritise what is important to people and their families when providing evidence based person-centred nursing care at end of life including the care of people who are dying, families, the deceased and bereaved
- 4.10 demonstrate the knowledge and ability to respond proactively and promptly to signs of deterioration or distress in mental, physical, cognitive and behavioural health and use this knowledge to make sound clinical decisions
- 4.11 demonstrate the ability to manage commonly encountered devices and confidently carry out related nursing procedures to meet people's needs for evidence based, person-centred care
- 4.12 demonstrate the knowledge, skills and confidence to provide first aid procedures and basic life support
- 4.13 understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies and demonstrate proficiency and accuracy when calculating dosages of prescribed medicines
- 4.14 demonstrate knowledge of pharmacology and the ability to recognise the effects of medicines, allergies, drug sensitivities, side effects, contraindications, incompatibilities, adverse reactions, prescribing errors and the impact of polypharmacy and over the counter medication usage
- 4.15 demonstrate knowledge of how prescriptions can be generated, the role of generic, unlicensed, and off-label prescribing and an understanding of the potential risks associated with these approaches to prescribing
- 4.16 apply knowledge of pharmacology to the care of people, demonstrating the ability to progress to a prescribing qualification following registration, and
- 4.17 demonstrate the ability to co-ordinate and undertake the processes and procedures involved in routine planning and management of safe discharge home or transfer of people between care settings.

Platform 5 Leading and managing nursing care and working in teams

Registered nurses provide leadership by acting as a role model for best practice in the delivery of nursing care. They are responsible for managing nursing care and are accountable for the appropriate delegation and supervision of care provided by others in the team including lay carers. They play an active and equal role in the interdisciplinary team, collaborating and communicating effectively with a range of colleagues.

- 5 **Outcomes:** The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in leading and managing nursing care and working effectively as part of an interdisciplinary team.

At the point of registration, the registered nurse will be able to:

- 5.1 understand the principles of effective leadership, management, group and organisational dynamics and culture and apply these to team working and decision making
- 5.2 understand and apply the principles of human factors, environmental factors and strength based approaches when working in teams
- 5.3 understand the principles and application of processes for performance management and how these apply to the nursing team
- 5.4 demonstrate an understanding of the roles, responsibilities and scope of practice of all members of the nursing and interdisciplinary team and how to make best use of the contributions of others involved in providing care
- 5.5 safely and effectively lead and manage the nursing care of a group of people demonstrating appropriate prioritisation, delegation and assignment of care responsibilities to others involved in providing care
- 5.6 exhibit leadership potential by demonstrating an ability to guide, support and motivate individuals and interact confidently with other members of the care team
- 5.7 demonstrate the ability to monitor and evaluate the quality of care delivered by others in the team and lay carers
- 5.8 support and supervise students in the delivery of nursing care, promoting reflection and providing constructive feedback, and evaluating and documenting their performance
- 5.9 demonstrate the ability to challenge and provide constructive feedback about care delivered by others in the team, and support them to identify and agree individual learning needs
- 5.10 contribute to supervision and team reflection activities to promote improvements in practice and services
- 5.11 effectively and responsibly use a range of digital technologies to access, input, share and apply information and data within teams and between agencies, and

- 5.12 understand the mechanisms that can be used to influence organisational change and public policy, demonstrating the development of political awareness and skills.

DRAFT

Platform 6 Improving safety and quality of care

Registered nurses make a key contribution to the continuous monitoring and quality improvement of care and treatment in order to enhance health outcomes and peoples experience of nursing and related care. They assess risks to safety or experience and take appropriate action to manage those, putting the best interests, needs and preferences of people first.

- 6 **Outcomes:** The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in contributing to risk monitoring and quality of care improvement agendas.

At the point of registration the registered nurse will be able to:

- 6.1 understand and apply the principles of health and safety legislation and regulations and maintain safe work and care environments
- 6.2 understand the relationship between safe staffing levels, appropriate skills mix, safety and quality of care, recognising risks to public protection and quality of care, escalating concerns appropriately
- 6.3 comply with local and national frameworks, legislation and regulations for assessing, managing and reporting risks, ensuring the appropriate action is taken
- 6.4 demonstrate an understanding of the principles of improvement methodologies, participate in all stages of audit activity and identify appropriate quality improvement strategies
- 6.5 demonstrate the ability to accurately undertake risk assessments in a range of care settings using a range of contemporary assessment and improvement tools
- 6.6 identify the need to make improvements and proactively respond to potential hazards that may affect the safety of people
- 6.7 understand how the quality and effectiveness of nursing care can be evaluated in practice and demonstrate how to use service delivery evaluation and audit findings to bring about continuous improvement
- 6.8 demonstrate an understanding of how to identify, report and critically reflect on near misses, critical incidents, major incidents and serious adverse events in order to learn from them and influence their future practice
- 6.9 work with people, their families, carers and colleagues, to develop effective improvement strategies for quality and safety, sharing feedback and learning from positive outcomes and experiences, mistakes and adverse outcomes and experiences
- 6.10 apply an understanding of the differences between risk aversion and risk management and how to avoid compromising quality of care and health outcomes

- 6.11 acknowledge the need to accept and manage uncertainty, and demonstrate an understanding of strategies that develop resilience in self and others, and
- 6.12 understand the role of registered nurses and other health and care professionals at different levels of experience and seniority when managing and prioritising actions and care in the event of a major incident.

DRAFT

Platform 7 Coordinating care

Registered nurses play a leadership role in coordinating and managing the complex nursing and integrated care needs of people at any stage of their lives, across a range of organisations and settings. They contribute to processes of organisational change through an awareness of local and national policies.

- 7 **Outcomes:** The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in coordinating and leading and managing the complex needs of people across organisations and settings.

At the point of registration, the registered nurse will be able to:

- 7.1 understand and apply the principles of partnership, collaboration and interagency working across all relevant sectors
- 7.2 understand health legislation and current health and social care policies, and the mechanisms involved in influencing policy development and change, differentiating where appropriate between the devolved legislatures of the United Kingdom
- 7.3 understand the principles of health economics and their relevance to resource allocation in health and social care organisations and other agencies
- 7.4 identify the implications of current health policy and future policy changes for nursing and other professions and understand the impact of policy changes on the delivery and coordination of care
- 7.5 understand and recognise the need to respond to the challenges of providing safe, effective and person-centred nursing care for people who have co-morbidities and complex care needs
- 7.6 demonstrate an understanding of the complexities of providing mental, cognitive, behavioural and physical care services across a wide range of integrated care settings
- 7.7 understand how to monitor and evaluate the quality of people's experience of complex care
- 7.8 understand the principles and processes involved in supporting people and families with a range of care needs to maintain optimal independence and avoid unnecessary interventions and disruptions to their lives
- 7.9 facilitate equitable access to healthcare for people who are vulnerable or have a disability and demonstrate the ability to advocate on their behalf when required and make necessary reasonable adjustments to the assessment, planning and delivery of their care
- 7.10 understand the principles and processes involved in planning and facilitating the safe discharge and transition of people between caseloads, settings and services

- 7.11 demonstrate the ability to identify and manage risks and take proactive measures to improve the quality of care and services when needed
- 7.12 demonstrate an understanding of the processes involved in developing a basic business case for additional care funding, by applying knowledge of finance, resources and safe staffing levels, and
- 7.13 demonstrate an understanding of the importance of exercising political awareness throughout their career, to maximise the influence and effect of registered nursing on quality of care, patient safety and cost effectiveness.

DRAFT

Annexe A

Communication and relationship management skills

Introduction

The communication and relationship management skills that a newly registered nurse must be able to demonstrate in order to meet the proficiency outcomes outlined in the main body of this document are set out in this annexe.

Effective communication is central to the provision of safe and compassionate person-centred care. Registered nurses in all fields of nursing practice must be able to demonstrate the ability to communicate and manage relationships with people of all ages with a range of mental, physical, cognitive and behavioural health challenges.

This is because a diverse range of communication and relationship management skills is required to ensure that individuals, their families and carers are actively involved in and understand care decisions. These skills are vital when making accurate, culturally aware assessments of care needs and ensuring that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Where people have special communication needs or a disability, it is essential that reasonable adjustments are made in order to communicate, provide and share information in a manner that promotes optimum understanding and engagement and facilitates equal access to high quality care.

The communication and relationship management skills within this annexe are set out in four sections. For the reasons above, these requirements are relevant to all fields of nursing practice and apply to all care settings. It is expected that that these skills would be assessed in a student's chosen field of practice.

Those skills outlined in **Annexe A, Section 3: Evidence based, best practice communication skills and approaches for providing therapeutic interventions** also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field of practice. Registered nurses must be able to demonstrate these skills to an appropriate level for their intended field(s) of practice.

At the point of registration, the registered nurse will be able to safely demonstrate the following skills:

- 1 Underpinning communication skills for assessing, planning, providing and managing best practice, evidence based nursing care
 - 1.1 actively listen, recognise and respond to verbal and non-verbal cues
 - 1.2 use prompts and positive verbal and non-verbal reinforcement
 - 1.3 use appropriate non-verbal communication including touch, eye contact and personal space
 - 1.4 make appropriate use of open and closed questioning
 - 1.5 use caring conversation techniques
 - 1.6 check understanding and use clarification techniques
 - 1.7 be aware of own unconscious bias in communication encounters
 - 1.8 write accurate, clear, legible records and documentation
 - 1.9 confidently and clearly share and present verbal and written reports with individuals and groups
 - 1.10 analyse and clearly record and share digital information and data
 - 1.11 provide clear verbal, digital or written information and instructions when delegating or handing over responsibility for care
 - 1.12 recognise the need for and facilitate access to translator services and material.
- 2 Evidence based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care
 - 2.1 share information and check understanding about the causes and implications and treatment of a range of common health conditions including anxiety, depression, memory loss, diabetes, dementia, respiratory disease, cardiac disease, neurological disease, cancer, skin problems, immune deficiencies, psychosis, stroke and arthritis
 - 2.2 use clear language and appropriate written materials, making reasonable adjustments where appropriate in order to optimise people's understanding of what has caused their health condition and the implications of their care and treatment
 - 2.3 recognise and accommodate sensory impairments during all communications
 - 2.4 support and manage the use of personal communication aids

- 2.5 identify the need for and manage a range of alternative communication techniques
 - 2.6 use repetition and positive reinforcement strategies
 - 2.7 assess motivation and capacity for behaviour change and clearly explain cause and effect relationships related to common health risk behaviours including smoking, obesity, sexual practice, alcohol and substance use
 - 2.8 provide information and explanation to people, families and carers and respond to questions about their treatment and care and possible ways of preventing ill health to enhance understanding
 - 2.9 engage in difficult conversations, including breaking bad news and support people who are feeling emotionally or physically vulnerable or in distress, conveying compassion and sensitivity.
- 3 Evidence based, best practice communication skills and approaches for providing therapeutic interventions
- 3.1 motivational interview techniques
 - 3.2 solution focused therapies
 - 3.3 reminiscence therapies
 - 3.4 talking therapies
 - 3.5 de-escalation strategies and techniques
 - 3.6 cognitive behavioural therapy techniques
 - 3.7 play therapy
 - 3.8 distraction and diversion strategies
 - 3.9 positive behaviour support approaches
- 4 Evidence based, best practice communication skills and approaches for working with people in professional teams
- 4.1 Demonstrate effective supervision, teaching and performance appraisal through the use of:
 - 4.1.1 clear instructions and explanations when supervising, teaching or appraising others
 - 4.1.2 clear instructions and check understanding when delegating care responsibilities to others
 - 4.1.3 unambiguous, constructive feedback about strengths and weaknesses and potential for improvement

- 4.1.4 encouragement to colleagues that helps them to reflect on their practice
- 4.1.5 unambiguous records of performance
- 4.2 Demonstrate effective person and team management through the use of:
 - 4.2.1 strengths based approaches to developing teams and managing change
 - 4.2.2 active listening when dealing with team members' concerns and anxieties
 - 4.2.3 a calm presence when dealing with conflict
 - 4.2.4 appropriate and effective confrontation strategies
 - 4.2.5 de-escalation strategies and techniques when dealing with conflict
 - 4.2.6 effective co-ordination and navigation skills through:
 - 4.2.6.1 appropriate negotiation strategies
 - 4.2.6.2 appropriate escalation procedures
 - 4.2.6.3 appropriate approaches to advocacy

Annexe B:

Nursing procedures

Introduction

The nursing procedures that a newly registered nurse must be able to demonstrate in order to meet the proficiency outcomes, outlined in the main body of this document, are set out in this annexe.

The registered nurse must be able to undertake these procedures effectively in order to provide, compassionate, evidence based person-centred nursing care. A holistic approach to the care of people is essential and all nursing procedures should be carried out in a way which reflects cultural awareness and ensures that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Registered nurses in all fields of practice must demonstrate the ability to provide nursing intervention and support for people of all ages who require nursing procedures) during the processes of assessment, diagnosis, care and treatment for mental, physical, cognitive and behavioural health challenges. Where people are disabled or have specific cognitive needs it is essential that reasonable adjustments are made to ensure that all procedures are undertaken safely.

The nursing procedures within this annexe are set out in two sections. These requirements are relevant to all fields of nursing practice although it is recognised that different care settings may require different approaches to the provision of care. It is expected that these procedures would be assessed in a student's chosen field of practice where practicable.

Those procedures outlined in **Annexe B, Part I: Procedures for assessing needs for person-centred care, sections 1 and 2** also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field(s) of practice. Registered nurses must therefore be able to demonstrate the ability to undertake these procedures at an appropriate level for their intended field(s) of practice.

At the point of registration, the registered nurse will be able to safely demonstrate the following procedures:

Part I: Procedures for assessing people's needs for person-centred care

- 1 Use evidence based, best practice approaches to take a history, observe, recognise and accurately assess people of all ages:
 - 1.1 mental health and wellbeing status
 - 1.1.1 signs of mental and emotional distress or vulnerability
 - 1.1.2 cognitive health status and wellbeing
 - 1.1.3 signs of cognitive distress and impairment
 - 1.1.4 behavioural distress based needs
 - 1.1.5 signs of mental and emotional distress including agitation, aggression and challenging behaviour
 - 1.2 physical health and wellbeing
 - 1.2.1 symptoms and signs of physical ill health
 - 1.2.2 symptoms and signs of physical distress
 - 1.2.3 symptoms and signs of deterioration and sepsis
- 2 Use evidence based, best practice approaches to undertake the following procedures:
 - 2.1 Take, record and interpret vital signs manually and via technological devices
 - 2.2 undertake venepuncture and cannulation and blood sampling, interpreting normal and common abnormal blood profiles and venous blood gases
 - 2.3 set up and manage routine electrocardiogram (ECG) investigations and interpret normal and commonly encountered abnormal traces
 - 2.4 manage and monitor blood component transfusions
 - 2.5 manage and interpret, cardiac monitors, infusion pumps, blood glucose monitors and other monitoring devices
 - 2.6 accurately measure weight, and height, calculate body mass index and recognise healthy ranges and clinically significant low/high readings
 - 2.7 undertake a whole body systems assessment including respiratory, circulatory, neurological, musculoskeletal, cardiovascular and skin status

- 2.8 undertake chest auscultation and interpret findings
- 2.9 collect and observe sputum, urine, stool and vomit specimens, undertaking routine analysis and interpreting findings
- 2.10 measure and interpret blood glucose levels
- 2.11 recognise and respond to signs of all forms of abuse
- 2.12 undertake, respond to and interpret neurological observations and assessments
- 2.13 identify and respond to signs of deterioration and sepsis
- 2.14 administer basic mental health first aid
- 2.15 administer basic physical first aid
- 2.16 recognise and manage seizures

II: Procedures for the planning, provision and management of person-centred nursing care

- 3 Use evidence based, best practice approaches for meeting needs for care and support with rest, sleep, comfort and the maintenance of dignity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions
 - 3.1 observe and assess comfort and pain levels and rest and sleep patterns
 - 3.2 use appropriate bed-making techniques including those required for people who are unconscious or who have limited mobility
 - 3.3 use appropriate positioning and pressure relieving techniques
 - 3.4 take appropriate action to ensure privacy and dignity at all times
 - 3.5 Take appropriate action to reduce or minimise pain or discomfort
 - 3.6 take appropriate action to reduce fatigue, minimise insomnia and support improved rest and sleep hygiene
- 4 Use evidence based, best practice approaches for meeting the needs for care and support with hygiene and the maintenance of skin integrity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions
 - 4.1 observe, assess and optimise skin and hygiene status and determine the need for support and intervention
 - 4.2 use contemporary approaches to the assessment of skin integrity and use appropriate products to prevent or manage skin breakdown

- 4.3 assess needs for and provide appropriate assistance with washing, bathing, shaving and dressing
 - 4.4 identify and manage skin irritations and rashes
 - 4.5 assess needs for and provide appropriate oral, dental, eye and nail care and decide when an onward referral is needed
 - 4.6 use aseptic techniques when undertaking wound care including dressings, pressure bandaging, suture removal, and vacuum closures
 - 4.7 use aseptic techniques when managing wound and drainage processes
 - 4.8 assess, respond and effectively manage pyrexia and hypothermia
- 5 Use evidence based, best practice approaches for meeting needs for care and support with nutrition and hydration, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions
- 5.1 observe, assess and optimise nutrition and hydration status and determine the need for intervention and support
 - 5.2 use contemporary nutritional assessment tools
 - 5.3 assist with feeding and drinking and use appropriate feeding and drinking aids
 - 5.4 record fluid intake and output and identify, respond to and manage dehydration or fluid retention
 - 5.5 identify, respond to and manage nausea and vomiting
 - 5.6 insert, manage and remove oral/nasal/gastric tubes
 - 5.7 manage artificial nutrition and hydration using oral, enteral and parenteral routes
 - 5.8 manage the administration of IV fluids
 - 5.9 manage fluid and nutritional infusion pumps and devices
- 6 Use evidence based, best practice approaches for meeting needs for care and support with bladder and bowel health, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions
- 6.1 observe and assess level of urinary and bowel continence to determine the need for support and intervention assisting with toileting, maintaining dignity and privacy and managing the use of appropriate aids
 - 6.2 select and use appropriate continence products; insert, manage and remove catheters for all genders; and assist with self-catheterisation when required

- 6.3 manage bladder drainage
 - 6.4 assess elimination patterns to identify and respond to constipation, diarrhoea and urinary and faecal retention
 - 6.5 administer enemas and suppositories and undertake rectal examination and manual evacuation when appropriate
 - 6.6 undertake stoma care identifying and using appropriate products and approaches
- 7 Use evidence based, best practice approaches for meeting needs for care and support with mobility and safety, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions
- 7.1 observe and use evidence based risk assessment tools to determine need for support and intervention to optimise mobility and safety, and to identify and manage risk of falls using best practice risk assessment approaches
 - 7.2 use a range of contemporary moving and handling techniques and mobility aids
 - 7.3 use appropriate moving and handling equipment to support people with impaired mobility
 - 7.4 use appropriate safety techniques and devices
- 8 Use evidence based, best practice approaches for meeting needs for respiratory care and support, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions
- 8.1 observe and assess the need for intervention and respond to restlessness, agitation and breathlessness using appropriate interventions
 - 8.2 manage the administration of oxygen using a range of routes and best practice approaches
 - 8.3 take and interpret peak flow and oximetry measurements
 - 8.4 use appropriate nasal and oral suctioning techniques
 - 8.5 manage inhalation, humidifier and nebuliser devices
 - 8.6 manage airway and respiratory processes and equipment
- 9 Use evidence based, best practice approaches for meeting needs for care and support with the prevention and management of infection, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions
- 9.1 observe, assess and respond rapidly to potential infection risks using best practice guidelines

- 9.2 use standard precautions protocols
 - 9.3 use effective aseptic, non-touch techniques
 - 9.4 use appropriate personal protection equipment
 - 9.5 implement isolation procedures
 - 9.6 use evidence based hand hygiene techniques
 - 9.7 safely decontaminate equipment and environment
 - 9.8 safely use and dispose of waste, laundry and sharps
 - 9.9 safely assess and manage invasive medical devices and lines
- 10 Use evidence based, best practice approaches for meeting needs for care and support at the end of life, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions
- 10.1 observe, and assess the need for intervention for people, families and carers, identify, assess and respond appropriately to uncontrolled symptoms and signs of distress including pain, nausea, thirst, constipation, restlessness, agitation, anxiety and depression
 - 10.2 manage and monitor effectiveness of symptom relief medication, infusion pumps and other devices
 - 10.3 assess and review preferences and care priorities of the dying person and their family and carers
 - 10.4 understand and apply organ and tissue donation protocols, advanced planning decisions, living wills and health and lasting powers of attorney for health
 - 10.5 understand and apply DNACPR (do not attempt cardiopulmonary resuscitation) decisions and verification of expected death
 - 10.6 provide care for the deceased person and the bereaved respecting cultural requirements and protocols
- 11 Procedural competencies required for best practice, evidence based medicines administration and optimisation
- 11.1 carry out initial and continued assessments of people receiving care and their ability to self-administer their own medications
 - 11.2 recognise the various procedural routes under which medicines can be prescribed, supplied, dispensed and administered; and the laws, policies, regulations and guidance that underpin them
 - 11.3 use the principles of safe remote prescribing and directions to administer medicines

- 11.4 undertake accurate drug calculations for a range of medications
- 11.5 undertake accurate checks, including transcription and titration, of any direction to supply or administer a medicinal product
- 11.6 exercise professional accountability in ensuring the safe administration of medicines to those receiving care
- 11.7 administer injections using intramuscular, subcutaneous, intradermal and intravenous routes and manage injection equipment
- 11.8 administer medications using a range of routes
- 11.9 administer and monitor medications using vascular access devices and enteral equipment
- 11.10 recognise and respond to adverse or abnormal reactions to medications
- 11.11 undertake safe storage, transportation and disposal of medicinal products

DRAFT

Glossary

Abuse: is something that may harm another person, or endanger their life, or violate their rights. The person responsible for the abuse may be doing this on purpose or may not realise the harm that they are doing. The type of abuse may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

Best interest decision: something that is done for a person, or a decision that is made on the person's behalf under the Mental Capacity Act 2005, which is in the person's best interests, when a person has been shown to lack the capacity to make such decisions themselves.

Candour: being open and honest with patients when things go wrong.

Clinical supervision: a registered nurse meeting regularly with another professional, not necessarily more senior, but normally with training in the skills of supervision, to discuss casework and other professional issues in a structured way.

Cognitive: The mental processes of perception, memory, judgment, and reasoning.

Co-morbidities: the presence of one or more additional diseases or disorders that occur with a primary disease or disorder.

Contraindications: a condition or factor that serves as a reason to withhold a certain medical treatment due to the harm that it would cause the patient.

Demography: the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing structure of human populations.

Evidence based person-centred care/nursing care: making sure that any care and treatment is given to people, by looking at what research has shown to be most effective. The judgment and experience of the nurse and the views of the person should also be taken into account when choosing which treatment is most likely to be successful for an individual patient.

Formulary: an official list giving details of prescribable medicines. The main function of a nursing and midwifery prescription formulary is to specify those particular medications that are approved to be prescribed by nurses and midwives, depending on the level of qualification they have obtained.

Genomics: branch of molecular biology concerned with the structure, function, evolution, and mapping of genomes.

Health economics: a branch of economics concerned with issues related to efficiency, effectiveness, value and behaviour in the production and consumption of health and healthcare.

Health literacy: the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Human factors: environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety.

Intervention: any investigations, procedures, or treatments given to a person.

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

Person-centred: an approach where the person is at the centre of the decision making processes and the design of their care needs, their nursing care and treatment plan.

Reflection: to carefully consider actions or decisions and learn from them.

Strength based approaches: strength based practice is a collaborative process between the person supported by services and those supporting them, working together to reach an outcome that draws on the person's strengths and assets.

Vulnerable people: those who at any age are at a higher risk of harm than others. Vulnerability might be in relation to a personal characteristic or a situation. The type of harm may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

DRAFT

Part 1: Standards framework for nursing and midwifery education

Introduction

Our *Standards framework for nursing and midwifery education* applies to all approved education institutions (AEIs) and their practice learning partners that are running NMC approved programmes.

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order')[1]¹ requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The *Standards framework for nursing and midwifery education* is established under the provision of Article 15(1) of the Order.

These standards aim to provide AEIs and practice learning partners with flexibility to develop innovative approaches to education for nurses and midwives, while being accountable for the local delivery and management of approved programmes in line with our standards.

These standards should be read with Part 2: *Standards for student supervision and assessment* and Part 3: *Programme standards* which are standards specific for each pre-registration or post-registration educational programme. Education institutions must be approved against these standards to run any NMC approved programmes.



¹ SI 2002/253

Our *Standards framework for nursing and midwifery education* is set out under the following five headings:

1 Learning culture

We will only approve programmes where the learning culture is ethical, open and honest, and is conducive to safe and effective learning that respects the principles of equality and diversity and where innovation, inter-professional learning and team working are embedded

2 Educational governance and quality

We expect education providers to comply with all legal and regulatory requirements

3 Student empowerment

We want students to be empowered and provided with the learning opportunities they need to achieve the desired proficiencies and programme outcomes

4 Educators and assessors

We will seek assurance that those who support, supervise and assess students are suitably qualified, prepared and skilled, and receive the necessary support for their role, and

5 Curricula and assessment

We set standards for curricula and assessment that enable students to achieve the outcomes required to practise safely and effectively in their chosen area

We use these standards to assess the safety and effectiveness of all learning environments.

1 Learning culture

Standards

S1.1 The learning culture prioritises the safety of people, including carers, students and educators, and enables the values of the Code² to be upheld.

S1.2 Education and training is valued in all learning environments.

Requirements

Approved education institutions together with practice learning partners must:

R1.1 demonstrate the safety of people is a primary consideration in all learning environments

R1.2 prioritise the wellbeing of people promoting critical self-reflection and safe practice in accordance with *the Code*

R1.3 ensure people have the opportunity to give and if required, withdraw their informed consent to students being involved in their care

R1.4 ensure educators and others involved in learning and assessment understand their role in preserving public safety

R1.5 ensure students and educators understand how to raise concerns or complaints and are encouraged and supported to do so in line with local and national policies without fear of adverse consequences

R1.6 ensure any concerns or complaints are investigated and dealt with effectively

R1.7 ensure concerns or complaints affecting the wellbeing of people are addressed immediately and effectively

R1.8 ensure mistakes and incidents are fully investigated and learning reflections and actions are recorded and disseminated

R1.9 ensure students are supported and supervised in being open and honest with people in accordance with the professional duty of candour³

R1.10 ensure the learning culture is fair, impartial, transparent, fosters good relations between individuals and diverse groups, and is compliant with equalities and human rights legislation⁴

R1.11 promote programme improvement and advance equality of opportunity through effective use of information and data

R1.12 ensure programmes are designed, developed, delivered, evaluated and co-produced with service users and other stakeholders

² <https://www.nmc.org.uk/standards/code/>

³ <https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/>

⁴ <https://www.equalityhumanrights.com/en/equality-act/equality-act-2010>, in Northern Ireland www.equalityni.org

R1.13 work with service providers to demonstrate and promote inter professional learning and working, and

R1.14 support opportunities for research collaboration and evidence-based improvement in education and service provision.

DRAFT

2 Educational governance and quality

Standards

S2.1 There are effective governance systems that ensure compliance with all legal, regulatory, professional and educational requirements, differentiating where appropriate between the devolved legislatures of the United Kingdom, with clear lines of responsibility and accountability for meeting those requirements and responding when standards are not met, in all learning environments.

S2.2 All learning environments optimise safety and quality, taking account of the diverse needs of, and working in partnership with, service users, students and all other stakeholders.

Requirements

Approved education institutions together with practice learning partners must:

R2.1 comply with all relevant legal⁵, regulatory, professional and educational requirements

R2.2 ensure programmes are designed to meet proficiencies and outcomes relevant to the programme

R2.3 comply with NMC *Programme standards* specific to the programme being delivered

R2.4 comply with NMC *Standards for student supervision and assessment*

R2.5 adopt a partnership approach with shared responsibility for theory and practice learning and assessment, including clear lines of communication and accountability for the development, delivery and evaluation of their programmes

R2.6 ensure that recruitment and selection of students is open, fair and transparent and includes measures to understand and address underrepresentation

R2.7 ensure that service users and representatives from relevant stakeholder groups are engaged in partnership in student recruitment and selection

R2.8 demonstrate a robust process for recognition of prior learning and how it has been mapped to the programme learning outcomes and proficiencies

R2.9 provide students with the information and support they require in all learning environments to enable them to understand and comply with relevant local and national governance processes and policies

R2.10 have robust, effective, fair, impartial and lawful fitness for practise procedures to swiftly address concerns about the conduct of students that might compromise public safety and protection

⁵ Includes, but not limited to, relevant European Union legislation and legislation passed by devolved administrations of the United Kingdom

R2.11 confirm that students meet the required proficiencies and programme outcomes in full, demonstrating their fitness for practice and eligibility for academic and professional award

R2.12 provide all information and evidence required by regulators

R2.13 provide assurance that all learning environments are safe and effective

R2.14 have the capacity, facilities and resources in place to deliver safe and effective learning opportunities and practical experiences for students as required by their programme learning outcomes

R2.15 be compliant with the NMC *Standards for education and training* for all periods of learning undertaken outside the UK

R2.16 improve quality, manage risk and disseminate effective practice through the proactive seeking and appropriate sharing of information and data

R2.17 proactively identify and act on any areas for improvement, regularly measuring programme performance and outcomes against the NMC standards and requirements, and other recognised quality frameworks in education

R2.18 appoint appropriately qualified and experienced people for programme delivery

R2.19 identify programme leaders to confirm that all proficiencies have been met by each student by the end of their programme, and

R2.20 ensure external examiners consider and report on the quality of theory and practice learning

3 Student empowerment

Standards

S3.1 Students are provided with a variety of learning opportunities and appropriate resources which enable them to achieve proficiencies and programme outcomes and be capable of demonstrating the professional behaviours in *the Code*.

S3.2 Students are empowered and supported to become resilient, caring, reflective and lifelong learners who are capable of working in inter professional and inter-agency teams.

Requirements

Approved education institutions together with practice learning partners must ensure that all students:

R3.1 have access to the resources they need to achieve the proficiencies and programme outcomes required for their professional role

R3.2 are provided with timely and accurate information about curriculum, approaches to teaching, supervision, assessment, practice placements and other information relevant to their programme

R3.3 have opportunities throughout their programme to work with and learn from a range of people in a variety of practice placements, preparing them to provide care to people with diverse needs

R3.4 are enabled to learn and are assessed using a range of methods, including technology enhanced and simulation-based learning appropriate for their programme as necessary for safe and effective practice

R3.5 are supervised and supported in practice learning in accordance with the NMC *Standards for student supervision and assessment*

R3.6 are supervised according to their individual learning needs, proficiency and confidence

R3.7 are allocated and can make use of supported learning time when in practice

R3.8 are assigned and have access to a nominated practice assessor in addition to a nominated academic assessor for each part of the programme in accordance with the NMC *Standards for student supervision and assessment*

R3.9 have the necessary support and information to manage any interruptions to the study of programmes for any reasons

R3.10 are provided with timely and accurate information regarding entry to NMC registration or annotation of their award

R3.11 have their diverse needs respected and taken into account across all learning environments, with support and adjustments provided in accordance with equalities and human rights legislation and good practice

R3.12 are protected from discrimination, harassment and other behaviour that undermines their performance or confidence

R3.13 are provided with information and support which encourages them to take responsibility for their own mental and physical health and wellbeing

R3.14 are provided with the learning and pastoral support necessary to empower them to prepare for independent, reflective professional practice

R3.15 are well prepared for learning in theory and practice having received relevant inductions

R3.16 have opportunities throughout their programme to collaborate and learn with other professionals, to learn with and from peers, and to develop supervision and leadership skills

R3.17 receive constructive feedback throughout the programme from stakeholders with experience of the programme to promote and encourage reflective learning, and

R3.18 have opportunities throughout their programme to give feedback on the quality of all aspects of their support and supervision in both theory and practice

DRAFT

4 Educators and assessors

Standard

S4.1 Theory and practice learning and assessment are facilitated effectively and objectively by appropriately qualified and experienced professionals with necessary expertise for their educational and assessor roles.

Requirements

Approved education institutions together with practice learning partners must ensure that all educators and assessors:

R.4.1 comply with all standards and requirements in the NMC *Standards for education and training*

R.4.2 act as professional role models at all times

R.4.3 receive relevant induction, ongoing support and access to education and training which includes training in equality and diversity

R.4.4 have supported time and resources to enable them to fulfil their roles in addition to their other professional responsibilities

R.4.5 respond effectively to the learning needs of individuals

R.4.6 are supportive and objective in their approach to student supervision and assessment

R.4.7 liaise and collaborate with colleagues and partner organisations in their approach to supervision and assessment

R.4.8 are expected to respond effectively to concerns and complaints about public protection and student performance in learning environments and are supported in doing so

R.4.9 receive and act upon constructive feedback from students and the people they engage with to enhance the effectiveness of their teaching, supervision and assessment

R.4.10 share effective practice and learn from others, and

R.4.11 appropriately share and use evidence to make decisions on student assessment and progression.

5 Curricula and assessment

Standard

S5.1 Curricula and assessments are designed, developed, delivered and evaluated to ensure that students achieve the proficiencies and outcomes for their approved programme.

Requirements

Approved education institutions together with practice learning partners must ensure:

R.5.1 curricula fulfil NMC *Programme standards*, providing learning opportunities that equip students to meet the proficiencies and programme outcomes⁶

R.5.2 curricula remain relevant in respect of the contemporary health and social care agenda

R.5.3 curricula weigh theory and practice learning appropriately to the programme

R.5.4 curricula are developed and evaluated by suitably experienced and qualified educators and practitioners who are accountable for ensuring that the curriculum incorporates relevant programme outcomes

R.5.5 curricula are co-produced with stakeholders who have experience relevant to the programme

R.5.6 curricula provide appropriate structure and sequencing that integrates theory and practice at increasing levels of complexity

R.5.7 curricula are structured and sequenced to enable students to manage their theory and practice learning experience effectively

R.5.8 assessment is fair, reliable and valid to enable students to demonstrate they have achieved the proficiencies for their programme

R.5.9 adjustments are provided in accordance with relevant equalities and human rights legislation for assessments in theory and practice

R.5.10 students are assessed across practice settings as required by their programme

R.5.11 assessment is mapped to the curriculum and occurs throughout the programme to determine student progression

R.5.12 practice assessment is facilitated and evidenced by observations and other appropriate methods

R.5.13 students' self-reflections contribute to, and are evidenced in, assessments

R.5.14 a range of people including service users contribute to student assessment

R.5.15 assessment of practice and theory is weighted appropriately to the programme, and

⁶ Applies equally to all programmes whether delivered as full time or less than full time

R.5.16 there is no compensation in assessment across theory and practice learning

DRAFT

Glossary

Adjustments: where a learner requires reasonable adjustments related to a disability or adjustments relating to any protected characteristics as set out in equalities and human rights legislation.

Approved education institutions (AEIs): is the status awarded to an institution, or part of an institution, or combination of institutions that works in partnership with practice placement and work placed learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

Co-production: when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered, acknowledging that people who use social care and health services (and their families) have knowledge and experience that can be used to help make services better. Co-production is one of the principles of the Care Act 2014.

Educators: in the context of the NMC Standards for education and training are those who deliver, support, supervise and assess theory, practice or work placed learning.

Equalities and human rights legislation: prohibits unlawful discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and other characteristics. Anti-discrimination laws can be country specific and there are some legally binding international protections

(Good) health and character requirements: as stipulated in NMC legislation (Articles 9(2)(b) and 5(2)(b) of the Nursing and Midwifery Order 2001) 'good health' means that the applicant is capable of safe and effective practice either with or without reasonable adjustments. It does not mean the absence of a health condition or disability. Each applicant seeking admission, readmission to the register or renewing their registration, whether or not they have been registered before, is required to declare any pending charges, convictions, police cautions and determinations made by other regulatory bodies.

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

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

Practice learning partners: organisations that provide practice learning necessary for supporting pre-registration and post-registration students in meeting proficiencies and programme outcomes.

Service user: people accessing health or social care services, and anyone supporting the needs and circumstances of these people.

Student: any individual enrolled onto an NMC-approved programme at pre-registration or post-registration level, whether full time or less than full time

Quality assurance: NMC processes for making sure all AEs continue to meet our requirements and their approved education programmes comply with our standards.

Recognition of prior learning (RPL): a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes and requirements; this means it includes both theory and practice achievement.

Simulation: an 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. Effective simulation facilitates patient safety by enhancing knowledge, behaviours and skills.

Stakeholders: any person, group or organisation that has an interest or concern in the situation in question, and may affect or be affected by its actions, objectives or policies. In the context of the NMC Standards for education and training this includes students, educators, partner organisations, service users, carers, employers, other professionals, other regulators and education commissioners.

Student: any individual enrolled onto an NMC-approved programme at pre- registration or post-registration level, whether full time or less than full time.

Supported learning time: protected time to facilitate learning, as with supernumerary status⁷ it enables students to be supported in safely and effectively achieving proficiency. Supernumerary status applies to pre-registration students, students in practice or work placed learning must be supported to learn without being counted as part of the staffing required for safe and effective care in that setting. For apprentices, this includes practice placements within their place of employment; this does not apply when they are working in their substantive role.

⁷ Supernumerary: see *Standards for student supervision and assessment* and specific programme standards

To be included on inside back page of published standards:

The role of the Nursing and Midwifery Council

What we do

We regulate nurses and midwives in the UK. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality care throughout their careers.

We make sure nurses and midwives keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate nurses and midwives who fall short of our standards. We maintain a register of nurses and midwives allowed to practise in the UK.

These standards were approved by Council at their meeting on xxxx

DRAFT

Part 2: Standards for student supervision and assessment

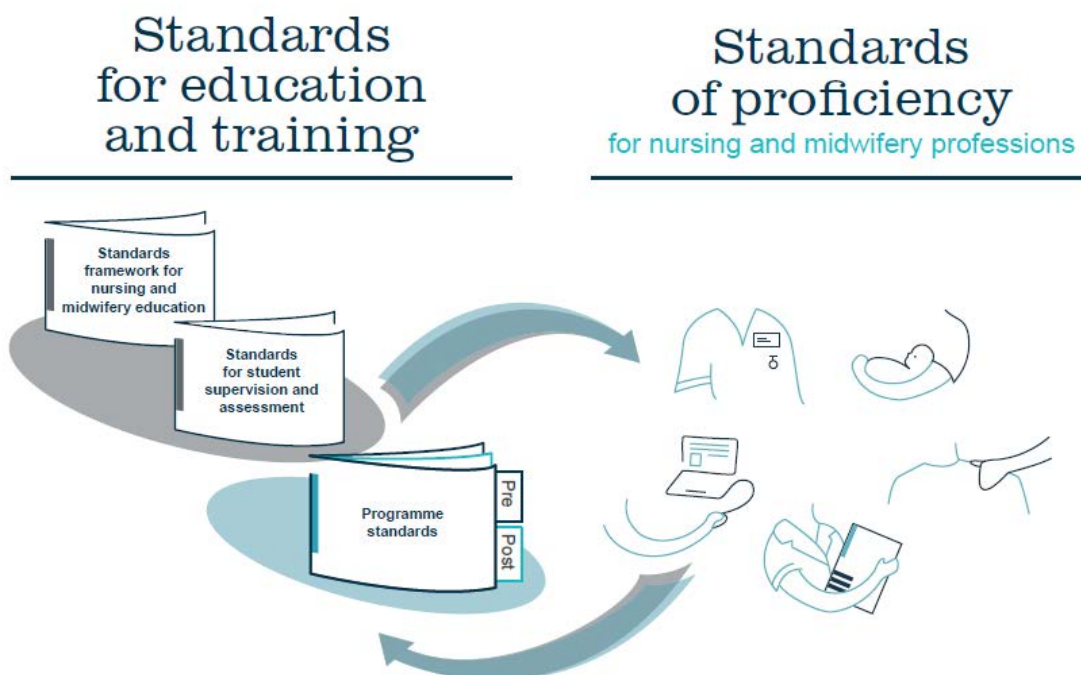
Introduction

Standards for student supervision and assessment set out our expectations for the learning, support and supervision of students in the practice environment. They also set out how students are assessed in theory and practice.

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order') requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The *Standards for student supervision and assessment* are established under the provision of Article 15(1) of the Order.

These standards aim to provide approved education institutions (AEIs) and practice learning partners with the flexibility to develop innovative approaches to education for nurses and midwives, while being accountable for the local delivery and management of approved programmes in line with our standards.

The *Standards for student supervision and assessment* apply to all NMC approved programmes and should be read with the NMC *Part 1: Standards framework for nursing and midwifery education* and the programme standards specific to the programme that is being delivered. There must be compliance with all these standards for an education institution to be approved and run NMC approved programmes.



Standards for student supervision and assessment are set out under the following three headings:

1 Effective practice learning

These standards describe what needs to be in place to deliver safe and effective learning experiences for nursing and midwifery students in practice.

2 Supervision of students

Here we describe the principles of student supervision in the practice environment, and the role of the practice supervisor.

3 Assessment of students and confirmation of proficiency

In these standards we set out what we require from educators who are confirming and assessing students' practice and academic achievement. We describe the role and responsibilities of the practice assessor and the academic assessor.

Each of the described roles must be in place for education institutions and practice learning partners to meet our standards. Additional roles may be introduced in line with local or national requirements. Programme leaders will confirm the achievement of proficiencies by each student on a programme as set out in *Part 1: Standards framework for nursing and midwifery education* and the programme standards specific to the programme.

The *Standards for student supervision and assessment* are outcome focused and allow for local innovation in programme delivery; they are designed to work across all programmes and in all settings. Student supervision and assessment can be flexible, provided the education institutions and practice learning partners meet our standards. Students in practice or work placed learning must be supported to learn without being counted as part of the staffing required for safe and effective care in that setting, this means they are supernumerary. For apprentices, this includes practice placements within their place of employment; this does not apply when they are working in their substantive role. The decision on the level of supervision provided for students should be based on the needs of the individual student. The level of supervision can decrease with the student's increasing proficiency and confidence. Students must be provided with adjustments in accordance with relevant equalities and human rights legislation in all learning environments and for supervision and assessment.

Effective practice learning

All students are provided with safe, effective and inclusive learning experiences. Each learning environment has the governance and resources needed to deliver education and training. Students actively participate in their own education, learning from a range of people across a variety of settings.

1 Organisation of practice learning

Approved education institutions, together with practice learning partners must ensure that:

- 1.1 practice learning complies with the NMC *Standards framework for nursing and midwifery education*

- 1.2 practice learning complies with specific programme standards
- 1.3 practice learning is designed to meet proficiencies and outcomes relevant to the programme
- 1.4 there are suitable systems, processes, resources and individuals in place to ensure safe and effective coordination of learning within practice learning environments
- 1.5 there is a nominated person for each practice setting to actively support students and address student concerns
- 1.6 students are made aware of the support and opportunities available to them within all learning environments
- 1.7 students are empowered to be proactive and to take responsibility for their learning
- 1.8 students have opportunities to learn from a range of relevant people in practice learning environments, including service users, registered and non-registered individuals, and other students as appropriate
- 1.9 learning experiences are inclusive and support the diverse needs of individual students
- 1.10 learning experiences are tailored to the student's stage of learning, proficiencies and programme outcomes, and
- 1.11 all nurses and midwives contribute to practice learning in accordance with the *Code* (2015).

Supervision of students

Practice supervision enables students to learn and safely achieve proficiency and autonomy in their professional role. All NMC registered nurses and midwives are capable of supervising students, serving as role models for safe and effective practice. Students may be supervised by other registered health and social care professionals.

2 Expectations of practice supervision

Approved education institutions, together with practice learning partners must ensure that:

- 2.1 all students on an NMC approved programme are supervised while learning in practice
- 2.2 there is support and oversight of practice supervision to ensure safe and effective learning
- 2.3 the level of supervision provided to students reflects their learning needs and stage of learning
- 2.4 practice supervision ensures safe and effective learning experiences that uphold public protection and the safety of people

- 2.5 there is sufficient coordination and continuity of support and supervision of students to ensure safe and effective learning experiences
- 2.6 practice supervision facilitates independent learning, and
- 2.7 all students on an NMC approved programme are supervised in practice by NMC registered nurses and midwives and other registered health and social care professionals.

Suggested wording to replace 2.7 to be included in nursing associate consultation version: ***all students on an NMC approved programme are supervised in practice by NMC registered nurses, midwives, nursing associates and other registered health and social care professionals***

3 Practice supervisors: role and responsibilities

Approved education institutions, together with practice learning partners must ensure that practice supervisors:

- 3.1 serve as role models for safe and effective practice in line with their code of conduct
- 3.2 support learning in line with their scope of practice to enable the student to meet their proficiencies and programme outcomes
- 3.3 support and supervise students, providing feedback on their progress towards, and achievement of, proficiencies and skills
- 3.4 have current knowledge and experience of the area in which they are providing support, supervision, and feedback, and
- 3.5 receive ongoing support to participate in practice learning of students.

4 Practice supervisors: contribution to assessment and progression

Approved education institutions, together with practice learning partners must ensure that practice supervisors:

- 4.1 contribute to the student's record of achievement by periodically recording relevant observations on the conduct, proficiency and achievement of the students they are supervising
- 4.2 contribute to student assessments to inform decisions for progression
- 4.3 have sufficient opportunities to engage with practice assessors and academic assessors to share relevant observations on the conduct, proficiency and achievement of the students they are supervising, and

- 4.4 are expected to appropriately raise and respond to student conduct and competence concerns and are supported in doing so.

5 Practice supervisors: preparation

Approved education institutions, together with practice learning partners must ensure that practice supervisors:

- 5.1 receive ongoing support to prepare, reflect and develop for effective supervision and contribution to student learning and assessment, and
- 5.2 have understanding of the proficiencies and programme outcomes they are supporting students to achieve.

Assessment of students and confirmation of proficiency

Student assessments are evidence based, robust and objective. Assessments and confirmation of proficiency are based on an understanding of student achievements across theory and practice. Assessments and confirmation of proficiency are timely, providing assurance of student achievements and competency.

6 Assessor roles

Approved education institutions, together with practice learning partners must ensure that:

- 6.1 all students on an NMC approved programme are assigned to a different nominated academic assessor for each part of the education programme
- 6.2 all students on an NMC approved programme are assigned to a nominated practice assessor for a practice placement or a series of practice placements, in line with local and national policies
- 6.3 nursing students are assigned to practice and academic assessors who are registered nurses with appropriate equivalent experience for the student's field of practice
- 6.4 midwifery students are assigned to practice and academic assessors who are registered midwives
- 6.5 specialist community public health nurse (SCPHN) students are assigned to practice and academic assessors who are registered SCPHNs with appropriate equivalent experience for the student's programme outcomes

Suggested wording for new standard 6.6 to be included in nursing associates consultation version: ***nursing associate students are assigned to practice and academic assessors who are either a registered nursing associate or a registered nurse***

- 6.6 students studying for an NMC approved post-registration qualification are assigned to practice and academic assessors in accordance with relevant programme standards
- 6.7 practice and academic assessors receive ongoing support to fulfil their roles, and
- 6.8 practice and academic assessors are expected to appropriately raise and respond to concerns regarding student conduct, competence and achievement and are supported in doing so.

7 Practice assessors: responsibilities

Approved education institutions, together with practice learning partners must ensure that:

- 7.1 practice assessors conduct assessments to confirm student achievement of proficiencies and programme outcomes for practice learning
- 7.2 assessment decisions by practice assessors are informed by feedback sought and received from practice supervisors
- 7.3 practice assessors make and record objective, evidenced based assessments on conduct, proficiency and achievement, drawing on student records, direct observations, student self-reflection, and other resources
- 7.4 practice assessors maintain current knowledge and expertise relevant for the proficiencies and programme outcomes they are assessing
- 7.5 a nominated practice assessor works in partnership with the nominated academic assessor to evaluate and recommend the student for progression for each part of the programme, in line with programme standards and local and national policies
- 7.6 there are sufficient opportunities for the practice assessor to periodically observe the student across environments in order to inform decisions for assessment and progression
- 7.7 there are sufficient opportunities for the practice assessor to gather and coordinate feedback from practice supervisors, any other practice assessors and relevant people, in order to be assured about their decisions for assessment and progression
- 7.8 practice assessors have an understanding of the student's learning and achievement in theory
- 7.9 communication and collaboration between practice and academic assessors is scheduled for relevant points in programme structure and student progression
- 7.10 practice assessors are not simultaneously the practice supervisor and academic assessor for the same student, and

- 7.11 practice assessors for students on NMC approved prescribing programmes support learning in line with the *NMC Standards for prescribing programmes*.

8 Practice assessors: preparation

Approved education institutions, together with practice learning partners must ensure that practice assessors:

- 8.1 undertake preparation or evidence prior learning and experience that enables them to demonstrate achievement of the following minimum outcomes:
- 8.1.1 interpersonal communication skills, relevant to student learning and assessment
 - 8.1.2 conducting objective, evidence based assessments of students
 - 8.1.3 providing constructive feedback to facilitate professional development in others, and
 - 8.1.4 knowledge of the assessment process and their role within it
- 8.2 receive ongoing support and training to reflect and develop in their role
- 8.3 continue to proactively develop their professional practice and knowledge in order to fulfil their role, and
- 8.4 have an understanding of the proficiencies and programme outcomes that the student they assess is aiming to achieve.

9 Academic assessors: responsibilities

Approved education institutions, together with practice learning partners must ensure that:

- 9.1 academic assessors collate and confirm student achievement of proficiencies and programme outcomes in the academic environment for each part of the programme
- 9.2 academic assessors make and record objective, evidence based decisions on conduct, proficiency and achievement, and recommendations for progression, drawing on student records and other resources
- 9.3 academic assessors maintain current knowledge and expertise relevant for the proficiencies and programme outcomes they are assessing and confirming
- 9.4 the nominated academic assessor works in partnership with a nominated practice assessor to evaluate and recommend the student for progression for each part of the programme, in line with programme standards and local and national policies
- 9.5 academic assessors have an understanding of the student's learning and achievement in practice

- 9.6 communication and collaboration between academic and practice assessors is scheduled for relevant points in programme structure and student progression, and
- 9.7 academic assessors are not simultaneously the practice supervisor and practice assessor for the same student.

10 Academic assessors: preparation

Approved education institutions, together with practice learning partners must ensure that academic assessors:

- 10.1 are working towards or hold relevant qualifications as required by their academic institution and local and national policies
- 10.2 demonstrate that they have achieved the following minimum outcomes:
 - 10.2.1 interpersonal communication skills, relevant to student learning and assessment
 - 10.2.2 conducting objective, evidence based assessments of students
 - 10.2.3 providing constructive feedback to facilitate professional development in others, and
 - 10.2.4 knowledge of the assessment process and their role within it
- 10.3 receive ongoing support and training to reflect and develop in their role
- 10.4 continue to proactively develop their professional practice and knowledge in order to fulfil their role, and
- 10.5 have an understanding of the proficiencies and programme outcomes that the student they confirm is aiming to achieve.

Part 3: Programme standards

Standards for pre-registration nursing programmes

Introduction

Our *Standards for pre-registration nursing programmes* set out the legal requirements, entry requirements, availability of recognition of prior learning, length of programme, methods of assessment and information on the award for all pre-registration nursing education programmes.

Student nurses must successfully complete an NMC approved pre-registration programme in order to meet the *Standards of proficiency for registered nurses* and to be eligible to apply, and be entered onto, the NMC register.

These specific programme standards should be read with the NMC *Standards framework for nursing and midwifery education* and *Standards for student supervision and assessment* which apply to all NMC approved programmes. There must be compliance with all these standards for an education institution to be approved and to run any NMC approved programme.



Education providers structure their educational programmes to comply with our programme standards. They also design their curricula around the published proficiencies for a particular programme and students are assessed against these proficiencies to make sure they are capable of providing safe and effective care. Proficiencies are the knowledge, skills and behaviours that nurses and midwives need in order to practise. We publish *Standards of proficiency for registered nurses and Standards of proficiency for registered midwives* as well as proficiencies for NMC approved post- registration programmes.

Through our quality assurance processes we check that education programmes meet all of our standards regarding the structure and delivery of educational programmes, that the programme outcomes relate to the expected proficiencies for particular qualifications and that the Approved Education Institutions (AEIs) and practice learning partners are managing risks effectively. Using internal and external intelligence we monitor risks to quality in education and training; this intelligence gathering includes analysis of system regulator reports.

Before a programme can be run, an approval process takes place through which we check that the proposed programme meets our standards.

Article 15(1) of the Nursing and Midwifery Order 2001 ('the Order')[1]¹ requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The standards for pre-registration nursing programmes are established under the provision of Article 15(1) of the Order.

Overall responsibility for the day-to-day management of the quality of any educational programme lies with an AEI in partnership with practice learning partners.

¹ SI 2002/253

Standards for pre-registration nursing education programmes follow the student journey and are grouped under the following five headings:

- 1 **Selection, admission and progression:** standards about an applicant's suitability and continued participation in a pre-registration nursing programme
- 2 **Curriculum:** standards for the content, delivery and evaluation of the pre-registration nursing education programme
- 3 **Practice learning:** standards specific to pre-registration learning for nurses that takes place in practice settings
- 4 **Supervision and assessment:** standards for safe and effective supervision and assessment for pre-registration nursing education programmes
- 5 **Qualification to be awarded:** standards which state the award and information for the NMC register.

DRAFT

1 Selection, admission and progression

Approved education institutions together with practice learning partners must:

- 1.1 Confirm on entry to the programme that students:
 - 1.1.1 are suitable for their intended field of nursing practice: adult, mental health, learning disabilities and children's nursing
 - 1.1.2 demonstrate values in accordance with *the Code*²
 - 1.1.3 have capability to learn behaviours in accordance with *the Code*
 - 1.1.4 have capability to develop numeracy skills required to meet programme outcomes
 - 1.1.5 can demonstrate proficiency in English language³
 - 1.1.6 have capability in literacy to meet programme outcomes
 - 1.1.7 have capability for digital and technological literacy to meet programme outcomes
- 1.2 ensure students' health and character are sufficient to enable safe and effective practice on entering the programme, throughout the programme and when submitting the supporting declaration of health and character in line with the NMC's health and character decision-making guidance. This includes satisfactory occupational health assessment and criminal record checks
- 1.3 ensure students are fully informed of the requirement to declare immediately any cautions or convictions, pending charges or adverse determinations made by other regulators, professional bodies and educational establishments and that any declarations are dealt with promptly, fairly and lawfully
- 1.4 ensure the registered nurse responsible for directing the educational programme or their designated registered nurse substitute are able to provide supporting declarations of health and character for students who have completed a pre-registration nursing programme⁴
- 1.5 permit recognition of prior learning that is capable of being mapped to the *Standards of proficiency for registered nurses* and programme outcomes, up to a maximum of 50 percent of the programme and comply with Article 31(3) of Directive 2005/36/EC

² <https://www.nmc.org.uk/standards/code/>

³ <https://www.nmc.org.uk/registration/joining-the-register/english-language-requirements>

⁴ Rule 6(1)(a)(i) of the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004 (SI 2004/1767)

- 1.6 for NMC registered nurses permit recognition of prior learning that is capable of being mapped to the *Standards of proficiency for registered nurses* and programme outcomes that may be more than 50 percent of the programme
- 1.7 support students throughout the programme in continuously developing their abilities in numeracy, literacy, digital and technological literacy to meet programme outcomes, and
- 1.8 ensure that all those enrolled on pre-registration nursing programmes are compliant with Directive 2005/36/EC regarding general education length as outlined in Annexe 1 of this document.

DRAFT

2 Curriculum

Approved education institutions together with practice learning partners must:

- 2.1 ensure that programmes comply with the *NMC Standards framework for nursing and midwifery education*
- 2.2 comply with the *NMC Standards for student supervision and assessment*
- 2.3 ensure that programme learning outcomes reflect the *Standards of proficiency for registered nurses* and each of the four fields of nursing practice: adult, mental health, learning disabilities and children's nursing
- 2.4 design and deliver a programme that supports students and provides exposure across all four fields of nursing practice: adult, mental health, learning disabilities and children's nursing
- 2.5 state routes within their pre-registration nursing education programme that allows students to enter the register in one or more of the specific fields of nursing practice: adult, mental health, learning disabilities or children's nursing
- 2.6 set out the general and professional content necessary to meet the *Standards of proficiency for registered nurses* and programme outcomes
- 2.7 set out the content necessary to meet the programme outcomes for each field of nursing practice: adult, mental health, learning disabilities and children's nursing
- 2.8 ensure that field specific content in relation to the law, safeguarding, consent, pharmacology and medicines administration and optimisation is included for entry to the register in one or more fields of nursing practice
- 2.9 ensure the curriculum provides an equal balance of theory and practice learning using a range of learning and teaching strategies
- 2.10 ensure that programmes delivered in Wales comply with legislation which supports use of the Welsh language
- 2.11 ensure pre-registration nursing programmes leading to registration in the adult field of practice are mapped to the content for nurses responsible for general care as set out in Annexe V.2 point 5.2.1 of Directive 2005/36/EC (included in Annexe 1 of this document), and
- 2.12 ensure that all pre-registration nursing programmes meet the equivalent of minimum programme length for nurses responsible for general care in Article 31(3) of Directive 2005/36/EC (included in Annexe 1 of this document)

3 Practice learning

Approved education institutions together with practice learning partners must:

- 3.1 provide practice learning opportunities that allow students to develop and meet the *Standards of proficiency for registered nurses* to deliver safe and effective care, to a diverse range of people, across the four fields of nursing practice: adult, mental health, learning disabilities and children's nursing
- 3.2 provide practice learning opportunities that allow students to meet the communication and relationship management skills and nursing procedures, as set out in *Standards of proficiency for registered nurses*, within their selected fields of nursing practice: adult, mental health, learning disabilities and children's nursing
- 3.3 ensure that students experience the variety of practice expected of registered nurses to meet the holistic needs of people of all ages
- 3.4 ensure technology enhanced and simulation-based learning opportunities are used effectively and proportionately to support learning and assessment and pre-registration nursing programmes leading to registration in the adult field of practice comply with Article 31(5) of Directive 2005/36/EC (included in Annexe 1 of this document)
- 3.5 take account of students' individual needs and personal circumstances when allocating their practice learning including making reasonable adjustments for students with disabilities
- 3.6 ensure students experience the range of hours expected of registered nurses, and
- 3.7 ensure that students are supernumerary

4 Supervision and assessment

Approved education institutions together with practice learning partners must:

- 4.1 ensure that support, supervision, learning and assessment provided complies with the NMC *Standards framework for nursing and midwifery education*
- 4.2 ensure that support, supervision, learning and assessment provided complies with the NMC *Standards for student supervision and assessment*
- 4.3 ensure they inform the NMC of the name of the registered nurse responsible for directing the education programme
- 4.4 provide students with feedback throughout the programme to support their development
- 4.5 ensure throughout the programme that students meet the *Standards of proficiency for registered nurses* and programme outcomes for their fields of nursing practice: adult, mental health, learning disabilities and children's nursing
- 4.6 ensure that students meet all communication and relationship management skills and nursing procedures within their fields of nursing practice: adult, mental health, learning disabilities and children's nursing
- 4.7 assess students to confirm proficiency in preparation for professional practice as a registered nurse
- 4.8 ensure that there is equal weighting in the assessment of theory and practice
- 4.9 ensure that all proficiencies are recorded in an ongoing record of achievement which must demonstrate the achievement of proficiencies and skills set out in *Standards of proficiency for registered nurses*, and
- 4.10 ensure the knowledge and skills for nurses responsible for general care set out in article 31(6) and the competencies for nurses responsible for general care set out in article 31(7) of Directive 2005/36/EC for pre-registration nursing programmes leading to registration in the adult field of practice have been met. (Annexe 1 of this document)

5 Qualification to be awarded

Approved education institutions together with practice learning partners must:

- 5.1 ensure that the minimum award for a pre-registration nursing programme is a bachelor's degree, and
- 5.2 notify students during and before completion of the programme that they have five years to register their award with the NMC. In the event of a student failing to register their qualification within five years they will have to undertake additional education and training or gain such experience as specified in our standards⁵.

DRAFT

⁵ <https://www.nmc.org.uk/globalassets/sitedocuments/registration/registering-more-than-five-years-after-qualifying.pdf>

Glossary

Reasonable adjustments: where a learner requires reasonable adjustment related to a disability or adjustment relating to any protected characteristics as set out in the equalities and human rights legislation.

Approved education institutions (AEIs): the status awarded by the NMC to an institution, or part of an institution, or combination of institutions that works in partnership with practice placement and work placed learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

Educators: in the context of the NMC *Standards for education and training* educators are those who deliver, support, supervise and assess theory, practice and /or work placed learning.

Equalities and human rights legislation: prohibits unlawful discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and other characteristics. Anti-discrimination laws can be country specific and there are some legally binding international protections

(Good) health and character requirements: as stipulated in NMC legislation (Articles 9(2)(b) and 5(2)(b) of the Nursing and Midwifery Order 2001) 'good health' means that the applicant is capable of safe and effective practice either with or without reasonable adjustments. It does not mean the absence of a health condition or disability. Each applicant seeking admission to the register or to renew registration, whether or not they have been registered before, is required to declare any pending charges, convictions, police cautions and determinations made by other regulatory bodies.

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

Practice learning partners: organisations that provide practice learning necessary for supporting pre-registration and post- registration students in meeting proficiencies and programme outcomes.

Quality assurance: NMC processes for making sure all AEIs and their approved education programmes comply with our standards.

Recognition of prior learning (RPL): a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes, this means it includes both theory and practice achievement.

Simulation: an artificial representation of a real world practice scenario that supports student development through experiential learning with the opportunity for repetition, feedback, evaluation and reflection. Effective simulation facilitates patient safety by enhancing knowledge, behaviours and skills.

Stakeholders: any person, group or organisation that has an interest or concern in the situation in question, and may affect or is affected by its actions, objectives or policies.

In the context of the NMC *Standards for education and training* this includes students, educators, partner organisations, service users, carers, employers, other professionals, other regulators and education commissioners.

Student: any individual enrolled onto an NMC approved education programme whether full time or less than full time.

Supernumerary: Students in practice or work placed learning must be supported to learn without being counted as part of the staffing required for safe and effective care in that setting. For apprentices, this includes practice placements within their place of employment; this does not apply when they are working in their substantive role. Placements should enable students to learn to provide safe and effective care, not merely to observe; students can and should add real value to care. The contribution students make will increase over time as they gain proficiency and they will continue to benefit from ongoing guidance and feedback. Once a student has demonstrated that they are proficient, they should be able to fulfil tasks without direct oversight. The level of supervision a student needs is based on the professional judgement of their supervisors, taking into account any associated risks and the students' knowledge, proficiency and confidence.

To be included on inside back page of published standards:

The role of the Nursing and Midwifery Council

What we do

We regulate nurses and midwives in the UK. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality care throughout their careers.

We make sure nurses and midwives keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate nurses and midwives who fall short of our standards. We maintain a register of nurses and midwives allowed to practise in the UK.

These standards were approved by Council at their meeting on xxxx

Annexe 1

DIRECTIVE 2005/36/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the recognition of professional qualifications (As Amended by Directive 2013/55/EU)

TITLE I GENERAL PROVISIONS

Section 3 Nurses responsible for general care

Article 31

Training of nurses responsible for general care

1 Admission to training for nurses responsible for general care shall be contingent upon either:

1.1 completion of general education of 12 years, as attested by a diploma, certificate or other evidence issued by the competent authorities or bodies in a Member State or a certificate attesting success in an examination of an equivalent level and giving access to universities or to higher education institutions of a level recognised as equivalent; or

1.2 completion of general education of at least 10 years, as attested by a diploma, certificate or other evidence issued by the competent authorities or bodies in a Member State or a certificate attesting success in an examination of an equivalent level and giving access to a vocational school or vocational training programme for nursing.

2 Training of nurses responsible for general care shall be given on a full-time basis and shall include at least the programme described in Annex V, point 5.2.1.

The Commission shall be empowered to adopt delegated acts in accordance with Article 57c concerning amendments to the list set out in point 5.2.1 of Annex V with a view to adapting it to scientific and technical progress.

The amendments referred to in the second subparagraph shall not entail an amendment of existing essential legislative principles in Member States regarding the structure of professions as regards training and conditions of access by natural persons. Such amendments shall respect the responsibility of the Member States for the organisation of education systems, as set out in Article 165(1) TFEU.

3 The training of nurses responsible for general care shall comprise a total of at least three years of study, which may in addition be expressed with the equivalent ECTS credits, and shall consist of at least 4 600 hours of theoretical and clinical training, the duration of the theoretical training representing at least one third and the duration of the clinical training at least one half of the minimum duration of the training. Member States may grant partial exemptions to professionals who have received part of their training on courses which are of at least an equivalent level.

The Member States shall ensure that institutions providing nursing training are responsible for the coordination of theoretical and clinical training throughout the entire study programme.

- 4 Theoretical education is that part of nurse training from which trainee nurses acquire the professional knowledge, skills and competences required under paragraphs 6 and 7. The training shall be given by teachers of nursing care and by other competent persons, at universities, higher education institutions of a level recognised as equivalent or at vocational schools or through vocational training programmes for nursing.
- 5 Clinical training is that part of nurse training in which trainee nurses learn, as part of a team and in direct contact with a healthy or sick individual and/or community, to organise, dispense and evaluate the required comprehensive nursing care, on the basis of the knowledge, skills and competences which they have acquired. The trainee nurse shall learn not only how to work in a team, but also how to lead a team and organise overall nursing care, including health education for individuals and small groups, within health institutes or in the community.

This training shall take place in hospitals and other health institutions and in the community, under the responsibility of nursing teachers, in cooperation with and assisted by other qualified nurses. Other qualified personnel may also take part in the teaching process.

Trainee nurses shall participate in the activities of the department in question insofar as those activities are appropriate to their training, enabling them to learn to assume the responsibilities involved in nursing care.

- 6 Training for nurses responsible for general care shall provide an assurance that the professional in question has acquired the following knowledge and skills:
 - 6.1 comprehensive knowledge of the sciences on which general nursing is based, including sufficient understanding of the structure, physiological functions and behaviour of healthy and sick persons, and of the relationship between the state of health and the physical and social environment of the human being;
 - 6.2 knowledge of the nature and ethics of the profession and of the general principles of health and nursing;
 - 6.3 adequate clinical experience; such experience, which should be selected for its training value, should be gained under the supervision of qualified nursing staff and in places where the number of qualified staff and equipment are appropriate for the nursing care of the patient;
 - 6.4 the ability to participate in the practical training of health personnel and experience of working with such personnel;
 - 6.5 experience of working together with members of other professions in the health sector.

- 7 Formal qualifications as a nurse responsible for general care shall provide evidence that the professional in question is able to apply at least the following competences regardless of whether the training took place at universities, higher education institutions of a level recognised as equivalent or at vocational schools or through vocational training programmes for nursing:
- 7.1 competence to independently diagnose the nursing care required using current theoretical and clinical knowledge and to plan, organise and implement nursing care when treating patients on the basis of the knowledge and skills acquired in accordance with points (a), (b) and (c) of paragraph 6 in order to improve professional practice;
 - 7.2 competence to work together effectively with other actors in the health sector, including participation in the practical training of health personnel on the basis of the knowledge and skills acquired in accordance with points (d) and (e) of paragraph 6;
 - 7.3 competence to empower individuals, families and groups towards healthy lifestyles and self-care on the basis of the knowledge and skills acquired in accordance with points (a) and (b) of paragraph 6;
 - 7.4 competence to independently initiate life-preserving immediate measures and to carry out measures in crises and disaster situations;
 - 7.5 competence to independently give advice to, instruct and support persons needing care and their attachment figures;
 - 7.6 competence to independently assure the quality of, and to evaluate, nursing care;
 - 7.7 competence to comprehensively communicate professionally and to cooperate with members of other professions in the health sector;
 - 7.8 competence to analyse the care quality to improve his own professional practice as a nurse responsible for general

V.2. NURSE RESPONSIBLE FOR GENERAL CARE

5.2.1. Training programme for nurses responsible for general care the training leading to the award of a formal qualification of nurses responsible for general care shall consist of the following two parts.

A. Theoretical instruction

a. Nursing:

- Nature and ethics of the profession
- General principles of health and nursing
- Nursing principles in relation to:
 - general and specialist medicine
 - general and specialist surgery
 - child care and paediatrics
 - maternity care
 - mental health and psychiatry
 - care of the old and geriatrics

b. Basic sciences:

- Anatomy and physiology
- Pathology
- Bacteriology, virology and parasitology
- Biophysics, biochemistry and radiology
- Dietetics
- Hygiene:
 - preventive medicine
 - health education
- Pharmacology

c. Social sciences:

- Sociology
- Psychology
- Principles of administration
- Principles of teaching
- Social and health legislation
- Legal aspects of nursing

B. Clinical instruction

- Nursing in relation to:
 - general and specialist medicine
 - general and specialist surgery
 - child care and paediatrics
 - maternity care
 - mental health and psychiatry
 - care of the old and geriatrics
 - home nursing

One or more of these subjects may be taught in the context of the other disciplines or in conjunction therewith.

The theoretical instruction must be weighted and coordinated with the clinical instruction in such a way that the knowledge and skills referred to in this Annex can be acquired in an adequate fashion.

DRAFT

Council

Standards for prescribing and medicines management

Action: For decision.

Issue: Asks Council to approve new standards of proficiency for nurse and midwife prescribers; approve new standards for programmes for nurse and midwife prescribing; and approve withdrawal of the current *Standards for medicines management*.

Core regulatory function: Education and standards.

Strategic priority: Strategic priority 1: Effective regulation.

Decision required: The Council is recommended to:

- approve adoption of the Royal Pharmaceutical Society's (RPS) *A Competency Framework for all Prescribers* (attached as annexe 1) as our standards of proficiency for the purpose of receiving a recordable qualification in nurse and midwife prescribing with effect from 28 January 2019 (paragraph 24);
- approve the draft standards for prescribing programmes (attached as annexe 2) as part of the standards for education and training that are necessary for the purpose of receiving a recordable qualification in nurse and midwife prescribing in accordance with Article 19 (6) of the Nursing and Midwifery Order 2001 ('the Order'), with effect from 28 January 2019 (paragraph 37) ;
- agree the transitional arrangements related to the above standards (paragraph 42); and
- agree to the withdrawal of the Standards of Medicines Management (paragraph 54).
- agree that we will support initiatives in the development of cross-professional guidance by the RPS and others (paragraph 55).

Annexes: The following annexes are attached to this paper:

- Annexe 1: Royal Pharmaceutical Society's *A Competency Framework for all Prescribers*.
- Annexe 2: Part 3: Programme standards - Standards for prescribing programmes.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Anne Trotter
Phone: 020 7681 5579
anne.trotter@nmc-uk.org

Director: Prof Geraldine Walters CBE
Phone: 020 7681 5924
geraldine.walters@nmc-uk.org

Context:**Nurse and midwife prescribing**

- 1 In March 2016, Council approved an ambitious five year strategic programme of change for education as part of the organisation's strategy for 2015-2020 that aims to review all of the NMC's standards for nursing and midwifery education and practice.
- 2 In 2017 the first of two consultations focused on our standards of proficiency for registered nurses and education and training standards. This paper addresses the second consultation that focused on the outcomes of our review of our existing *Standards of proficiency for nurse and midwife prescribers* (SPNMP, 2004) and current *Standards for medicines management* (SMM, 2007).
- 3 We are committed to modernising and optimising the opportunities for inter-professional education and training of future nurse and midwife prescribers to enable them to meet the needs of patients and the public now, and in the future. This is critical to our core purpose of public protection.
- 4 Nurses and midwives are increasingly being expected to take on more responsibility as they respond to the changing needs and expectations of patients and the public. As new models of care include more care being delivered in the community and in integrated health and social care settings, prescribing practice is expected to become a key requirement of future care delivery.
- 5 Therefore it is anticipated there will be increasing pressure placed on nurses and midwives to undertake prescribing programmes in order to gain the necessary qualifications to be able to prescribe from one of the formularies available to nurses, midwives and Specialist Community Public Health Nurses (SCPHNs).
- 6 We received a pleasing number of responses from organisations and individuals during the 13 week public consultation in 2017. The independent analysis of these responses has informed the refinements to the final draft standards we now present to Council.
- 7 This paper sets out in turn the high level feedback to this public consultation, the rationale for any amendments since these draft prescribing standards were consulted on in 2017 and our refined draft standard proposals.

Standards for medicines management (SMM)

- 8 We consulted on withdrawal of the SMM. Published in 2007, these standards are now our only wholly practice focused standards. We are the only professional regulator who sets such standards in this area. Managing medicines is covered in the Code as well as in both the current competencies for nurses and midwives and the draft new

proficiencies for registered nurses.

- 9 Managing medicines is a complex area in which to achieve the right balance to ensure public protection and patient safety. Prior to the public consultation many stakeholders agreed that it is not our role to set practice standards, and the governance of this area of clinical practice lies firmly with service delivery providers. Others indicated the current detailed standards can be a barrier to more contemporary medicines optimisation approaches.
 - 10 We recognise that some external stakeholders have never been in favour of withdrawing SMM, citing a preference for having all standards and guidance in this area of practice contained within a single NMC published document. We are also aware that a number of organisations and individuals continue to rely on these standards as a foundation for their own managing medicines policies and guidance.
 - 11 At an early stage of our work in this area we thoroughly reviewed whether withdrawing these standards would leave any professional regulatory gaps and identified alternative guidance available relating to managing medicines that is produced by other professional bodies that are better placed to produce fully up to date guidance in this area of practice.
 - 12 It has always been our position that if a decision was taken to remove these standards we would take opportunities to work with others to signpost to such existing guidance from our website, or where appropriate support the work of relevant key stakeholder partner organisations to develop new guidance, thus offering a more proportionate approach to patient safety and public protection.
- Four country factors:**
- 13 The prescribing and SMM consultation engagement activity included engagement events and liaison with stakeholder partners across the four countries including prescribing and medicines subject matter experts from across the four countries.
 - 14 As reported previously to Council we established consultation assimilation teams (CATs). A subject matter group was set up whose knowledge and experience of nursing and midwifery prescribing and medicines optimisation education supported us to finalise the standards. The group members offered diverse range of opinions and cover all four countries.
 - 15 The standards, if approved, will apply across all four countries.

Discussion: Adopting the Royal Pharmaceutical Society (RPS) A Competency Framework for all Prescribers

Rationale for initial proposals

- 16 As part of our commitment to be a dynamic regulator and in recognition of a multi-professional approach to prescribing proficiency, we are proposing that in future all NMC approved prescribing programmes deliver outcomes which meet the RPS *Competency Framework for all Prescribers*. This competency framework would therefore become our proficiencies for prescribing practice. They would also form the required outcomes for all NMC approved prescribing programmes going forward.

Feedback from consultation and engagement feedback

- 17 Views expressed via the consultation in this area were strongly supportive of our proposals. 82% of consultation responses supported adopting the RPS Competency Framework and 95% of those felt doing so would lead to shared approaches to prescribing competency across health and social care professions.
- 18 In addition, 91% of respondents felt that there were certain key areas of prescribing practice where further guidance would also be required, with cosmetic prescribing, private sector prescribing, remote prescribing, prescribing in pregnancy and prescribing for children being those areas of prescribing practice most often highlighted as requiring guidance.
- 19 These views were supported by external engagement during the 13 week consultation in 2017 and in our post consultation activity.

Proposal to adopt the RPS *Competency Framework for all Prescribers*

- 20 It is proposed that we adopt the RPS Competency Framework as our proficiency framework for prescribing practice. In future all NMC approved prescribing programmes will be expected to deliver these competencies as their course outcomes, and all nurse and midwife prescribers will use the framework as the benchmark for safe and effective prescribing practice.
- 21 It is also proposed that we continue to support the ongoing work of key stakeholder partners, in particular the RPS and organisations such as the Royal College of Nursing (RCN) and Royal College of Midwives (RCM), to support the development of cross-regulatory guidance in key areas of prescribing practice.
- 22 The RPS has regularly indicated its willingness to take a lead in developing guidance that takes account of people's different needs and specialty areas as they have the relevant expertise to develop high quality guidance in this field. Supporting this initiative provides

us with an opportunity to continue to collaborate in a proportionate way.

- 23 Adopting the RPS Competency Framework does not represent an amendment from our original draft proposal. Responses from our public consultation are also supportive. Prescribing practice is increasingly expanding into other professional groups and as the first professional regulator proposing to adopt a multi-professional competency framework we can play a leading role in being at the forefront of promoting cross regulatory and interagency working through seeking and supporting collaborations.

Recommendation

- 24 **Council is recommended to approve the adoption of the Royal Pharmaceutical Society's (RPS) *A Competency Framework for all Prescribers* (attached as annexe 1) as our standards of proficiency for the purpose of receiving a recordable qualification in nurse and midwife prescribing with effect from 28 January 2019.**

Nurse and midwife prescribing education and training

Rationale for initial proposals

- 25 Approved Education Institutions (AEIs) who deliver prescribing programmes indicate the current programme requirements for prescribing programmes are unduly focused on process that diminish opportunities for innovative programme delivery. Consequently as part of the suite of education and training standards we proposed new programme requirements that allow providers to be more creative in the design, and content of their curricula.
- 26 We consulted on standards of proficiency that seeks to include a greater level of prescribing theory related content in the pre-registration nursing degree programme. Consequently we consulted on the removal of requiring a period of time a nurse or midwife is registered before being able to apply to undertake a prescribing programme (known as V100 / V150) that enables them to prescribe from the British National Community Formulary.
- 27 For those nurses and midwives seeking to undertake a supplementary / independent prescriber programme (V300) we proposed the time period before being eligible to apply to undertake this programme should be reduced from three years to one.
- 28 As part of our ambition to promote inter-professional learning and working we also proposed widening the supervision and assessment of trainee prescribers to all suitably qualified and experienced prescribers. Supervision is currently only undertaken by a

designated medical practitioner. This proposal was in line with the General Pharmaceutical Council's (GPhC) future plans to widen the supervision of trainee prescribers on their register to pharmacist prescribers and other non-medical prescribers.

- 29 Feedback from consultation and engagement and feedback on our draft standards with regard to future prescribing programme requirements was generally positive, however the proposal to permit nurses and midwives to apply to undertake a prescribing programme at an earlier stage in their registered career was contentious.
- 30 Subject matter experts advised that time served entry requirements are process driven rather than outcome focused and does not always guarantee applicants have the right knowledge and experience to ensure readiness for a prescribing preparation programme.
- 31 Responses from educators and further deliberation from the CAT group indicated there was a preference for programme entry criteria requirements that ensures individual applicants can demonstrate achievement of experience in certain areas, for example, clinical assessment, diagnosis and care management. This would provide a stronger outcome indicator of student readiness necessary for learning to become a prescriber than stating a period of time on the register before being able to apply for a prescribing programme.

The new draft standards for nurse and midwife prescribing programmes

- 32 We have refined certain standards in response to consultation feedback however we also want to continue to reflect our ambition to focus on outcomes and interdisciplinary collaboration and these are summarised as follows:
- 33 We have made changes in relation to the entry requirements for prescribing programmes:
 - 33.1 As part of our commitment to developing outcome focused standards we are proposing to continue to avoid a reliance on 'time since initial registration' as an indication of readiness to enter a prescribing programme that permits nurses and midwives to prescribe from a limited formulary (V100 / V150). This provides continuity with our proposed inclusion of prescribing theory in the refined draft standards of proficiency for registered nurses.
 - 33.2 We do however recognise that there was a significant number of responses, including the RCN that did not agree with reducing the entry requirement for those nurses and midwives seeking to enter an independent / supplementary prescribing programme from three years to one year and indeed the RCN

suggested two years following initial registration.

- 33.3 We have not concurred with this position as we are proposing that the one year post registration experience requirement for independent / supplementary prescribing that we consulted on stands. We have however included an additional standard that now states that applicants will be required to evidence that they have the competence, experience and academic ability necessary to commence the programme and that they are proficient to a level appropriate to the prescribing programme they wish to undertake and their intended area of prescribing practice in areas such as clinical / health assessment, diagnostics / care management and the planning and evaluation of care.
- 34 We have emphasised the role of AEs in ensuring that arrangements for practice learning are suitably robust. Specific emphasis is placed on ensuring that these are in place for those students are self-employed, with a particular view to making sure that those who are undergoing practice learning are doing so in settings that are suitable and that effective governance is in place to ensure that the highest standards are met.
- 35 We have also refined our standard in relation to recording a prescribing qualification with the NMC to five years. This is in line with our legislation.
- 36 These refinements will reinforce our commitment to patient safety and public protection. They also ensure that entry requirements for prescribing programmes are increasingly outcome focused and based upon the achievement of the necessary experience and skills for prescribing practice. They also ensure the robustness of governance required for practice learning environments and for those who are self-employed who may not have access to the range of learning environments available to NHS employed registrants.

Recommendation

- 37 **It is recommended that Council approve the draft standards for prescribing programmes (attached as annexe 2) as part of the standards for education and training that are necessary for the purpose of receiving a recordable qualification in nurse and midwife prescribing in accordance with Article 19 (6) of the Nursing and Midwifery Order 2001 ('the Order'), with effect from 28 January 2019.**

Transitional arrangements

- 38 Article 3 (15) of the Order requires Council to publish standards that they establish. We will publish new standards documents on 17 May 2018 and share them with all our approved education

institutions.

- 39 All new approvals after 28 January 2019 will be made against the new standards of proficiency for nurse and midwife prescribers (the Royal Pharmaceutical Society's (RPS) *A Competency Framework for all Prescribers*) and the new standards for prescribing programmes.
- 40 All nursing and midwifery education providers must be approved against the new standards by September 2020. No students will be entitled to commence a programme approved against the *2006 Standards of proficiency for nurse and midwife prescribers* from September 2020.
- 41 All underpinning circulars related to existing standards in these areas will be withdrawn from the relevant transitional dates.

Recommendation

- 42 **The Council is recommended to approve the transitional arrangements related to the above standards.**

Proposal to withdraw our *Standards for medicines management*

Rationale for initial proposals

- 43 Our rationale for withdrawal was made clear throughout our consultation activity in 2017. These legacy standards are our only wholly practice focused standards. They are neither proportionate nor right touch and we are the only professional regulator who sets such standards. Managing medicines is now covered in the Code as well as in both the current 2010 pre-registration nursing standards, the draft new proficiencies for the future registered nurse and the current *Pre registration midwifery standards (2009)* that are currently under review.
- 44 We therefore consulted on the basis of withdrawing our *Standards for medicines management* and not replacing them with a document produced by the NMC. We did propose, however, to signpost to alternative sources of guidance via our website.
- 45 Responses to consultation questions in this area were mixed and in some respects counter-intuitive. There was strong agreement with the premise that policy decisions about medicines management should be made at a local level by service providers and that guidance in this aspect of clinical practice should apply equally to all health and social care professionals rather than just to nurses and midwives. Conversely, however, there were mixed views about whether the SMM should be withdrawn as proposed.
- 46 Feedback from consultation engagement activities was similarly mixed with some believing that these standards needed to be

replaced rather than withdrawn. This viewpoint was discussed in considerable detail as part of the post consultation review to consider views that standards were needed to be available to nurses and midwives who work in diverse care settings. However the underlying principles that we consulted on were noted throughout.

Updated position

- 47 We propose that the current SMM be withdrawn as the rationale for withdrawal remains. This outcome is not wholly in line with some of the views expressed in the consultation.
- 48 We recognise however that we need to make nurses and midwives aware of alternative sources of information relating to medicines management through our website and ongoing engagement activities.
- 49 We have therefore discussed with the relevant stakeholder groups that, pending Council approval, if the SMM are to be withdrawn we will work with others, including the RPS and other key stakeholder partner groups in developing additional cross-professional guidance on safe and effective medicines management.
- 50 This is an area in which the RPS already has extensive experience. It already produces guidance on safe and effective handling of medicines and medicinal products that is used by a range of healthcare professionals (not just pharmacists) and which is due for review and updating. The RPS has already in its consultation response expressed its strong wish to develop this guidance further so that it covers all areas of medicines management, including medicines administration and to make it readily applicable in all settings and to all professions (including nurses and midwives).
- 51 The RPS is currently holding a consultation on revisions to their Professional guidance¹ *Safe and Secure Handling of Medicines in all Care Settings*: an updated draft that is due to close on 20 April 2018. This is a multi-professional piece of work and they intend to seek endorsement through engagement with different professional groups. We are supportive of this initiative and intend to respond to their consultation and provide appropriate input to their multi-professional advisory group.
- 52 We believe that supporting initiatives that leads to the development of cross-professional guidance in this area will address concerns from respondents and reflects a proportionate approach to collaborating with others. Working in conjunction with the RPS and others such as the RCN and RCM will ensure that the guidance development is led by those who are experts in the field, whilst its

¹ <https://www.rpharms.com/making-a-difference/projects-and-campaigns/safe-and-secure-handling-of-medicines>

cross-professional nature will ensure that the views expressed in the consultation that additional guidance is the right way forward are shown to have been listened to.

- 53 Should Council agree to the recommendation to withdraw SMM, a date will be set for withdrawal and communicated in advance to all strategic stakeholders, this will be no later than 31 July 2018.

Recommendation

- 54 **It is recommended that the Council agree to the withdrawal of the SMM.**

- 55 **It is recommended that the Council agree that we will support initiatives in the development of cross-professional guidance by the RPS and others.**

Public protection implications:

- 56 Safe and effective medicines management is key to patient safety and public protection. Our role in ensuring that nurses and midwives knowledge and competence in this area is clearly stated in the Code and in our pre registration standards.
- 57 The development of guidance that can be applied to all health and care professions, that is appropriate to all settings to ensure consistency and high levels of safe and effective practice in medicines administration and prescribing, will optimise patient safety and public protection.

Resource implications:

- 58 Future resources necessary includes resource for design, and web based publications and further UK wide stakeholder engagement activity that will support the development and implementation of new programmes against the new standards. £74,500 has been forecast for these and the other standards implementation costs as part of the education programme budget.

Equality and diversity implications:

- 59 A full impact assessment has been carried out for these proposals. Further reviews of the refined draft standards and the proposal have been considered by legal and equality and diversity colleagues to ensure their compliance with our obligations in this area.

Stakeholder engagement:

- 60 This proposal has been subject to extensive stakeholder engagement including a formal consultation exercise. Engagement will continue following Council's decision as part of the launch and roll out of new standards and web based materials.

Risk implications:

- 61 There is a risk that the withdrawal of SMM will suggest to nurses and midwives that we no longer have a role in safe medicines

administration. This is not the case and we will continue to emphasise our role in setting standards of proficiency and in our Code in this area of practice.

Legal implications:

- 62 The legal basis for our education, standards setting and quality assurance functions are all set out in the Order, our education and registration rules and in requirements on the education of nurses and midwives set out in EU legislation.
- 63 Article 3 (14) of the Order requires the NMC to consult before establishing new standards. In the development of these standards extensive public consultation and engagement has taken place in line with our legislation and the public law principles.

NMC/18/25

28 March 2018



ROYAL PHARMACEUTICAL SOCIETY



A Competency Framework for all Prescribers

Publication date: July 2016

Review date: July 2020



NICE has accredited the process used by the Royal Pharmaceutical Society to produce its professional guidance and standards. Accreditation is valid for 5 years from 17 February 2017.

For full details on NICE accreditation visit: www.nice.org.uk/accreditation



CONTENTS

1.0	INTRODUCTION	2
2.0	HOW THE FRAMEWORK WAS UPDATED	3
3.0	PURPOSE AND USES OF THE FRAMEWORK	4
4.0	SCOPE OF THE FRAMEWORK	7
5.0	THE ROLE OF PROFESSIONALISM	8
6.0	THE PRESCRIBING COMPETENCY FRAMEWORK	9
7.0	PUTTING THE FRAMEWORK INTO PRACTICE	15
	GLOSSARY	16
	REFERENCES	17
	APPENDIX 1 HOW THE FRAMEWORK WAS UPDATED	18
	APPENDIX 2 ACKNOWLEDGEMENTS	20

I.0 INTRODUCTION

Medicines are used more than any other intervention by patients to manage their medical conditions. Both the number of medicines prescribed and the complexity of the medicines regimes that patients take are increasing. As the population ages and multiple co-morbidities become more prevalent, polypharmacy is increasingly becoming the norm for patients^{1,2}. This increase in complexity means that besides developing and maintaining prescribing competency for individual conditions, prescribers have the challenge of keeping up to date with new medicines as they come onto the market and being aware of the potential for interaction between medicines in patients with multiple co-morbidities³.

When prescribed and used effectively medicines have the potential to significantly improve the quality of lives and improve patient outcomes. However, the challenges associated with prescribing the right medicines and supporting patients to use them effectively should not be underestimated. There is a considerable amount of evidence nationally and internationally to demonstrate that much needs to be done to improve the way that we prescribe and support patients in effective medicines use^{4,5,6}.

Doctors are by far the largest group of prescribers who, along with dentists, are able to prescribe on registration. They have been joined over the last fifteen years by independent and supplementary prescribers from a range of other healthcare professions who are able to prescribe within their scope of practice once they have completed an approved education programme. This extension of prescribing responsibilities to other professional groups is likely to continue where it is safe to do so and there is clear patient benefit.

To support all prescribers to prescribe effectively a single prescribing competency framework was published by the National Prescribing Centre/National Institute for Health and Clinical Excellence (NICE) in 2012⁷. Based on earlier profession specific prescribing competency frameworks^{8,9,10,11} the framework was developed because it became clear that a common set of competencies should underpin prescribing regardless of professional background.

The 2012 framework is now in wide use across the UK (see 'Uses of the framework' – Section 3) and was due for review in 2014. NICE and Health Education England approached the Royal Pharmaceutical Society (RPS) to manage the update of the framework on behalf of all the prescribing professions in the UK. The RPS agreed to update the competency framework in collaboration with patients and the other prescribing professions many of whose professional bodies have endorsed this updated framework.

Going forward the RPS will continue to publish (and maintain) the updated competency framework in collaboration with the other prescribing professions. The framework will be published on the RPS website for all regulators, professional bodies, prescribing professions and patients to use.

2.0 HOW THE FRAMEWORK WAS UPDATED

A project steering group consisting of prescribers from across all the professions and patients (see Appendix 2 for membership) updated the framework using a process consistent with the development of previous competency frameworks. For full details of the process used to update the framework see Appendix 1.

The updating process included a six week consultation of the draft competency framework to which almost one hundred organisations and individuals responded.

To ensure the framework has applicability across the UK, a strategic level Project Board consisting of representatives of the Chief Pharmaceutical Officers England, Scotland, Wales and Northern Ireland as well as Health Education England, NHS Education for Scotland and NICE supported the update of the framework. See Appendix 2 for membership.

Multi professional input into the updating process and dissemination post publication was supported by regular engagement with an external reference group of over seventy organisations and individuals including professional regulators, professional bodies, patient groups and higher education institutes. See Appendix 2 for membership.

3.0 PURPOSE AND USES OF THE FRAMEWORK

A competency is a quality or characteristic of a person that is related to effective performance. Competencies can be described as a combination of knowledge, skills, motives and personal traits. Competencies help individuals and their organisations look at how they do their jobs. A competency framework is a collection of competencies thought to be central to effective performance. Development of competencies should therefore help individuals to continually improve their performance and to work more effectively.

If acquired and maintained, the prescribing competencies in this framework, will help healthcare professionals to be safe, effective prescribers who are able to support patients to get the best outcomes from their medicines.

The prescribing competency framework can be used by any prescriber at any point in their career to underpin professional responsibility for prescribing. It can also be used by regulators, education providers, professional organisations and specialist groups to inform standards, the development of education, and to inform guidance and advice. It provides the opportunity to bring professions together and harmonise education for prescribers by offering a competency framework for all prescribers.

The prescribing competency framework has a wide range of uses and the previous version has already been extensively used in practice. Uses of the framework are highlighted here along with some examples of practice. More examples of how the framework can and has been used can be found on the RPS website. The framework can be used to:

1. Inform the design and delivery of education programmes, for example through validation of educational sessions (including rationale for need), and as a framework to structure learning and assessment.

"I have used the prescribing competency framework in designing a seven week teaching programme for fifth year medical undergraduates, the effectiveness of which has been demonstrated by a pre- and post-teaching assessment that allows the students to demonstrate competency in many of the areas identified in the framework (calculations, identifying adverse drug reactions, considering contraindications to therapies, use of formularies)."

– Medical Education, NHS – Betsi Cadwaladr University Health Board

2. Help healthcare professionals prepare to prescribe and provide the basis for on-going continuing education and development programmes, and revalidation processes. For example, use as a framework for a portfolio to demonstrate competency in prescribing.

"Non-medical prescribing courses in the North West region are all structured around the prescribing competency framework so prescribers are familiar with its contents prior to qualification. I expect every non-medical prescriber in my organisation to be familiar with the framework and I direct new prescribers and those new to the organisation to it at our first meeting. Personally I intend to use the framework to evidence how I have stayed up to date as a prescriber as part of the Nursing and Midwifery Council revalidation process."

– Non-medical prescribing lead, East Lancashire Hospitals NHS Trust

3. Help prescribers identify strengths and areas for development through self-assessment, appraisal and as a way of structuring feedback from colleagues.

“At City Health Care Partnership the competency framework forms the basis of a passport for all non-medical prescribers. All prescribers receive a passport when they join the organisation or are newly qualified. Having the competencies in the passport allows prescribers to reflect on their prescribing and helps them to structure their CPD records as well as informing clinical supervision discussions. As an organisation we expect prescribers to ensure that the competencies are demonstrated in their prescribing practice.”

– City Health Care Partnership, Hull

4. Provide professional organisations or specialist groups with a basis for the development of levels of prescribing competency, for example, from recently qualified prescriber through to advanced prescriber.

“Within NHS Greater Glasgow and Clyde Addiction Services the competency framework forms part of our non-medical prescribing Operational Policy. The policy is a working document which follows on from our Service’s non-medical prescribing Strategy for the period 2015-2020. Within our policy there are three levels of prescribers based on qualification status, level of experience and clinical competence. The competency framework is used to support the progression of prescribers through prescribing levels and supports designated medical prescribers and line managers to assess competence and clinical expertise.

– NHS Greater Glasgow and Clyde Addiction Services

5. Stimulate discussions around prescribing competencies and multidisciplinary skill mix at an organisational level.

6. Inform organisational recruitment processes to help frame questions and benchmark candidates prescribing experience.

7. Inform the development of organisational systems and processes that support safe effective prescribing, for example, local clinical governance frameworks.

“The competency framework has been included within the organisation’s three yearly revalidation programme for nurse prescribers. Other allied health professional prescribers and pharmacist prescribers will also be asked to complete revalidation. Throughout the three years the framework will be used as part of individual prescriber’s appraisals and supervision.”

– Northumberland Tyne and Wear NHS Foundation Trust

8. Inform the development of education curricula and relevant accreditation of prescribing programmes for all prescribing professions.

“The framework has been used to underpin the outline curriculum frameworks for supplementary and independent prescribing to be used by radiographers (this also includes a framework for a conversion course for existing therapeutic radiographer supplementary prescribers to become independent prescribers).”

– The Society and College of Radiographers

4.0 SCOPE OF THE FRAMEWORK

The key points to note about the scope of the prescribing framework are that:

- It is a generic framework for any prescriber (independent or supplementary) regardless of their professional background. It therefore does not contain statements that relate only to specialist areas of prescribing.
- It must be contextualised to reflect different areas of practice and levels of expertise.
- It reflects the key competencies needed by all prescribers; it should not be viewed as a curriculum but rather the basis on which one can be built.
- It applies equally to independent prescribers and to supplementary prescribers but the latter should contextualise the framework to reflect the structures imposed by entering into a supplementary prescribing relationship (see Glossary).

“The General Pharmaceutical Council sets standards for the education and training of pharmacists to become prescribers. These standards require that the curriculum of a prescribing programme reflect relevant curriculum guidance, which includes the prescribing competency framework. Our prescribing standards work in conjunction with the competency framework and other standard for pharmacy professionals, to help ensure consistency and quality in programme design.”

–The General Pharmaceutical Council

5.0 THE ROLE OF PROFESSIONALISM

To sharpen the focus of the prescribing competency framework and maintain the focus on key prescribing competencies, a change to this update is the removal of several statements that relate to the application of professionalism. However it is important to recognise that healthcare professionals need to apply professionalism to all aspects of their practice in line with their own professional codes of conduct, standards and guidance.

Whilst the framework does contain a competency on prescribing professionally, there are elements of wider professional practice that will impact on how healthcare professionals behave when they prescribe.

These include the importance of maintaining a patient-centred approach when speaking to patients/carers, maintaining confidentiality, the need for continuing professional development and the importance of forming networks for support and learning.

To encourage prescribers to reflect on their wider professional practice and how it might apply to prescribing examples of these behaviours have been captured below under the heading Apply Professionalism. This is not an exhaustive list and prescribers are encouraged to use their own professional codes and guidance alongside the competency framework.

APPLY PROFESSIONALISM

Always introduces self and role to the patient and carer.

Adapts consultations to meet the needs of different patients/carers (e.g. for language, age, capacity, physical or sensory impairments).

Undertakes the consultation in an appropriate setting taking account of confidentiality, consent, dignity and respect.

Maintains patient confidentiality in line with best practice and regulatory standards and contractual requirements.

Takes responsibility for own learning and continuing professional development.

Learns and improves from reflecting on practice and makes use of networks for support, reflection and learning.

Recognises when safe systems are not in place to support prescribing and acts appropriately.

6.0 THE PRESCRIBING COMPETENCY FRAMEWORK

The competency framework (illustrated below) sets out what good prescribing looks like. There are ten competencies split into two domains. Within each

of the ten competency dimensions there are statements which describe the activity or outcomes prescribers should be able to demonstrate.



THE CONSULTATION

1. Assess the patient
2. Consider the options
3. Reach a shared decision
4. Prescribe
5. Provide information
6. Monitor and review

PRESCRIBING GOVERNANCE

7. Prescribe safely
8. Prescribe professionally
9. Improve prescribing practice
10. Prescribe as part of a team

Figure 1 The prescribing competency framework

THE CONSULTATION (COMPETENCIES 1-6)

1: ASSESS THE PATIENT

- 1.1** Takes an appropriate medical, social and medication history¹ including allergies and intolerances.
- 1.2** Undertakes an appropriate clinical assessment.
- 1.3** Accesses and interprets all available and relevant patient records to ensure knowledge of the patient's management to date.
- 1.4** Requests and interprets relevant investigations necessary to inform treatment options.
- 1.5** Makes, confirms or understands, the working or final diagnosis by systematically considering the various possibilities (differential diagnosis).
- 1.6** Understands the condition(s) being treated, their natural progression and how to assess their severity, deterioration and anticipated response to treatment.
- 1.7** Reviews adherence to and effectiveness of current medicines.
- 1.8** Refers to or seeks guidance from another member of the team, a specialist or a prescribing information source when necessary.

2: CONSIDER THE OPTIONS

- 2.1** Considers both non-pharmacological (including no treatment) and pharmacological approaches to modifying disease and promoting health.
- 2.2** Considers all pharmacological treatment options including optimising doses as well as stopping treatment (appropriate polypharmacy, de-prescribing).
- 2.3** Assesses the risks and benefits to the patient of taking or not taking a medicine or treatment.
- 2.4** Applies understanding of the mode of action and pharmacokinetics of medicines and how these may be altered (e.g. by genetics, age, renal impairment, pregnancy).
- 2.5** Assesses how co-morbidities, existing medication, allergies, contraindications and quality of life impact on management options.
- 2.6** Takes into account any relevant patient factors (e.g. ability to swallow, religion) and the potential impact on route of administration and formulation of medicines.
- 2.7** Identifies, accesses, and uses reliable and validated sources of information and critically evaluates other information.
- 2.8** Stays up-to-date in own area of practice and applies the principles of evidence-based practice, including clinical and cost-effectiveness.

¹ This includes current and previously prescribed and non-prescribed medicines, on-line medicines, supplements, complementary remedies, illicit drugs and vaccines.

2: CONSIDER THE OPTIONS (CONTINUED)

- 2.9** Takes into account the wider perspective including the public health issues related to medicines and their use and promoting health.
- 2.10** Understands antimicrobial resistance and the roles of infection prevention, control and antimicrobial stewardship measures.²

3: REACH A SHARED DECISION

- 3.1** Works with the patient/carer³ in partnership to make informed choices, agreeing a plan that respects patient preferences including their right to refuse or limit treatment.
- 3.2** Identifies and respects the patient in relation to diversity, values, beliefs and expectations about their health and treatment with medicines.
- 3.3** Explains the rationale behind and the potential risks and benefits of management options in a way the patient/carer understands.
- 3.4** Routinely assesses adherence in a non-judgemental way and understands the different reasons non-adherence can occur (intentional or non-intentional) and how best to support patients/carers.
- 3.5** Builds a relationship which encourages appropriate prescribing and not the expectation that a prescription will be supplied.
- 3.6** Explores the patient/carers understanding of a consultation and aims for a satisfactory outcome for the patient/carer and prescriber.

4: PRESCRIBE

- 4.1** Prescribes a medicine⁴ only with adequate, up-to-date awareness of its actions, indications, dose, contraindications, interactions, cautions, and unwanted effects.
- 4.2** Understands the potential for adverse effects and takes steps to avoid/minimise, recognise and manage them.
- 4.3** Prescribes within relevant frameworks for medicines use as appropriate (e.g. local formularies, care pathways, protocols and guidelines).
- 4.4** Prescribes generic medicines where practical and safe for the patient and knows when medicines should be prescribed by branded product.
- 4.5** Understands and applies relevant national frameworks for medicines use (e.g. NICE, SMC, AWMSG⁵ and medicines management/optimisation) to own prescribing practice.

² See also Expert Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) and Public Health England (PHE) prescribing competencies. <https://www.gov.uk/government/publications/antimicrobial-prescribing-and-stewardship-competencies>

³ The term carer is used throughout the prescribing competency framework as an umbrella term that covers care givers, parents and patient advocates or representatives.

⁴ For the purpose of the framework medicines can be taken to include all prescribable products.

⁵ NICE – National Institute for Health and Clinical Excellence; SMC – Scottish Medicines Consortium; AWMSG – All Wales Medicines Strategy Group

4: PRESCRIBE (CONTINUED)

- 4.6 Accurately completes and routinely checks calculations relevant to prescribing and practical dosing.
- 4.7 Considers the potential for misuse of medicines.
- 4.8 Uses up-to-date information about prescribed medicines (e.g. availability, pack sizes, storage conditions, excipients, costs).
- 4.9 Electronically generates or writes legible unambiguous and complete prescriptions which meet legal requirements.
- 4.10 Effectively uses the systems necessary to prescribe medicines (e.g. medicine charts, electronic prescribing, decision support).
- 4.11 Only prescribes medicines that are unlicensed, 'off-label', or outside standard practice if satisfied that an alternative licensed medicine would not meet the patient's clinical needs⁶.
- 4.12 Makes accurate legible and contemporaneous records and clinical notes of prescribing decisions.
- 4.13 Communicates information about medicines and what they are being used for when sharing or transferring prescribing responsibilities/ information.

5: PROVIDE INFORMATION

- 5.1 Checks the patient/carer's understanding of and commitment to the patient's management, monitoring and follow-up.
- 5.2 Gives the patient/carer clear, understandable and accessible information about their medicines (e.g. what it is for, how to use it, possible unwanted effects and how to report them, expected duration of treatment).
- 5.3 Guides patients/carers on how to identify reliable sources of information about their medicines and treatments.
- 5.4 Ensures that the patient/carer knows what to do if there are any concerns about the management of their condition, if the condition deteriorates or if there is no improvement in a specific time frame.
- 5.5 When possible, encourages and supports patients/carers to take responsibility for their medicines and self-manage their conditions.

⁶ At the time of publication only doctors, dentists, nurses and pharmacists are able to independently prescribe unlicensed medicines

6: MONITOR AND REVIEW

- 6.1** Establishes and maintains a plan for reviewing the patient's treatment.
- 6.2** Ensures that the effectiveness of treatment and potential unwanted effects are monitored.
- 6.3** Detects and reports suspected adverse drug reactions using appropriate reporting systems.
- 6.4** Adapts the management plan in response to on-going monitoring and review of the patient's condition and preferences.

PRESCRIBING GOVERNANCE (COMPETENCIES 7-10)

7: PRESCRIBE SAFELY

- 7.1** Prescribes within own scope of practice and recognises the limits of own knowledge and skill.
- 7.2** Knows about common types and causes of medication errors and how to prevent, avoid and detect them.
- 7.3** Identifies the potential risks associated with prescribing via remote media (telephone, email or through a third party) and takes steps to minimise them.
- 7.4** Minimises risks to patients by using or developing processes that support safe prescribing particularly in areas of high risk (e.g. transfer of information about medicines, prescribing of repeat medicines).
- 7.5** Keeps up to date with emerging safety concerns related to prescribing.
- 7.6** Reports prescribing errors, near misses and critical incidents, and reviews practice to prevent recurrence.

8: PRESCRIBE PROFESSIONALLY

- 8.1** Ensures confidence and competence to prescribe are maintained.
- 8.2** Accepts personal responsibility for prescribing and understands the legal and ethical implications.
- 8.3** Knows and works within legal and regulatory frameworks affecting prescribing practice (e.g. controlled drugs, prescribing of unlicensed/off label medicines, regulators guidance, supplementary prescribing).
- 8.4** Makes prescribing decisions based on the needs of patients and not the prescriber's personal considerations.
- 8.5** Recognises and deals with factors that might unduly influence prescribing (e.g. pharmaceutical industry, media, patient, colleagues).
- 8.6** Works within the NHS/organisational/regulatory and other codes of conduct when interacting with the pharmaceutical industry.

9: IMPROVE PRESCRIBING PRACTICE

- 9.1 Reflects on own and others prescribing practice, and acts upon feedback and discussion.
- 9.2 Acts upon colleagues' inappropriate or unsafe prescribing practice using appropriate mechanisms.
- 9.3 Understands and uses available tools to improve prescribing (e.g. patient and peer review feedback, prescribing data analysis and audit).

10: PRESCRIBE AS PART OF A TEAM

- 10.1 Acts as part of a multidisciplinary team to ensure that continuity of care across care settings is developed and not compromised.
- 10.2 Establishes relationships with other professionals based on understanding, trust and respect for each other's roles in relation to prescribing.
- 10.3 Negotiates the appropriate level of support and supervision for role as a prescriber.
- 10.4 Provides support and advice to other prescribers or those involved in administration of medicines where appropriate.

7.0 PUTTING THE FRAMEWORK INTO PRACTICE

A range of resources can be found on the RPS website to help stimulate use of the competency framework in practice these include:

- FAQs
- a downloadable word template version of the framework
- PowerPoint presentation
- practice examples from organisations and individuals who have been using the competency framework.

To further stimulate use of the framework prescribers or organisations using it are encouraged to contact the Royal Pharmaceutical Society (RPS) at support@rpharms.com to share their examples of the framework's application in practice. These examples will be shared through the RPS website and will help inform future updates of the framework.

“The Northern Ireland Centre for Pharmacy Learning and Development (NICPLD) has embedded the competency framework into a practice portfolio which forms part of our accredited independent pharmacist prescribing programme. All pharmacists use the practice portfolio to document their developing competency over the course of the programme with the expectation that pharmacists document their competency against most statements in the competency framework before qualifying as a prescriber. The practice portfolio is submitted to NICPLD for assessment and must be passed independently of all other elements of the course to qualify as a prescriber.”

–The Northern Ireland Centre for Pharmacy Learning and Development

GLOSSARY

Polypharmacy	Polypharmacy means “many medications” and has often been defined to be present when a patient takes five or more medications. Polypharmacy is not necessarily a bad thing, it can be both rational and required however it is important to distinguish appropriate from inappropriate polypharmacy.
Inappropriate polypharmacy	When one or more drugs are prescribed that are not or no longer needed, either because: (a) there is no evidence based indication, the indication has expired or the dose is unnecessarily high; (b) one or more medicines fail to achieve the therapeutic objectives they are intended to achieve; (c) one, or the combination of several drugs cause unacceptable adverse drug reactions (ADRs), or put the patient at an unacceptably high risk of such ADRs, or because (d) the patient is not willing or able to take one or more medicines as intended.
Appropriate polypharmacy	When: (a) all drugs are prescribed for the purpose of achieving specific therapeutic objectives that have been agreed with the patient; (b) therapeutic objectives are actually being achieved or there is a reasonable chance they will be achieved in the future; (c) drug therapy has been optimised to minimise the risk of ADRs and (d) the patient is motivated and able to take all medicines as intended.
Deprescribing	The process of stopping or reducing medicines with the aim of eliminating problematic (inappropriate) polypharmacy, and then monitoring the individual for unintended adverse effects or worsening of disease. It is essential to involve the individual (and their carer) closely in deprescribing decisions in order to build and maintain their confidence in the process.
Non-medical prescribing	Non-medical prescribing is prescribing by specially trained nurses, optometrists, pharmacists, physiotherapists, podiatrists, radiographers and dietitians working within their clinical competence as either independent and/or supplementary prescribers.
Independent prescribing	Independent prescribing is prescribing by a practitioner, who is responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. In practice, there are TWO distinct forms of non-medical independent prescriber: i) At time of publication an independent prescriber may be a specially trained nurse, pharmacist, optometrist, physiotherapist, therapeutic radiographer or podiatrist who can prescribe licensed medicines within their clinical competence. Nurse and pharmacist independent prescribers can also prescribe unlicensed medicines and controlled drugs. ii) A community practitioner nurse prescriber (CPNP), for example district nurse, health visitor or school nurse, can independently prescribe from a limited formulary called the Nurse Prescribers’ Formulary for Community Practitioners, which can be found in the British National Formulary (BNF).
Supplementary prescribing	Supplementary prescribing is a voluntary partnership between a doctor or dentist and a supplementary prescriber to prescribe within an agreed patient-specific clinical management plan (CMP) with the patient’s agreement. Nurses, optometrists, pharmacists, physiotherapists, podiatrists, radiographers and dietitians may become supplementary prescribers and once qualified may prescribe any medicine within their clinical competence, according to the CMP.

REFERENCES

1. Duerden M, Avery T, Payne R. *Polypharmacy and Medicines Optimisation. Making it safe and Sound*. Kings Fund 2013. <http://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation>
2. NHS Scotland. *Polypharmacy Guidance*. March 2015. http://www.sign.ac.uk/pdf/polypharmacy_guidance.pdf and available as an App from <http://www.knowledge.scot.nhs.uk/home/tools-and-apps/mobile-knowledge/search.aspx?device=None&q=polypharmacy&p=1&rpp=20> or by searching the iTunes and Google Play app stores. The Web Version of the app is available at <http://www.polypharmacy.scot.nhs.uk/>
3. National Institute for Health and Clinical Excellence. *Multimorbidity: clinical assessment and management*. Expected publication September 2016. <https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0704>
4. Royal Pharmaceutical Society. *Medicines optimisation: helping patients to make the most of medicines*. May 2014 <https://www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf>
5. National Institute for Health and Clinical Excellence. *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes*. March 2015. <https://www.nice.org.uk/guidance/ng5>
6. Department of Health, Social Services and Public Safety. *Northern Ireland Medicines Optimisation Quality Framework*. March 2016 <https://www.health-ni.gov.uk/sites/default/files/consultations/dhssps/medicines-optimisation-quality-framework.pdf>
7. National Prescribing Centre. *A single competency framework for all prescribers*. May 2012
8. National Prescribing Centre. *Maintaining Competency in Prescribing. An outline framework to help nurse prescribers. First Edition*. November 2001.
9. National Prescribing Centre. *Maintaining Competency in Prescribing. An outline framework to help nurse supplementary prescribers*. March 2003.
10. National Prescribing Centre. *Maintaining Competency in Prescribing. An outline framework to help pharmacist supplementary prescribers. First Edition*. March 2003.
11. National Prescribing Centre and General Optical Council. *Competency framework for prescribing optometrists. First Edition*. May 2004.
12. National Prescribing Centre. *Maintaining Competency in Prescribing. An Outline Framework to help Allied Health Professional Supplementary Prescribers. First Edition*. July 2004.
13. National Prescribing Centre. *Maintaining Competency in Prescribing. An outline framework to help pharmacist prescribers. Second Edition*. October 2006.
14. Whiddett S, Hollyforde, S. *The Competencies Handbook*. Institute of Personnel and Development, 1999.

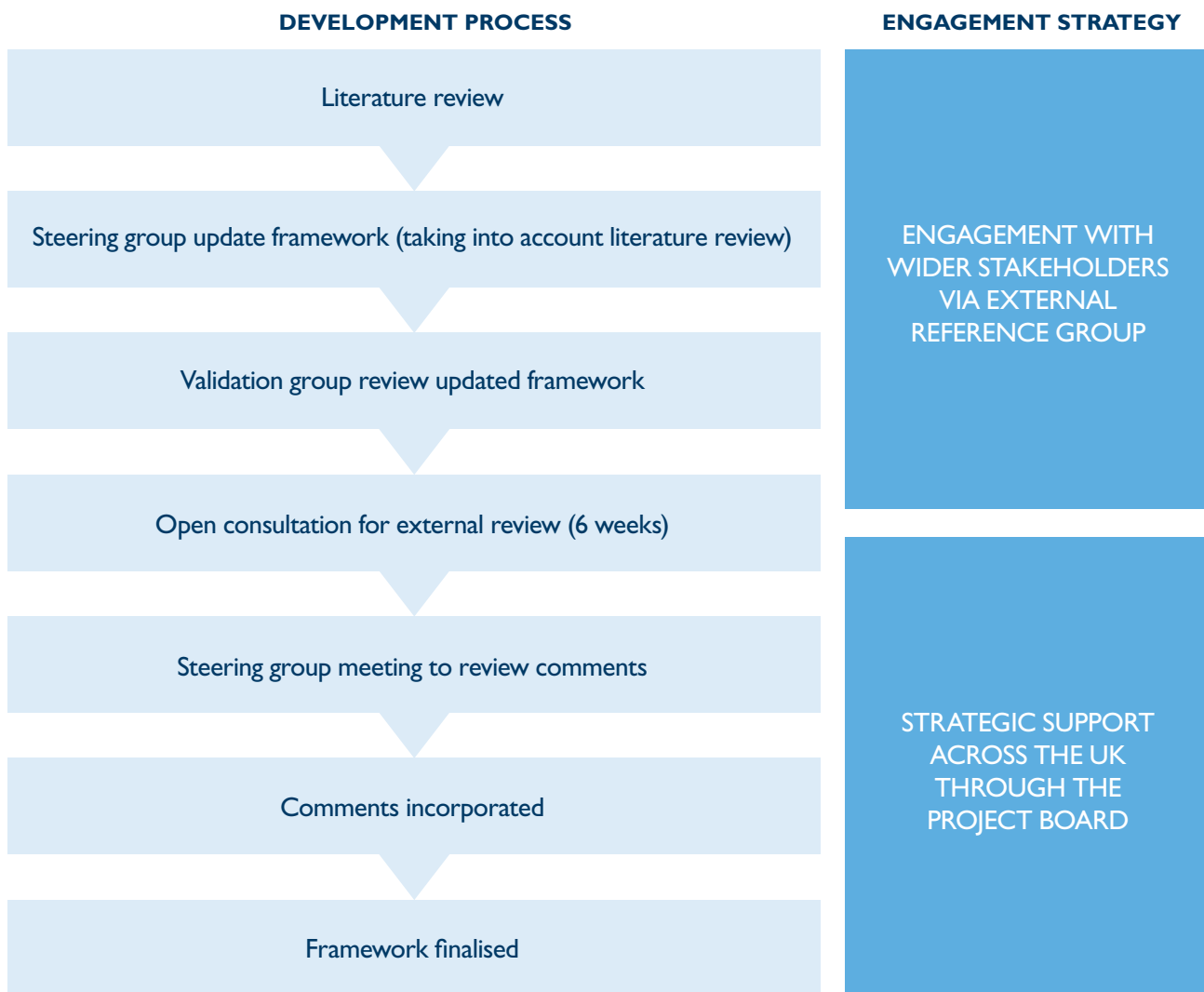
APPENDIX I

HOW THE FRAMEWORK WAS UPDATED

The process used to update the framework is illustrated below. It is consistent with the methodology used to develop and refine the previous prescribing competency frameworks published by the National Prescribing Centre and NICE.

The update of the framework was a review of an existing resource widely used in practice. The project steering group concluded, based on a literature view

and extensive use of the framework in practice, that the 2012 framework was broadly fit for purpose. The process used to update the framework is proportionate to that view and reflects an iterative development of the content.



ENGAGEMENT STRATEGY

The prescribing competency framework will be used by a range of healthcare professions. An external reference group comprising regulators, professional organisations and other relevant and interested stakeholder groups was constituted. Webinars were held with the group three times over the duration of the project to keep members of the group informed about progress and to stimulate discussion about how the framework might be disseminated and used once published. See Appendix 2 for membership.

The update of the prescribing competency framework was 'project sponsored' at a strategic level by a Project Board to help ensure UK wide applicability. Membership consisted of representatives of the Chief Pharmaceutical Officers England, Scotland, Wales and Northern Ireland as well as Health Education England, NHS Education for Scotland, The Welsh Assembly and NICE. See Appendix 2 for membership.

DEVELOPMENT PROCESS

An external lead author was commissioned by the RPS to ensure that the process for updating of the competency framework was independent.

A literature review was undertaken in October 2015 to identify key evidence relating to competency and good practice in prescribing since the publication of the 2012 single competency framework.

A steering group with prescribers from all the professions able to prescribe and patient representatives used a consensus process to review and update the competency framework in the context of the literature review. The multidisciplinary nature of the group ensured the generic nature of the framework was maintained – see Appendix 2 for membership. The group was chaired by the independent lead author and all members were asked to declare conflicts of interest * which were managed in line with [RPS Professional standards, guidance and frameworks process development manual](#).

A separate group of existing prescribers (again reflecting all groups able to prescribe) and patients **validated the updated framework** in a focus group setting to ensure that the changes made by the steering group were in line with current prescribing practice and were understandable to prescribers. Refinements made to the

framework were agreed using a consensus process and members of the validation group were asked to declare conflicts of interest*. See appendix 2 for membership.

As a result of the steering group review and validation group scrutiny refinements were made to the framework that included:

- ▶ Removal of statements that relate more generally to professional practice (see section 4).
- ▶ Reordering of the framework into ten competencies that have been grouped into two competency areas.
- ▶ Addition of new statements or modification of existing statements to include omissions identified through the literature review.
- ▶ Deletion of statements felt to be less relevant to prescribing or where duplication became apparent as the structure of the framework was updated.
- ▶ Editing of statements for clarity or consistency of terminology.
- ▶ Splitting of statements for clarity or to fit with the reordered structure of the framework.
- ▶ Improving the wording of statements.

The competency document was posted on the RPS website for six weeks for open **consultation**.

The external reference group, project board and steering group were all asked to draw attention to the availability of the framework for comment. Ninety five responses to the consultation were received.

Comments from the consultation were reviewed by the steering group and those that were in scope and relevant were incorporated into the prescribing framework. The project steering group used a consensus process to agree all final refinements to the framework. Consensus was achieved.

STATEMENT OF FUNDING

The update to this framework has been wholly funded by the RPS who have not received any payment from a third party for its development. Further information on "How the RPS is funded" can be viewed in [Professional standards, guidance and frameworks process development manual](#).

*Declarations are available upon request by e-mailing support@rpharms.com.

APPENDIX 2 ACKNOWLEDGEMENTS

STEERING GROUP MEMBERS

Professor Angela Alexander	Director of the Centre for Inter-Professional Postgraduate Education and Training, University of Reading
Dave Baker	Extended Scope Physiotherapist – Locomotor Service, Homerton University Hospital NHS Foundation Trust and Complete Physio Limited
Dr Jane Brown	Pharmacy Local Professional Network Chair (formerly Director at the National Prescribing Centre), Greater Manchester
Hazel Boyce	Advanced Therapy Radiographer and Non-Medical Prescriber, University Hospitals Bristol NHS Foundation Trust
Richard Harris	Professional Development Pharmacist, H.I.Weldrick Ltd
Angie Hill	Director of Nursing and Professions – Primary Care, Care Uk
Karen Hodson	Programme Director of the Pharmacist Independent Prescribing Programme, Cardiff University
Fran Husson	Lay representative
Parbir Jagpal	Programme Director, Independent Prescribing; and Practice Pharmacist and Independent Prescriber, University of Birmingham and Dudley Clinical Commissioning Group
Fiona Jones	Advanced Clinical Pharmacist Prescriber in Primary Care, Betsi Cadwaladr University Health Board and Member of Welsh Pharmacy Board
Teresa Kearney	Nurse Prescriber, Association of Nurse Prescribers
Dr Claire Loughrey	Director of Postgraduate General Practice Education, Northern Ireland Medical and Dental Training Agency
Professor Simon Maxwell	Medical Director, Prescribing, Prescribing Safety Assessment, University of Edinburgh
Dr James McKinlay	General Practitioner
Dr Nikolaus Palmer	Dental Surgeon, British Dental Association
Catherine Picton (chair)	Lead author and consultant to RPS
Professor Jane Portlock	Professor of Pharmacy Practice, Head of Pharmacy Practice Division, University of Portsmouth

Debbie Sharman	Consultant Podiatrist – Diabetes Professional lead for Podiatry and Visiting Lecturer (University of Southampton), Dorset HealthCare University Foundation Trust
Mark Tomlin	Consultant Pharmacist: Critical care, Consultant Pharmacist and Independent Prescriber, University Hospital Southampton NHS Foundation Trust
Dr Andy Webb	Senior Lecturer/Honorary Consultant, Kings College London (Guy's & St Thomas' NHS Foundation Trust/ King's Health Partners)
Alison Weston	Principal Optometrist, St James's University Hospital, Leeds
Nigel Westwood	Lay representative
Professor David Wray	Emeritus Professor, Dental School, Glasgow University

PROJECT BOARD MEMBERS

Margaret Allen <i>(representing Roger Walker, Chief Pharmaceutical Officer for Wales)</i>	Director, Wales Centre for Pharmacy Professional Education
Michele Cossey <i>(representing Keith Ridge, Chief Pharmaceutical Officer for England)</i>	Head of Clinical Strategy / Regional Pharmaceutical Advisor NHS England (North), NHS England (North)
Cathy Harrison <i>(representing Mark Timoney, Chief Pharmaceutical Officer for Northern Ireland)</i>	Senior Principal Pharmaceutical Officer, Department of Health, Northern Ireland
Alpana Mair <i>(representing Rosemarie Parr, Chief Pharmaceutical Officer for Scotland)</i>	Deputy Chief Pharmaceutical Officer Scotland, Scottish Government
Patricia Saunders	Senior Education and Training Policy Manager, Health Education England
Jonathan Underhill	Associate Director, Medicines and Prescribing Centre, National Institute for Health and Care Excellence
Anne Watson	Associate Director of Pharmacy, NHS Education for Scotland

VALIDATION GROUP MEMBERS

Patricia Armstrong	Pharmacist Assistant Professional Support Manager, Boots
Sue Axe	Course leader for Independent and Supplementary Nurse Prescribing, Buckinghamshire New University
Dr Gill Beck	General Practitioner
Dr Mohsin Choudry	National Medical Director's Clinical Fellow, Royal College of Physicians, London
Professor Robin E Ferner	Secretary of the Joint Specialist Committee of the Royal College of Physicians and the British Pharmacological Society
Penny Fletcher	Senior lead pharmacist, Women and Children, Imperial College Healthcare NHS Trust
Sue Gassor	Nurse Practitioner/ Practice Nurse Advisor, working for Pencester Health Surgery Dover/South East CSU.
Nick Haddington	Director of Taught Postgraduate Programmes, Department of Pharmacy and Pharmacology, University of Bath
Peter Hawkes	Lay representative
Dr Rebecca Hoskins	Consultant Nurse & Senior Lecturer Emergency Care, Non Medical Prescribing Trust Lead, University Hospitals Bristol NHS Foundation Trust
Dr Catrin Jones	FY2 Doctor South East Scotland Deanery
Jancis Kinsman	Lung specialist radiographer, Bristol Cancer Institute
Dr Kerry Layne	Clinical PhD Student, King's College London
Professor Gunter Loffler	Programme Lead BSc Optometry, Programme Lead Post-graduate Ocular Therapeutics Programme, Glasgow Caledonian University
Nicky Mackenzie	Independent Prescribing Physiotherapist, Musculoskeletal Therapy Team Leader
Nick Masucci	Consultant Podiatrist, Ashford & St Peter's NHS Trust
Nicholas J. Rumney	MScOptom FCOptom DipTP(IP) ProfCertMedRet FAAO FEAOO FIACLE FBCLA, Federation of Ophthalmic and Dispensing Opticians (FODO)
Dr Robert Rutland	General and Cosmetic Dentist and Doctor. Examiner, Royal College of Physicians & Surgeons. Medical Appraiser.
Andy Sharman	Specialist Paramedic – Urgent and Emergency Care

Dr Jude Tweedie	Clinical Fellow, Royal College of Physicians
Professor Cate Whittlesea	School of Medicine, Pharmacy and Health, Durham University

EXTERNAL REFERENCE GROUP MEMBERS

Catherine Armstrong	Lead Pharmacist, Pharmicus, CBC
Dr Diane Ashiru-Oredope	Antimicrobial Resistance Programme; Public Health England
Sue Axe	Course leader for Independent and Supplementary Nurse Prescribing, Buckinghamshire New University
Inge Bateman	Lead Clinical Nurse Specialist In-patient Pain Service, Western Sussex Hospitals NHS Foundation Trust
Dianne Bell	Senior Learning Development Pharmacist, Centre for Pharmacy Postgraduate Education
Kate Bennett	Tissue Viability Specialist Nurse
Jayne Bridge	NMP lead for MerseyCare NHS
Christine Buicke	Policy Manager, General Medical Council
Stephanie Butler	Lead Specialist Renal Pharmacist and Independent Prescriber
Dr Wendy Caddy	Senior Clinical Nurse Specialist Inpatient Pain Management BSUH NHS Trust
Ian Cameron	Managing Director, Cameron Optometry Ltd
Nicole Casey	Policy Manager, Health and Care Professions Council
Lisa Chaters	Advanced Neonatal Nurse Practitioner
Tanya Downes	Cheshire and Wirral partnership, Advanced Paediatric Nurse Practitioner / Nurse Clinician GP out of hours
Marcus Dye	Standards Manager, General Optical Council
Gerald Ellis	Associate Director Pharmacy Transformation, Newark and Sherwood CCG

Professor Robin Ferner	Secretary of the Joint Specialist Committee of the Royal College of Physicians and the British Pharmacological Society
Matthew Fitzpatrick	Managing Director A&E and Acute Medicine
Helen Flint	For British Oncology Pharmacy Association
Christina Freeman	Professional Officer: policy, guidance and advice, Society and College of Radiographers
Sue Gassor	Nurse Practitioner/ Practice Nurse Advisor working for Poucester Health Surgery Dover/South East CSU.
Mohit Gupta	Consultant ophthalmologist, Royal College of Ophthalmologists.
Nicholas Haddington	Director of Taught Postgraduate Programmes, Department of Pharmacy and Pharmacology, University of Bath
Sophie Harper	Principal Optometrist Cataract Services, Manchester Royal Eye Hospital
Clare Worrall Hill	Professional Engagement Manager, Parkinson's UK
Dianne Hogg	Non-medical Prescribing Lead, Queen's Nurse, East Lancashire Hospitals NHS Trust
Sue Hudson	Clinical specialist podiatrist, working for East Lancashire Hospital Trust
Jen Hulme	Senior Clinical Pharmacist-Antibiotics and NMP Co-Lead, Mid Cheshire Hospitals NHS Foundation Trust
Dr Mani Hussain	Chair Shropshire & Staffordshire Pharmacy LPN NHS England
Dr Farah Jameel	GP, British Medical Association
Sally Jarman	Non-Medical Prescribing Lead, Northern Devon Healthcare Trust
Lindsay Johnston	NMP & Advanced Nurse Practitioner (in training) at Salford Royal Hospitals NHS Foundation Trust – Emergency Department
Anja St Clair Jones	Lead Pharmacist Digestive Diseases Centre BSUH NHS Trust
Jan Keenan	Consultant Nurse and Non-Medical Prescribing Lead' Oxford University Hospitals NHS Foundation Trust
Menaz Kermali	Specialist Pharmacist CMHT, Berkshire Healthcare Foundation Trust
Jacqui Kinsey	Director of Prescribing Education, Centre for Professional Development and Lifelong Learning, school of Pharmacy, Keele University

Professor John Lawrenson	College of Optometrists, Professor of Clinical Visual Science, City University London
Dr Fran Lloyd	NI Centre for Pharmacy Learning and Development
Prof Gunter Loffler	Professor; Programme Lead – BSc Optometry; Programme Lead – Post-graduate Ocular Therapeutics Programme, Glasgow Caledonian University
Sue Lyne	Advanced Community Nurse Practitioner, East Sussex Healthcare NHS Trust (ESHT)
Nicky Mackenzie	Musculoskeletal Therapy Team Leader, Sandwell and Birmingham NHS trusts
Helen Marriott	AHP Medicines Project Lead, NHS England
Joanne Martin	Quality Assurance Manager, General Pharmaceutical Council
Dr Arianne Matlin	Health and Science Policy Advisor, British Dental Association
Claire May	Senior Lecturer in Pharmacy Practice, School of Pharmacy and Biomolecular Sciences, University of Brighton
Nick Masucci	Consultant Podiatrist (podiatric surgeon), Barts and the London
Michelle McCorry	Pharmaceutical Society of Northern Ireland
Maire McManus	Principal Pharmacist, Medicines Division – Antrim Area Hospital.
Eleri Mills	Queens Nurse, Senior Lecturer / Programme Leader – Non Medical Prescribing. School of Social and Life Sciences, Wrexham Glyndwr University, Wales.
Kuljit Nandhara	Lead Pharmacist at Birmingham and Solihull Mental Health Trust
Ruth Newton	For British Pharmaceutical Nutrition Group
JP Nolan	Royal College of Nursing
Laura O’Loan	Assistant Director for Distance Learning and Course Director Pharmacist Prescribing course, NI Centre for Pharmacy Learning and Development
Emma Pilkington	Cystic Fibrosis Physiotherapist
Celia Proudfoot	TB nurse specialist
Najja Qureshi	Head of Education and Professional Development, The British Dietetic Association

Bernadette Rae	Senior Lecturer Non-Medical Prescribing, School of Health & Social Care, London South Bank University
Martin C Richardson	HMP Garth Healthcare, Lancashire Care NHS Foundation Trust
Nicholas Rumney	MScOptom FCOptom DipTP(IP) ProfCertMedRet FAAO FEAOO FIACLE FBCLA. Federation of Ophthalmic and Dispensing Opticians (FODO)
Sharon Shaw	ELMS Clinical Lead Nurse, Safeguarding Lead, NMP lead
Suzie Shepherd	Lay patient representative. RCP PCN, BSR VICE CHAIR
Sam Sherrington	Association of Nurse Prescribing
Andrew Simpson	ANNP, Neonatal Intensive Care Unit, Royal Oldham Hospital
Doug Stirling	Programme Manager, Scottish Dental Clinical Effectiveness Programme, Dundee Dental Education Centre
Anne Trotter	Assistant Director: Education and Standards Education, Standards and Policy Directorate, Nursing and Midwifery Council
Kevin Wallace	The Association of Optometrists
Helen Ward	Associate Professor Non-Medical Prescribing, London South Bank University
Professor Cate Whittlesea	Professor of Pharmacy Practice, School of Medicine, Pharmacy and Health, Durham University
Lesley Woods	Nurse practitioner, urgent care, Burnley General
Sally Young	UHMB Quality Assurance Matron, Senior Clinical Leader/Nurse Practitioner, NMP Lead, University Hospitals Morecambe Bay NHS Trust

RPS TEAM MEMBERS

Dr Catherine Duggan	Director of Professional Development and Support
Ruth Wakeman	Assistant Director of Professional Development and Support

LITERATURE REVIEW

Miriam Gichuhi Pharmacist Consultant

Barry Jubraj Clinical Senior Lecturer in Medicines Optimisation, King's College London

CONSULTATION RESPONDENTS

RPS would like to thank all the individuals and organisations who sent in comments on the draft framework. In all 95 individuals and organisations responded to the consultation.

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain.

Copyright © The Royal Pharmaceutical Society 2016.
All rights reserved. This publication may not be redistributed or reproduced in whole or in part without the permission of the copyright holder.

Part 3: Programme standards

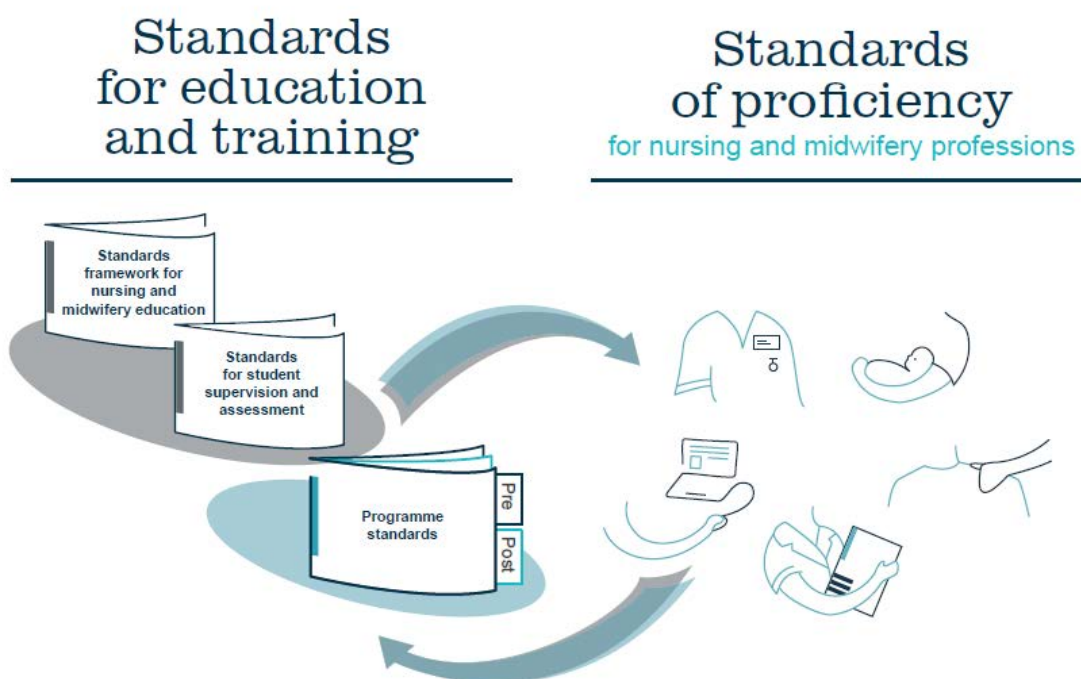
Standards for prescribing programmes

Introduction

Our *Standards for prescribing programmes* set out the legal requirements, entry requirements, availability of recognition of prior learning, methods of assessment and information on the award for all NMC approved prescribing programmes.

Student nurse and midwife prescribers in the UK must successfully complete an NMC approved post-registration prescribing programme in order to meet the standards of proficiency necessary for an annotation to be made against an entry on the NMC register as a nurse or midwife prescriber.

These standards should be read with the NMC *Standards framework for nursing and midwifery education* and *Standards for student supervision and assessment* which apply to all NMC approved programmes. There must be compliance with all these standards for an education institution to be approved and to run any NMC approved programme.



Education providers structure their educational programmes to comply with our programme standards. They also design their curricula around the published proficiencies for a particular programme and students are assessed against these proficiencies to make sure they are capable of providing safe and effective care. Proficiencies are the knowledge, skills and behaviours that nurses and midwives need in order to practise. We publish *Standards of proficiency for registered nurses and Standards of proficiency for registered midwives* as well as proficiencies for NMC approved post-registration programmes.

Through our quality assurance processes we check that education programmes meet all of our standards regarding the structure and delivery of educational programmes, that the programme outcomes relate to the expected proficiencies for particular qualifications and that the approved education institutions (AEIs) and practice learning partners are managing risks effectively. Using internal and external intelligence we monitor risks to quality in education and training; this intelligence gathering includes analysis of system regulator reports.

Before a programme can be run, an approval process takes place through which we check that the proposed programme meets our standards.

Legislative framework

Article 19(6) of the Nursing and Midwifery Order 2001¹ allows the NMC to establish standards for education and training that lead to additional qualifications which may be recorded on the NMC register. The *Standards for prescribing programmes* are made under this provision.

Approved education institutions (AEIs), their practice learning partners, and employers all have ownership and accountability for the development, delivery and management of nurse and midwife prescriber programmes, including curricula and assessment, in line with our standards.

The student journey

Standards for prescribing programmes follow the student prescriber's journey and are grouped under the following five headings:

- 1 **Selection, admission and progression:** standards about an applicant's suitability and continued participation in a prescribing nursing programme
- 2 **Curriculum:** standards for the content, delivery and evaluation of prescribing programmes
- 3 **Practice learning:** standards specific to learning for student prescribers that takes place in practice settings
- 4 **Supervision and assessment:** standards for safe and effective supervision and assessment for prescribing programmes
- 5 **Qualification to be awarded:** standards which state the award and information for annotation onto the NMC register.

¹ SI 2002/253

The Royal Pharmaceutical Society Competency Framework

As part of our commitment to inter-professional learning and in recognition of the emphasis now being placed on adopting interdisciplinary approaches to prescribing proficiency, we have decided that in future all NMC approved prescribing programmes must deliver outcomes which meet the Royal Pharmaceutical Society's (RPS) *A Competency Framework for all Prescribers*.²

For all categories of prescriber, the RPS Competency Framework applies in full and demonstration of all those competencies contained within it must be achieved in order to be awarded prescriber status. They must also be maintained thereafter throughout subsequent prescribing practice. The category of award determines the formulary a qualified prescriber may prescribe from.

Titles, qualifications and formularies

The following three titles apply to registered nurses, midwives and Specialist Community Public Health Nurses (SCPHNs) who are able to prescribe.

1. Community practitioner nurse (or midwife) prescriber: This refers to a registered nurse (level 1), midwife or SCPHN who has an annotation next to their name on our register confirming that they are qualified to prescribe drugs, medicines and appliances from the *Nurse Prescribers' Formulary for Community Practitioners*³ in the current edition of the *British National Formulary*⁴.

In order to obtain community practitioner nurse (or midwife) prescriber status, a registered nurse, midwife or SCPHN must successfully complete either:

1.1 A community practitioner nurse prescribing course as part of an existing approved SCPHN or district nursing specialist practitioner qualification (SPQ) education programme. This is sometimes known as a 'V100 course' from the code that is used to enter the annotation onto the NMC register indicating that a registrant has successfully completed a prescribing course as part of a SCPHN or district nursing SPQ programme and can prescribe from the limited community formulary; or

1.2 A stand-alone prescribing course for nurse or midwives who have not undertaken the community practitioner nurse (V100) qualification as part of an integrated programme of education, for example as part of a specialist practice qualification in district nursing or a SCPHN health visiting programme but who wish to be able to prescribe from the *Nurse Prescribers' Formulary for Community Practitioners* in the current edition of the *British National Formulary*. This is sometimes known as a 'V150 course' from the code that is used to enter the annotation onto the NMC register indicating that a nurse or midwife (who is not a SCPHN and has not completed an SPQ as, for example, a district nurse that includes a prescribing qualification) has

² This and subsequent references in these standards to the RPS Competency Framework apply to the version of that document that was in place when these standards came into effect and to any subsequent revisions to it or any documents that replace it www.rpharms.com/resources/frameworks/prescribers-competency-framework

³ www.evidence.nhs.uk/formulary/bnfc/current/nurse-prescribers-formulary/nurse-prescribers-formulary-for-community-practitioners

⁴ www.evidence.nhs.uk/formulary/bnf/current

successfully completed an approved NMC prescribing programme and can prescribe from the limited community formulary.

2. Nurse (or midwife) independent prescriber: This refers to a registered nurse (level 1), midwife or SCPHN who has an annotation next to their name on our register confirming that they may prescribe any medicine for any medical condition within their competence (with the exception of certain controlled drugs).

3. Supplementary prescriber: This refers to a registered nurse (level 1), midwife or SCPHN who has an annotation next to their name on our register confirming that they are able to work in partnership with an independent prescriber (such as a doctor or dentist) to implement an agreed patient/client-specific clinical management plan with the patient/client's agreement.

In order to obtain independent/supplementary prescriber status, a registered nurse, midwife or SCPHN must successfully complete an independent/supplementary prescriber preparation programme. This is sometimes known as a 'V300 course', from the code that is used to enter the annotation onto the NMC register indicating that a nurse or midwife has successfully completed an NMC approved prescribing programme that gives them independent/supplementary prescriber status, allowing them to prescribe any drugs (except certain controlled drugs) appropriate to their scope of practice.

Stand-alone extended formulary prescriber status was previously available by way of successfully completing the now discontinued V200 prescribing programme, before supplementary prescribing was introduced in 2003.

The above titles are set out in law⁵ and in NMC legislation⁶.

⁵ Human Medicines Regulations SI 2012/1916, regulations 214(3)(c), 214(3)(d) and 214(4).

⁶ The Nurses and Midwives (Parts of and Entries in the Register) Order of Council 2004 ("the Parts and Entries Order") SI 2004/1765, Article 7(2).

Standards for prescribing programmes

1 Selection, admission and progression

Approved education institutions together with practice learning partners must:

1.1 ensure that the applicant is a registered nurse (level 1), a registered midwife or a SCPHN before being considered as eligible to apply for entry onto an NMC approved prescribing programme

1.2 provide opportunities that enable all nurse (level 1), midwife or SCPHN registrants (including NHS, self-employed or non-NHS employed registrants) to apply for entry onto an NMC approved prescribing programme

1.3 confirm that the necessary governance structures are in place (including clinical support, access to protected learning time and employer support where appropriate) to enable students to undertake, and be adequately supported throughout, the programme

1.4 consider recognition of prior learning that is capable of being mapped to the RPS *Competency Framework for all Prescribers*

1.5 confirm on entry that any applicant selected to undertake a prescribing programme has the competence, experience and academic ability to study at the level required for that programme

1.6 confirm that the applicant is capable of safe and effective practice at a level of proficiency appropriate to the programme to be undertaken and their intended area of prescribing practice in the following areas:

1.6.1. Clinical/health assessment

1.6.1. Diagnostics/care management

1.6.1. Planning and evaluation of care

and

1.7 ensure that applicants for V300 supplementary/independent prescribing programmes have been registered with the NMC for a minimum of one year prior to application for entry onto the programme.

2 Curriculum

Approved education institutions together with practice learning partners must:

2.1 ensure programmes comply with the NMC *Standards framework for nursing and midwifery education*

2.2 ensure that all prescribing programmes are designed to fully deliver the competencies set out in the RPS *Competency Framework for all Prescribers*, as necessary for safe and effective prescribing practice

2.3 state the learning and teaching strategies that will be used to support achievement of those competencies

2.4 develop programme outcomes that inform learning in relation to the formulary relevant to the individual's intended scope of prescribing practice:-

2.4.1 stating the general and professional content necessary to meet the programme outcomes

2.4.2 stating the prescribing specific content necessary to meet the programme outcomes

2.4.3 confirming that the programme outcomes can be applied to all parts of the NMC register: the four fields of nursing practice (adult, mental health, learning disabilities and children's nursing); midwifery; and specialist community public health nursing;

2.5 ensure that the curriculum provides a balance of theory and practice learning, using a range of learning and teaching strategies, and

2.6 ensure that programmes delivered in Wales comply with any legislation which supports the use of the Welsh language.

3 Practice learning

Approved education institutions must:

3.1 ensure that suitable and effective arrangements and governance for practice learning are in place for all applicants including arrangements specifically tailored to those applicants who are self-employed.

Approved education institutions together with practice learning partners must:

3.2 ensure that practice learning complies with the NMC *Standards for student supervision and assessment*

3.3 ensure technology enhanced and simulation-based learning opportunities are used effectively and proportionately to support learning and assessment, and

3.4 ensure that students work in partnership with the education provider and their practice learning partners to arrange supervision and assessment that complies with the NMC *Standards for student supervision and assessment*.

DRAFT

4 Supervision and assessment

Approved education institutions together with practice learning partners must:

4.1 ensure that support, supervision, learning and assessment provided complies with the NMC *Standards framework for nursing and midwifery education*

4.2 ensure that support, supervision, learning and assessment provided complies with the NMC *Standards for student supervision and assessment*

4.3 appoint a programme leader in accordance with the requirements of the NMC *Standards framework for nursing and midwifery education*. The programme leader of a prescribing programme may be any registered healthcare professional with appropriate knowledge, skills and experience

4.4 ensure the programme leader works in conjunction with the Lead Midwife for Education (LME) and the practice assessor to ensure adequate support for any midwives undertaking prescribing programmes

4.5 ensure the student is assigned to a practice assessor who is a registered healthcare professional and an experienced prescriber with suitable equivalent qualifications for the programme the student is undertaking

4.5.1 In exceptional circumstances, the same person may fulfil the role of practice supervisor and practice assessor for that part of the programme where the prescribing student is undergoing training in a practice learning setting. In such instances, the student, practice supervisor/assessor and the AEI will need to evidence why it was necessary for the practice supervisor and assessor roles to be carried out by the same person

4.6 ensure the student is assigned to an academic assessor who is a registered healthcare professional with suitable equivalent qualifications for the programme the student is undertaking

4.7 provide feedback to students throughout the programme to support their development as necessary for meeting the RPS competencies and programme outcomes

4.8 assess the student's suitability for award based on the successful completion of a period of practice based learning relevant to their field of prescribing practice

4.9 ensure that all programme learning outcomes are met, addressing all areas necessary to meet the RPS competencies. This includes all students:

4.9.1 successfully passing a pharmacology exam (the pharmacology exam must be passed with a minimum score of 80%), and

4.9.2 successfully passing a numeracy assessment related to prescribing and calculation of medicines (the numeracy assessment must be passed with a score of 100%).

5 Qualification to be awarded

Approved education institutions together with practice learning partners must:

5.1 following successful completion of an NMC approved programme of preparation, confirm that the registered nurse (level 1), midwife or SCPHN is eligible to be recorded as a prescriber, in either or both categories of:

5.1.1 a community practitioner nurse (or midwife) prescriber (V100/V150), or

5.1.2 a nurse or midwife independent/supplementary prescriber (V300)

5.2 ensure that successful participation in and completion of an NMC approved prescribing programme leads to accreditation at a level equivalent to a bachelor's degree⁷ as a minimum award

5.3 inform the student that the award must be registered with us within five years⁸ of successfully completing the programme and if they fail to do so they will have to retake and successfully complete the programme in order to qualify and register their award as a prescriber, and

5.4 inform the student that they may only prescribe once their prescribing qualification has been annotated on the NMC register and they may only prescribe from the formulary they are qualified to prescribe from and within their competence and scope of practice.

⁷ Level 6 in England or equivalent in the rest of the UK: <https://www.gov.uk/what-different-qualification-levels-mean/list-of-qualification-levels>; <http://scqf.org.uk/the-framework/>

⁸ The requirement to undertake the qualification again is a standard made by Council under its powers contained at Article 19(3) of the Nursing and Midwifery Order (2001 as amended)

Glossary

Approved education institutions (AEIs): this is the status awarded to an institution, or part of an institution, or combination of institutions, that works in partnership with practice learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

Formulary: an official list giving details of prescribable medicines. The main function of a nursing and midwifery prescription formulary is to specify those particular medications that are approved to be prescribed by nurses and midwives, depending on the level of qualification they have obtained.

Nurse and midwife prescribers: the collective title for those nurses and midwives who have successfully completed an NMC approved prescribing programme and had that qualification added as an annotation to their entry on the NMC register.

Pharmacology: the study of medicinal drugs and their effect on the body. This includes both pharmacokinetics (the effect of the body on drugs) and pharmacodynamics (the effect of drugs on the body).

Practice learning partners: organisations that provide practice learning necessary for supporting pre-registration and post registration students in meeting proficiencies and programme outcomes.

Recognition of prior learning (RPL): a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes and requirements; this means it includes both theory and practice achievement.

Student: any individual enrolled onto an NMC approved programme at pre-registration or post-registration level, whether full time or less than full time.

To be included on inside back page of published standards:

The role of the Nursing and Midwifery Council

What we do

We regulate nurses and midwives in the UK. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality care throughout their careers.

We make sure nurses and midwives keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate nurses and midwives who fall short of our standards. We maintain a register of nurses and midwives allowed to practise in the UK.

The **Standards for prescribing programmes** were approved by Council on dd/mm/yyyy

DRAFT

Council

Education quality assurance framework

Action: For decision.

Issue: A description of the new education quality assurance framework, which we propose to implement from September 2019.

Core regulatory function: Education and standards.

Strategic priority: Strategic priority 1: Effective regulation
Strategic priority 2: Use of intelligence
Strategic priority 4: An effective organisation.

Decision required: The Council is recommended to:

- approve the new education quality assurance framework (paragraph 51)
- agree to the undertaking of further work to scope out the approach, possible collaborations, benefits, risks and costs to developing a NMC student survey (paragraph 52).

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Peter Thompson
Phone: 020 7681 5751
peter.thompson.1@nmc-uk.org

Director: Geraldine Walters
Phone: 020 7681 5924
geraldine.walters@nmc-uk.org

- Context:**
- 1 Council's Strategy 2015–2020 identifies education as a key corporate priority. In 2016, following approval by Council, we commenced a programme of reform in education to ensure that our standards are outcomes based, proportionate, flexible, future focused and emphasise public protection.
 - 2 In order to discharge our statutory obligations, as set out in Part IV of the NMC Order, we must ensure that the education institutions are meeting our standards and requirements for all our regulated professions. We achieve this through a programme of quality assurance (QA).
 - 3 In July 2016, Council authorised the executive to commission an independent review of the scope and shape of future QA. The review took into account the need for flexibility to accommodate changes in the higher education and health and social care landscape, increasing diversification across the four countries, different programme models and the nursing associate role.
 - 4 We are also changing our education standards. Going forward, these will be more outcomes focused and therefore this requires us to review how we undertake QA activity.
 - 5 In March, April, July and September 2017, Council discussed the main findings and options from the review. Council proposed that the risk and intelligence led framework be developed further.
 - 6 This paper describes the proposed new education QA framework. The aim is to have an agile and dynamic approach to QA that reflects our commitment to being a dynamic regulator. We propose that the new framework is fully implemented from September 2019.
- Four country factors:**
- 7 The new QA framework will be implemented across all four countries, reflecting our position as a UK wide regulator. Our approach will need to be sufficiently agile to accommodate country differences in higher education approaches and routes to nursing and midwifery education.
 - 8 The new framework will be used to QA nursing associate programmes. The nursing associate role is currently England only.
- Discussion:**
- 9 In developing the new QA framework, we used a set of design principles. The new framework should:
 - 9.1 align to our new standards;
 - 9.2 be proportionate, focusing our resource appropriately where there is the greatest risk;

- 9.3 enhance the contribution of our current data and intelligence;
- 9.4 make good use of third party data; and
- 9.5 not be costly or overly burdensome to higher education or healthcare delivery sectors.

Risk based approach to QA

- 10 Our current QA framework uses a risk-based approach to monitoring. Otherwise, we apply the same processes to all approved education institutions (AEIs) and associated QA activity, regardless of what we know about them. Although we treat all AEIs the same, we recognise there may be opportunities for a more proportionate approach that deals with difference.
- 11 The new framework will apply a risk based approach across our QA activities. The implementation of this approach will allow us to identify and understand risk in the sector and take appropriate mitigation measures in accordance with the level of risk identified. Factors which influence risk may include:
 - 11.1 if an education provider is new;
 - 11.2 the complexity and size of a programme;
 - 11.3 the past performance of an AEI in QA activity;
 - 11.4 intelligence about practice placement partners; and
 - 11.5 external data sources across the education and healthcare sector (e.g. reports from other regulators, NHS data, data from the Higher Education Statistics Agency (HESA)).
- 12 The intelligence gained from reviewing this data will be used to determine our regulatory approach.

Programme approval

- 13 Our current QA framework requires that an education institution that would like to deliver nursing and midwifery education must first achieve Approved Education Institution (AEI) status before applying for programme approval. Institutional and programme approval both require a separate documentary review and a visit.
- 14 Programme approval is valid for a period of six years at which point the AEI must apply for re-approval. We follow the same approval process for all AEIs.
- 15 In the new framework, we will no longer require that an education institution must first seek institutional approval before moving to programme approval. Education institutions will instead move

straight to programme approval and as part of this process, we will consider whether the institution is properly organised and equipped to deliver the programme. This will streamline the process both for the NMC and for education institutions.

- 16 Programme approval will continue to consist of two elements; documentary reviews and visits. However not all approvals may require a visit to take place. If an AEI is able to give assurance after documentary review, programme approval will be granted. However in some cases, a visit will be required to provide further assurance. The approval will be measured against a published statement of criteria.
- 17 A visit may be required, for example, where:
 - 17.1 An AEI has not previously run a nursing or midwifery programme and is seeking NMC approval for the first time;
 - 17.2 Recent QA approval or monitoring activity had not met outcomes or conditions set;
 - 17.3 System regulators have raised concerns about practice placement partners.
- 18 We do not visit practice settings as part of our current approvals activity. Representatives from practice instead visit the AEI to meet our visitors. However, we know from our recent QA activity that the greatest risk is in the area of practice learning. Therefore in the new framework where we do carry out visits, there will be a greater focus on practice learning.
- 19 In the new framework, programme approval will be indefinite and last until either:
 - 19.1 we publish new relevant standards; or
 - 19.2 we withdraw approval due to serious concerns about a programme.
- 20 The new approach to programme approvals should lead to a reduction in the overall number of QA visits but will enable us to use resources where the greatest risk is present. We will continue to monitor AEIs and their approved programmes to ensure that our standards continue to be met once approval has been granted.

Modifications

- 21 AEIs can make modifications to approved programmes. How we currently manage these depends on the extent of the proposed change.
- 22 Minor modifications do not require NMC approval. However we

currently require that they are reported to us in order to ascertain that the change is minor and does not disadvantage students on the programme or significantly alter the prospective approval granted.

- 23 Where a significant change is proposed, this would be classed as a major modification. This may be dealt with by a documentary review or a visit depending on the degree of change that is proposed.
- 24 In the new QA framework, we would remove the requirement for AEIs to notify us of minor modifications to their programmes. We may ask for this information from AEIs if needed for assurance but would not require routine reporting.
- 25 Our process for major modifications would continue to use either a documentary review and/or a visit. Those modifications which were considered more significant or high-risk would require a visit.

Monitoring

- 26 Monitoring is the process by which we assure that AEIs continue to meet our standards for the programmes they run. We currently require all AEIs to complete an annual self-assessment report and also select a proportion of AEIs to visit. These AEIs are selected using a risk-based approach.
- 27 In the new framework, we will continue to require all AEIs to complete an annual self-assessment which we will continue to refine to give us adequate assurance. The information collected through this will be used to provide assurance about the AEI and will also provide further data and intelligence outlined in paragraphs 11 and 12 to feed into our risk based model.
- 28 Based on the information provided in the self-assessment, we will escalate our approach to monitoring. This may include telephone calls, meetings and/or visits depending on the level of risk identified.
- 29 We will also retain the right to monitor AEIs at other times during the year where serious concerns or incidents are identified.
- 30 Through our monitoring activity, if we were to find that AEIs were not meeting our standards for education and training, we would seek assurance that they had taken steps to remedy this. If the AEI did not make the required changes and there are significant concerns, we can withdraw programme approval.

Thematic reviews

- 31 Thematic reviews will be part of our monitoring activity. These will enable us to look in more detail at sector wide challenges in specific areas. These challenges may be identified through intelligence gained in our QA work, for example the results of self-assessment

reports or approval activity.

- 32 Once a theme is identified which would benefit from further scrutiny, this could be done through desktop review and / or visits to AEIs and practice.
- 33 Following analysis of the data collected, we would share good practice, lessons learned and solutions identified from across the sector to support the improvement of nursing and midwifery education and training across the UK. We may also hold UK wide engagement events to share our findings and to promote learning.

Enhanced scrutiny for new providers

- 34 In our current QA framework, after an AEI has had a first programme approved, we treat the AEI the same as all other providers and they move straight into our usual monitoring processes.
- 35 In the new framework, we propose a period of enhanced scrutiny to new providers to recognise the risk that new institutions may have less experience of programme delivery in accordance with the NMC's standards.
- 36 This would apply to the first cohort of any new education provider or an existing education provider's first pre registration cohort delivery.
- 37 During the period of enhanced scrutiny, we would require self-assessments and data returns every six months in order to provide assurance that our standards are being met by new AEIs and their placement partners. If required, we may also have regular telephone contact with the AEI or visit if the data provided requires further assurance.
- 38 The period of scrutiny will last for the length of the first programme cohort. However, the period of scrutiny would be flexed to allow AEIs to 'step off' and be subject to normal monitoring requirements where sufficient assurance has been given.
- 39 If concerns are identified, an action plan would be set with the AEI which would require conditions to be met. If there were ongoing concerns and it was evident that the AEI was not managing the risk effectively, this could lead to programme approval being withdrawn.

Engagement activity

- 40 In the new QA framework, we will seek to increase our engagement with AEIs and practice placement partners. This engagement activity supports enhancement of our regulatory relationship with AEIs and practice placement providers and offers opportunities to share best practice and gather 'soft intelligence' on the application of our standards.

- 41 Engagement events would provide opportunities to disseminate the findings of thematic reviews or other QA activity. A variety of formats will be used including face to face events, webinars and newsletters.

Student survey

- 42 To support an enhancement led model of QA, the new framework could introduce an NMC student survey. This survey would obtain insights into the student experience, including the quality of practice learning. Obtaining information directly from students could be beneficial in obtaining feedback on the implementation of our new standards.
- 43 The survey would form a key part of the intelligence gathering required to robustly operate a risk-based approach to QA and the results could help inform the risk-based selection of placement and AEs during monitoring.
- 44 The survey would seek to collect additional information beyond that already collected through other routes such as the national student survey. There may be opportunities to potentially collaborate with others on the development of the survey, e.g. the GMC already has an annual national training survey.
- 45 We recognise that making a final decision on whether we proceed to develop and implement a student survey will require further work in order to present options, benefits and costs to Council.

Timeline for implementation

- 46 It is intended that the new QA framework will be fully implemented from September 2019.
- 47 Providers of pre registration nursing and nurse and midwife prescribing programmes will need to seek approval against our new standards by September 2020. Providers of nursing associate programmes will also seek approval for the first time from autumn 2018. For these approvals, it is anticipated that they will all involve a documentary review and a visit. This is because the introduction of new standards and regulation of a new role represents significant change for the sector. Once approved, the risk based approach would then be applied.

Benefits of new framework

- 48 We believe the new framework will enable us to be more proportionate in the QA of nursing and midwifery education and that a more flexible and dynamic approach will enable us to target risk appropriately and direct appropriate resource to where it is needed.
- 49 Our new framework would also allow us to make better use of data and intelligence to inform our QA approach and the use of external

third party data would enable us to use the findings of other regulators in order to reduce the burden on AEs.

50 Over time the new framework should also lead to a reduction in the number of visits that we carry out as part of our QA and therefore will give us more capacity to proportionately monitor programmes that we approve against our standards.

51 **Recommendation: The Council is recommended to approve the new education quality assurance framework.**

52 **Recommendation: The Council is recommended to agree to the undertaking of further work to scope out the approach, possible collaborations, benefits, risks and costs to developing an NMC student survey.**

Public protection implications:

53 We must have a QA framework which allows us to meet our statutory objective of protecting the public. If we are not able to provide assurance that AEs are delivering programmes in accordance with our education standards, we would be putting the public at risk and undermining the reputation and integrity of the professions.

Resource implications:

54 The proposed new framework is a risk based model that makes better use of internal and external intelligence. As such our financial modelling concludes that, at current activity levels, the cost of operating the new framework is no more expensive than the current arrangements.

Equality and diversity implications:

55 Equality and diversity implications are under consideration and will be finalised subject to Council's decision on the new framework.

Stakeholder engagement:

56 Subject to Council approval we will communicate to all AEs regarding our implementation of the new QA framework.

57 Close collaboration with NMC stakeholders in education remains key to QA activity and our new approach to QA will be communicated with sufficient notice. The Council of Deans of Health is being regularly updated.

58 We have established a QA reference group to support development of our plans. The group includes representatives from education and practice, lay members and students. Two meetings have been held to date and further meetings are planned for 2018. We will seek feedback from this group on our plans for implementation of the new QA framework.

- Risk implications:** 59 If the proposed new framework is not agreed, our default would be to continue implementing the current QA framework, which may mean increased costs.
- Legal implications:** 60 This approach aligns with the statutory requirements for education set out in Part IV of the Nursing and Midwifery Order 2001.

Council

Consulting on the regulation of nursing associates

Action: For decision.

Issue: Seeks Council's approval to consult on the regulation of nursing associates.

Core regulatory function: All regulatory functions.

Strategic priority: Strategic priority 1: Effective regulation.
Strategic priority 4: An effective organisation.

Decision required: The Council is asked to approve the launch of our consultation on the approach and tools we will use for the regulation of nursing associates (paragraph 40).

Annexes: The following annexes are attached to this paper:

- Annexe 1: Draft standards of proficiency for nursing associates.
- Annexe 2: Draft standards for pre-registration nursing associate programmes.
- Annexe 3: Draft Code for nurses, midwives and nursing associates.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Emma Westcott
Phone: 020 7681 5797
emma.westcott@nmc-uk.org

Director: Geraldine Walters
Phone: 020 7681 5924
geraldine.walters@nmc-uk.org

- Context:**
- 1 In October 2015, the Government announced the creation of the nursing associate role in England. In January 2017, in response to a request from the Secretary of State the NMC agreed to regulate the role.
 - 2 Over the last couple of years there have already been three consultations relating to this new role:
 - 2.1 Health Education England (HEE) consulted¹ on the proposal to introduce a nursing support role (January–March 2016).
 - 2.2 The Department of Health and Social Care (DHSC) consulted² on the amendments to the NMC’s legislation required to give us new powers to regulate nursing associates via a section 60 Order (October–December 2017).
 - 2.3 We consulted on changes to our Rules to allow us to set fees for nursing associates (December 2017–February 2018).
 - 3 These consultations gave people the opportunity to comment on:
 - 3.1 the need for the role in England;
 - 3.2 whether the role should be regulated;
 - 3.3 the nature of the role;
 - 3.4 required changes to the NMC’s legislation;
 - 3.5 proposed fees for nursing associates.
 - 4 The Government is currently in the process of amending our legislation (Nursing and Midwifery Order 2001 (the Order)) to give us new powers to regulate nursing associates following the DHSC’s consultation that closed on 26 December 2017 (see paragraph 3.2).
 - 5 The DHSC’s consultation on changes to our legislation makes it clear that the approach to the regulation of nursing associates will be broadly the same as the approach that applies to nurses and midwives.
 - 6 On 9 April 2018 (subject to Council’s approval) we will launch our main consultation on our proposed approach for nursing associate regulation. The consultation will be open for 12 weeks.
 - 7 We are required to consult stakeholders on aspects of our regulatory approach and these will all be included in our consultation. We will not be consulting on those matters already covered in paragraphs 2 and 3 above. We aim to ensure that all of our consultations are user-friendly and accessible, and we recognise that this is particularly important in this instance because some respondents will be

¹<https://hee.nhs.uk/sites/default/files/documents/Response%20to%20Nursing%20Associate%20consultation%2026%20May%202016.pdf>.

²<https://www.gov.uk/government/consultations/regulation-of-nursing-associates-in-england>.

unfamiliar with regulatory tools and processes.

- 8 A significant programme of pre-consultation engagement has helped us to develop these proposals, and we have benefited from the opportunity for detailed discussion with Council members. During the consultation phase we will continue to engage widely, ensuring that the broad community of interest in nursing associate regulation has the opportunity to form and share views.

Four country factors:

- 9 Health policy and workforce are devolved matters. The NMC is a four country regulator, regulating nurses and midwives in England, Wales, Northern Ireland and Scotland. Taking on the regulation of nursing associates represents the first professional group which the NMC will regulate in only in one of these four countries; England.
- 10 From the NMC's perspective, all four countries of the UK retain a stake in the NMC's approach to regulation, as we are a UK-wide regulator. We welcome responses to the consultation from stakeholders across the UK and are committed to supporting any UK-wide requests for engagement on the subject of nursing associate regulation.

Detail:

- 11 In line with Council's steer, and DHSC's consultation, we will be consulting on broadly the same regulatory approach which is in place for nurses and midwives and how it may apply to nursing associates. Our consultation will therefore cover:
- 11.1 **New regulatory tools for nursing associates:** Standards of proficiency (see paragraphs 20-24), education standards and programme standards (see paragraphs 25-29).
- 11.2 **Extending current regulatory tools/approaches to nursing associates:** The Code (see paragraphs 30-37) and regulatory processes such as the quality assurance of education, registration, revalidation and fitness to practise.
- 12 Where we propose to extend our existing approaches/tools to the regulation of nursing associates, we will be asking stakeholders whether they agree or disagree that the same approaches/tools should apply, and giving them the opportunity to say why they agree or disagree. This will be our approach to questions on registration, revalidation and fitness to practise.
- 13 We will go into more detail where we need stakeholders to review and respond to new regulatory tools (i.e. for the standards of proficiency; and nursing associate education programme standards). Although we are not consulting on a new Code, because the standards will remain broadly the same, we want people to review and provide comments on the revised version of the Code with a

new introduction and some specific amendments which we think necessary in order to make the Code applicable to nursing associates, as well as nurses and midwives.

Our powers

- 14 The NMC has some specific powers to shape the nursing associate role. Those include setting standards of proficiency that must be demonstrated in order to join the register, and requiring nursing associates, via the Code, to work within the limits of their competence. Our powers do not extend to specifying tasks that only nurse can do, or that nursing associates cannot do. There are limited instances in legislation where specific functions or tasks are expressly reserved to named professionals. In our legislation, we have only one: you must be a midwife (or a doctor) to attend a woman in childbirth. The DHSC's consultation on changes to our legislation did not propose any new protected functions in conjunction with the regulation of nursing associates. However, we have developed standards of proficiency that we believe distinguish the proficiencies of the nurse and the nursing associate at the point of registration.
- 15 A number of organisations, including the NMC, play a role in the safe and effective implementation of this new role. We are working with others to make sure that all of the pieces of the safety 'jigsaw' are in place.
- 16 Of particular importance will be national guidance on the use of the role, particularly at the outset and before an evidence base about nursing associates has been developed. We also look forward to system regulators setting out how they will ensure staffing decisions are sound, risks are managed and attention continues to be given to the graduate nurse component of safe staffing decisions.

Engagement on our regulatory approach to date

- 17 To develop the new regulatory tools for nursing associates we have engaged with a wide range of stakeholders including members of our Nursing Associate External Stakeholder Group (ESG), nurses, educators, service users, employers and trainee nursing associates.
- 18 We have also drawn on the extensive stakeholder engagement undertaken as part of the development of our changes to the education programme.
- 19 We have benefited from the close involvement of Council in the development of our regulatory approach. In particular, the Council approved the early releases of a working draft of the standards of proficiency in September 2017 and the accompanying skills annex in January 2018. Taking this unusual step has allowed test sites to get an early indication of our likely expectations, and it means we

have benefitted from additional early feedback on the proficiencies prior to consultation.

Standards of proficiency for nursing associates

- 20 The standards of proficiency are the minimum standards required to join the new nursing associates' part of our register.
- 21 Approved education institutions (AEIs), with their practice placement partners, will need to ensure that nursing associate programmes enable students to demonstrate these proficiencies and qualify as a nursing associate.

What are we consulting on?

- 22 Our draft standards of proficiency for nursing associates are provided at **annexe 1**.
- 23 The standards of proficiency are derived from the proposed standards of proficiency for registered nurses (which Council is being asked to agree at this meeting). Council supported this design principle because it helps to show the synergies and the differences between the two roles, and makes it easy to identify what further learning is required to progress via a nursing degree from one role to the other.
- 24 The standards have been developed within some parameters. They need to:
 - 24.1 be suitable for the award of a foundation degree, typically involving two years of higher education.
 - 24.2 represent a suitable breadth of knowledge and skills for admission on to a generic part of the register (not specified by fields).
 - 24.3 provide a progression route to nursing degrees for those with the aspiration and ability to progress.
 - 24.4 provide a higher level of knowledge and skill to that of a health or care assistant.
 - 24.5 clearly distinguish the nursing associate, with two years' generic learning, from the nurse, with three or more years of field specific learning.

Education standards and standards for pre-registration nursing associate programmes

- 25 All AEIs, and their practice partners will need to meet the NMC's proposed:

25.1 Standards framework for nursing and midwifery education.

25.2 Standards for student supervision and assessment.

What are we consulting on?

- 26 We are consulting on our proposed standards for pre-registration nursing associate programmes. These are provided at **annexe 2**. We are also consulting stakeholders on the proposal that our new standards for education and training should apply to providers of nursing associate education.
- 27 In many respects our proposed approach to nursing associate education programmes is the same as our approach to pre registration nursing and midwifery programmes. Common aspects include:
- 27.1 Entry requirements.
 - 27.2 Programme structure - theory/practice split.
 - 27.3 Progression in programme.
 - 27.4 Supported learning time (including supernumerary status).
 - 27.5 Support requirement during learning.
 - 27.6 Assessment.
 - 27.7 Recognition of prior learning - from nursing associate programmes into nursing programmes.
- 28 Different requirements are proposed for:
- 28.1 Recognition of prior learning – for nurses joining nursing associate programmes.
 - 28.2 Programme structure – programme hours.
 - 28.3 Programme structure – programme length.
 - 28.4 Programme structure – practice learning.
 - 28.5 Qualification level.
- 29 There is a complex set of inter-dependent factors among our education requirements: programme length, programme hours, supernumerary status, academic level, and theory: practice split that require particular attention during the consultation period. In these, as in all matters, we will take stakeholders views seriously. We want to meet the challenge of approving programmes that are safe, include sufficient and broad practical experience, meet the academic expectations of a Foundation Degree, provide a meaningful

progression route to nursing degrees, and which work for employers. We hope to achieve this through open and constructive dialogue over the coming months.

The Code

- 30 People on our register are required to uphold the standards in the Code. The Code sets out public expectations of behaviour and practice on the part of registered professionals. The latest version was published in 2015.

What are we consulting on?

- 31 We are proposing to update the Code in response to nursing associates becoming a regulated profession in England. We have drafted a new introduction and a small number of textual amendments to the wording of the standards to make sure that it is fit for the purpose of regulating three different professions.
- 32 We are consulting on a solution to take us up to the next substantive review of the Code, we are not conducting a wholesale review of the Code now. We can and will improve on this version when we next review the Code.
- 33 Our proposed version of the Code is provided at **annexe 3**.
- 34 Council's steer has been that we should consult on the application of one Code to all of our registrants. A number of healthcare regulators (including the NMC) already regulate more than one profession, but they have a single Code. Regulators such as the General Pharmaceutical Council and the General Dental Council regulate an established profession alongside related newer professions (pharmacy and dental technicians) with a common Code. This is because the Code applies within each registrant's scope of practice.
- 35 The differences between the professions we regulate should be clearly discernible in the standards of proficiency, but we hold the same expectations of professional behaviour from all of our registrants.
- 36 Additionally, we have developed a new introduction that reinforces the message that people on our register are all accountable for their practice, will exercise their professional judgement at different levels, and will apply the Code within their scope of practice. There are also a small number of textual amendments needed to make the Code suitable for the regulation of all three professions.
- 37 At a high level, the Code addresses the issues of delegation and accountability. Many stakeholders have told us that nurses and nursing associates may value some additional information about delegation and accountability in the context of this new professional relationship. We have produced some information material in

response and this will be published in due course.

Core regulatory processes

What are we consulting on?

- 38 The DHSC has consulted on the same core regulatory processes applying to nurses, midwives and nursing associates. It is therefore proposed that we will extend our approaches to education quality assurance, registration, revalidation and fitness to practise to nursing associates.
- 39 In the consultation we will provide a brief overview of our current approach and signpost respondents to more detailed information.
- 40 **Recommendation: that the Council approves the launch of our consultation on the approach and tools we will use for the regulation of nursing associates.**

Next steps

- 41 Subject to Council's approval, the consultation will begin on 9 April 2018. It will run for 12 weeks until 29 June 2018.
- 42 There is a full communications and engagement plan for the consultation phase.
- 43 In July and August 2018, we will analyse the outcomes of the consultation and update our proposals. The DHSC hopes to have completed changes to our legislation in July 2018, before summer recess.
- 44 Assuming legislative change is in place, we will ask Council to approve the final version of the standards of proficiency, education programme standards and the Code in September 2018. The final versions will be published in October 2018.

Public protection implications:

- 45 The NMC agreed to regulate nursing associates because we believe we are well placed to do so in a manner that protects the public. Public protection is the primary objective of all of our regulatory tools and processes.

Resource implications:

- 46 The DHSC is meeting costs incurred by the NMC in setting up the regulation of nursing associates.

Equality and diversity implications:

- 47 The nursing associate programme is the subject of a full equality impact assessment which is informed by data from the pilot and apprenticeship programmes.

- Stakeholder engagement:** 48 We have a detailed plan engagement during the consultation period.
- Risk implications:** 49 The development of our regulatory tools and processes is time constrained in advance of becoming the legal regulator for nursing associates and the opening of our register. We have prepared a detailed plan to ensure that we have sufficient time to adequately consider feedback from our stakeholders during and after the consultation.
- Legal implications:** 50 Legislative change is required to enable the NMC to regulate nursing associates.

DRAFT

Standards of proficiency for nursing associates

DRAFT

Introduction

The standards of proficiency presented here represent the standards of knowledge and skills that a nursing associate will need to meet in order to be considered by the NMC as capable of safe and effective nursing associate practice. These standards have been designed to apply across all health and care settings.

The proficiencies serve a number of purposes:

- They set out for **patients and the public** what nursing associates know and can do when they join the NMC register.
- The standards help **nursing associates** by providing clarity about their role. Read alongside the nursing standards of proficiency, they demonstrate the synergies and differences between the two roles.
- For **nurses and other health and care professionals**, the standards provide clarity on the knowledge and skills they can reasonably expect all nursing associates to have and this will help inform safe decisions about delegation.
- **Employers** understand what nursing associates can contribute to the health and wellbeing of patients and service users, and can make effective decisions about whether and how to use the role
- **Educators** must develop and deliver programmes that equip nursing associates with the skills, knowledge and behaviours needed to meet these standards of proficiency when they qualify.

Nursing associate is a new role being introduced into the health and care workforce in England from 2019¹. It is a generic role (not defined by a field of nursing) but within the discipline of nursing. Nursing associates are intended to bridge a gap between health and care assistants, and registered nurses.

While the nursing associate role is new, it is particularly important that the public, health and care professionals, and employers can develop an understanding of what nursing associates know and can do.

Nursing associates are members of the nursing team, who have gained a Foundation Degree, typically involving two years of higher education. They are not nurses; nursing is a graduate entry profession and those joining the nursing part of the NMC register require a degree. Nurses also develop additional skills and knowledge within a specific field of nursing.

Nursing associates are a new profession, accountable for their practice. These proficiencies set out what pre-registration training will equip nursing associates to know, and do. Once they are practising, nursing associates can undertake further education

¹ The nursing associate role is being introduced and regulated in England from 2019. If other countries of the UK decide to use and regulate the role in future it will require a change to our legislation, and the updating of our standards.

and training and demonstrate additional knowledge and skills, enhancing their competence as other registered professionals routinely do. The roles played by nursing associates will vary from setting to setting, depending on local clinical frameworks, and it may also be shaped by national guidance.

We have designed these proficiencies to align with the latest standards of proficiency for nurses:

- To allow people to understand the differences between the two roles
- To enable education providers to facilitate educational progression from nursing associate to nurse
- To demonstrate how the nursing associate role can support the registered nurse, to allow registered nurses to deliver the NMC's enhanced "Future Nurse" standards of proficiency.

In common with all of our regulatory standards and guidance, these proficiencies will be subject to periodic review. The current version of our proficiencies can always be found on our website.

DRAFT

Standards of proficiency for nursing associates

Platform 1: Being an accountable professional

Nursing associates act in the best interests of the people they care for, putting them first and providing nursing care that is person centred, safe and compassionate. They act professionally at all times and use their knowledge and experience to make evidence based decisions and solve problems. They recognise and work within the limits of their competence and are responsible for their actions.

1. Outcomes: the outcomes set out below reflect the proficiencies for accountable practice that must be applied across all standards of proficiency for nursing associates, as described in platforms 2-6.

At the point of registration, the nursing associate will be able to:

- 1.1 Understand and act in accordance with 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates' and fulfil all registration requirements and the requirement to act within their scope of practice².
- 1.2 Understand and apply relevant legal, regulatory and governance requirements, policies, and ethical frameworks to all areas of practice.
- 1.3 Understand and apply the principles of courage, transparency and duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes.
- 1.4 Demonstrate an understanding of, and the ability to, challenge discriminatory behaviour.
- 1.5 Understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to health.
- 1.6 Understand the professional responsibility to adopt a healthy lifestyle and maintain a level of personal fitness and wellbeing required to meet people's needs for mental and physical care.
- 1.7 Understand and explain the meaning of resilience and emotional intelligence, and their influence on an individual's ability to provide care.
- 1.8 Describe the principles of research and how research findings are used to inform evidence based practice.
- 1.9 Communicate effectively using a range of skills and strategies with colleagues and with people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges.

² The professional commitment to work within one's competence is a key underpinning principle of the Code

- 1.10 Demonstrate the skills and abilities required to develop, manage and maintain appropriate relationships with people, their families and carers and colleagues.
- 1.11 Provide and promote non-discriminatory, person centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, needs, and preferences, taking account of any necessary reasonable adjustments for people with disabilities.
- 1.12 Recognise and report any factors that may unduly influence safe and effective care provision.
- 1.13 Demonstrate the numeracy, literacy, digital and technological literacy skills required to meet the needs of people in your care and ensure safe and effective practice.
- 1.14 Demonstrate the ability to keep complete, clear, accurate and timely records.
- 1.15 Take responsibility for continuous self-reflection, seeking and responding to support and feedback to develop professional knowledge and skills.
- 1.16 Act as an ambassador for the profession and promote public confidence in health and care services.
- 1.17 Safely demonstrate evidence based practice in all skills and procedures stated in Annexes A and B.

Platform 2: Promoting health and preventing ill health

Nursing associates play a role in supporting people to improve and maintain their mental, physical, behavioural health and wellbeing. They are actively involved in the prevention of and protection against disease and ill health, and engage in public health, community development, and in the reduction of health inequalities.

2. Outcomes: The proficiencies identified below will equip the newly registered nursing associate with the underpinning knowledge and skills required for their role in health promotion and protection and prevention of ill health.

At the point of registration, the nursing associate will be able to:

- 2.1 Understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health when engaging with people.
- 2.2 Promote preventive health behaviours and provide information to support people to make informed choices to improve their mental, physical, behavioural health and wellbeing.
- 2.3 Describe the principles of epidemiology, demography, genomics and how these may influence health and wellbeing outcomes.
- 2.4 Understand the factors that may lead to inequalities in health outcomes.
- 2.5 Understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours and lifestyle choices to mental, physical and behavioural health outcomes.
- 2.6 Understand the importance of early years and childhood experiences and the possible impact on life choices, mental, physical and behavioural health and wellbeing.
- 2.7 Explain why health screening is important and identify those who are eligible for screening.
- 2.8 Promote health and prevent ill health by understanding the evidence base for immunisation, vaccination and herd immunity.
- 2.9 Protect health through understanding and applying the principles of infection prevention and control, including communicable disease surveillance and antimicrobial stewardship and resistance.

Platform 3: Provide and monitor care

Nursing associates provide compassionate, safe and effective care and support to people in a range of care settings. They monitor the condition and health needs of people within their care on a continual basis in partnership with people, families, and carers. They contribute to ongoing assessment and can recognise when it is necessary to refer to others for reassessment.

3. Outcomes: The proficiencies identified below will equip the newly registered nursing associate with the underpinning knowledge and skills required for their role in providing and monitoring care.

At the point of registration, the nursing associate will be able to:

- 3.1 Demonstrate an understanding of human development from conception to death, to enable delivery of safe and effective care.
- 3.2 Demonstrate and apply knowledge of body systems and homeostasis, human anatomy and physiology, biology, pharmacology, social and behavioural sciences when delivering care.
- 3.3 Recognise and apply knowledge of commonly encountered mental, physical, behavioural and cognitive health conditions when delivering care.
- 3.4 Demonstrate the knowledge, communication and relationship management skills required to provide people, families and carers with accurate information that meets their needs before, during and after a range of interventions.
- 3.5 Work in partnership with people, to encourage shared decision making, in order to support people, their families and carers to manage their own care when appropriate.
- 3.6 Demonstrate an understanding of how and when to escalate to the appropriate professional for expert help and advice.
- 3.7 Demonstrate and apply an understanding of how people's needs for safety, dignity, privacy, comfort and sleep can be met.
- 3.8 Demonstrate the knowledge, skills and ability required to meet people's needs related to nutrition, hydration and elimination.
- 3.9 Demonstrate the knowledge, skills and ability to act as required to meet people's needs related to mobility, hygiene, oral care, wound care and skin integrity.
- 3.10 Demonstrate the ability to recognise when a person's condition has deviated from their normal state by undertaking health monitoring. Interpret, promptly respond, share findings, and escalate as needed.
- 3.11 Demonstrate the knowledge and skills required to support people with the commonly encountered symptoms of anxiety, confusion, discomfort and pain.

- 3.12 Demonstrate the ability to deliver sensitive and compassionate end of life care to support people to plan for their end of life, giving information and support to people who are dying, their families and carers. Provide appropriate support to the deceased and people who are bereaved.
- 3.13 Demonstrate the knowledge, skills and ability to perform a range of nursing procedures and manage devices, to meet people's need for safe, effective and person centred care.
- 3.14 Understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies.
- 3.15 Demonstrate the ability to recognise signs of allergy, drug sensitivity and adverse reaction.
- 3.16 Recognise the different ways by which medicines can be prescribed.
- 3.17 Demonstrate the ability to monitor the effectiveness of care in partnership with people, families and carers. Document progress and report outcomes.
- 3.18 Demonstrate an understanding of co-morbidities and the demands of meeting people's holistic needs when prioritising care.
- 3.19 Recognise how a person's capacity affects their ability to make decisions about their own care and to give or withhold consent.
- 3.20 Recognise when capacity has changed and understand where and how to seek guidance and support from others to ensure that the best interests of those receiving care are upheld.
- 3.21 Recognise people at risk of harm and the situations that may put them and others at risk.
- 3.22 Take personal responsibility to ensure that relevant information is shared according to local policy and appropriate immediate action is taken to provide adequate safeguarding and that concerns are escalated.

Platform 4: Working in teams

Nursing associates play an active role as members of interdisciplinary teams, collaborating and communicating effectively with nurses, a range of other health and care professionals and lay carers.

4. Outcomes: The proficiencies identified below will equip the newly registered nursing associate with the underpinning knowledge and skills required to understand and apply their role to work effectively as part of an interdisciplinary team.

At the point of registration, the nursing associate will be able to:

- 4.1 Understand the four fields of nursing, and explain the roles, responsibilities and scope of practice of all members of the nursing and interdisciplinary team, and their own role within it.
- 4.2 Demonstrate an ability to support and motivate other members of the care team and interact confidently with them.
- 4.3 Understand and apply the principles of human factors and environmental factors when working in teams.
- 4.4 Effectively and responsibly access, input, and apply information and data using a range of methods including digital technologies, and share appropriately within interdisciplinary teams.
- 4.5 Demonstrate an ability to prioritise and manage their own workload, and recognise where elements of care can safely be delegated to other colleagues, carers and family members.
- 4.6 Demonstrate the ability to monitor and review the quality of care delivered, providing challenge and constructive feedback, when an aspect of care has been delegated to others.
- 4.7 Support and supervise nursing associate students, health care support workers and those new to care roles, review the quality of the care they provide, promoting reflection and providing constructive feedback.
- 4.8 Contribute to team reflection activities, to promote improvements in practice and services.
- 4.9 Discuss the influence of policy and political drivers that impact health and care provision.

Platform 5: Improving safety and quality of care

Nursing associates improve the quality of care by contributing to the continuous monitoring of people's experience of care. They identify risks to safety or experience and take appropriate action, putting the best interests, needs and preferences of people first.

5. Outcomes: The proficiencies identified below will equip the newly registered nursing associate with the underpinning knowledge and skills required for their role in contributing to risk monitoring and quality of care.

At the point of registration, the nursing associate will be able to:

- 5.1 Understand and apply the principles of health and safety legislation and regulations and maintain safe work and care environments.
- 5.2 Participate in data collection to support audit activity, and contribute to the implementation of quality improvement strategies.
- 5.3 Accurately undertake risk assessments, using established assessment and improvement tools.
- 5.4 Respond to and escalate potential hazards that may affect the safety of people.
- 5.5 Recognise when safe care may be jeopardised due to inadequate staffing levels and escalate concerns appropriately.
- 5.6 Understand and act in line with local and national organisational frameworks, legislation and regulations to report risks, and implement actions as instructed, following up and escalating as required.
- 5.7 Understand what constitutes a near miss, a critical incident, a major incident and a serious adverse event.
- 5.8 Understand when to seek more senior advice to manage a risk appropriately to avoid compromising quality of care and health outcomes.
- 5.9 Recognise uncertainty, and demonstrate an awareness of strategies to develop resilience in themselves. Know how to seek support to help deal with uncertain situations.
- 5.10 Understand their own role and the roles of all other staff at different levels of experience and seniority, in the event of a major incident.

Platform 6: Contributing to integrated care

Nursing associates contribute to the provision of care for people, including those with complex needs. They understand the roles of a range of professionals and carers from other organisations and settings who may be participating in the care of a person and their family, and their responsibilities in relation to communication and collaboration.

6. Outcomes: The proficiencies identified below will equip the newly registered nursing associate with the underpinning knowledge and skills required for their role in contributing to integrated care to meet the needs of people across organisations and settings.

At the point of registration, the nursing associate will be able to:

- 6.1 Explain the roles of the different providers of health and care. Demonstrate the ability to work collaboratively and in partnership with professionals from different agencies in interdisciplinary teams.
- 6.2 Understand and explore the challenges of providing safe nursing care for people with complex co-morbidities and complex care needs.
- 6.3 Demonstrate an understanding of the complexities of providing mental, cognitive, behavioural and physical care needs across a wide range of integrated care settings.
- 6.4 Demonstrate an understanding of their own role and contribution when involved in the care of a person who is undergoing a transition of care between professionals, settings or services.
- 6.5 Be able to identify when people need help to facilitate equitable access to care, support and escalate concerns appropriately.
- 6.6 Understand the principles and processes involved in supporting people and families with a range of care needs to maintain their independence and avoid unnecessary interventions and disruptions to their lives.

Annexe A: Communication and relationship management skills

Introduction

In order to meet the proficiency outcomes outlined in the main body of this document, nursing associates must be able to demonstrate the communication and relationship management skills described in this annexe at the point of registration.

The ability to communicate effectively, with sensitivity and compassion, and to manage relationships with people is central to the provision of high quality person-centred care. These competencies must be demonstrated in practice settings and adapted to meet the needs of people across their lifespan. Nursing associates need a diverse range of communication skills and strategies to ensure that individuals, their families and carers are supported to be actively involved in their own care wherever appropriate, and that they are kept informed and well prepared.

Where people have special communication needs or a disability, it is essential that nursing associates make reasonable adjustments. This means they'll be able to provide and share information in a way that promotes good health and health outcomes and does not prevent people from having equal access to the highest quality of care.

The skills listed below are those that all nursing associates are expected to demonstrate at the point of registration.

Communication and relationship management skills required to effectively provide and monitor care

1. Underpinning communication skills. Demonstrate the ability to:

- a) actively listen, recognise and respond to verbal and non-verbal cues
- b) use prompts and provide positive verbal and non-verbal reinforcement
- c) use appropriate non-verbal communication including touch, eye contact and sensitivity to personal space
- d) use appropriate open and closed questioning
- e) speak clearly and accurately
- f) use caring conversation techniques
- g) check understanding and use clarification techniques
- h) be aware of the possibility of unconscious bias in communication encounters
- i) write accurate clear, legible records and documentation
- j) clearly record digital information and data
- k) provide clear verbal, digital or written information and instructions when delegating or handing over responsibility for care
- l) recognise the need for translator services and material.

2. Communication skills for supporting people to prevent ill health and manage their health challenges

- a) Demonstrate the ability to effectively share information and check understanding about:
 - preventative health behaviours that help people to make lifestyle choices and improve their own health and wellbeing
 - a range of common conditions including: anxiety, depression, memory loss, diabetes, dementia, respiratory disease, cardiac disease, neurological disease, cancer, skin problems, immune deficiencies, psychosis, stroke and arthritis in accordance with care plans.
- b) Demonstrate the ability to clearly and confidently explain to the individual and family how their lifestyle choices may influence their future health. This includes the impact of common health risk behaviours including smoking, obesity, sexual practice, alcohol and substance use

- c) use clear language and appropriate written materials to support people's understanding of what has caused their health condition and the implications for care and treatments
- d) use repetition and positive reinforcement strategies
- e) recognise sensory impairments during all communications and the need to make reasonable adjustments
- f) support and monitor the use of personal communication aids
- g) address and respond to people's questions, recognising when to refer to others in order to provide accurate responses
- h) identify the need for and manage a range of alternative communication techniques
- i) engage in difficult conversations with support from others, helping people who are feeling vulnerable or in distress, conveying compassion, sensitivity and using appropriate communication strategies.

3. Communication skills and approaches for providing therapeutic interventions

- a) identify the need for and use appropriate approaches to develop therapeutic relationships with people
- b) demonstrate the use of a variety of effective communication strategies:
 - reassurance and affirmation
 - de-escalation strategies and techniques
 - distraction and diversion strategies
 - positive behaviour support approaches.

4. Communication skills for working in professional teams

Demonstrate effective skills when working in teams by:

- a) active listening when receiving feedback and when dealing with team members' concerns and anxieties
- b) timely and appropriate escalation
- c) being a calm presence when exposed to situations involving conflict
- d) appropriate and effective confrontation strategies
- e) using de-escalation strategies and techniques when dealing with conflict.

Demonstrate effective supervision skills by providing:

- a) clear instructions and explanations when supervising others

- b) clear instructions and checking understanding when delegating care responsibilities to others
- c) clear constructive feedback in relation to care delivered by others
- d) encouragement to colleagues that helps them to reflect on their practice.

DRAFT

Annexe B: Procedures to be undertaken by the nursing associate

Introduction

In order to meet the proficiency outcomes outlined in the main body of this document, nursing associates must be able to carry out the procedures described in this annexe at the point of their registration.

The ability to carry out these procedures, safely, effectively, with sensitivity and compassion (while demonstrating the communication and relationship management skills described in Annexe A) is crucial to the provision of person-centred care. These procedures must be demonstrated in a range of practice settings with people across their lifespan. They must be carried out in a way that reflects cultural awareness and ensures that the needs, priorities, expertise and preferences of individuals and their families and carers are always valued.

DRAFT

Procedures to enable effective monitoring of a person's condition

1. In order to demonstrate effective approaches to monitoring signs and symptoms of physical, mental, cognitive, behavioural and emotional distress, deterioration and improvement, the nursing associate should be able to demonstrate the ability to:

- a) accurately measure weight and height, calculate body mass index, recognise healthy ranges and the clinical significance of low and high readings
- b) use manual techniques and electronic devices to take, record and interpret vital signs including temperature, pulse, respiration (TPR), blood pressure (BP) and pulse oximetry in order to identify signs of improvement, deterioration or concern
- c) undertake venepuncture, cannulation, blood sampling, and routine ECG recording
- d) undertake urinalysis, and blood glucose monitoring and interpret results
- e) collect and observe sputum, urine and stool specimens
- f) recognise and escalate signs of all forms of abuse
- g) undertake and interpret basic neurological observations
- h) recognise and take immediate action to respond in an emergency to burns, choking, haemorrhage, neck injury, fitting, seizures and anaphylaxis
- i) recognise mental distress and administer basic mental health first aid
- j) recognise emergency situations and administer basic physical first aid, including immediate life support.

Procedures for provision of evidence-based nursing care

2. To support meeting the needs of people in relation to rest, sleep, comfort and the maintenance of dignity, the nursing associate must demonstrate the ability to:

- a) observe and monitor comfort levels, rest and sleep patterns
- b) use appropriate bed-making techniques
- c) support the comfort of people including those who are unconscious or who have limited mobility
- d) use appropriate positioning and pressure relieving techniques including pillows and other support aids

- e) ensure privacy and dignity at all times
- f) support people to reduce fatigue, minimise insomnia and take appropriate rest
- g) Support people who are experiencing discomfort and pain.

3. To provide care and support with hygiene and the maintenance of skin integrity, the nursing associate must demonstrate the ability to:

- a) observe and reassess skin and hygiene status using contemporary approaches to determine the need for support and ongoing intervention.
- b) help with washing, bathing, shaving and dressing
- c) identify the need for and provide appropriate oral care, dental care, eye care and nail care and suggest to others when an onward referral is needed
- d) appropriately use products to prevent and manage skin breakdown effectively
- e) undertake wound care using aseptic techniques.

4. To provide support with nutrition and hydration, the nursing associate must demonstrate the ability to:

- a) use appropriate nutritional assessment tools
- b) help people to eat and drink and use appropriate feeding and drinking aids
- c) record fluid intake and output to identify signs of dehydration or fluid retention and escalate as necessary
- d) support the delivery of artificial nutrition and hydration using oral and enteral routes in line with person's care plan.

5. To provide support with bladder and bowel care, the nursing associate must demonstrate the ability to:

- a) observe and monitor the level of urinary and bowel continence to determine the need for ongoing support and intervention, the level of independence and self-management of care that an individual can manage
- b) assist with toileting, maintaining dignity and privacy and use appropriate continence products including pads, sheaths and appliances
- c) care for and manage catheters for all genders and help with self-catheterisation
- d) recognise elimination patterns to identify incontinence, constipation, diarrhoea and urinary and faecal retention
- e) undertake stoma care.

- 6. To provide support with mobility and safety the nursing associate must demonstrate the ability to:**
- a) use appropriate risk assessment tools to determine the ongoing need for support and intervention, the level of independence and self-care that an individual can manage
 - b) use appropriate assessment tools to determine, manage and escalate the ongoing risk of falls
 - c) use a range of appropriate moving and handling techniques and mobility aids
- 7. To provide support with respiratory care the nursing associate must demonstrate the ability to:**
- a) manage the administration of oxygen using a range of routes and approaches
 - b) take and be able to identify normal peak flow and oximetry measurements
 - c) use appropriate nasal and oral suctioning techniques
 - d) manage inhalation, humidifier and nebuliser devices in line with prescription
 - e) manage airway and respiratory processes and equipment.
- 8. To prevent and manage infection, the nursing associate must demonstrate the ability to:**
- a) observe and respond rapidly to potential infection risks using guidelines
 - b) use of standard precautions protocols
 - c) use of effective aseptic, non-touch techniques
 - d) use personal protection equipment appropriately
 - e) implement isolation procedures
 - f) use hand hygiene techniques
 - g) safely decontaminate equipment and environment
 - h) safely use and dispose of waste, laundry and sharps
 - i) safely manage commonly used medical devices.

9. To meet the needs for care and support at the end of life, the nursing associate must demonstrate the ability to:

- a) recognise and take immediate steps to respond to uncontrolled symptoms and signs of distress including pain, nausea, thirst, constipation, restlessness, agitation, anxiety and depression. Record and update others on observations and actions taken
- b) review preferences and care priorities of the dying person and their family and carers, and ensure changes are communicated as appropriate
- c) work within organ and tissue donation protocols, forensic and infection protocols, advanced planning decisions, living wills and lasting powers of attorney for health
- d) understand 'do not attempt cardiopulmonary resuscitation' decisions and orders (DNACPR)
- e) provide care for the deceased person respecting cultural requirements and protocols, involving families and carers.

10. To manage medicines safely, nursing associates must be able to demonstrate the ability to

- a) continually assess people receiving care and their ongoing ability to self-administer their own medications. Know when and how to escalate any concerns.
- b) undertake accurate drug calculations for a range of medications
- c) exercise professional accountability in administering medicines safely to those receiving care
- d) administer medication via oral, topical and inhalation routes.
- e) administer injections using subcutaneous and intradermal routes and manage injection equipment
- f) administer and monitor medications using enteral equipment
- g) administer enemas and suppositories in line with prescription
- h) manage and monitor symptom relief medication
- i) recognise and respond to adverse or abnormal reactions to medications, and when and how to escalate any concerns.
- j) store transport and dispose of medicinal products safely.

DRAFT

Standards for pre- registration nursing associate programmes

DRAFT

1. Introduction

Our *Standards for pre-registration nursing associate programmes* set out the legal requirements, entry requirements, availability of recognition of prior learning, length of programme, methods of assessment and information on the award for all pre-registration nursing associate education programmes.

Overall responsibility for the day-to-day management of the quality of any educational programme lies with an approved education institution (AEI) in partnership with health and care settings that offer practice experience to nursing associate students.

Standards for pre-registration nursing associate programmes follow the student journey and are grouped under the following five headings:

- 1 **Selection, admission and progression:** standards about an applicant's suitability and continued participation in a pre-registration nursing associate programme.
- 2 **Curriculum:** standards for the content, delivery and evaluation of the pre-registration nursing associate education programme.
- 3 **Practice learning:** standards specific to pre-registration learning for nursing associates that takes place in practice settings.
- 4 **Supervision and assessment:** standards for safe and effective supervision and assessment for pre-registration nursing associate education programmes.
- 5 **Qualification to be awarded:** standards which state the award and information for the NMC register.

1. Selection, admission and progression

Approved education institutions together with practice learning partners must:

- 1.1 confirm on entry to the programme that students:
 - 1.1.1 demonstrate values in accordance with *the Code*.¹
 - 1.1.2 have capability to learn behaviours in accordance with *the Code*.
 - 1.1.3 have capability to develop numeracy skills required to meet programme outcomes.
 - 1.1.4 can demonstrate proficiency in English language.²
 - 1.1.5 have capability in literacy to meet programme outcomes.
 - 1.1.6 have capability for digital and technological literacy to meet programme outcomes.
- 1.2 ensure students' health and character are sufficient to enable safe and effective practice on entering the programme, throughout the programme and when submitting the supporting declaration of 'health and good character' in line with the NMC's health and character decision-making guidance. This includes satisfactory occupational health assessment and criminal record checks;
- 1.3 ensure students are fully informed of the requirement to declare immediately any cautions or convictions, pending charges or adverse determinations made by other regulators, professional bodies and educational establishments and that any declarations are dealt with promptly, fairly and lawfully;
- 1.4 ensure that the registered nurse or registered nursing associate responsible for directing the educational programme or their designated registered nurse substitute or designated registered nursing associate substitute, are able to provide supporting declarations of health and character for students who have completed a pre-registration nursing associate programme;³
- 1.5 permit recognition of prior learning that is capable of being mapped to the *Standards of proficiency for registered nursing associates* and programme outcomes, up to a maximum of 50% of the programme. This maximum limit of 50% does not apply for current registered nurses, or those former registered nurses that have lapsed within five years, that apply to join a nursing associate programme; and
- 1.6 support students throughout the programme in continuously developing their abilities in numeracy, literacy, digital and technological literacy to meet programme outcomes.

¹ <https://www.nmc.org.uk/standards/code/>

² <https://www.nmc.org.uk/registration/joining-the-register/english-language-requirements>

³ As proposed by Rule 6(1)(a)(iii) of the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004 (SI 2004/1767), as proposed by the draft Nursing and Midwifery (Amendment) Order 2018, consulted on by the Department of Health and Social Care in 2017.

2. Curriculum

Approved education institutions together with practice learning partners must:

- 2.1 ensure that programmes comply with the *NMC Standards framework for nursing and midwifery education*;
- 2.2 comply with the *NMC Standards for student supervision and assessment*;
- 2.3 ensure that all programme learning outcomes reflect the *Standards of proficiency for nursing associates*;
- 2.4 design and deliver a programme that supports students and provides experience for a non-field specific nursing associate programme, across the lifespan and in a variety of settings;
- 2.5 set out the general and professional content necessary to meet the *Standards of proficiency for nursing associates* and programme outcomes;
- 2.6 ensure that the programme hours⁴ and programme length are:
 - 2.6.1 sufficient to allow the students to be able to meet the *Standards of proficiency for nursing associates*;
 - 2.6.2 no less than 50 per cent of the programme hours required of nursing degree programmes (4,600 hours);⁵
 - 2.6.3 consonant with the award of a Foundation degree; and
- 2.7 ensure the curriculum provides an equal balance of theory and practice learning using a range of learning and teaching strategies.

3. Practice learning

Approved education institutions together with practice learning partners must:

- 3.1 provide practice learning opportunities that allow students to develop and meet the *Standards of proficiency for nursing associates* to deliver safe and effective care, to a diverse range of people, across the lifespan and in a variety of settings;⁶
- 3.2 ensure that students experience the variety of practice expected of nursing associates to meet the holistic needs of people of all ages;
- 3.3 ensure technology enhanced and simulation-based learning opportunities are used effectively and proportionately to support learning and assessment;
- 3.4 take account of students' individual needs and personal circumstances when allocating their practice learning including making reasonable adjustments for students with disabilities; and

⁴ 'Programme hours' are hours of formal learning, in theory and practice. They do not include time that students on work-based learning routes spend working in their substantive roles.

⁵ EU Directive 2005/36/EC (as amended by Directive 2013/55/EU) on the recognition of professional qualifications - Article 31

⁶ Nursing associate students are not required to have placements in each field of nursing, but should, through their education programme, benefit from experience of children and adults, and patients/service users with mental health conditions and learning disabilities.

3.5 ensure that students are supernumerary.

4. Supervision and assessment

Approved education institutions together with practice learning partners must:

- 4.1 ensure that, support, supervision, learning and assessment provided complies with the *NMC Standards framework for nursing and midwifery education*;
- 4.2 ensure that support, supervision, learning and assessment provided complies with the *NMC Standards for student supervision and assessment*;
- 4.3 ensure they inform the NMC of the name of the registered nurse or registered nursing associate responsible for directing the education programme;⁷
- 4.4 provide students with feedback throughout the programme to support their development;
- 4.5 ensure throughout the programme that students meet the *Standards of proficiency for nursing associates*;
- 4.6 assess students to confirm proficiency in preparation for professional practice as a nursing associate;
- 4.7 ensure that there is equal weighting in the assessment of theory and practice; and
- 4.8 ensure that all proficiencies are recorded in an ongoing record of achievement which must demonstrate the achievement of proficiencies and skills as set out in *Standards of proficiency for nursing associates*.

5. Qualification to be awarded

Approved education institutions together with practice learning partners must:

- 5.1 ensure that the minimum award for a nursing associate programme is a Foundation Degree of the Regulated Qualifications Framework (England), which is typically two years in length; and
- 5.2 notify students during and before completion of the programme that they have five years in which to register their award with the NMC. In the event of a student failing to register their qualification within five years they will have to undertake additional education and training or gain such experience as specified in our standards.⁸

⁷ As proposed by Rule 6(1)(a)(iii) of the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004 (SI 2004/1767), as proposed by the draft Nursing and Midwifery (Amendment) Order 2018, consulted on by the Department of Health and Social Care in 2017.

⁸ <https://www.nmc.org.uk/globalassets/sitedocuments/registration/registering-more-than-five-years-after-qualifying.pdf>

The Code
Professional standards of practice and behaviour for nurses,
midwives and nursing associates

DRAFT

About us

The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, **or a nursing associate in England**. We take action if concerns are raised about whether a nurse, midwife **or nursing associate** is fit to practise.

It is illegal to practise as a nurse or midwife in the UK, or as a nursing associate in England, if you are not on our register.

Publication date: 29 January 2015

Effective from: 31 March 2015

Updated to reflect the regulation of nursing associates: xx/xx/201x

A note on this version of the Code

All regulators review their Codes from time to time to make sure they continue to reflect public expectations. This version of the Code was published in 2015 for nurses and midwives. The 2015 version is still current, but it was updated in 2019 in response to nursing associates joining our register. In joining the register, nursing associates will uphold the Code.

The current versions of our Code, standards and guidance can always be found on our website. Those on our register should make sure they are using the most up to date version of the Code.

For more information about the Code, please visit: www.nmc.org.uk/code

Introduction

The Code contains the professional standards that registered nurses, midwives **and nursing associates**¹ must uphold. Nurses, midwives **and nursing associates** must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing² and midwifery practice in other roles, such as leadership, education, or research. The values and principles set out in the Code **can be interpreted** in a range of different practice settings, **but** they are not negotiable or discretionary.

Our role is to set the standards in the Code, but these are not just our standards. They are the standards that patients and members of the public tell us they expect from health professionals. They are the standards shown every day by **those on our register**.

When joining our register, and then renewing their registration, nurses, midwives **and nursing associates** commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. We can take action if **those on our register** fail to uphold the Code. In serious cases, this can include removing them from the register.

The Code sets out common standards of conduct and behaviour for those on our register. This provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care.

The professions we regulate have different knowledge and skills, set out in three distinct standards of proficiency. They can work in diverse contexts and have different levels of autonomy and responsibility. However, all of the professions we regulate exercise professional judgement and are accountable for their work.

Nurses, midwives and nursing associates uphold the Code within the limits of their competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the standards in the Code within the contribution they make to overall care. The professional commitment to work within one's competence is a key underpinning principle of the Code which, given the significance of its impact on public protection, should be upheld at all times.

The Code should be useful for everyone who cares about good nursing and midwifery.

- Patients and service users, and those who care for them, can use it to provide feedback to nurses, midwives **and nursing associates** about the care they receive.

¹ Anyone practising as a registered nurse or midwife in the UK, or a nursing associate in England, has to be registered with us. The nursing associate role is only being used in England, and so the Code applies only to nursing associates in England.

² We have used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.

- **Those on our register** can use it to promote safe and effective practice in their place of work.
- Employer organisations should support their staff in upholding the standards in their professional Code as part of providing the quality and safety expected by service users and regulators.
- Educators can use the Code to help students understand what it means to be a registered professional and how keeping to the Code helps to achieve that.

For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing professionalism. Through revalidation, **nurses, midwives and nursing associates** provide evidence of **their** continued ability to practise safely and effectively. The Code **is** central in the revalidation process as a focus for professional reflection. This gives the Code significance **in the** professional life **of those on our register**, and raises its status and importance for employers.

The Code contains a series of statements that taken together signify what good nursing and midwifery looks like. It puts the interests of patients and service users first, is safe and effective, and promotes trust through professionalism.

Professional standards of practice and behaviour for
nurses, midwives and nursing associates
All standards apply within your professional scope of practice

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1. Treat people as individuals and uphold their dignity

To achieve this, you must:

- 1.1 treat people with kindness, respect and compassion
- 1.2 make sure you deliver the fundamentals of care effectively
- 1.3 avoid making assumptions and recognise diversity and individual choice
- 1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
- 1.5 respect and uphold people's human rights

(The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.)

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

- 2.1 work in partnership with people to make sure you deliver care effectively
- 2.2 recognise and respect the contribution that people can make to their own health and wellbeing
- 2.3 encourage and empower people to share in decisions about their treatment and care
- 2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care
- 2.5 respect, support and document a person's right to accept or refuse care and treatment
- 2.6 recognise when people are anxious or in distress and respond compassionately and politely

Professional standards of practice and behaviour for
nurses, midwives and nursing associates
All standards apply within your professional scope of practice

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

- 3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages
- 3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life
- 3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it
- 3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

- 4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment
- 4.2 make sure that you get properly informed consent and document it before carrying out any action
- 4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process
- 4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

(You can only make a 'conscientious objection' in limited circumstances. For more information, please visit our website at www.nmc-uk.org/standards.)

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

- 5.1 respect a person's right to privacy in all aspects of their care

Professional standards of practice and behaviour for
nurses, midwives and nursing associates

All standards apply within your professional scope of practice

- 5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care
- 5.3 respect that a person's right to privacy and confidentiality continues after they have died
- 5.4 share necessary information with other health **and** care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality
- 5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

Professional standards of practice and behaviour for
nurses, midwives and nursing associates
All standards apply within your professional scope of practice

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

To achieve this, you must:

- 6.1 make sure that any information or advice given is evidence-based including information relating to using any health **and** care products or services
- 6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

- 7.1 use terms that people in your care, colleagues and the public can understand
- 7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs
- 7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs
- 7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum
- 7.5 be able to communicate clearly and effectively in English

8 Work co-operatively

To achieve this, you must:

- 8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
- 8.2 maintain effective communication with colleagues
- 8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
- 8.4 work with colleagues to evaluate the quality of your work and that of the team

All standards apply within your professional scope of practice

- 8.5 work with colleagues to preserve the safety of those receiving care
- 8.6 share information to identify and reduce risk
- 8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

- 9.1 provide honest, accurate and constructive feedback to colleagues
- 9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance
- 9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times
- 9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

This includes the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

- 10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
- 10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
- 10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
- 10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
- 10.5 take all steps to make sure that records are kept securely
- 10.6 collect, treat and store all data and research findings appropriately

All standards apply within your professional scope of practice

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

- 11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions
- 11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care
- 11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

- 12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice

For more information, please visit our website at www.nmc.org.uk/indemnity.

Professional standards of practice and behaviour for
nurses, midwives and nursing associates
All standards apply within your professional scope of practice

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, **as appropriate**:

- 13.1 accurately **identify, observe and** assess signs of normal or worsening physical and mental health in the person receiving care
- 13.2** make a timely referral to another practitioner when any action, care or **treatment is required**
- 13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
- 13.4 take account of your own personal safety as well as the safety of people in your care
- 13.5 complete the necessary training before carrying out a new role

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

- 14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.
- 14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
- 14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

(The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals)

15 Always offer help if an emergency arises in your practice setting or anywhere else

Professional standards of practice and behaviour for
nurses, midwives and nursing associates
All standards apply within your professional scope of practice

To achieve this, you must:

- 15.1 only act in an emergency within the limits of your knowledge and competence
- 15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly
- 15.3 take account of your own safety, the safety of others and the availability of other options for providing care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

- 16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
- 16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training
- 16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can
- 16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so
- 16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern
- 16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

For more information, please visit our website at www.nmc-uk.org/raisingconcerns.

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

- 17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse.
- 17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

Professional standards of practice and behaviour for
nurses, midwives and nursing associates
All standards apply within your professional scope of practice

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship

Prescribing isn't within the scope of practice of everyone on our register. Nursing associates don't prescribe, but they may supply, dispense and administer medicines. Nurses and midwives who have successfully completed a further qualification in prescribing and recorded it on our register are the only people on our register that can prescribe.

For more information, please visit our website at www.nmc.org.uk/standards.

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

All standards apply within your professional scope of practice

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

(Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive. You can find more information at www.hse.gov.uk.)

Professional standards of practice and behaviour for
nurses, midwives and nursing associates
All standards apply within your professional scope of practice

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

- 20.1 keep to and uphold the standards and values set out in the Code
- 20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
- 20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
- 20.4 keep to the laws of the country in which you are practising
- 20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
- 20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers
- 20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way
- 20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives **and nursing associates** to aspire to
- 20.9 maintain the level of health you need to carry out your professional role
- 20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

For more guidance on using social media and networking sites, please visit our website at www.nmc.org.uk/standards.

21 Uphold your position as a registered nurse, midwife **or nursing associate**

To achieve this, you must:

- 21.1 refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment
- 21.2 never ask for or accept loans from anyone in your care or anyone close to them

Professional standards of practice and behaviour for
nurses, midwives and nursing associates

All standards apply within your professional scope of practice

- 21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care
- 21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications
- 21.5 never use your status **as a registered professional** to promote causes that are not related to health
- 21.6 cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care

22 Fulfil all registration requirements

To achieve this, you must:

- 22.1 keep to any reasonable requests so we can oversee the registration process
- 22.2 keep to our prescribed hours of practice and carry out continuing professional development activities
- 22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

For more information, please visit our website at www.nmc.org.uk/standards.

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

- 23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise
- 23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)

Professional standards of practice and behaviour for
nurses, midwives and nursing associates

All standards apply within your professional scope of practice

- 23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.
- 23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health **and** care environment
- 23.5 give your NMC Pin when any reasonable request for it is made

(When telling your employers, this includes telling (i) any person, body or organisation you are employed by, or intend to be employed by, as a nurse, midwife **or nursing associate**; and (ii) any person, body or organisation with whom you have an arrangement to provide services as a nurse, midwife **or nursing associate**.)

For more information, please visit our website at www.nmc.org.uk.

24 Respond to any complaints made against you professionally

To achieve this, you must:

- 24.1 never allow someone's complaint to affect the care that is provided to them
- 24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health **and care system**

To achieve this, you must:

- 25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first
- 25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

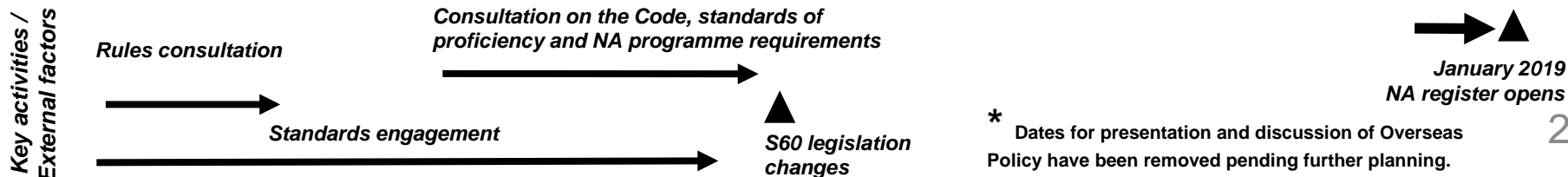
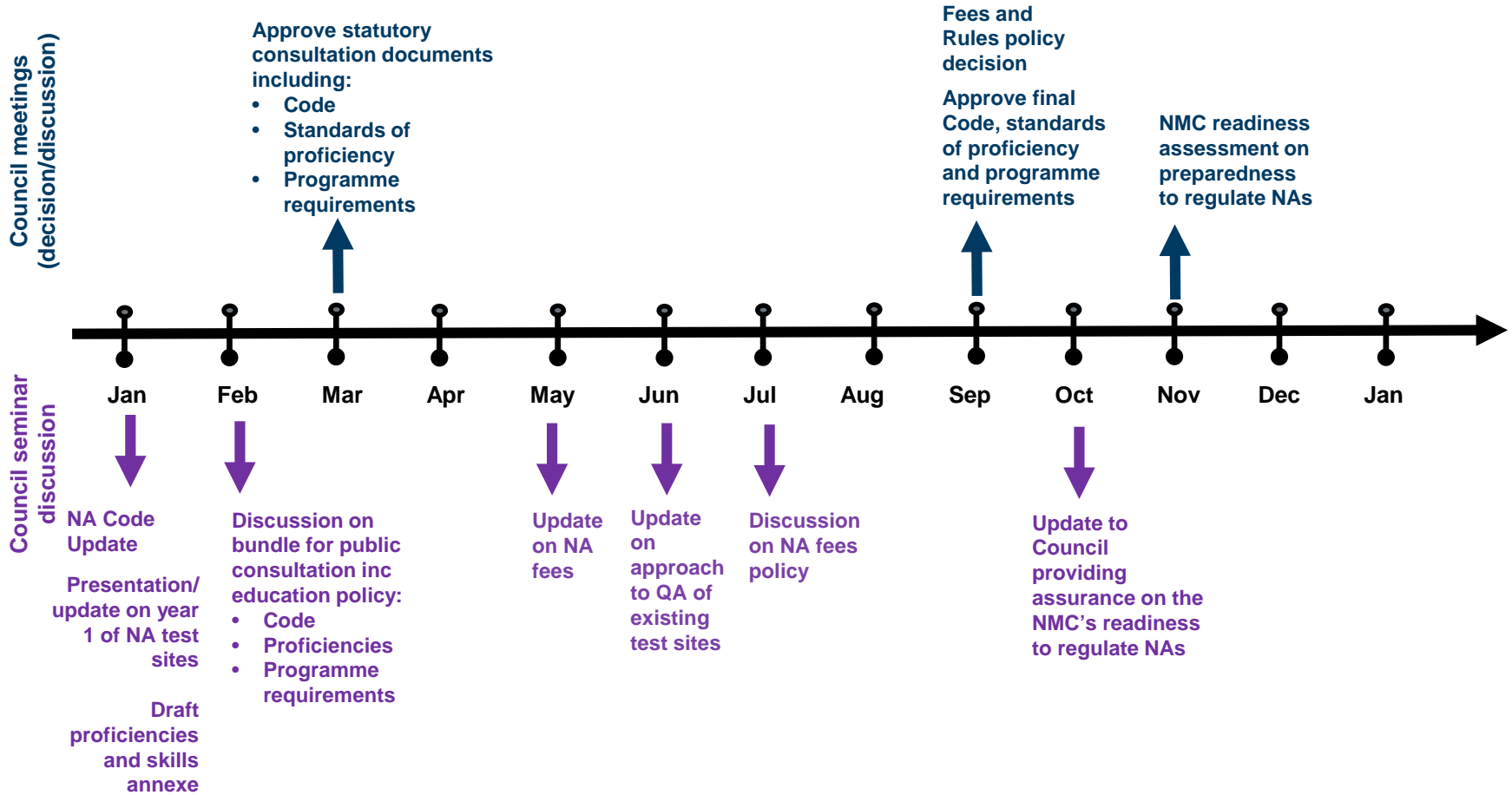
Throughout their career, all our registrants will have opportunities to demonstrate leadership in their role, but not all will occupy formal leadership positions.

Council timeline

(as at March 2018)

NA Programme: timeline

Council: Jan 2018 – Jan 2019



Council

Council Scheme of Delegation

- Action:** For decision.
- Issue:** Seeks approval for an amendment to the Council Scheme of Delegation.
- Core regulatory function:** Supporting functions.
- Strategic priority:** Strategic priority 4: An effective organisation.
- Decision required:** The Council is asked to agree the revised terms of reference for the Remuneration Committee in the Scheme of Delegation at Annexe 1 (paragraph 10).
- Annexe:** The following annexe is attached to this paper:
- Annexe 1: Revised Terms of Reference for the Remuneration Committee.
- Further information:** If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Secretary: Fionnuala Gill
Phone: 020 7681 5842
Fionnuala.Gill@nmc-uk.org

- Context:**
- 1 The Standing Orders and Scheme of Delegation set out the Council's powers and responsibilities; govern the conduct of Council business; and set out matters reserved to the Council or delegated to Committees or the Chief Executive and Registrar.
 - 2 Some minor adjustments are needed to the Remuneration Committee Terms of Reference in the Scheme of Delegation as a consequence of a recent legal review.
- Four country factors:**
- 3 None relevant to this paper.
- Discussion:**
- 4 The Remuneration Committee's current terms of reference include responsibility for approving applications to HM Treasury for approval for any non-contractual (special) payment to any employee. This is based on previous practice under which approval for such payments was sought from in HM Treasury in accordance with Managing Public Money (MPM).
 - 5 A legal review of the provisions of MPM during 2017 concluded that the NMC is not bound to obtain HM Treasury approval in such cases. This was discussed with the Audit Committee, the external auditors and National Audit Office who agreed our approach, as reported in the Audit Committee's report to Council in November 2017.
 - 6 Subsequently, robust revised governance arrangements for handling such cases have been developed in consultation with the Remuneration Committee. The Remuneration Committee will be responsible for approving all non-contractual payments, except where it decides to delegate authority for approval to the Chief Executive and Registrar, as Accounting Officer. The new process envisages that the Committee will delegate authority up to a maximum level (currently £10,500). Approvals by the Chief Executive will be reported to and scrutinised by the Remuneration Committee. All payments approved or endorsed by the Remuneration Committee will be reported to the Council and, as now, will be disclosed in the statutory annual report and accounts.
 - 7 As an organisation which delivers a public service and one that is funded by income from fees paid by registrants, a sector of the public, the NMC intends to continue to follow the general principles in *Managing Public Money* (MPM) which relate to managing public resources. Those general principles include honesty, impartiality, accountability, transparency and fairness. The new governance process is modelled on those contained in MPM.
 - 8 In addition to developing a robust process for approving proposals for non-contractual payments, the Remuneration Committee has separately recommended to the Council a robust framework to guide

handling of such cases which is transparent, defensible and can be applied fairly and consistently.

- 9 A consequence of the above is that minor adjustments are needed to the Remuneration Committee Terms of Reference to reflect the new governance arrangements. The proposed adjustments are shown in mark up in Annexe 1.
- 10 **Recommendation: The Council is asked to agree the amendments to the Remuneration Committee Terms of Reference in the Scheme of Delegation as set out in Annexe 1.**

Public protection implications:

- 11 The Council's overarching statutory duty to protect the public is reflected in the Scheme of Delegation.

Resource implications:

- 12 None.

Equality and diversity implications:

- 13 None.

Stakeholder engagement:

- 14 None.

Risk implications:

- 15 The Standing Orders and Scheme of Delegation are a fundamental element of the Council's governance framework and should be kept up-to-date.

Legal implications:

- 16 The Standing Orders are compliant with the Councils' powers and responsibilities in the Order.

NMC Standing Orders: Scheme of delegation

Annexe 2b: Terms of reference of the Remuneration Committee

- 1 The Remuneration Committee is established by the Council under Article 3 (12) of the Nursing and Midwifery Order 2001.

Remit

- 2 The remit of the Remuneration Committee is to ensure that there are appropriate systems in place for remuneration and succession planning at the NMC.

Responsibilities

Chief Executive and Registrar, Directors, and other employees

- 3 Approve and oversee the process for the recruitment and selection of the Chief Executive and Registrar.
- 4 Consider and recommend to the Council an appropriate reward strategy for the Chief Executive and Registrar and the Directors.
- 5 Approve annually the reward package, including any performance related element, of the Chief Executive and Registrar and the Directors in line with the reward strategy set by the Council.
- 6 Approve the process for the setting of objectives for and performance appraisal of the Chief Executive and Registrar.
- 7 Review reports from the Chief Executive and Registrar regarding the setting of objectives for and performance appraisal of the Directors.
- 8 Approve the arrangements for succession planning for the Chief Executive and Registrar and review those for the Directors.
- 9 ~~Decide and, if approved, report to the Council~~ Approve any request to be made to HM Treasury by the Chief Executive, as Accounting Officer, to make a non-contractual payment to Directors or other employees in relation to special severance payments in the event of the termination of employment or, in the case of the Chief Executive and Registrar, any request made by the Chair of the Council. Review any non-contractual payments authorised by the Chief Executive and Registrar as delegated by the Committee, or a Director, and any other special payments to employees⁴.

⁴ ~~The respective roles of the Remuneration Committee, the Chief Executive and Registrar, and the Privy Council are set out in a separate explanatory memorandum.~~

~~409~~ Review, as necessary, any significant changes to the People Strategy, the employee pay and grading structure, or the pension schemes.

The Chair and the Council

~~41~~10 Recommend to the Council any changes to the remuneration and terms of service of the Chair and Council members, seeking independent advice as appropriate.

~~42~~11 Approve the expenses policy for the Chair, Council and Partner members.

~~43~~12 Recommend to the Council the arrangements for the induction, appraisal and development of the Chair and Council members.

~~44~~13 Approve and oversee the process for the recruitment or reappointment of the Chair and Council members, in accordance with PSA guidance and the requirements of the Privy Council.

Approved by the Council

18 July 2013 (amended 25 November 2015 and 24 May 2017)

Council

Panel member reappointments, transfers and removal

- Action:** For decision.
- Issue:** Re-appointment of two panel members of the Fitness to Practise Committee; Transfer of two panel members to the Investigating Committee and the removal of a panel member.
- Core regulatory function:** Fitness to Practise.
- Strategic priority:** Strategic priority 1: Effective regulation.
Strategic priority 4: An effective organisation.
- Decision required:** The Council is recommended to approve the:
- reappointment of panel members 1 and 2 listed at Annexe 1 to a second term on the Fitness to Practise Committee of four years from 28 March 2018 to 27 March 2022 (paragraph 9).
 - transfer of panel members 3 and 4 to the Investigating Committee as listed in Annexe 1 effective from 28 March 2018 (paragraph 12).
 - removal of panel member 5 as listed in Annexe 1 with effect from 28 March 2018 (paragraph 16).
- Annexe:** The following annexe is attached to this paper:
- Annexe 1: List of recommended changes to appointments.
- Further information:** If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Claire Davidson
Phone: 020 7681 5733
claire.davidson@nmc-uk.org

Director: Matthew McClelland
Phone: 020 7681 5987
Matthew.McClelland@nmc-uk.org

- Context:**
- 1 The Nursing and Midwifery Council (Midwifery and Practice Committees) (Constitution) Rules 2008 state that a panel member appointed to a practice committee may be appointed to a further term by the Council. No person can serve more than two terms.
 - 2 There are two panel members who finished their first term in February 2018 that the NMC wishes to appoint to a second term.
 - 3 Two panel members have requested a transfer to the Investigating Committee.
 - 4 One panel member has failed to obtain the minimum number of sitting days for the last three consecutive review periods. We are recommending they be removed from the list of members for the Fitness to Practise Committee.
 - 5 At its meeting on 7 March 2018 the Appointments Board approved the recommendation to Council to reappoint the two panel members to the Fitness to Practice Committee, transfer two panel members from the Fitness to Practise Committee to the Investigating Committee and remove one panel member from the Fitness to Practise Committee.

Four country factors: 6 Same in all UK countries.

Discussion: Reappointments

- 7 The two panel members have met the required standards for reappointment.
- 8 The Appointments Board has scrutinised the performance data of the two panel members and recommends to Council the re-appointment of panel members 1 and 2 listed in Annexe 1 to the Fitness to Practise Committee.
- 9 **Recommendation: The Council is recommended to approve the reappointment of panel members 1 and 2 listed at Annexe 1 to a second term on the Fitness to Practise Committee of four years from 28 March 2018 to 27 March 2022.**

Transfer

- 10 The Appointments Board has scrutinised the request of two panel members to transfer to the Investigating Committee.
- 11 The panel members are meeting the required standards of performance.
- 12 **Recommendation: The Council is recommended to approve the**

transfer of panel members 3 and 4 to the Investigating Committee as listed in Annexe 1 effective from 28 March 2018.

Removal of a panel member

- 13 We have advised the Appointments Board that a panel member has not met the minimum number of sitting days for the last three consecutive review periods.
- 14 We have contacted the panel member on three occasions to advise the minimum sitting days were not being met and that the Appointments Board would consider their continuing appointment and may make a recommendation to Council that they be removed from the practice committee.
- 15 The Appointments Board considered the information that was put before it and has recommended that the Council remove the individual from the appointed members list.
- 16 **Recommendation: The Council is recommended to approve the removal of panel member 5 as listed in Annexe 1 with effect from 28 March 2018.**

Public protection implications:

- 17 Panel members are required to make decisions at fitness to practise events that protect the public.

Resource implications:

- 18 No direct resource implications. Panel member costs are included in existing budgets.

Equality and diversity implications:

- 19 No equality and diversity implications have been identified as a result of these changes.

Stakeholder engagement:

- 20 The NMC has engaged with all four panel members. Each individual in this group has been provided with a personal activity and engagement report, and the opportunity to comment upon it.

Risk implications:

- 21 None identified.

Legal implications:

- 22 No legal implications identified.
- 23 Panel members are not employees and the panel member service agreement in place does not guarantee a second term of appointment.

Item 11: **Annexe 1**
NMC/18/29
28 March 2018

List of recommended changes to appointments

Panel Member Number	Name	Practice Committee	Recommendation
1	Caroline Healy	FtPC	Reappoint to a second term of office for a period of four years from 28 March 2018 to 27 March 2022.
2	Carla Hartnell	FtPC	Reappoint to a second term of office for a period of four years from 28 March 2018 to 27 March 2022.
3	Maureen Gunn	FtPC	Transfer to the Investigating Committee on 28 March 2018.
4	Ann Brown	FtPC	Transfer to the Investigating Committee on 28 March 2018.
5	Simon Dejong	FtPC	Remove the panel member from the Fitness to Practise Committee on 28 March 2018.

Council

Midwifery update

Action: For discussion.

Issue: Provides an update on midwifery matters.

Core regulatory function: All regulatory functions.

Strategic priority: Effective regulation.

Decision required: None.

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below:

Author: Anne Trotter
Phone: 020 7681 5779
anne.trotter@nmc-uk.org

Director: Geraldine Walters
Phone: 020 7681 5924
geraldine.walters@nmc-uk.org

- Context:**
- 1 In January 2017, the Council agreed that a number of measures would be put in place to ensure that the Council received regular advice relating to midwifery regulation, following the removal of the statutory Midwifery Committee. One of those measures included a report at each meeting to update the Council on midwifery issues.
 - 2 This report provides the Council with an update on recent midwifery activity including the work of the Midwifery Panel, the development of new standards of proficiency for midwives, and recent and planned engagement.

- Four country factors:**
- 3 As there are different approaches across the four countries to midwifery issues and maternity services, where different approaches apply these will be highlighted throughout the report.

Discussion

Midwifery Panel

- 4 The Panel's membership has been extended to include Lord Willis of Knaresborough, a member of the House of Lords, and Leigh Kendall, a maternity campaigner and communications expert.
- 5 The Midwifery Panel met most recently on 8 February 2018 and was pleased to welcome both Lord Wills and Leigh Kendall to the Panel.
- 6 The Panel received an update from Scotland's Chief Midwifery Officer on *The Best Start*: a five year forward plan which signals a fundamental shift in maternity and neonatal care in Scotland.
- 7 An update was provided on the review of pre-registration midwifery standards. The Panel discussed emerging themes, progress to date and planned next stages. The Panel also discussed the scope for extending the next engagement phase to include strengthening the social media campaign to reach mothers and families.
- 8 The Panel received a presentation from the Director of Fitness to Practise and welcomed the NMC's plans for a new strategic direction for fitness to practise and how this would relate to midwives.
- 9 The NMC's senior midwifery adviser updated the panel on her work and engagements over the previous three months.

External reports and publications

WHO recommendations: intrapartum care for a positive childbirth experience

- 10 WHO has issued new recommendations on essential labour and childbirth practices that should be provided to all pregnant women and their babies.

- 11 The guideline include 56 evidence-based recommendations on what care is needed throughout labour and immediately after for women and newborns. It highlights the importance of women centred care to optimise the labour and childbirth experience through a holistic, human rights-based approach.
- 12 The recommendations include good communication between maternity care providers and women; respectful care that maintains women's dignity, privacy and confidentiality; enabling women to make informed choices; and midwifery support throughout the antenatal, intrapartum and postnatal continuum, among others. These recommendations will inform our work on the development of the future midwife proficiencies.

Healthcare education funding for postgraduate nursing and midwifery students

- 13 The Department of Health and Social Care has announced that from August 2018 new postgraduate pre-registration nursing and midwifery students in England will be able to access loans from the Student Loans Company. Students will have access to the Learning Support Fund, administered by the NHS Business Services Authority, for support with child dependents, exceptional hardship and attending clinical placements.

Update on future midwife standards

- 14 As Council is aware, the future midwife project has now concluded the engagement and research gathering phase which involved extensive engagement across the UK. This included: large workshops; small focus groups; meetings; webinars; Thought Leadership Group meetings; and an online Virtual Thought Leadership Group. We now have a list containing nearly 500 subscribers who receive updates and invitations to events and webinars.
- 15 The key objective during this phase of work was to listen to people's views on the knowledge and skills midwives need today and in the future. Specific groups of stakeholders included:
 - 15.1 Employers: The five listening workshops in Manchester, Belfast, London, Cardiff and Glasgow included practice placement coordinators, and heads of midwifery from across the UK.
 - 15.2 Education sector: The listening workshops included educators in Belfast, London and York. Smaller engagement events, such as meetings, webinars and focus groups, were held with midwifery educators, professors of midwifery across the UK, the Council of Deans of Health, student midwives, access course students, and a number of medical royal colleges.
 - 15.3 Four country engagement: As mentioned above, heads of midwifery from the four countries attended the listening

workshops, along with a number of policy makers.

- 15.4 Other attendees of the workshops and focus groups included experienced midwives, newly qualified midwives, mothers and family members, and advocacy groups.
- 15.5 Discussions with a range of advocacy groups including Maternity Action, The Traveller Movement, Refugee Action, Terrence Higgins Trust, Mumsnet, Women's Aid, Stonewall and Mummy's Star. We also engaged with the RCN's midwifery committee, Sands, Birthrights, National Infant Feeding Network, and mother support groups.
- 16 In addition to the input from the above engagement, other sources of evidence to support the development of the proficiencies include a literature review by the University of Dundee focusing on three areas: the needs of women, babies and families; standards development; and effective education. This work was received at the end of January 2018, is being analysed and will inform the drafting of future standards of proficiency.
- 17 The future midwife team is also collating and analysing other pieces of evidence, for example: midwifery reviews; enquiries and coroners reports; our own previous reports; press articles on midwifery related topics; reports such as the MBRRACE-UK Confidential Enquiry into Maternal Deaths; the Council of Deans of Health 'Educating the Future Midwife' paper; ICM competencies; and our independent evaluation of the NMC pre-registration standards, which will also inform the work.
- 18 All of the evidence and engagement activity will inform the development of the draft proficiencies and programme requirements ready for consultation during the next phase.
- 19 Following discussion of the emerging issues and themes from the engagement and evidence collected so far, the Council has been able to clarify its expectations and identify the characteristics which it expects the future standards to demonstrate. This includes that they should:
 - 19.1 Be appropriate for all four countries of the UK;
 - 19.2 Prepare students to practise safely in all types of setting;
 - 19.3 Be outcome focused: focused on what a midwife needs to know, and be able to do, at the point of initial registration;
 - 19.4 Encompass multi-agency, multi-professional learning and team working;
 - 19.5 Allow flexibility to Approved Education Institutions to develop programmes that achieve those outcomes, minimising input and process requirements;

- 19.6 Be evidence based, as far as is possible within the available evidence;
 - 19.7 Include taking account of evidence from Fitness to Practise of areas where strengthened focus in educational standards could improve public safety and prevent harm;
 - 19.8 Anticipate likely future conditions for midwifery practice and develop standards accordingly;
 - 19.9 Facilitate access to midwifery education for students from diverse backgrounds;
 - 19.10 Have been shared widely with interested parties, including, for example, other regulators, and the outcomes of this reported impartially when presenting proposals; and
 - 19.11 Take full account of all recommendations arising from key relevant reports.
- 20 The Council has asked the Midwifery Panel to oversee progress of this work and assess the draft standards as they develop against the above framework.
 - 21 The draft standards and programme requirements will be considered by the Council in November 2018, with a view to beginning consultation in February 2019.

Public protection implications:

22 None directly arising from this report.

Resource implications:

23 None directly arising from this report.

Equality and diversity implications:

24 None directly arising from this report.

Stakeholder engagement:

25 This is covered in the body of the report.

Risk implications:

26 No specific risk implications arising from this report. Risks relating to development of the future midwife standards are captured through the programme.

Legal implications:

27 None arising from this paper.

Council

Performance and Risk report

Action: For discussion.

Issue: The latest overview of performance and risk management.

Core regulatory function: All functions.

Strategic priority: All.

Decision required: The Council is asked to:

- Discuss our KPI performance for January 2018 to February 2018 (paragraph 15).
- Discuss the corporate risk summary (paragraph 19).

Annexes: The following annexes are attached to this paper:

- Annexe 1: Performance reports including year to date progress update against corporate KPIs.
- Annexe 2: Corporate risk summary.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Roberta Beaton
Phone: 020 7681 5243
roberta.beaton@nmc-uk.org

Director: Gary Walker
Phone: 020 7681 5754
gary.walker@nmc-uk.org

- Context:**
- 1 This report provides the latest overview of performance and risk management across the organisation.
 - 2 Further improvements in reporting about performance and risk are intended for 2018–2019 and will be a key outcome of 2018–2019 annual business planning.
- Four country factors:**
- 3 These are taken into account in considering our risks and through our operational performance.

Discussion: Performance

- 4 Performance for January 2018 to February 2018 including a year to date summary against our five corporate key performance indicators (KPIs) is presented at **Annexes 1a to 1h**.

Highlights

- 5 Progress against our corporate KPIs for UK initial registration applications (KPI 1) and EU/Overseas registrations applications (KPI 2) remain stable and above target. The year to date performance for UK registrations is 98% against our target of 95%, and EU/Overseas registrations is 99.6% against our target of 99% (**Annexe 1a**).
- 6 Call answering rates remain above 90%. Whilst the volume of calls has decreased by 21% compared to same period last year, the complexity of calls means the length of calls (talk time) remains high. The number of simple calls has reduced with customers choosing to self-serve through the online service (**Annexe 1a**).
- 7 We continue to exceed our 80% target for imposing Fitness to Practise (FtP) interim orders within 28 days as shown at **Annexe 1c**.
- 8 Conclusion of FtP cases within 15 months of being opened has reached our target of 80% for the first time (**Annexe 1c**).
- 9 A summary of FtP operating performance and dashboard showing caseload and timeliness performance data can be found at **Annexes 1b and 1d**.
- 10 We continue to embed our approach to measuring the customer service of Registrations and Revalidation and FtP with our latest results presented at **Annexe 1e**. Overall satisfaction remains stable with an average of 76% customers reporting that they are very satisfied/satisfied with the service they received this year. 71% of customers strongly agreed/agreed that the NMC made it easy for them to manage their issue. Details about why customers are reporting dissatisfaction (which stands at 15% plus), and actions being taken to reduce this will be reported to Council Members in

May 2018. We continue to analyse survey data to consider the actions we can take to improve the experience for service users.

- 11 Staff turnover results are presented at **Annexe 1f**. Since December 2017, staff turnover has reduced by 0.7% to 22.4%. When compared to February 2017 there has been an overall reduction in turnover by 1.9%. Leaver reasons remain consistent with those reported to Council in January 2018.
- 12 27% of leavers had less than six months' service. Actions being taken to mitigate departures within six months are included in **Annexe 1f**. These include 1-month reviews with new staff, follow ups at the 3-month period, a re-launch of the Recruitment and Careers website and increased focus on corporate risk 3 regarding capacity and capability.
- 13 Progress against corporate KPIs is presented at **Annexe 1g** with all corporate KPIs meeting annual targets in February 2018.
- 14 Serious Event Reviews (SERs) are a key tool used by NMC to ensure that we learn lessons when errors or near misses occur so they can be avoided in the future. The Council requested further details about the number of SERs taking place and the main outcomes resulting from these reviews. A report will be provided to the Council in May 2018.
- 15 **Recommendation: The Council is invited to discuss our KPI performance for January 2018 to February 2018.**

Corporate risks (Annexe 2)

- 16 Our corporate risk summary is provided at **Annexe 2**. The Council undertook an annual risk review in April 2017 to consider the current corporate risks the NMC faces. The summary contains these corporate risks, mitigations in place and planned risk management actions still to be implemented.
- 17 Risk three (capacity and capability to deliver) remains NMC's top priority to address. A number of mitigations have been updated to reflect the change of focus and we forecast this risk reducing to amber by 2019.
- 18 Suggested updates to reflect the draft corporate plan and budget for 2018–2019 will be presented to Council for inclusion in the corporate risk register for presentation in May 2018.
- 19 **Recommendation: The Council is invited to discuss the corporate risk summary.**

Public protection

- 20 Public protection implications are considered when reviewing performance and the factors behind poor or good performance.

implications:

- Resource implications:** 21 Performance and Risk Reporting are a corporate requirement and are resourced from within business as usual budgets with no additional cost attached. We do not anticipate future additional costs above and beyond day to day management costs unless we make refinements to our framework which will be fully costed. No external resources have been used to produce this report.
- Equality and diversity implications:** 22 Equality and diversity implications are considered in reviewing our performance and risks.
- Stakeholder engagement:** 23 KPI and risk information is in the public domain. There is therefore the opportunity for the public to ask questions of the information provided at Open Council meetings.
- Risk implications:** 24 The impact of risks is assessed and rated within our corporate risk register.
- Legal implications:** 25 None.

This cover page is an overarching summary of progress and performance.

The accompanying reports within Annexe 1 contain the detail.

Contents of Annexe 1:

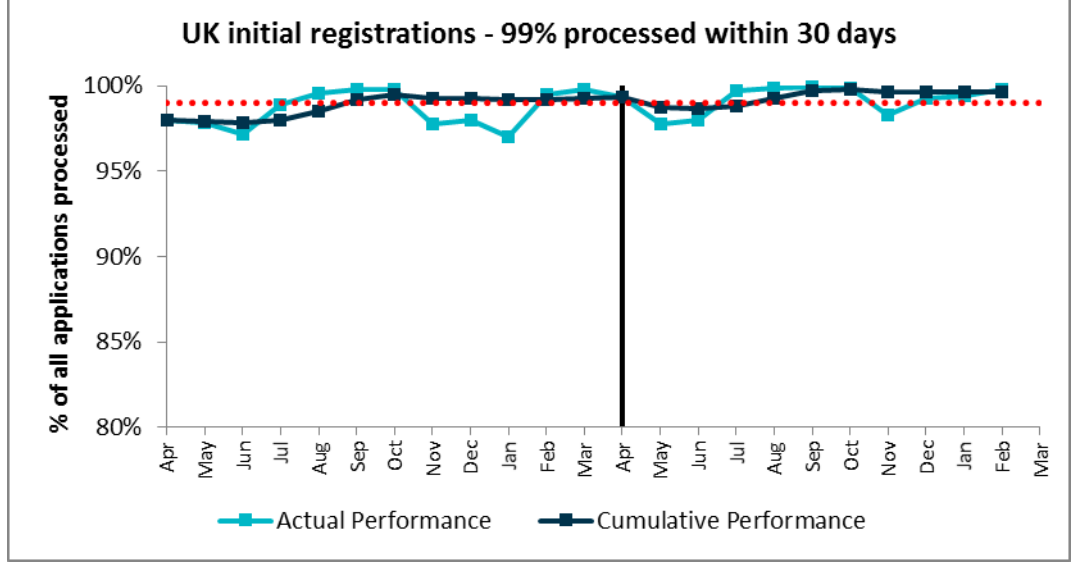
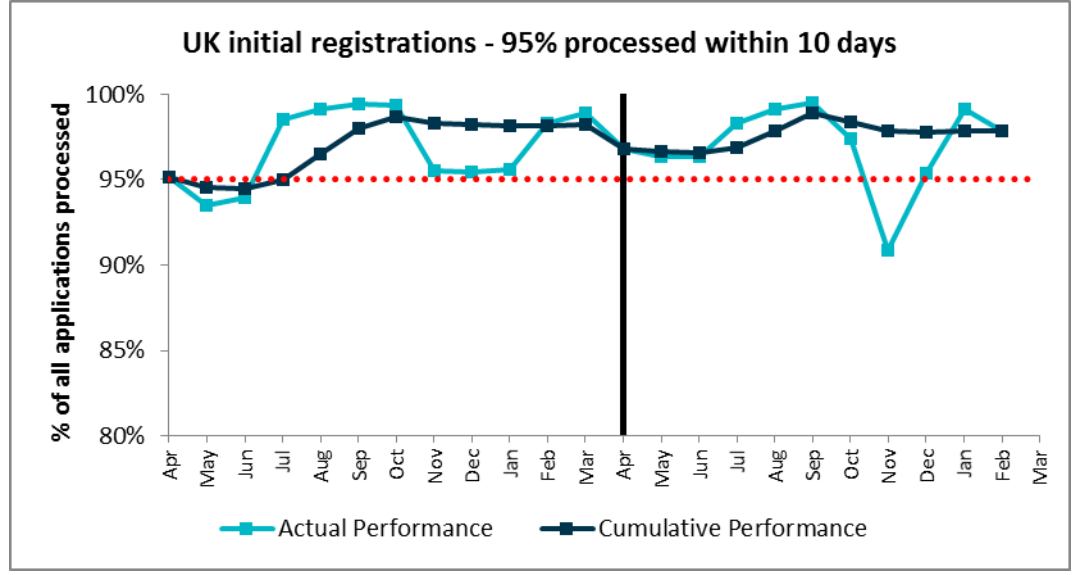
- 1a** Registration and Revalidation performance report
- 1b** FtP Performance Summary
- 1c** FtP performance report
- 1d** FtP dashboard
- 1e** Customer service
- 1f** Staff turnover
- 1g** 12 month summary of corporate KPIs

[Please note that as the Council requested the axes for the charts on the following pages have been set to 80%]

KPIs 1 and 2 - Percentage of UK initial registration applications completed									
KPI	Average for 2016–2017	December 2017		January 2018		February 2018		Year to date average	Year end average target
		No.	As a %	No.	As a %	No.	As a %		
KPI 1 10 Days	98.2%	409	95.3%	890	99.1%	906	97.8%	97.9% (Green)	95% within 10 days
KPI 2 30 Days	99.2%	426	99.3%	893	99.4%	924	99.8%	99.6% (Green)	99% within 30 days

Commentary:
 Performance has remained strong during January and February 2018. We are on track to meet our year end targets. The team continues to prepare for the annual spike in Initial Applications from March 2018 onwards.

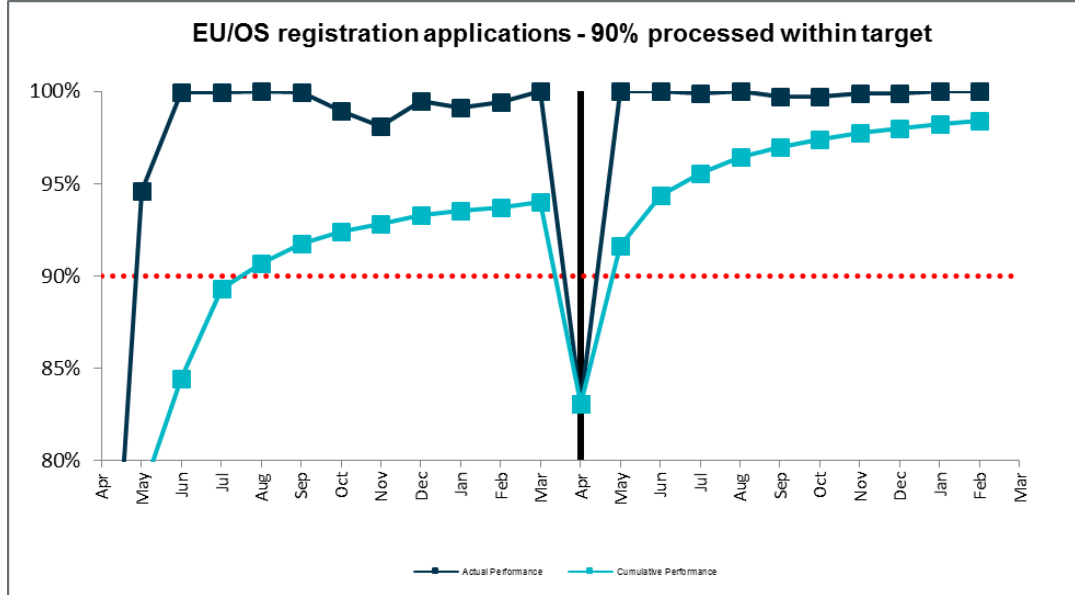
Rating definitions:	Green	Amber	Red
KPI 1 – 10 days	≥ 95.0%	90.0% – 94.9%	≤89.9%
KPI 2 – 30 days	≥ 99.0%	98.9% – 94.0%	≤93.9%



KPI 3 - Percentage of EU/Overseas registration applications assessed within 60 days							
December 2017		January 2018		February 2018		Year to date average	Year end average target
No.	As a %	No.	As a %	No.	As a %		
892	99.9%	1,258	100.0%	1,073	100.0%	98.4% (Green)	90%

Commentary:
 Performance continues to remain strong. We are forecast to be significantly above target at year end.

Rating definitions:	Green	Amber	Red
KPI 3 – 60 days	≥ 90.0%	85.0% – 89.9%	≤84.9%

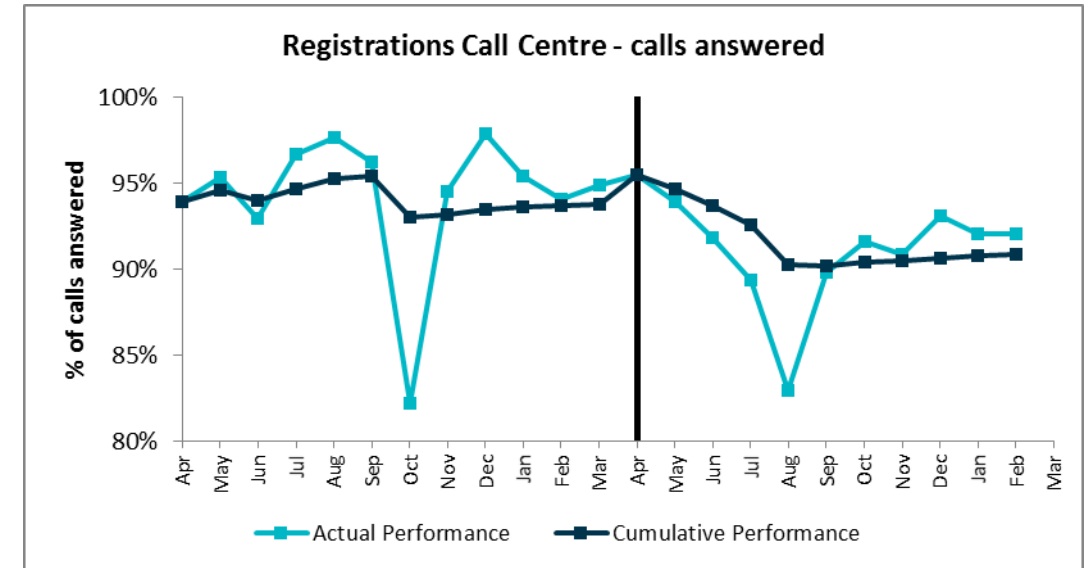


Call Centre

Percentage of calls answered			
December 2017	January 2018	February 2018	Year to date
93.1%	92.1%	92.0%	
15,044 / 1,034 offered/abandoned	22,421 / 1,782 offered/abandoned	19,403 / 1,544 offered/abandoned	90.9%

Commentary:

- Performance was above 90% for January and February 2018.
- Call volumes for January and February 2018 were 21% lower than in 2016-2017 (53,088 vs. 41,824 calls); talk time remains high due to higher complexity of calls (January 2017 compared to January 2018 calls increased by 41 seconds per call, and February 2017 compared to February 2018 calls increased by 33 seconds per call). This is a result of more technical queries being logged.
- The number of simpler calls has reduced as customers continue to self-serve through our online service.



Revalidation

Percentage of revalidation rates for each UK country				
	England	Scotland	Northern Ireland	Wales
December	90.0%	92.8%	94.8%	89.1%
January	93.8%	94.8%	95.5%	91.0%
February	%	%	%	%

Note:

Both tables show monthly revalidation rates, with the whole register table including those based outside of the UK.

Revalidation volumes and percentages - whole register			
	December	January	February
Number	12,187	12,766	13,977
As a percentage (of those due to revalidate)	89.7%	93.0%	94.0%

Commentary:

- Revalidation rates for December 2017, January and February 2018 are comparable to the same months in 2016-2017; with slightly higher rates for some months.
- We are confident that nurses and midwives continue to engage with revalidation with no evidence that revalidation is leading to an increase in lapsing at renewal.

Verifications:

All applications verified in this period were compliant with the requirements.

Fitness to Practise Performance Summary: Jan to Feb 2018

Introduction

- 1 At the start of 2017-2018 we set a forecast for caseload reduction and a timeliness pathway and have reported performance against these on our dashboard at every Council meeting.
- 2 The key risk for the Council to note in this report is lower than planned output at the investigation stage, which is having an impact on overall caseload and timeliness. Further information about the risk and mitigations is set out in paragraphs 3.3 and 8 below.

Caseload

- 3 Caseload is shown in graphs A1 and A2 of the dashboard. Key points to note:
 - 3.1 At the end of February 2018, overall caseload stood at 3,055. We expect to finish the year with slightly more cases in the caseload than we had planned to have.
 - 3.2 Screening caseload is broadly in line with the planned position.
 - 3.3 There are more cases in the Investigations caseload than planned at this point in the year. Output remains a challenge, largely due to capacity issues. At the beginning of February 2018, eleven out of 54 investigator posts were vacant. Turnover in investigations is stable, although higher than we would like it to be. The high number of vacancies reflects challenges in recruiting to roles, rather than a change in the turnover rate. Following the latest recruitment round we have filled four roles and two more investigators are about to start in post. The next recruitment round is underway and applications close on 19 March 2018. In the interim, we have (i) brought in temporary paralegals and administrators to support the investigation teams; (ii) authorised additional overtime; (iii) instructed some additional external investigations. The costs of these mitigations are reflected in our financial forecast. We are continuing our work with the People and Organisational Development directorate to improve turnover, focussing in particular on improving opportunities for training and development. For the time being, output remains a challenge and investigations will end the year with more cases in the caseload than planned. Given the lead time in recruiting and training new investigators, we are unlikely to see significant improvements in output for the next 6 to 12 months.
 - 3.4 There are fewer cases in the Adjudications caseload that we planned at this point in the year. Output in February 2018 was lower than expected as a result of a high number of cancelled hearings. We experienced some teething issues following changes to structure and process at the start of the calendar year; these have now been resolved.

- 4 The referral rate is shown in graph A3 of the dashboard. Key points to note:
- 4.1 on average, we are receiving 457 referrals a month in the year to date.
- 4.2 maximum capacity in the screening teams is 500 referrals a month.

Timeliness

- 5 Median ages of cases at the different stages of our process are shown in graphs B1, B2, and B3 of the dashboard.
- 6 The age profile of cases at the different stages of our process are shown in graphs C1, C2, C3, and C4 of the dashboard. They provide assurance that there is no build-up of older cases.
- 7 Table 2 below shows performance against the timeliness pathway since the start of the financial year.

Table 2: Timeliness pathway¹	Apr-17	Jul-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
No Screening cases over 8 weeks (from April 2017)	30 (7%)	8 (7%)	14 (3%)	0 (0%)	10 (3%)	14 (3%)	11 (3%)
No Investigation cases over 32 weeks (from December 2017)	266 (24%)	255 (24%)	222 (20%)	195 (18%)	225 (20%)	226 (21%)	220 (21%)
No CE cases over 39 weeks (from December 2017)	129 (34%)	164 (39%)	140 (38%)	139 (38%)	124 (36%)	135 (36%)	162 (42%)
No Adjudication cases over 65 weeks (from June 2018)	462 (59%)	371 (59%)	284 (55%)	247 (52%)	224 (48%)	218 (51%)	218 (53%)

- 8 Although we have made significant headway, we have not got as far as we planned; output at the investigations stage has been the major factor. An unintended consequence of the focus on timeliness as a 'lag indicator' has been less focus on the early stages of casework; this has meant that progress has not been fully sustainable. We intend to engage an external supplier to assist with planning and execution in 2018-2019.

¹ Excludes cases that have been held up by third party investigations.

- 9 We will continue to report against the timeliness pathway next year. The pathway will be realigned to 33 weeks for Investigations to better reflect the operational handover points.

Update following legislation changes

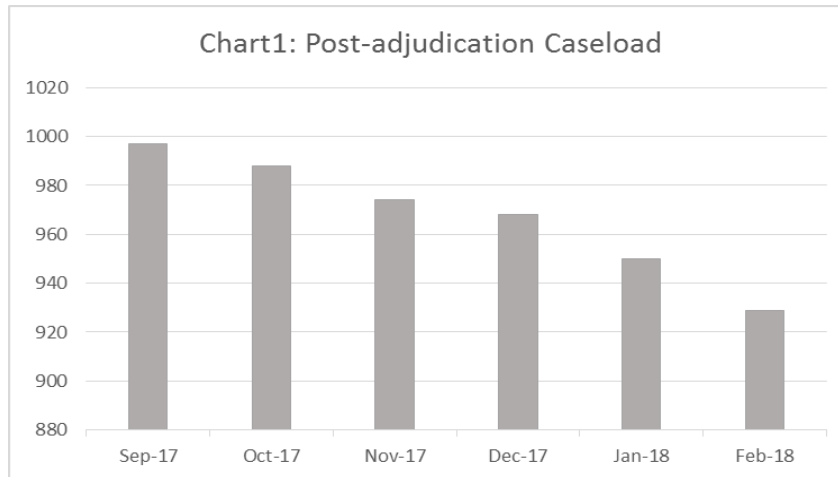
- 10 Legislation changes were introduced in April and July 2017 to place midwifery regulation on the same footing as nursing regulation and to improve efficiency in the fitness to practise process, including introducing new powers for Case Examiners to dispose of cases by means of undertakings, warnings, and advice.
- 11 Table 4 below shows the number and proportion of Case Examiner disposals since the new powers came into force on 31 July 2017. There has been no substantive change in the disposal rates since the Council last met in January 2018. Although the number of new disposals remains lower than the planning assumptions, they represent avoided costs of c. £2 million to date. Overall, the case to answer rate is in line with our budget for 2018-2019. As previously reported, we will continue to monitor disposals carefully and will make a full assessment in September 2018 after one year of operation.

Table 4 Case Examiner disposal	Planning assumption	Q2 (Aug & Sep)	Q3	Jan	Feb	Q4 (to date)	YTD
Case to answer	42%	35% (140)	35% (221)	33% (65)	26% (44)	29% (109)	34% (470)
Undertakings offered	5%	3% (11)	3% (17)	3% (5)	3% (6)	3% (11)	3% (39)
Warnings issued	11%	5% (18)	5% (30)	7% (17)	7% (12)	8% (29)	6% (77)
Advice issued	6%	1% (5)	2% (13)	1% (1)	1% (1)	1% (2)	1% (20)
No case to answer	36%	57% (226)	55% (342)	56% (110)	63% (109)	59% (219)	56% (787)

Post-Adjudication

- 12 The Post Adjudication Team is responsible for the monitoring and compliance of cases where a practice committee has imposed a substantive order which requires a panel to review it prior to its expiry. The team ensures that the cases are listed for review and prepares the necessary evidence for panels to consider. The team also monitors the compliance with the order, taking necessary steps when a potential breach of the order has been identified.

- 13 From April 2018 onwards, the Post Adjudication team will also be responsible for managing the 'Undertakings' case load, as the skills required to ensure compliance are similar of that of the substantive orders.
- 14 At the end of February 2018, the post-adjudication caseload for substantive order reviews was 929 cases. These cases are not included in our overall caseload numbers reported on the dashboard. Chart 1 below shows the movement in the caseload over the last six months:



KPI 4 – Percentage of interim orders (IO) imposed within 28 days of opening the case

12 month rolling performance March 2017	December 2017*	January 2018*	February 2018*	12 month rolling performance October 2017	12 month rolling performance target
91%	88%	92%	94%	86% Green	80%

KPI 5 - Percentage of FtP cases concluded within 15 months of being opened

12 month rolling performance March 2017	December 2017*	January 2018*	February 2018*	12 month rolling performance February 2018	12 month rolling performance target
75%	81%	84%	87%	80% Green	80%

* Figure shown is monthly actual

Commentary

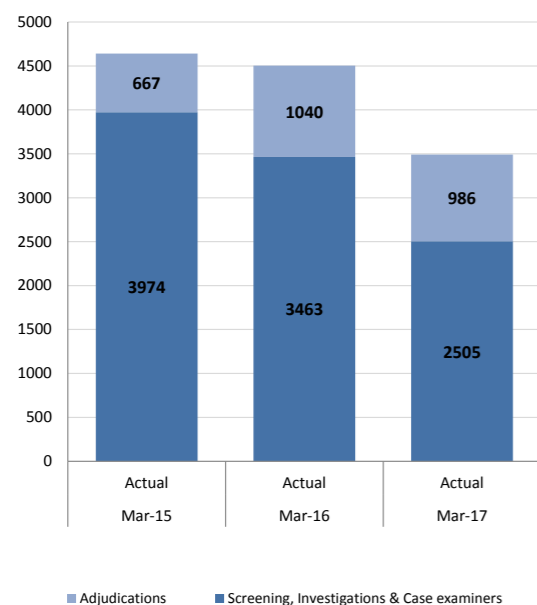
KPI4: Interim Orders: The rolling 12 month performance remains on target.

KPI5: Cases concluded within 15 months: At April 2017, 75% of cases were concluded within 15 months, this rose to 78% by December 2017, and has risen again to 80% at February 2018, hitting our annual target for the first time during the year. This shows that actions taken to improve the timeliness of case conclusion have been effective.

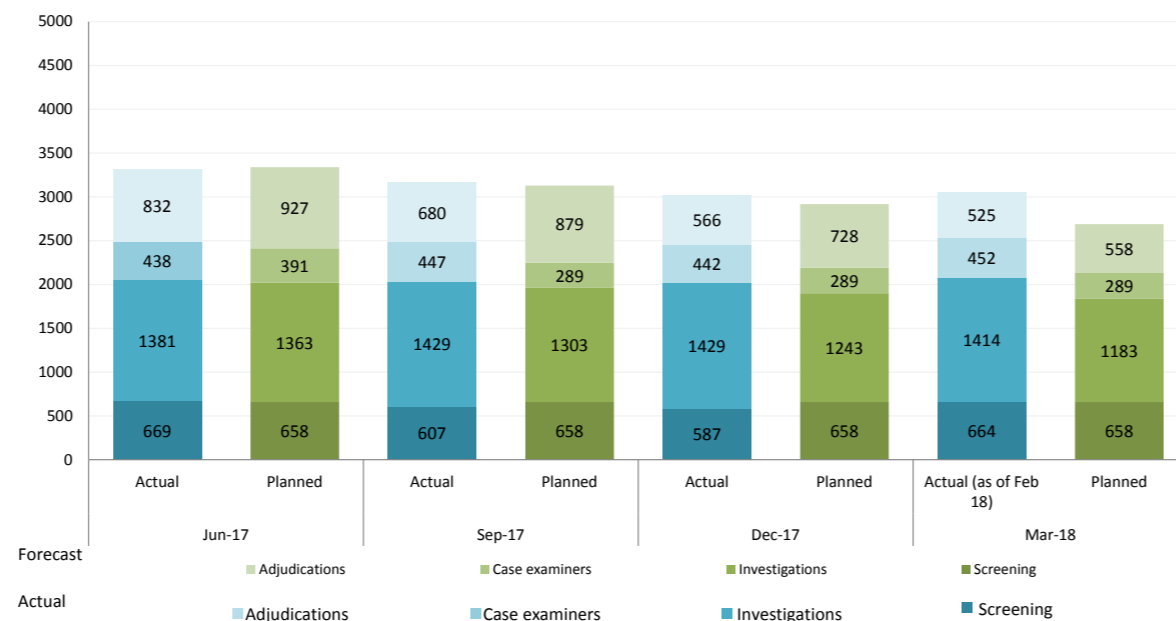
Red/Amber/Green rating: Red - cumulative performance for previous 12 months is less than 72%; Amber - between 72% and 80%; Green - greater than or equal to 80%

FtP performance dashboard February 2018

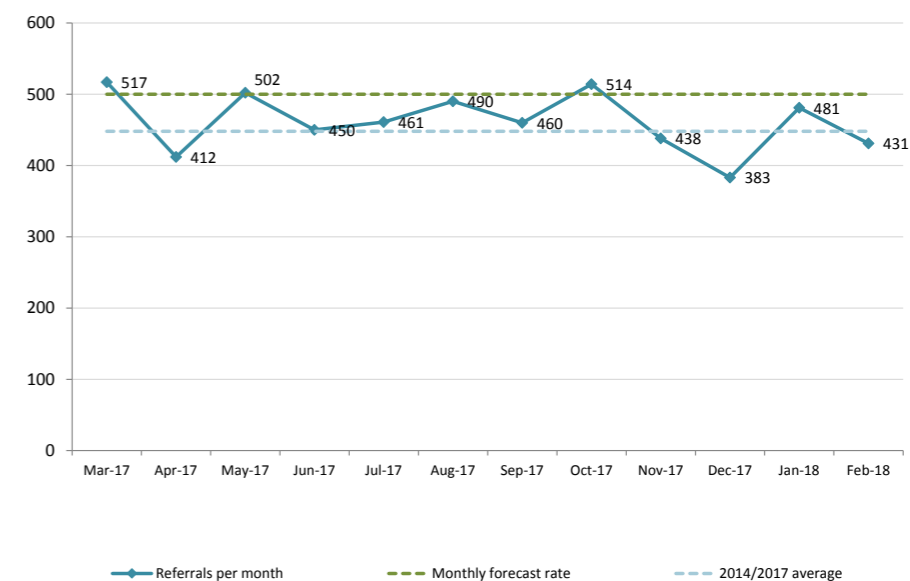
A1 Historic caseload



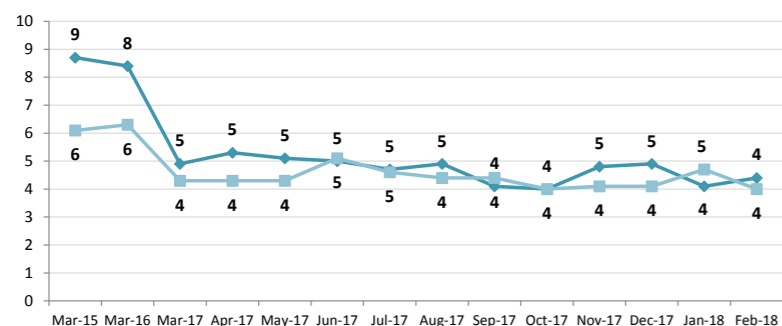
A2 FtP caseload



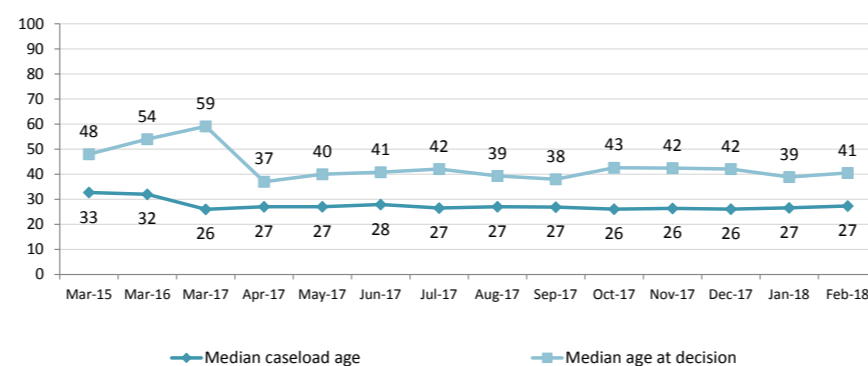
A3 New referrals



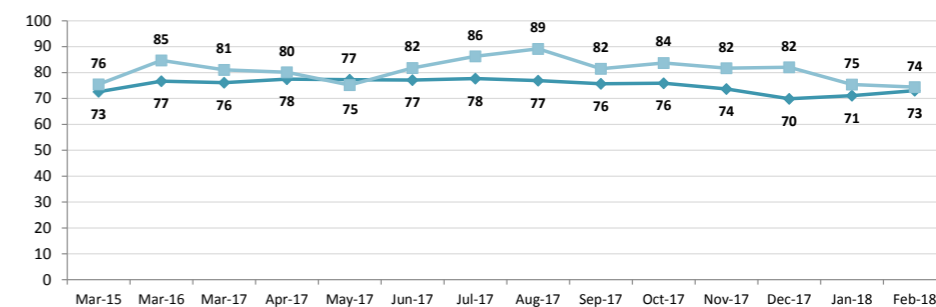
B1 Median age at Screening



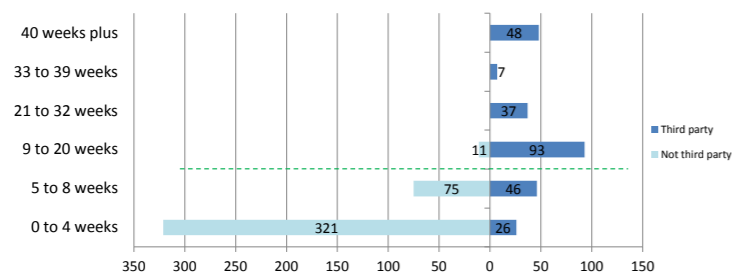
B2 Median age at Investigations and Case Examiners



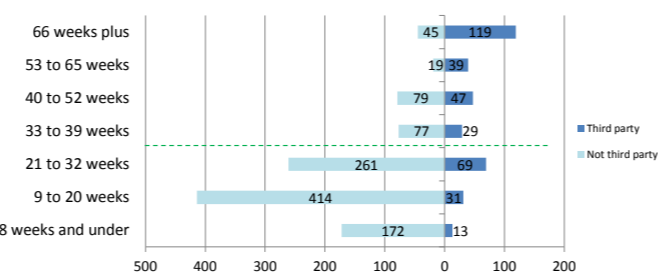
B3 Median age at Adjudications



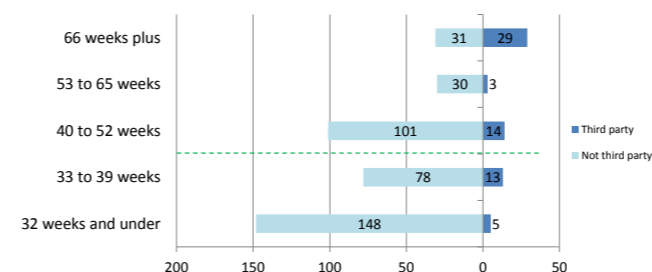
C1 Screening caseload



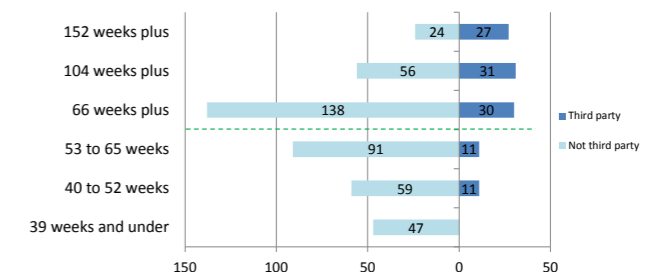
C2 Investigations caseload



C3 Case Examiner caseload



C4 Adjudication caseload



Caseload Movement Summary
February 2018

Opening caseload 3,024

431 cases received

400 cases closed

3,055 Closing caseload

Percentage of customers satisfied with the service received and percentage of customers who felt the NMC made it easy for them to deal with their issue

Measure	December 2017	January 2018	February 2018	Year to date
Overall Satisfaction	74.0%	76.6%	80.7%	75.8%
Effort	71.4%	71.2%	76.7%	70.9%

Commentary:

1. Satisfaction (Customers were satisfied with the service they received)

- Year to date customer satisfaction (highly satisfied / satisfied) has marginally increased since December 2017 by 0.5% (from 75.3% to 75.8%).
- Dissatisfaction (highly dissatisfied/dissatisfied) stands at 15.5%. Analysis of dissatisfaction will be provided in May 2018.

Since April 2017: % of respondents satisfied or highly satisfied

- **Fitness to Practise:** 63.2% out of 317 responses.
- **Registrations and Revalidation:** 76.5% out of 5,662 responses.

Variance is likely due to the different focus of each service.

2. Effort (Customers felt the NMC made it easy for them to deal with their issue)

- Year to date effort (strongly agree/agree) stands at 70.9%. This has marginally increased since December 2017 by 0.5% (from 70.4% to 70.9%).
- Customers that strongly disagreed or disagreed stands at 15.8%.

Since April 2017: % of respondents that agreed or strongly disagreed

- **Fitness to Practise:** 51.9% of Fitness to Practise respondents agreed or strongly agreed.
- **Registration and Revalidation:** 72.0% of Registration and Revalidation respondents agreed or strongly agreed.

3. Response rates:

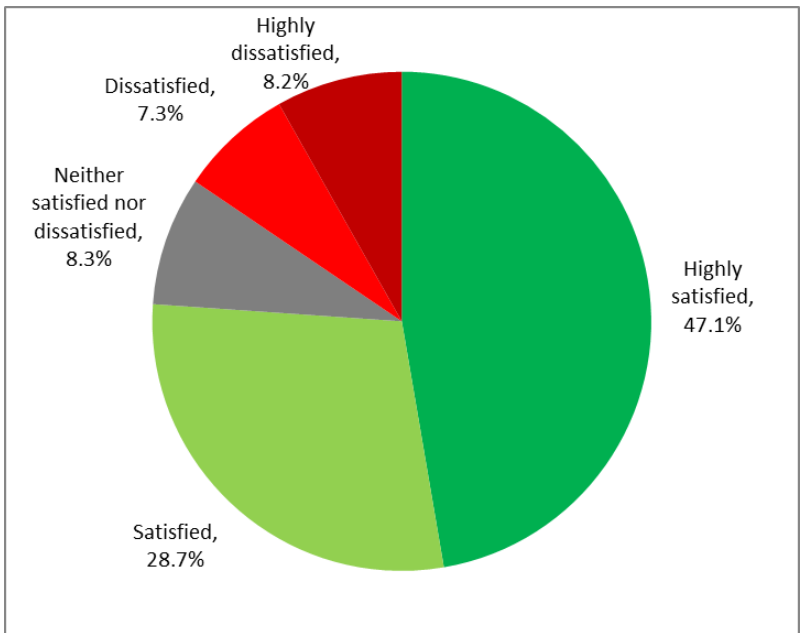
- **Total:** 5,979 total feedback responses since April.
- **Registration and Revalidation:** 95% (5,662 responses).
- **Fitness to Practise:** 5% (317 responses).

Definitions:

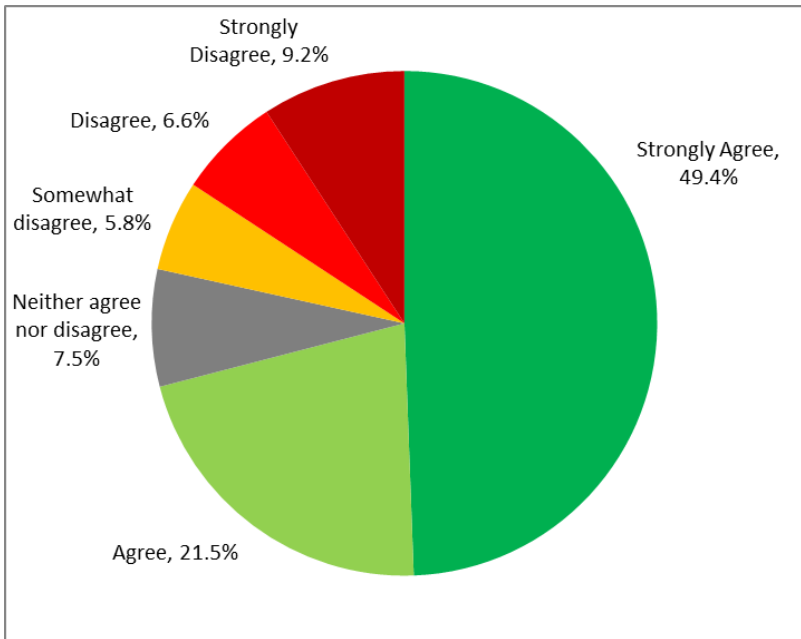
Satisfaction - % of customers Highly Satisfied and Satisfied with the service received

Effort - % of customers who Strongly Agree and Agree that the NMC made it easy for them to manage their issue

Overall customer satisfaction year to date



Overall customer effort year to date

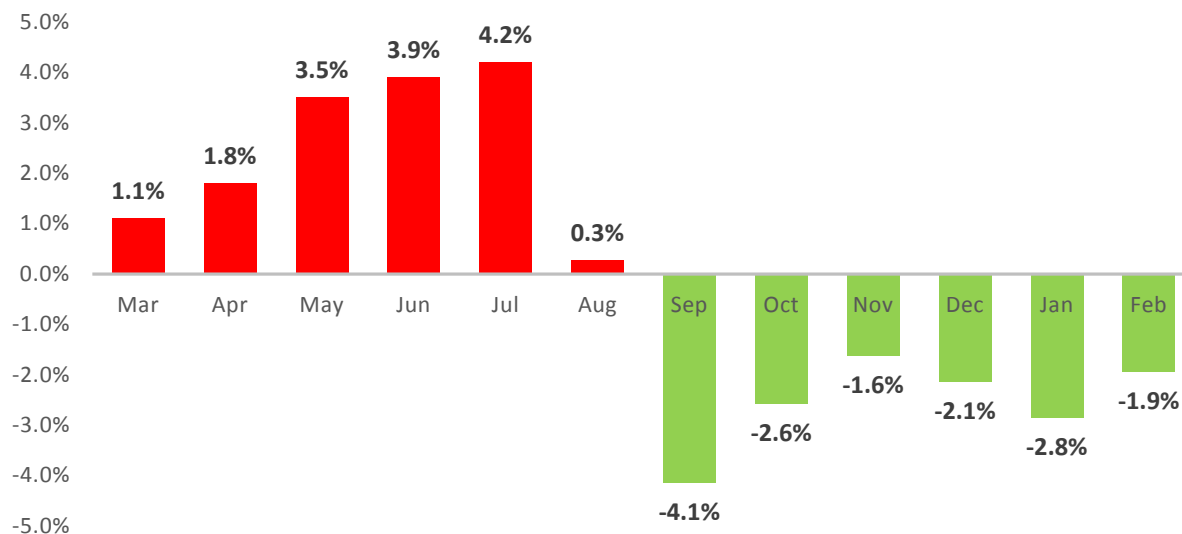


Overall Staff Turnover Rate			
Turnover Type	Mar-2017	Dec-2017	Feb-2018
Overall	24.6%	23.1%	22.4%

Commentary

- ↓ NMC turnover has decreased to 22.4% from 23.1% since December 2017 (0.7%). In the same period permanent headcount has increased from 678 to 696 employees.
- ↓ Compared to February 2017 turnover has decreased by **1.9%**. This follows a pattern of year on year turnover rates showing an average reduction of 2.5% each month for the past 6 months. This is shown in the chart below.

Year on Year Turnover trend



The most common reason given in exit interviews was **career progression**. The other factors that continue to score poorly are:

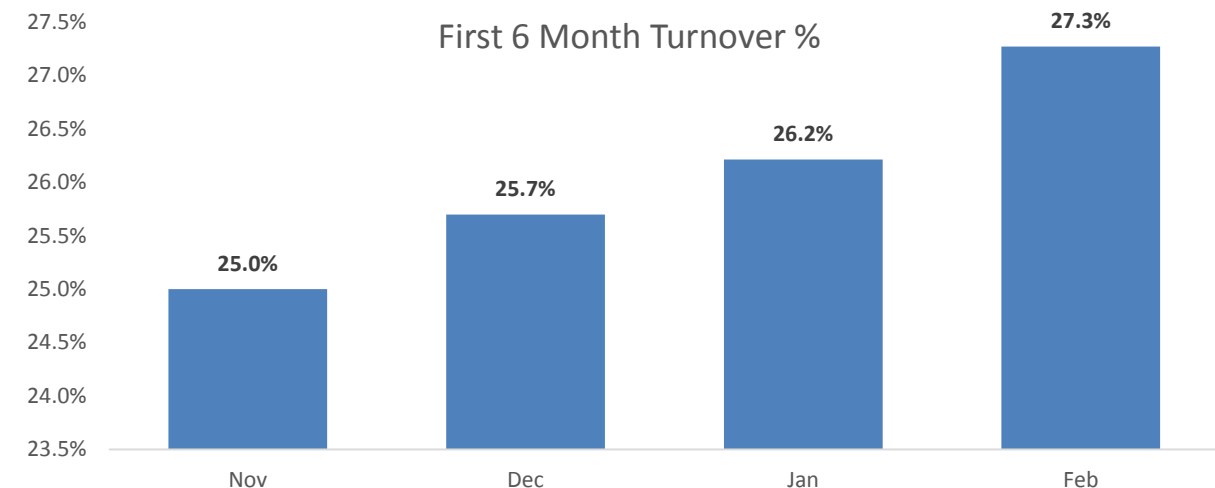
- **Pay**
- **NMC communication**
- **Feeling valued in role**

Work continues on these themes in 2018-2019 including the development of career pathways, development of the reward strategy, increased attention to internal communication and Leadership Development Programme and new appraisal process to improve feeling valued feedback.

Staff Turnover Rate: Less than 6 month service		
0-6 Months	December 2017	February 2018
Overall	25.7%	27.3%

Commentary

- ↑ Since September 2017, 27.3% of new starters left within their first 6 months of service. This is up 1.6% on December 2017. This is an increasing trend since November 2017.
- The area with the highest turnover of new starters leaving within the first 6 months is Technology and Business Innovation. This is mainly due to the rescoping of the change portfolio.
- The most common reason for leaving in the first 6 months of service are work related issues and career progression which we continue to analyse.



Action being taken to mitigate new starters leaving within 6 months

- **1 month reviews with newly appointed staff:** In January 2018, we introduced interviews with staff after their first months service. We will continue to analyse exit interview data to improve our induction and on-boarding process.
- **Follow up sessions with new staff at 3 months:** From March 2018 at three months service, we will continue to problem solve in partnership with new staff and to promote ongoing staff engagement.
- **Recruitment and Careers website re-launch:** In February 2018, the NMC recruitment page was redesigned and has since gone live with the aim of providing a more modern application process.
- **Focus on corporate risk 3, capacity and capability:** Senior leaders have been assessing capacity and capability pressures within their delivery teams. Actions will be implemented locally to reduce high risk areas. Updates will be provided to Council through the corporate risk register as we work to improve this risk over the next nine months.

12 month summary of corporate KPI figures

Corporate KPI		2016-2017 Average	2017-2018										YTD avg	Target	
			Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan			Feb
1	% of UK reg applications completed within 10 days	98.2%	96.8%	96.4%	96.3%	98.3%	99.2%	99.5%	97.4%	90.8%	95.3%	99.1%	97.8%	97.9%	95%
2	% of UK reg applications completed within 30 days	99.2%	99%	97.8%	98.0%	99.7%	99.9%	99.9%	99.9%	98.3%	99.3%	99.4%	99.8%	99.6%	99%
3	% of EU/OS reg applications assessed within 60 days	n/a*	85.0%	99.9%	100.0%	99.9%	100.0%	99.7%	99.7%	99.9%	99.9%	100.0%	100.0%	98.4%	90%
4	% of interim orders imposed within 28 days of opening the case	91%	91.0%	90.0%	90.0%	89.0%	89.0%	90.0%	88.0%	86.0%	88.0%	92.0%	94.0%	86.0%	80%
5	Proportion of FtP cases concluded within 15 months of being opened	75%	75.0%	76.0%	76.0%	76.0%	81.0%	79.0%	78.0%	80.0%	81.0%	84.0%	87.0%	80.0%	80%

Corporate risk summary

Current rating = a rating of the risk as it currently stands (with mitigation in place).

Movement = score movement since last review / meeting

Risk Number	Corporate Risk	Rating	Movement
1	Risk that we may register, or may have registered people who do not meet our requirements or standards	Amber	◀▶
2	Risk that we may fail to take appropriate action to address a regulatory concern	Amber	◀▶
3	Risk that we may have insufficient capacity and resilience to deliver change programmes and business as usual	Red	◀▶
5	Risk that there may be adverse incidents related to business continuity and health and safety	Amber	◀▶
6	Risk of information security and data protection breaches	Amber	◀▶
7	Risk that we may lack the right capability to influence and respond to changes in the external environment	Amber	◀▶
8	Risk that we may not meet external expectations of us (reputation and perceptions)	Amber	◀▶

[Please note that Green-rated risks are dealt with at the Business Unit level and therefore not included within the Corporate Risk Register]

Corporate risks	Current rating	Movement	Status - mitigations in place and planned
1 Risk that we may register, or may have registered people who do not meet our requirements or standards	Amber	No change	<p>In place:</p> <ul style="list-style-type: none"> • Registration and revalidation processes to ensure only those who meet requirements join the register or revalidate. • Identity and quality checks for UK, EU, Overseas initial registrants. • Strengthened reconciliation process. • Increased automation of processes. • Quality assurance framework to assure education providers. • Strengthened staff induction, training and communication. • Stronger links between Serious Event Reviews and complaints and assurance controls. • Business-wide legal compliance review. <p>Planned:</p> <ul style="list-style-type: none"> • Data and systems work to improve robustness. • Further automation of processes to reduce human errors. • Strengthening of process for early identification of failures and risks. • Strengthening of delegation of decision making. • Continued improvements to training. • Review of Overseas registrations process. • Updated guidance to Higher Education Institutions.

Corporate risks	Current rating	Movement	Status - mitigations in place and planned
2 Risk that we may fail to take appropriate action to address a regulatory concern	Amber	No change	<p>In place:</p> <ul style="list-style-type: none"> Existing Fitness to Practise (FtP), Registrations and Education processes and controls. Employer Link Service and engagement with employers and other stakeholders improves knowledge of FtP processes supporting early engagement. New powers for case examiner disposals to manage FtP cases quickly and effectively. Staff induction, training and Learning and Development. Information sharing regarding processes and risk. <p>Planned:</p> <ul style="list-style-type: none"> Implement identified process improvements between Registration and FtP to address areas of potential weakness. Focused approach to providing intelligence to stakeholders. Implement actions arising from Professional Standards Authority Lessons Learned Review.
3 Risk that we may have insufficient capacity, resilience and capability to deliver change activities (service improvements, projects and programmes) and business as usual	Red	No change	<p>In place:</p> <ul style="list-style-type: none"> Limit placed on commitments in corporate plan 2017–2018. Department of Health funding to deliver new Nursing Associates role. Corporate portfolio management office and related processes strengthened to manage change initiatives. Robust recruitment processes for staff and contractors. Trend analysis of declining register built into assumptions underpinning corporate budgeting process. <p>Planned:</p> <ul style="list-style-type: none"> Strengthening of Executive Board with new directorates established for People and Organisational Development and External Affairs. Staff recruitment and retention analysis to identify capacity and capability pressure points and targeted action plan to reduce risks locally. Targeted recruitment for key roles. Updated staff reward strategy. Implement employee engagement action plans. Complete leadership development programme. Review of NMC employer brand to attract the best staff. Implement action plans for identified low capacity areas.
5 Risk that there may be adverse incidents related to business continuity and health and safety	Amber	No change	<p>In place:</p> <ul style="list-style-type: none"> Business Impact Assessments. Business continuity and disaster recovery plans. IT infrastructure disaster recovery arrangements. Business Continuity Working Group. Training and desktop exercises. Fire Risk Assessments across all premises. Lockdown procedure in event of an emergency. <p>Planned:</p> <ul style="list-style-type: none"> Implement updated business continuity policy. IT infrastructure disaster recovery test planned.
6 Risk of information	Amber	No change	<p>In place:</p>

Corporate risks	Current rating	Movement	Status - mitigations in place and planned
security and data protection breaches			<ul style="list-style-type: none"> • Information security risk register and treatment plan. • Technical controls e.g. updating patches, IT security measures, encrypted email. • Staff awareness. • Audit action plans implemented. • Oversight by Information Governance and Security Board. • Maintaining and strengthening controls. Insurance cover for cyber security threats. <p>Planned:</p> <ul style="list-style-type: none"> • GDPR project which will deliver updates required to meet data protection regulations.
7 Risk that we may lack the right capability to influence and respond to changes in the external environment	Amber	No change	<p>A. Mitigations for external risks: We have some influence over likelihood but focus remains on controlling the impact of external changes by anticipating and planning for possible eventualities.</p> <p>In place:</p> <ul style="list-style-type: none"> • External monitoring. • Brexit scenario planning via working group. • Strengthened leadership of external affairs. <p>B. Mitigations for internal risks</p> <p>In place:</p> <ul style="list-style-type: none"> • A Regulatory Intelligence unit providing critical regulatory intelligence for internal and external stakeholders. <p>Planned:</p> <ul style="list-style-type: none"> • Detailed stakeholder mapping.
8 Risk that we may not meet external expectations of us (reputation and perceptions)	Amber	No change	<p>In place:</p> <ul style="list-style-type: none"> • Ongoing engagement with key stakeholders. <p>Planned:</p> <ul style="list-style-type: none"> • Delivery of commitments we have publically made.

Key to the risk ratings

The rating table below provides a summary of what the red / amber / green ratings mean. The following scoring tables demonstrate how the scores and therefore ratings are determined. Each risk is assessed and given a likelihood and an impact score.

Rating definitions

Red	A high likelihood that the risk could happen and a huge impact on public protection and the achievement of our objectives if the risk happened.
Amber	A medium to high likelihood that the risk could happen and/or moderate to major impact on public protection and the achievement of our objectives if the risk happened.
Green	A low likelihood that the risk could happen and a low impact on public protection and the achievement of our objectives if the risk happened.

Risk movement

- **No change:** Risk rating has experienced no movement since previous Council meeting.
- **Increased:** Risk rating has increased (either likelihood or impact or both) since previous Council meeting.
- **Reduced:** Risk rating (either likelihood or impact or both) has reduced since previous Council meeting.

Risk scoring

1. Rating the likelihood

Likelihood of risk occurring			
Term	Score	Guidance	Evidence
Very high	5	There is strong evidence (or belief) to suggest that the risk will occur during the timescale concerned. Typical likelihood of 81-100%	A history of it happening at the NMC. Expected to occur in most circumstances.
High	4	There is some evidence (or belief) to suggest that the risk will occur during the timescale concerned. Typical likelihood of 51-80%	Has happened at the NMC in the recent past. Expected to occur at some time soon.
Medium	3	There is some evidence (or belief) to suggest that the risk may occur during the timescale concerned. Typical likelihood of 21-50%	Has happened at the NMC in the past. Can see it happening at some point in the future.
Low	2	There is little evidence (or belief) to suggest that the risk may occur during the timescale concerned. Typical likelihood of 6-20%	May have happened at the NMC in the distant past. Not expected to occur for years.
Very low	1	There is no evidence (or belief) to suggest that the risk may occur at all during the timescale concerned. Typical likelihood of 0-5%	No history of it happening at the NMC. Not expected to occur.

2. Rating the impact (consequence)

Impact if risk occurs		
Term	Score	Guidance
Critical	5	Critical impact on the achievement of business, project and public protection objectives, and overall performance. Huge impact on public protection, costs and/or reputation. Very difficult to recover from and long term consequences.
Major	4	Major impact on costs and achievement of objectives. Affects a significant part of the business or project. Serious impact on output, quality, reputation and public protection. Difficult and expensive to recover from and medium to long term consequences.
Moderate	3	Significant waste of time and resources. Impact on operational efficiency, output and quality, hindering effective progress against objectives. Adverse impact on public protection, costs and/or reputation. Not easy to recover from and medium term consequences.
Minor	2	Minor loss, delay, inconvenience or interruption. Objectives not compromised. Low impact on public protection and/or reputation. Easy to recover from and mostly short term consequences.
Insignificant	1	Minimal loss, delay, inconvenience or interruption. Very low or no impact on public protection, costs and/or reputation. Very easy to recover from and no lasting consequences.

3. Scoring likelihood against impact

Impact	CRITICAL	5	5	10	15	20	25
	MAJOR	4	4	8	12	16	20
	MODERATE	3	3	6	9	12	15
	MINOR	2	2	4	6	8	10
	INSIGNIFICANT	1	1	2	3	4	5
	Score		1	2	3	4	5
			VERY LOW	LOW	MEDIUM	HIGH	VERY HIGH
			Likelihood				

Risk scores: 1-8 Green 9-15* Amber 16-25 Red

* due to their 'Critical' impact, an amber rating is also given to risks which score 5 for Impact and 1 for Likelihood

Council

Financial Monitoring Report to 28 February 2018

Action: For information.

Issue: Provides the financial monitoring report for the 11 months to 28 February 2018 with a forecast to the year ending 31 March 2018.

Core regulatory function: All regulatory functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: None.

Annexes: The following annexes are attached:

- Annex 1: Summary financial results to 28 February 2018.
- Annex 2: Balance sheet position including cash holdings.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Richard Wilkinson
Phone: 020 7681 5172
richard.wilkinson@nmc-uk.org

Director: Gary Walker
Phone: 020 7681 5754
gary.walker@nmc-uk.org

- Context:**
- 1 The Council receives a financial monitoring report of spend against the budget at each meeting.
 - 2 We are continuing to manage actively our finances, reflecting a challenging external environment, a continuing fall in registrant numbers, and strategic programmes and projects within the organisation.

- Four country factors:**
- 3 None relevant to this paper.

Discussion Overall picture and year to date (YTD)

- 4 This paper sets out the financial position at 28 February 2018.
- 5 Key messages are:
 - 5.1 We are forecasting an underspend against budget of £1.9 million on our Business As Usual (BAU) and programme and project spend at year end. This compares to the equivalent £0.8 million forecast underspend reported in January 2018.
 - 5.2 Whilst this reflects successful efforts to reduce cost in response to our income shortfall and cost pressures, the change in forecast is due to slippage of planned activity across a number of programme and BAU areas in between forecasts being reviewed in December 2017 and the current view. With the current forecast we have remained cautious, with the level of spend forecast being at the upper end of expectations. Where there is programme slippage, we currently anticipate that this can be contained within the proposed budgets for 2018–2019 being separately considered by Council.
 - 5.3 We continue to forecast a shortfall in our income from registrants for this financial year which we could not have reasonably foreseen at the point when the budget was set in March 2017. However, the size of the shortfall in income of around £0.7 million is lower than the £1.0 million previously forecast, reflecting actual registrant income slightly exceeding that anticipated in our forecasting model.
 - 5.4 The overall effect of the spend and income forecasts is an expected underspend against our budgeted net position, excluding Transformation, of around £1.2 million at year end as compared to the £0.2 million overspend previously forecast.
 - 5.5 This leads to a slightly higher than budgeted level for Available Free Reserves at £22.6 million at the year end. This

remains within the target range set by Council of £10-25 million, which is appropriate given the uncertain external environment and risks around the change projects that we are implementing and planning.

- 6 There are some pressures, not anticipated at the time we set the budget. These have been highlighted to Council and are primarily the new Overseas review programme and the Fitness to Practise new strategic direction. Whilst significant costs for both are likely to fall into next year (subject to budget discussions), some initial elements of cost have been incurred in 2017–2018.
- 7 Overall, this represents an improvement in our financial position from the forecast presented to Council in January 2018. The detail behind this is outlined in the later sections of this report and in **annexes 1 and 2. annexe 2** includes an analysis of key reductions to forecasts between the current and prior report to Council.

Income

- 8 During the year to date there has been a downturn in the number of nurses and midwives registered to practise in the UK. As register volumes are the primary driver of income, reductions in register volume results in income reductions for the NMC. Based on our latest information, we anticipate that in the current year the NMC will receive around £0.7 million less income than projected in the budget. This is an improvement on the forecast presented to Council in January 2018.
- 9 During 2018–2019, we will improve our long term prediction of registrant numbers, and, therefore, our income forecast.

Business as usual expenditure

- 10 A detailed analysis is set out below reflecting the table at **annexe 1**.

Directorate Expenditure

- 10.1 **Office of the Chair and Chief Executive:** Which currently includes External Affairs and the Communications teams, is £0.7 million adverse to budget year to date. This is expected to reduce to £0.6 million by the end of the year.
- 10.2 **People and Organisational Development:** is £0.1 million favourable to budget year to date, and is expected to remain at a similar level at year end.
- 10.3 **Registration and Revalidation:** is £0.7 million favourable to budget YTD due to efficiency savings. These savings are expected to continue through to year end. Additional pressures relating to the introduction of new English Language requirements mean that this underspend is

expected to be slightly lower by year end.

- 10.4 **FtP:** is £0.1 million favourable to budget year to date, despite cost pressures discussed in earlier reports. This is the result of cost reduction measures that were put in place earlier in the year and lower adjudications activity than planned in February 2018. The year end position is expected to be an overspend of c. £0.4 million or 1 percent of budget, which is inline with the third quarter forecast for the year.
- 10.5 **Education Standards and Policy:** is £0.5 million favourable to budget YTD due to lower business as usual Quality Assurance (QA) activity and costs than budgeted. The year-end position is expected to be similar.
- 10.6 **Technology Business Innovation:** is £0.4 million favourable to budget YTD due to slippage in planned spend on core technology services and project support. TBI is forecast to be £0.3 million above budget by year-end, as slippage is addressed, and reflecting some spend to plan future the IT improvements.
- 10.7 **Estates, Finance & Procurement:** is forecast to be £0.7 million favourable to budget by year end, in line with its current actual position. This is due to revisions to the planned maintenance work to the NMC estate and, following a tender process, a reduction in budgeted security costs at the hearing venues.

Programmes and Projects

- 11 The portfolio of projects and programmes, excluding Nursing Associates and Transformation, is now expecting to spend £3.9 million by year end, which is £0.7 million below budget. This is a lower forecast than reported to Council in January 2018. The decrease in forecast is mainly due to lower spend than initially anticipated on People Strategy, the Overseas Programme, and the Education Programme. Some of this is due to slippage in activity. We are currently taking the view that any slippage should be containable within the budgets being proposed separately to Council for 2018–2019.
- 12 Current and forecast spend on programmes and projects is as follows:
- 12.1 **People Strategy:** Work is progressing but is forecast to be at least £0.1 million below budget mainly due to slippage in the procurement of some contracts to deliver elements of the project.
- 12.2 **Registration and Revalidation improvement projects:** The

full year budget on the originally planned projects is expected to be underspent by around £0.4 million reflecting slippage on some elements of the projects.

- 12.3 **FtP Projects:** as previously reported, the FtP Section 60 project is expected to be £0.4 million adverse to budget by year end. In addition, costs of £0.1 million which were not originally budgeted for have been included to cover work on development of the new FtP strategic direction.
- 12.4 **Education Programme:** spend to the end of February 2018 is £0.8 million below the profiled budget. Re-scheduling of work, including work on the new QA framework, means that this underspend is likely to be at a similar level at the year end as some work slips into 2018–2019.
- 12.5 **TBI projects:** is in line with budget YTD and this spend is not expected to increase substantially with only lower cost projects expected to be undertaken prior to year end.
- 12.6 **Nursing Associates (NA):** Our cost neutral full year forecast is based on full expenditure recovery from the Department of Health (DH). DH has reimbursed us for the initial tranche of costs incurred and we plan to invoice for the next tranche of costs to the end of December 2018 shortly, in line with our funding agreement with DH. YTD cost shown in **annexe 1** represents costs not yet invoiced to DH.

Corporate Expenditure

- 13 Current and forecast spend on corporate expenditure is:
 - 13.1 **Depreciation:** is £0.1 million higher than budget, year to date, due to the capitalisation, and subsequent depreciation, of two NMC assets, Digital Audio Recording and NMC Online not anticipated at the time of budget setting. By year end, depreciation is expected to be in line with budget due to some capital projects taking longer to finish than planned and, therefore, depreciated less.
 - 13.2 **Contingency and other:** the £0.5 million contingency has not been allocated to specific projects at the year end and is, therefore, being used to offset against pressures across all areas.

Capital

- 14 The full year capital expenditure budget of £0.3 million has already been spent and is expected to be £0.2 million over budget by year end. This is due to work on the core registration system £0.2 million and to purchasing additional digital audio recording equipment for FtP hearing rooms, £0.3 million. Both of these investments are

anticipated to deliver cost and efficiency savings into the business in subsequent years.

Transformation

- 15 We are forecasting to spend no more than £2.3 million by year end of the budgeted £2.5 million. The reduction in the forecast reflects work to review and correct cost transfers from other parts of the organisation, and a conservative view of some costs that had not been finalised at the time the forecast was last reviewed in December 2018.
- 16 Deliverables from Transformation spend in 2017–2018 include a wide range of outputs that are supporting future activity. Examples include:
- 16.1 Support to our work to improve our access to, and use of data, for instance establishing a ‘data warehouse’ to enable us to draw on and analyse data from a range of databases, and piloting new software to improve our internal financial reporting.
 - 16.2 Mapping our complex IT systems and developing proposals for future more efficient design.
 - 16.3 Mapping of data on the existing Register and suggesting options for migration to new database.
 - 16.4 Customer surveys and customer needs assessment to help improve our website and customer service, for instance in Registrations.
 - 16.5 Support to modernising HR policies and planning to underpin the People Strategy.

Cash

- 17 Cash is in line with that planned in the budget.
- 18 Cash holdings of £81.3 million are detailed in **annexe 2** along with available free reserves. Cash holdings meet the requirement of the agreed investment strategy that no more than 40% of cash should be held with one institution.
- 19 NMC funds are held in current and deposit accounts spread across four UK high street banks and a building society.

Resource implications:

- 20 Detailed in the body of the paper. To the extent that our net spend is less than anticipated, this increases our Available Free Reserves. However, with a year end forecast of £22.6 million they are expected to remain within the range of £10-25 million set as desirable by

Council.

Equality and diversity implications:	21	None.
Stakeholder engagement:	22	None.
Risk implications:	23	Risks to achieving budgeted spend are discussed in the main body of this paper.
Legal implications:	24	None.

Actual, budget & forecast 2017-2018
£000

INCOME AND EXPENDITURE (£'000s)	YTD Feb.18 v Budget				Full Year v Budget				
	2017/2018	Actual	Budget	Variance	% of budget	Dec17 Forecast	Latest Forecast	Budget	Variance
NMC Income	78,456	78,868	(412)	99%	85,082	85,341	86,038	(697)	99%
Directorates - BAU									
OCCE	3,546	2,888	(658)	(123%)	4,049	4,008	3,416	(592)	(117%)
People and Organisational Development	2,055	2,127	72	97%	2,373	2,304	2,418	114	95%
Registration & Revalidation	4,715	5,376	661	88%	5,444	5,289	5,865	576	90%
Fitness to Practise	38,843	38,972	129	100%	42,765	42,610	42,175	(435)	(101%)
Education Standards & Policy	2,845	3,360	514	85%	3,527	3,245	3,836	590	85%
Resources									
Technology Business Innovation	6,235	6,647	412	94%	7,364	7,568	7,277	(291)	(104%)
Estates Finance & Procurement	8,509	9,280	771	92%	9,568	9,507	10,201	694	93%
Total Directorates - BAU	66,749	68,651	1,902	97%	75,091	74,531	75,186	655	99%
Programmes & Projects*									
People Strategy	197	460	263	43%	502	400	502	102	(80%)
Registration & Revalidation Projects	219	783	563	28%	422	491	874	382	56%
Overseas Programme	46	0	(46)	(100%)	277	100	138	38	72%
FIP Section 60	1,266	849	(417)	(149%)	1,263	1,266	849	(417)	(149%)
FIP Change Strategy	48	0	(48)	(100%)	116	116	0	(116)	(100%)
Education Programme	1,013	1,837	824	55%	1,510	1,192	1,894	702	63%
TBI Projects	224	275	51	82%	300	299	300	1	100%
Nursing Associates	259	0	(259)	(100%)	0	0	0	0	(100%)
Total Programmes & Projects	3,272	4,203	932	78%	4,391	3,865	4,556	692	85%
Corporate expenditure									
Depreciation	3,056	3,001	(55)	(102%)	3,284	3,295	3,274	(21)	(101%)
PSA Fee	1,604	1,604	0	100%	1,750	1,750	1,750	0	100%
Contingency & Other	273	789	516	35%	465	406	986	581	41%
Total BAU & Programme Expenditure	74,954	78,248	3,295	96%	84,980	83,846	85,752	1,906	98%
Income less Expenditure	3,502	620	2,883	565%	102	1,495	286	1,209	523%
Transformation	2,206	2,500	294	88%	2,500	2,300	2,500	200	92%
Income less Expenditure (Including Transformation)	1,297	(1,880)	3,177	(69%)	(2,398)	(805)	(2,214)	1,408	36%
Less payments towards pension deficit**	968	968	0	0%	1,056	1,056	1,056	0	0%
Income less Expenditure (after pension payment)	329	(2,848)	3,177	(12%)	(3,454)	(1,861)	(3,270)	1,408	57%
Capital Projects	484	250	(234)	(194%)	473	489	300	(189)	(163%)

**Excludes any potential actuarial adjustments made at year end

Staff v non-staff expenditure	YTD Feb.18 v Budget				Full Year v Budget				
	2017/2018	Actual	Budget	Variance	% of budget	Dec17 Forecast	Latest Forecast	Budget	Variance
Staff Sals & Other Staff	40,611	39,955	(657)	(102%)	42,869	44,525	43,695	(831)	(102%)
Non staff expenditure	36,548	40,794	4,245	90%	45,329	41,621	44,557	2,936	93%
Total Expenditure	77,159	80,748	3,589	96%	88,199	86,147	88,252	2,105	98%

Colour Key:

In line with or favourable to budget
Up to 5% adverse to budget
More than 5% adverse to budget

Analysis of key changes to forecasts

The table below compares key reductions to forecasts from those presented to Council in January 2018 (reflecting forecasts made in December 2017) with the forecast presented in the current paper.

Directorate - BAU	Dec 2017 Forecast	Latest Forecast	Change	Comments
Registration & Revalidation	5,444	5,289	155	Mainly due to lower actual need to use seasonal staff than initially planned as well as better than expected reductions in printing and postage
Fitness to Practise	42,765	42,610	155	Lower adjudication volumes than initially planned
Education Standards & Policy	3,527	3,245	282	Mainly due to lower QA activity than initially planned
Total changes above			593	

Programme and Projects	Dec 2017 Forecast	Latest Forecast	Change	Comments
Education Programme	1,510	1,192	318	Reduced forecast mainly due to slippage of some consultancy work on Standards. Also, some work on new QA framework has also been rescheduled to 2018-2019
People Strategy	502	400	102	Due to slippage in the procurement of a contract
Overseas Programme	277	100	177	Due to slippage of some project activities into 2018-2019
Total changes above			598	

Total BAU and programme and project forecast changes described	1,191	
---	--------------	--

Actual, budget & forecast 2017-2018

BALANCE SHEET INDICATORS

Available free reserves		YTD Feb.18 v Budget				Year End v Budget				
		Actual	Budget	Variance	% vs budget	Dec17 Forecast	Latest Forecast	Budget	Variance	% vs budget
A	Net assets	53,692	50,515	3,177	6%	49,031	51,501	50,093	1,408	3%
B	less: Fixed assets	19,170	19,317	(147)	(1%)	18,960	18,936	18,771	164	1%
C = A - B	Total free reserves before pensions deficit	34,522	31,198	3,324	11%	30,071	32,566	31,322	1,244	4%
D	less: Pension deficit (latest actuarial basis)	11,220	11,220	0	0%	11,132	11,132	11,132	0	0%
E = C - D	Available free reserves (latest actuarial basis)	23,302	19,978	3,324	17%	18,939	21,433	20,190	1,244	6%
F	less: Pension deficit (cash committed basis)	10,076	10,076	0	0%	9,900	9,900	9,900	0	0%
G = C - F	Available free reserves (cash committed basis)	24,446	21,122	3,324	16%	20,171	22,666	21,422	1,244	6%

Colour Key:

In line with or favourable to budget

Up to 5% adverse to budget

More than 5% adverse to budget

Cash summary (£'000s)	Feb 2018	Lloyds	Barclays	HSBC	Nationwide	Santander
Less than 12 month deposits	65,423	16,034	16,010		17,852	15,527
Total Investments	65,423	16,034	16,010	0	17,852	15,527
Current Account	15,924			15,924		
Total Cash	81,347	16,034	16,010	15,924	17,852	15,527
% Split		20%	20%	20%	22%	19%

Council

Ensuring patient safety, enabling professionalism: a new strategic direction for fitness to practise

Action: For decision.

Issue: Sets out a proposed consultation on a new strategic direction for fitness to practise.

Core regulatory function: Fitness to Practise.

Strategic priority: Strategic priority 1: Effective regulation.
Strategic priority 2: Use of intelligence.
Strategic priority 3: Collaboration and communication.
Strategic priority 4: An effective organisation.

Decision required: The Council is recommended to approve the consultation document (paragraph 12).

Annexes: The following annexes are attached to this paper:

- Annexe 1: Strategy map.
- Annexe 2: Consultation document.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Niki Wild
Phone: 020 7681 5094
niki.wild@nmc-uk.org

Director: Matthew McClelland
Phone: 020 7681 5987
matthew.mcclelland@nmc-uk.org

Author: Fausto Felice
Phone: 020 7681 5618
fausto.felice@nmc-uk.org

- Context:** 1 During 2017-2018, we have been working to develop a new strategic direction for fitness to practise. We now wish to consult on the principles that underpin our proposed new approach.
- Four country factors:** 2 We intend our proposals to apply across the UK. Through our initial engagement work, we recognise that there are significant differences in the healthcare economies across the four nations. We will continue to engage across the four nations to deepen our understanding of the issues and how we can take account of them.
- Discussion:** 3 We are now entering the third year of the NMC's 2015-2020 strategy, dynamic regulation for a changing world. The strategy aims to rebalance our corporate focus on 'upstream activities' and we have made significant progress in that regard, introducing the new Code and the professional duty of candour, establishing revalidation, and launching a comprehensive education programme to develop new outcome-focussed standards of proficiency.
- 4 The strategy commits us in fitness to practise to:
- *striking the right balance between the public interest and proportionate use of resources by making appropriate use of alternative means of disposal, in place of full hearings.*
 - *engaging with employers to ensure our referral thresholds are understood and matters better handled locally do not result in referrals.*
 - *exploring the benefits of other approaches to adjudication.*
- 5 We have already made a lot of progress against these commitments, introducing voluntary removal and consensual panel disposal, establishing our Employer Link Service, launching our Witness Liaison Team, and bringing in new powers for case examiners to dispose of cases earlier in our process. We have improved our operating performance, significantly reducing the time it takes us to reach outcomes that protect the public.
- 6 However, there is a pressing need for further change to fitness to practise for the following reasons:
- 6.1 A growing body of evidence suggests that an unintended consequence of regulators' current fitness to practise model is a culture of blame and denial. That runs contrary to the values of openness and learning that are central to a patient safety culture.
- 6.2 We know from our own research that black and minority ethnic nurses and midwives are more likely to be referred to

us by employers. That disproportionality creates a perception of unfairness which, again, runs contrary to patient safety.

- 6.3 Learning from the way in which we have handled sensitive cases in the past highlights the need for us to be much better at helping members of the public to engage with our processes.
 - 6.4 Our process is cumbersome, lengthy, and adversarial and, as a result, has a significant impact on all parties who engage with it.
- 7 In the longer term, legislative change is required to fundamentally reform the system of professional regulation. The Government's recent consultation on regulatory reform is welcome in that regard, as is the Professional Standards Authority's (PSA) series of policy papers.
- 8 We wish to start the process of reform now, by setting a new strategic direction for fitness to practise working for the time being within our existing legislation. We have developed proposals, summarised in the strategy map (**annexe 1**), which are structured within the following framework:
- 8.1 statutory objective: remaining focused on public protection, and articulating more clearly our understanding of the three limbs (public safety; public confidence; professional standards);
 - 8.2 regulatory outcomes: articulating for the first time the outcomes we expect to see from fitness to practise, shifting our focus towards supporting patient safety and enabling professionalism;
 - 8.3 how we regulate: setting out the principal ways in which we propose to apply our regulatory powers differently;
 - 8.4 how we operate: identifying the main areas where our operation needs to be improved.
- 9 Our proposals are intended to deliver measurable benefits (which we will track and report against periodically) in the following areas:
- 9.1 improved professional culture.
 - 9.2 earlier resolution of cases.
 - 9.3 improved customer experience.
 - 9.4 increased confidence in NMC as a regulator.

9.5 reduced cost and improved efficiency.

10 We wish to consult publicly on our proposals to ensure that we hear the views of patients and members of the public, nursing and midwifery professionals, and other key stakeholders. The proposed consultation document is attached (**annexe 2**). It sets out the strategic policy principles which underpin the new strategic direction, explains what we are intending to do and why, and invites responses to specific questions. The intended consultation timeframe is set out below:

10.1 Consultation will go live on 3 April 2018.

10.2 Consultation will close on 29 May 2018.

10.3 Consultation summary and response will be provided for Council in July 2018.

11 At the same time as the consultation, we will be undertaking targeted research with patients and service users, employers, and registrants.

12 **Recommendation: The Council is invited to approve the consultation document and authorise the consultation on the basis of the timeframe set out above.**

13 Subject to the outcome of the consultation, we will start to implement proposals during 2018-2019.

Public protection implications:

14 The proposed new strategic direction is intended to deliver our overarching objective to protect the public. The consultation covers how we interpret public protection.

Resource implications:

15 We have made provision in the 2018-2019 budget for c. £870,000, subject to business case approval. The proposed budget reflects the cost of consultation, implementation work planned for 2018-2019, and programme management. Cost reductions will be budgeted from 2019-2020. The strategic investment case which is in the Council's confidential papers contains more information about internal and external costs in the budget.

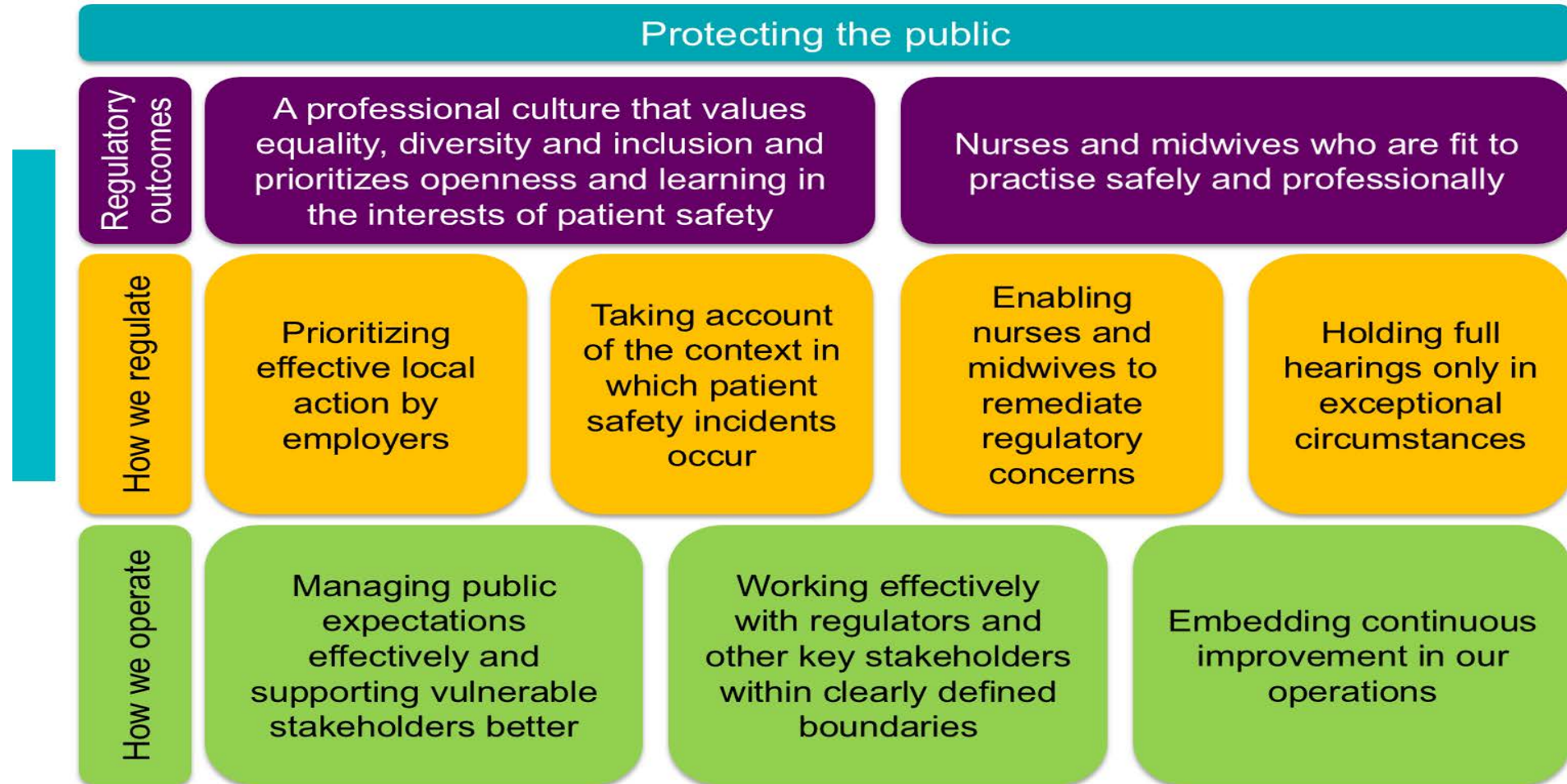
Equality and diversity implications:

16 An equality, diversity and inclusion (EDI) assessment took place early on in the programme planning, and specific priorities were identified that will be delivered to ensure EDI considerations are made throughout delivery. Our consultation and research will seek further evidence from respondents as to how our proposed activities will affect those with protected characteristics.

Stakeholder

17 We have already undertaking some stakeholder engagement,

- engagement:** including strategy briefings with some employers; representative bodies (who are keen to be involved in co-creation activities in relation to regulatory theme deliverables); other regulators; patient safety and EDI experts; and staff from across the NMC. Further engagement with stakeholders across the UK will take place during the consultation and research period.
- Risk implications:** 18 Risks to the programme delivery include lack of external stakeholder support / engagement which will be mitigated through ongoing engagement activities. Any change in corporate priorities that would divert resources away from the programme would also pose a risk to delivery.
- Legal implications:** 19 Our proposals are intended to be delivered within our existing legislative framework. Corporate Legal Services have provided input to ensure our proposals are consistent with our legislation and the case law.



Ensuring patient safety, enabling professionalism

**A public consultation on changes to our fitness to practise
function**

Ensuring patient safety, enabling professionalism

Foreword

Our Strategy 2015-2020 commits us to becoming a dynamic, innovative and leading regulator. We have made significant strides in achieving that aim, including:

- In 2015, we launched a new Code for registrants, developed in collaboration with many who care about good nursing and midwifery. The Code reflects the world in which we live and work today, and the changing roles and expectations of registrants.
- In the same year, in collaboration with the General Medical Council we published joint guidance for registrants on the professional duty of candour, which builds on the requirements in the Code for registrants to be open and honest when things go wrong.
- In 2016, we launched revalidation, meaning that every registrant on our register must now demonstrate on a regular basis that they are able to deliver care in a safe, effective and professional way. The continuing commitment of the professions and support of our stakeholders across the UK has contributed to the success of revalidation.
- We have initiated an ambitious programme of reform to our education functions. In March 2018, following a public consultation we have agreed new standards of proficiency for nurses and changes to the way nurses and midwives will be educated in the future. We have also started reviewing the standards of proficiency for midwives.

Our fitness to practise function helps us to protect patients and the public. We receive around 5,500 complaints a year about nursing and midwifery professionals, which we call referrals. The majority of referrals come from three sources: employers (39%), members of the public (28%), and self-referrals (10%). We conclude around 80% of cases in 15 months. In 2016/17, our independent panels imposed more than 1,200 sanctions, around half of which involved removing a professional from our register permanently or temporarily.

In recent years, we have made significant improvements to our process to make sure we are focussing our resources on the right cases. We have:

- introduced voluntary removal and consensual panel determination to reduce the need for unnecessary full hearings

- introduced case examiners to improve the efficiency, quality and consistency of decision-making at the end of the investigation stage
- set up the Employer Link Service (ELS), which is an important tool in employer engagement, supporting healthcare providers with referrals, providing learning and induction for fitness to practise and sharing information
- set up a risk intelligence unit to help us understand risk factors and deliver evidence-informed regulation, and to share information with others
- secured additional powers for case examiners, allowing them to conclude certain types of cases at an earlier stage, ensuring that the public is protected without the need for a full hearing.

There remains an urgent need for reform in healthcare regulation. The UK Government's recent consultation on regulatory reform was a welcome step in the right direction. However, now is the right time for us to think more radically about how we undertake fitness to practise without waiting for new legislation. This consultation paper is about how we can do that. In essence, it comes down to:

- *ensuring patient safety*: using our regulatory powers to encourage fairness, openness and learning; taking regulatory action where it is warranted; and avoiding punishing nursing and midwifery professionals for mistakes
- *enabling professionalism*: supporting nursing and midwifery professionals to address concerns about their practice, so that members of the public can continue to have confidence in the professions and confidence in us to promote and defend high standards.

We want to hear from members of the professions, the public and our stakeholders, and to encourage as much participation in this debate as possible

What is this consultation about?

The nature and context of nursing and midwifery practice are shifting rapidly. The way we regulate is evolving, as we respond to a changing landscape. We consider that effective and proportionate fitness to practise means putting patient safety first, and that an open, transparent and learning culture will best achieve this. We are not alone¹ in thinking that a culture of blame and punishment is likely to encourage, cover-up, fear and disengagement. We want registrants to engage with the fitness to practise process in a positive way and see it as an opportunity to learn and reflect on their practice, while increasing patient safety.

We need to build on recent reforms, to make sure our fitness to practise process encourages this approach. We know our process can be adversarial and lengthy. It doesn't always provide enough incentive to registrants to engage early in the process. By continuing to evolve, we can better protect the public, but we need to be clearer on what we want to get out of the fitness to practise process.

How fitness to practise currently works

Being fit to practise means that a registrant has the skills, knowledge, health and character to do their job safely and effectively. If someone has concerns about a registrant's fitness to practise, they can raise them with us and we will decide what action we need to take to protect the public. In every case, we aim to reach the outcome that best protects the public interest at the earliest opportunity.

Anyone can tell us at any time if they have concerns about a registrant's fitness to practise. We can also open cases ourselves if we consider it necessary. We will make initial enquiries about the concern. If we decide that it isn't serious enough for us to take action, we usually won't investigate the matter further. If we have investigated the concern, our case examiners or Investigating Committee will decide whether there is a 'case to answer'.

If there is a case to answer, we will hold a hearing or a meeting to reach a final decision and determine what action, if any, to take.

¹ See, for example, Berwick, D. (2013). A promise to learn—a commitment to act: improving the safety of patients in England. London: Department of Health, 6, Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary (Vol. 947). The Stationery Office. The Francis Report itself cited Professor Ian Kennedy's report into Bristol Royal Infirmary (Inquiry, B. R. I., & Kennedy, I. (2001). the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. Stationery Office.) and Professor Sir Liam Donaldson's An organisation with a memory (Donaldson, L. (2002). *Clinical Medicine*, 2(5), 452-457) as reports well over a decade ago that called for a move away from a culture of blame, and which the evidence suggested healthcare has yet to achieve.

Before a hearing or meeting is held, registrants can apply to be voluntarily removed from the register. We use voluntary removal in cases where a registrant admits the allegation and doesn't intend to continue practising. A registrant can also ask for a consensual panel determination. This is where we reach an agreed position about how the concern should be dealt with, without the need for a full hearing.

At a final hearing or meeting, a panel of the Fitness to Practise Committee will decide whether a registrant's fitness to practise is impaired and if it needs to take action to protect the public

To find out more about how fitness to practise currently works and how we make decisions, please see our website.

Our proposed strategy

We believe that we need to rethink how fitness to practise operates, and ensure that we are always placing public protection at the heart of what we do. We need to be clear how promoting or maintaining public safety, public confidence in the professions and professional standards and conduct protects the public.

We know that there are some cases where a registrant will have to be removed from the register. This still includes cases where a registrant is unable to remediate or chooses not to remediate the concern. However, we also propose that this should happen when the conduct complained about so seriously damages public trust in the professions or undermines public safety that it can't be remediated.

We recognise that we need to secure and maintain the confidence of the public. However, we don't think this means that we need to take regulatory action every time a registrant does something that a member of the public may not approve of.

We believe that if we act in accordance with the Professional Standards Authority (PSA) right-touch regulation principles² the public will have confidence in us as a regulator.

This consultation sets out our proposed strategy in this area. It defines our desired regulatory outcomes as:

- a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety
- registrants who are fit to practise safely and professionally

² PSA, right-touch regulation principles, 2015 and Better Regulation Executive, principles of good regulation, 2000.

To achieve these aims, we need to take a consistent and proportionate approach to fitness to practise. We also need to be fully transparent and accountable. We want to build on the changes we've already made to our processes and continue to strengthen partnerships with employers, so that they feel able to manage concerns appropriately at a local level. We will support employers to incorporate the principles of equality, diversity and inclusion when considering making referrals, so that our fitness to practise proceedings contribute to a healthcare culture that values diversity, equality and inclusion.

We will need to deal with concerns when they are serious enough that we need to take regulatory action to ensure patient safety, or because they cannot be managed locally. In these types of cases we should take into account the context in which patient safety incidents occur and also enable registrants to remediate concerns at the earliest opportunity. Then we should only hold hearings where there are real areas of dispute to be resolved.

We've developed ten policy principles that encapsulate our approach.

Strategic policy principles

1. Fitness to practise is about managing the risk that a registrant poses to patients or members of the public in the future. It isn't about punishing people for past events.
2. We can best protect patients and members of the public by making final fitness to practise decisions swiftly and publishing the reasons openly.
3. Employers should act first to deal with concerns about a registrant's practice, unless the risk to patients and the public is so serious that we need to take immediate action.
4. We will always take regulatory action when there is a risk to patient safety which is not being effectively managed by an employer.
5. We will take account of the context in which the registrant was practising when deciding whether there is a risk to patient safety that requires us to take regulatory action.
6. We may not need to take regulatory action for a clinical mistake, even where there has been serious harm to a patient or service-user, if there is no longer a risk to patient safety and the registrant has been open about what went wrong and can demonstrate that they have learned from it.
7. Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. A registrant who does so should be removed from the register.

8. We will only take regulatory action to uphold public confidence if the regulatory concern is so serious that otherwise the public would be discouraged from using the services of registrants.
9. Some regulatory concerns, particularly if they raise fundamental concerns about the registrant's professionalism, can't be remedied and require removal from the register.
10. Hearings best protect patients and members of the public by resolving central aspects of a case that we and the registrant don't agree on.

An illustrative example

Figure 1 is a typical example of how we might handle a case under our current approach to fitness to practise. In part 2, we've used this scenario as an example, to show how our proposed new model of fitness to practise would work.

Figure 1, Example scenario

A nurse was referred to us by a relative of a patient who died following a catastrophic medication error. The patient was receiving end of life care in a care home. On the day the error took place, the patient was due insulin at 09:00, after breakfast. The nurse needed to check the patient's blood sugar levels before administering insulin, but was distracted by a care assistant and a call from another patient. She was the only nurse on duty and the home had 20 residents.

Following the distraction, the nurse forgot to do the checks before giving the resident the insulin. Having not had breakfast, the patient fell into a hypoglycaemic state and died shortly afterwards. The nurse realised her error as soon as she had given the patient the injection, and immediately summoned emergency assistance. The nurse was dismissed immediately after the incident.

The nurse has attended a course on diabetes care and secured a new post.

After we investigate the matter the case examiners find that there is a case to answer as the nurse has not remediated in the areas of medicines administration and working in a challenging environment. Also, the nurse didn't provide any information about what happened on the day of the incident.

The case is scheduled for a hearing. At the hearing, the nurse admits the allegation and the new employer attends the hearing to provide a positive reference.

The panel decides that the nurse's fitness to practise is impaired, because there is still a risk to patient safety. The panel makes a conditions of practice order. The order states that the nurse should only administer medicines under direct supervision.

How to respond to this consultation

The consultation is presented in in four parts and sets out our intended strategic direction for our fitness to practise function.

In part one we open the discussion about public protection and public confidence in the regulatory process. We consider this in light of the wider discussions on patient safety and regulatory reform. We introduce and define our regulatory outcomes.

In part two we set out how we intend to achieve our regulatory outcomes using our existing regulatory powers.

Part three explains changes we are making to the way we operate.

Part four is a chance for you to tell us about you.

Part five in the annexe and contains our glossary.

You can respond by **[hold for Comms]**

DRAFT

Part 1 – Our regulatory outcomes

DRAFT

Rethinking how we protect the public and what the public expect from us

We are clear that our focus is protecting the public. What does this require in terms of fitness to practise activity?

A small but significant part of our current caseload is made up of registrants who don't pose any ongoing patient safety risks. We take these cases forward on a 'wider public interest' basis to uphold professional standards and maintain confidence in the professions.

There is no defined threshold for which cases should be taken forward purely to uphold public confidence. The decision is made on a case-by-case basis, with reference to the particular facts of the case. This can lead to the criticism that our fitness to practise process is inconsistent, with us acting as a 'moral guardian', and unduly punitive. This approach becomes harder to justify for regulatory concerns that would result in less serious sanctions or case disposal. Why are we taking regulatory action in these cases? Is it proportionate?

Public protection

One potential criticism of how we do fitness to practise is that our regulatory remit has widened beyond pure public protection issues and into a world where we are undertaking regulatory activity that may not be essential. We do it on the basis that we have believed that it's expected of us by others. This can have a significant impact on our resources and confidence in us.

We propose to reconsider how we undertake fitness to practise by refocusing on public protection.

We consider that public safety, public confidence in the professions and the need to promote and maintain proper professional standards and conduct should be interpreted from a public protection viewpoint. Where there are public safety concerns, there will always be a clear link to public protection. But in cases concerning the promotion and maintenance of professional standards and public confidence, there won't always be that link, for example, where a registrant has been convicted of a minor criminal offence. In those cases, we don't think that we should promote and maintain professional standards and

Article 3(4) of the Nursing and Midwifery Order 2001 states:

'The over-arching objective of the Council in exercising its functions is the protection of the public.'

Article 3(4A) states:

'The pursuit by the Council of its over-arching objective involves the pursuit of the following objectives—

- (a) *to protect, promote and maintain the health, safety and wellbeing of the public;*
- (b) *to promote and maintain public confidence in the professions regulated under this Order; and*
- (c) *to promote and maintain proper professional standards and conduct for members of those professions.'*

public confidence in the professions unless there is a clear link to our overarching objective of public protection.

We believe that public protection is best achieved through reducing the risk of harm. When looking at harm, we need to differentiate carefully between accidental errors or failures in the system, and deliberate or reckless behaviour and those who conceal patient safety concerns.

We know the importance of keeping our decision-making process transparent, and so where we decide not to take formal regulatory action, we will provide the person or employer raising the concern with our reasons for not taking action.

DRAFT

Public safety

For us to take action on the basis of maintaining the health, safety and wellbeing of the public we need to be very clear as to why we say that there is an ongoing public protection risk presented by the registrant.

Maintaining public confidence in the professions

We are aware that there can be a difference between what the people or organisation raising the concern expects us to do and the purpose of fitness to practise. But the fact that a member of the public disapproves of a registrant's behaviour doesn't necessarily mean that we should take action. There may be a desire to see the registrant punished, and this can create some dissatisfaction with those raising concerns, especially if we choose not to take any regulatory action. Maintaining public confidence in the professions doesn't mean that we need to punish people when something goes wrong. Making a registrant go through a lengthy fitness to practise process just to punish them would be counterproductive, given that a blame culture undermines patient safety.

To link public confidence to our overarching objective of public protection, the regulatory concern needs to involve something that is so serious that it would have a material impact on the likelihood of a member of public using the services provided by registrants in the future. If the public avoids using those services, because they lack confidence in registrants, the risk of harm to the public increases.

Maintaining professional standards

We want to promote and maintain professional standards in order to reduce future risk to patient safety. However, the need to maintain professional standards should not, on its own, justify us taking fitness to practise action. The Fitness to Practise Committee may take it into account when deciding whether a registrant's fitness to practise is impaired. But, it is not enough on its own to establish that a registrant's fitness to practise is impaired.

We think that we can best reduce patient risk by ensuring that we've the correct standards in place, and enabling registrants to promote and uphold high standards. We can achieve this through working with the professions, employers and the public to promote a clear vision of professionalism

- 1. We think that fitness to practise should primarily be about managing the risk that a registrant poses to patients or members of the public in the future. Do you agree?**
- 2. We don't think fitness to practise is about punishing people for past events. Do you agree?**
- 3. We propose that we will only take action to uphold public confidence when the conduct is so serious, that if we did not take action, the public wouldn't want to use the services of registrants. Do you agree?**
- 4. Some clinical conduct, such as deliberately covering up when things go wrong, seriously damages public trust in the professions and undermines patient safety? Do you agree?**
- 5. In those types of cases, the registrant should be removed from the register. Do you agree?**

Public confidence in the regulatory process

Public confidence in the regulatory process goes beyond public confidence in fitness to practise. Our other functions, including registration, revalidation, education and standards, are a large part of ensuring patient safety and enabling professionalism. We need to consider how fitness to practise can maintain the confidence established by those functions.

When a concern is raised, we believe that if it's possible to enable the registrant to practise safely and effectively, we should do so. This involves working with employers and registrants to enable reflection and remediation.

We believe that the public can have confidence in us as a regulator if we follow the PSA principles of good regulation:

- proportionate
- consistent
- targeted
- transparent
- accountable and
- agile.

Being transparent and accountable doesn't mean we need to take every concern we receive through the entire fitness to practise process (ending in a fully contested public hearing). We won't need to do this, and may not even need to send the case to our investigators, if we know that the registrant has already put any risk to patient safety right, and the concern isn't one which means they need to be removed from our register.

Even where there is still a risk to safety, or the concern is so serious that removal is required, we may not need to go through the entire fitness to practise process. Where there is no disagreement about the issues in the case, we don't need to hold costly and time-consuming public hearings. We can resolve cases at an early stage in the process by using our existing powers for case examiners to agree undertakings, issue warnings, or give advice if the registrant accepts our concerns. We already have the power to ask the Fitness to Practise Committee to decide cases on paper at a private meeting without the parties attending at a private meeting. We want to extend this to every case where the registrant does not disagree with our assessment of the case. We can remain transparent and accountable by publishing the panel's reasons. This will allow the public to see the concerns raised and how they have been dealt with.

Currently we don't publish the details of voluntary removal decisions that are granted by the Registrar before a hearing. Under the new strategy, to be fully transparent and accountable, we propose that we should publish all decisions to grant a registrant voluntary removal, taking out any private information, such as information about a health condition.

- 6. We propose that cases should be resolved at an early stage in the process if a registrant has fully remediated their clinical failings, even where those clinical failings have led to serious patient harm. Do you agree?**
- 7. We propose that every decision that relates to a restriction being placed on a registrant's practice (including voluntary removal) should be published. Do you agree?**

Regulatory outcomes

In every fitness to practise case we seek to protect the public. We also believe that we should consider more broadly what regulatory outcomes we expect to see as a result of our fitness to practise process. We are proposing two regulatory outcomes that reflect our distinctive role as part of a wider system to ensure patient safety and enable professionalism.

Regulatory outcome one

A professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety.

To achieve a learning and inclusive culture within the healthcare sector we need to look at how employers deal with concerns at a local level and the context in which patient safety incidents occur.

We believe that fitness to practise should be about managing the risk that a registrant poses to patients or members of the public in the future. We don't think it's about punishing people for past events. We recognise that if people perceive there to be a culture of punishment in the profession, this could prevent an open, learning culture. It can lead to denial and cover-up and doesn't put patient safety first.

Academic studies³ about how fitness to practise affects professionals have found that if people think their regulator is punitive or focused on blame, they are more likely to be anxious or even preoccupied about how their regulator might see their practice. This can lead to them being more likely to hide incidents that could affect patient safety. Recent work⁴ has found that cultures of blame are 'pervasive' in healthcare. We are aware of this problem, and we want the way we regulate to be focused on helping to solve it.

Research also tells us that our current fitness to practise processes don't contribute to a healthcare culture that values diversity, equality and inclusion. There is an overrepresentation of registrants from outside the EU and from black and minority ethnic (BME) backgrounds in fitness to practise proceedings, driven by disproportionate

³ McGivern, Gerry, and Michael Fischer. "Medical regulation, spectacular transparency and the blame business." *Journal of health organization and management* 24.6 (2010): 597-610.

McGivern, Gerry, et al. "Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice." (2015).

⁴ Armstrong, N., Brewster, L., Tarrant, C., Dixon, R., Willars, J., Power, M., & Dixon-Woods, M. (2018). Taking the heat or taking the temperature? A qualitative study of a large-scale exercise in seeking to measure for improvement, not blame. *Social Science & Medicine*.

referrals from employers.⁵ This is a concern in other parts of the regulatory sector. General Medical Council research found that BME and non-UK doctors are overrepresented in investigations,⁶ while five years of General Dental Council hearings data reviewed by the British Dental Journal in 2009 showed that dentists trained outside the UK made up 42% of registrants charged.⁷

- 8. We propose that fitness to practise should support a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety. Do you think this is the right regulatory outcome?**

Regulatory outcome two

Registrants who are fit to practise safely and professionally.

In recent years, we've markedly improved our ability to protect the public through legislative changes and improvements to our operations. However, our processes focus on restricting a registrant's practice, are complex and take a long time. Many cases are resolved at full hearings which are adversarial in nature and can have a negative impact on people involved in the process, such as witnesses, employers, and registrants.

To ensure that registrants who are referred to us can practise safely and effectively, we should enable registrants to remediate regulatory concerns at the earliest opportunity and, if needed, reach an agreed position with us as to how the concern should be dealt with. This means that we would only hold full hearings in exceptional circumstances.

If we do this, there would be fewer cases going through the full fitness to practise process. Those matters which do, will be dealt with in a way which is designed to prompt openness and remediation from the registrants and encourages engagement.

- 9. We propose that fitness to practise should ensure that registrants are fit to practise safely and professionally. Do you think this is the right regulatory outcome?**

⁵ West, Elizabeth, and Shoba Nayar. 'A Review of the Literature on the Experiences of Black, Minority and Internationally Recruited Nurses and Midwives in the UK Healthcare system.' (2016).

⁶ General Medical Council: 'The state of medical education and practice in the UK 2015' http://www.gmc-uk.org/SOMEPEP_2015.pdf_63501874.pdf (pp. 58- 83)

⁷ Singh et al 'A five-year review of cases appearing before the General Dental Council's Professional Conduct Committee' British Dental Journal vol 206 no. 4 Feb 28 2009

Part 2 – How we regulate

DRAFT

Achieving our regulatory outcomes

We've identified four different ways in which we can achieve our regulatory outcomes using our current regulatory powers:

Prioritising effective local action by employers

When something goes wrong, members of the public generally want to know that it will be dealt with quickly and effectively so that it doesn't happen again. Employers are usually in the best position to address concerns immediately before they escalate into more serious issues. We can look at whether a registrant is meeting our professional standards; we can't resolve complaints from members of the public, or address systems issues within employers.

By prioritising effective local action by employers we will:

- Ask employers to investigate locally first if we receive a referral from a member of the public that the employer has not had a chance to look at first. We will expect the employer to deal with the concern under their local procedures first, unless we think there need to be an immediate interim restriction on the registrant's practice.
- Set out very clearly for employers what we expect from a referral. All referrals will need to be signed off by a senior manager responsible for clinical governance.
- Work with our Regulatory Intelligence Unit to collect information from the referrals we receive and use that information when we investigate concerns.

This will improve the quality of referrals as we will be able to assess them when we receive them. We won't require additional initial information.

We will ensure transparency by working with employers on local complaints handling processes, to make sure that that the process adopted is transparent, user friendly and communicated to members of the public.

- 10. We think that employers are usually in the best position to resolve concerns immediately, and we should only take regulatory action if the concern has already been raised with and investigated by the employer (where there is one), unless there is an immediate risk to patient safety that we have to deal with. Do you agree?**

In our scenario, the nurse was dismissed by her employers immediately. By prioritising local action, the employer in this scenario could have managed this situation, investigating fully and training the nurse in medications administration. The investigation would also have highlighted any problems in the care home and the environment the nurse was working in, making the home safer for all patients.

Taking the context into account

The context in which patient safety incidents occur is extremely important. By considering the context we are asking what caused an incident, rather than who is to blame. Although we currently take account of context on a case-by-case basis, we don't have a consistent methodology for doing so.

By taking into account the context, we will:

- introduce guidance that sets out why context is relevant and how we will take it into account when we make decisions
- introduce a tool to standardise the way we assess context, and build this into to our decision-making
- share intelligence about context with employers and other regulators.

This will support us in developing an open and learning culture in the workplace, and make sure that we focus only on matters that raise genuine regulatory concerns.

11. Do you agree that we should always take the context in which a patient safety incident occurs into account when deciding what regulatory action is appropriate?

Enabling registrants to remediate regulatory concerns at the earliest opportunity

It's clearly in the interests of patient safety for registrants to remediate areas of weakness in their practice as soon as possible. But we note that there are some types of conduct that are so serious as to be fundamentally incompatible with registration – they can't be remediated.

If the employer, having addressed the issue locally, still referred the matter to us, we'd look at the context in which the nurse operated. The nurse was working as the only registered adult nurse in a 20 bed care home. She was called away to care for to another resident. We'd want to take into account the staffing levels at the home and the support the nurse was given. It won't be misconduct if we decide that the nurse was working in a system which might have caused any professional to make the same mistake. We wouldn't take the case any further. We may instead refer the home to a systems regulator.

If we decide that we should deal with the concern, we would contact the nurse and set out what we think the regulatory concern is. We would then advise them on how their concern could be remediated. If, following the advice, the nurse shows us that they've remediated, the case would go no further as there would be no outstanding public protection concerns.

Our decision-makers take remediation into account throughout our process. Remediation often determines whether a case requires regulatory action.

By enabling registrants to remediate regulatory concerns at the earliest opportunity, we will:

- encourage early remediation by engaging more with the registrant at the beginning of the process
- provide employers and registrants with guidance on remediation that is specific to the registrant
- refer all non-remediable cases directly to the Fitness to Practise committee.

12. Do you agree that we should be exploring other ways to enable registrants to remediate at the earliest opportunity?

Holding full hearings only in exceptional circumstances

Currently, once case examiners have found a case to answer, most cases go to a full hearing. Around 25 percent of cases are resolved by alternative means: meetings (i.e. hearings on the papers), consensual panel disposal, and voluntary removal.

We do not believe that full public hearings are always required to reach a decision that protects the public. Their adversarial nature often has a negative impact on referrers, witnesses and registrants, and they are slow and resource intensive.

By holding full hearings only in exceptional circumstances, we will:

- As early as possible, produce a draft determination, including provisional findings on charges, impairment, and sanction. We will use this as the basis for engaging with the registrant and seeking to resolve as many aspects as possible of the case by consent.
- Use hearings to adjudicate the outstanding matters in dispute. None of this would prevent a registrant from requesting a full hearing at the appropriate point.
- Make more use of meetings (i.e. hearings on the papers), as opposed to full hearings, where issues are not in dispute or where the registrant is not engaging with us.

Having engaged with us at the earliest opportunity, we know that the regulatory concern has been remediated and that there are no areas of dispute. A hearing would not be necessary as it would not achieve anything.

If there is remediation outstanding, we could use the alternative disposal of a CPD agreement, agreeing conditions of practice.

This will improve the way we work, so that the principal function of hearings is to resolve outstanding areas of dispute with a focus on reaching an agreed position with the registrant.

13. We propose that unless there is a serious dispute about the facts or disposal of a case, or a registrant has requested a hearing, all cases should be dealt with at a meeting. Do you agree?

DRAFT

Part 3 – How we operate

DRAFT

We've identified three areas where we can improve how we operate. We've focused on these areas as they're aligned to issues we know about in our current process, lessons we have learned from past events, and the proposed changes to how we regulate.

Managing public expectations and supporting vulnerable stakeholders better

We've improved the information that we provide to members of the public. We've also significantly improved the support we provide to witnesses who attend our hearings.

Many people engaging with our process have been involved in distressing and traumatic incidents, and so require a greater degree of support than we provide at the moment.

It's also the case that some members of the public are not clear about what the fitness to practise process can and can't achieve. At the moment, we don't have a system that allows us to proactively manage their expectations. This can lead to further distress for them and damage confidence in us as regulator.

We are setting up a public support service that aims to anticipate and meet the needs of members of the public who are involved in cases. It will also support vulnerable people, including people who have experienced bereavement or trauma, or who need support because of a disability, or age. We will seek input from patient groups and other relevant stakeholders to inform the development of the service.

We will improve further by:

- introducing a strategy for proactively contacting members of the public at the point we open an investigation
- explaining better how our process works and set expectations more effectively
- improving how we communicate with members of the public
- explaining key decisions to members of the public who have an interest in the case and seeking their input where it is appropriate to do so.

Working effectively with regulators and other key stakeholders within clearly defined boundaries

Over the last few years, we've improved the way in which we work and share information with regulators and other key stakeholders in the interests of public protection. We routinely share information with the Disclosure and Barring Service, Disclosure Scotland, and with system and professional regulators across the UK.

We will improve further by:

- defining more clearly the routine interactions we expect to have, and the information we expect to share, with other organisations in the interests of public protection
- referring concerns to other organisations where they are better placed to deal with them than we are
- exploring opportunities for joint working where they're in the interests of public protection.

Continuously improving

We could get more from improvements by using a consistent quality improvement methodology and embedding it in the way we design and run our processes. Learning from the way we currently handle cases tells us that we should seize the opportunity to take a more systematic view of process improvement.

We will improve further by:

- adopting a consistent quality improvement methodology and embedding it in our management culture
- reviewing our processes to identify opportunities to improve quality and efficiency
- developing an improvement plan that is in line with our organisation-wide plan to replace our information technology systems.

Part 4 – About you

[Hold for questions on details of individuals and organisations]

[Hold for question on impacts]

Part 5 – Annexe

[Hold for Annexe 1: Glossary]

DRAFT

Council

Draft Corporate Plan and Budget 2018–2021

Action: For decision.

Issue: Seeks Council's approval for the corporate plan and corporate key performance indicators (KPIs) for 2018–2019, and for the budget for 2018–2021.

Core regulatory function: All regulatory functions.

Strategic priority: Strategic priority 1: Effective regulation.
Strategic priority 2: Use of intelligence.
Strategic priority 3: Collaboration and communication.
Strategic priority 4: An effective organisation.

Decision required: The Council is recommended to approve:

- the Corporate Plan for 2018–2019 (paragraph 7.1);
- the KPIs and targets for 2018–2019 (paragraph 7.2);
- the Available Free Reserves (AFR) Policy, maintaining AFR within the range £10–25 million (paragraph 10) ;
- that the annual registration fee for all registrants should remain at its current level of £120 (paragraph 15);
- the budget for 2018–2019, as set out in Table 1 of this paper (paragraph 37).

Annexes: The following annexes are attached to this paper:

- Annexe 1: draft corporate plan for 2018–2019
- Annexe 2: draft KPIs and targets for 2018–2019

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Richard Wilkinson
Phone: 020 7681 5172
richard.wilkinson@nmc-uk.org

Director: Gary Walker
Phone: 020 7681 5754
gary.walker@nmc-uk.org

- Context:**
- 1 We prepare our corporate plan each year in the context of our longer term “Strategy 2015–2020” and the developing external environment. The corporate plan itself describes that environment, setting out our key priorities for the year, including business as usual KPIs.
 - 2 The budget reflects the allocation of resources to deliver the corporate plan. The financial context in which we are operating includes:
 - 2.1 The NMC remains in a stable and healthy financial position with significant reserves and strong financial controls.
 - 2.2 We actively monitor external pressures facing us including demand for FtP, workforce changes and the impact on the register, external cost pressures, and other external factors that may have an impact on the financial health of the organisation.
 - 2.3 Our AFR target range is £10 million to £25 million and we forecast that we will hold around £22 million of AFR at the end of March 2018.
 - 2.4 The financial position at the end of March 2018 is forecast as follows:
 - 2.4.1 BAU and planned strategic projects underspent by £1.9 million against budget.
 - 2.4.2 Income received approximately £0.7 million under plan.
 - 2.4.3 Capital spend will be £0.2 million over budget.
 - 2.4.4 Transformation will remain within the £2.5 million budget.
 - 2.4.5 Cash to be in line with the planned budget of £82 million.

Four country factors: 3 Not applicable for this paper.

Discussion: Corporate Plan, KPIs and Targets for 2018–2019

- 4 A draft of the Corporate Plan is enclosed at **annexe 1**. This is a strategic document setting out a summary of what we aim to achieve in 2018–2019 in the context of the proposed budget. The plan is consistent with the NMC’s strategy 2015–2020.
- 5 The Council monitors against priorities using Key Performance Indicators (KPIs) and targets. The proposed KPIs and targets for 2018–2019 are at **annexe 2**.
- 6 We will continue to review and improve our KPIs, setting more ambitious targets where appropriate. In particular, we will review the target for the

percentage of FtP cases concluded within 15 months at the mid-year, and improve the measurement of service quality within Registrations and Revalidation.

7 The Council is recommended to approve:

7.1 the Corporate Plan for 2018–2019.

7.2 the KPIs and targets for 2018–2019.

Available Free Reserves (AFRs)

8 The Council has a risk-based reserves policy that states our AFR range is between £10 million and £25 million. The AFR range is based on an annual assessment of the financial impact of the risks facing the NMC. We forecast the AFR to be about £22 million at the end of March 2018.

9 Given our income is primarily registrant fees, our greatest risk is a continued decline in the size of the register. Whilst we do not expect register numbers to fall dramatically in coming years we do expect this current trend will continue. We have, therefore, assumed a decline of income of £1.4m between the current financial year and 2018–2019 for an expected further reduction in the register and overseas income. We are undertaking further modelling to determine the risk level in future years and we have included provisional estimates for future years.

10 The Council is recommended to approve the Available Free Reserves (AFR) Policy of maintaining AFR within the range £10–25 million.

Annual Fee Review

11 The Council has committed to undertake an annual review of the registration fee level.

12 Our primary role in relation to the fee is to determine a fee level that enables us to carry out effective regulation and fulfil our statutory duty to protect the public.

13 The current annual registration fee of £120 has been in place since February 2015. In 2017–2018, we derived 97% of our income from the standard registration fee. Our budget for 2018–2019 assumes a continuation of the fee at £120 with a further potential decline in income as described previously. Given we are in a relatively healthy financial position we are not proposing an increase in the fee this year.

14 During 2018–2019, we will be reviewing the fee level in more detail, as well as improving the modelling of income for future years. This reflects growing concern about the long-term trend of the size of the register.

- 15 **Council is recommended to approve that the annual registration fee for all registrants should remain at the current level of £120.**

Proposed Budget

- 16 The proposed budget for 2018–2019 has been developed to support delivery of the Corporate Plan commitments. It reflects:
- 16.1 Business as usual (BAU) activities to deliver our core services.
 - 16.2 A number of strategic projects. These are discussed below.
- 17 The budget is based on a number of key assumptions discussed below.

Income

- 18 After a period of relative stability in the register and, therefore, income, trends through 2017 show a decline in registrant numbers, and reduced income. We also expect some impact as a result of our overseas review. We have, therefore, planned for a further reduction of £1.4 million. We have assumed registration fees are retained at the current level, with standard fees remaining at £120.

PSA Fees

- 19 These are based on the actual PSA 2018–2019 fee inflated for 2019–2021.

Pay review

- 20 The Council undertakes an annual review of staff pay. In 2017–2018, the Executive and most staff received a cost of living annual pay award of 2 percent. Some, lower paid staff received 2.5 percent or 3 percent. The overall cost of the pay award for 2017–2018 was £0.7 million.
- 21 In proposing the pay award for this year, we have considered both current and projected levels of inflation, as well as external benchmarks. Inflation, as measured by the Consumer Price Index (CPI) is currently near 3 percent with Bank of England projections indicating a level of 2 to 3 percent over the next year. Benchmarks include local government, where most employees have been offered 2 percent from April 2018, and nurses and midwives, where the expectation is that the previous 1 percent pay cap will be lifted. This also applies to the Civil Service. It should be noted, however, that many local government, NHS and Civil Service staff are eligible for annual pay increments along a pay spine in addition to the annual cost of living increase. This does not apply to the NMC.
- 22 In the light of the CPI projections, external benchmarking and taking account of affordability, we are proposing a cost of living increase of 2

percent for all employees, including the Executive. Executive pay was reviewed by the Remuneration Committee which recommended that the Executive receive the same cost of living increase as staff. The overall cost of this pay award would be £0.7 million.

Contingency

- 23 Based on our experience in 2017–2018, we are proposing a contingency of £2.3 million (about 2.5 percent of budget). This reflects the uncertain external environment which may, for instance, impact on income, on the need to act to address specific issues unknown at this point, on the volume of fitness to practise referrals. In setting aside a central contingency, we have sought to remove locally held contingencies, improving our ability to prioritise, at a corporate level, the funding needed to address pressures.
- 24 Directors will deliver within the budget set aside for their areas and will not seek additional funding, except where significant unforeseen and unplanned event requires it and only after efforts have been made to reprioritise or finding savings elsewhere. Any funding requests would be subject to a business case and signed off by Executive Board before funds are released.

Efficiency

- 25 Efficiency savings are built into budgets. The main efficiencies in 2018–2019 include £3.5 million from FtP enabled by Section 60 changes; £0.8 million from the implementation of Digital Audio Recording (DAR) in FtP hearings; reduction in Registration and Revalidation (R&R) staffing saving £0.2 million; smart working including hot-desking enabling a saving of £0.8 million a year in estates costs.
- 26 Our approach to improving efficiency remains focused on: realising significant gains through the strategic projects as we develop these; pursuing the continuous improvement agenda already in place (which has resulted in many of the savings, such as DAR, and in R&R); and using improved measurement of the unit cost of key high cost processes as a lever to increase process efficiency.

Pension costs

- 27 We have taken into account that the employer contribution to the defined contribution pension scheme will increase by 1% to 8% of salary in 2018–2019 in line with the previously agreed approach. This compares to the statutory minimum employer contribution for next year of 2%. Our wider review of reward, as part of the People Strategy, will include consideration of pension benefits and may impact on costs in 2020–2021.

Investment strategy

- 28 We have assumed no change to the current investment strategy which ensures high liquidity but low returns on our cash deposits of about £82 million. We are reviewing this strategy seeking options for achieving more from our investments. We intend to present this to the Council early in 2018–2019.
- 29 The proposed income and business as usual budget is set out below.

Budget summary

- 30 Our overall budget summary, reflecting these key assumptions, is shown in Table 1 below.

Table 1: 2018–2021 budget summary

Budget Summary (£M)	2017–18 Forecast	2018–19 Budget	2019–20 Budget	2020–21 Budget
Total income	85.3	83.7	82.9	82.4
Directorates – BAU				
OCCE	2.7	3.0	2.9	2.9
External Affairs	1.3	1.5	1.5	1.5
People and OD	2.3	2.5	2.5	2.5
Registration and Revalidation	5.3	5.5	5.5	5.5
Fitness to Practise	42.6	37.9	36.6	36.8
Education, Standards & Policy	3.2	4.0	3.9	3.8
Resources	17.0	16.5	15.1	15.1
Other – BAU				
Depreciation	3.3	2.7	1.3	1.0
PSA Fee	1.8	1.8	1.8	1.9
Pay Review*	**-	0.7	1.4	2.1
Contingency and Other	0.4	2.3	2.3	2.3
Total BAU Expenditure	80.0	78.3	74.7	75.2
Net BAU Position	5.4	5.4	8.2	7.2
Strategic Projects Portfolio (Table 2) (subject to approval)	3.9	5.0	1.5	0.1
Excess of income over spend	1.5	0.4	6.7	7.1

Notes:

* Amounts set aside for pay reviews in 2019–21 assume annual 2 percent increase

** Within Directorates' BAU budgets in 2017–18

Some totals may not sum exactly due to rounding

Strategic projects

- 31 There are a number of strategic projects which form key elements of the draft Corporate Plan and Budget. These are set in in Table 2 below. Two projects are currently in delivery. These are the Education programme, delivering modernised Nursing and Midwifery and QA standards, and the Nursing Associates project. The latter has all its costs refunded by the Department of Health (DoH) and so is not shown as a cost in our budgets.
- 32 Three other strategic projects have budgets proposed, subject to confirmation by Council being sought separately. These are the project to deliver the proposed new strategic direction for Fitness to Practise (FtP) project; the Overseas Registration review programme and the People Strategy implementation project.
- 33 Given expected income of £83.7 million and forecast BAU of £78.3 million in 2018–2019, we propose to fund some or all of the five strategic projects within the budget, subject to confirmation of satisfactory investment proposals. Whilst the estimated cost for these five projects is £4.5 million in 2018–2019 and £1.2 million in 2018–2019, we plan to manage them as a portfolio within an overall budget of £5 million and £1.5 million. On budgeted income and cost, this will produce an excess of income over spend of £0.4 million in 2018–2019. Costs in later years are still being reviewed, but we have set out our current best estimate in Table 2 below. This will be revisited as business cases are developed and in next year's budgeting round.

Table 2: Strategic Projects

Project (£M)	2018–19 Budget	2019–20 Budget	2020–21 Budget
Agreed Strategic projects			
Education programme	1.7	0.7	0.1
Nursing Associates programme (DoH funded)	-	-	-
Strategic projects subject to confirmation			
Fitness to Practise	0.9	-	-
Overseas Registration	1.4	-	-
People Strategy implementation	0.5	0.5	-
Estimated Strategic Change Project Total	4.5	1.2	0.1
Budget for Strategic Projects portfolio (Table 1)	5.0	1.5	0.1

Note: 2019–2021 costs are early estimates subject to confirmation

Infrastructure projects

- 34 In addition, Council will consider separately an outline investment proposal for essential upgrades or replacement of our IT systems at an estimated cost of £3 million in 2018–2019 and £2 million in 2019–2020.
- 35 In May, we will bring our proposed accommodation strategy to Council, including the business case to replace our offices in Kemble Street. This will require up to a maximum of £1 million for 2018–2019. The main fit-out costs will fall in 2019–2020 and will be agreed as part of the business case.
- 36 Funding sources for these projects in 2018–2019 will need to be considered by Council when it considers the specific proposals and so are not shown in the proposed budget in Table 1 above. Options include funding from the contingency or from reserves. Current estimated costs are shown in Table 3 below.

Table 3: Infrastructure projects

Project (£M)	2018–19 Budget	2019–20 Budget	2020–21 Budget
Infrastructure projects subject to confirmation			
IT strategy	3.0	2.0	-
Accommodation (includes elements of capital)	1.0	-	-
Total infrastructure	4.0	2.0	-

- 37 **Council is recommended to approve the Budget for 2018–2019 as set out in Table 1 of this paper.**

Public protection implications:

- 38 The corporate plan and budget underpin all our work to protect the public.

Resource implications:

- 39 These are dealt with in the body of the paper.

Equality and diversity implications:

- 40 None.

Stakeholder engagement:

- 41 None.

Risk implications:

- 42 Risks are reflected in the Corporate Risk register. Risks around Corporate Plan and budget delivery will need to be mitigated through

careful monitoring during the year.

Legal implications: 43 None.

Draft Corporate Plan 2018–2019

Introduction

About us

We are the independent regulator for nurses and midwives in the UK. Our purpose is to protect patients and the public through efficient and effective regulation.

We aspire to deliver excellent patient and public-focused regulation and in doing this we strive to meet the Standards of Good Regulation developed by the Professional Standards Authority.

Our ambition is to be a dynamic, leading regulator, delivering the best value for nurses' and midwives' fees.

Our role

Our regulatory responsibilities are to:

- maintain a register of all nurses and midwives who meet the requirements for registration in the UK
- set standards for education, training, conduct and performance so that nurses and midwives are able to deliver high-quality healthcare consistently throughout their careers
- take action to deal with individuals whose integrity or ability to provide safe care is compromised, so that the public can have confidence in the quality and standards of care provided by nurses and midwives.

Our strategy

Overview

Our *Strategy 2015–2020: Dynamic regulation for a changing world* sets out four strategic priorities to help guide our work in pursuit of our ambition to become an innovative, forward-looking regulator that is easily able to adapt to changes in healthcare and the demands on nurses and midwives. These are:

- effective regulation
- use of intelligence
- collaboration and communication
- an effective organisation.

This plan focuses on the fourth year of our five year strategy. Our plan for 2018–2019 builds on past success and sets our priorities and commitments for 2018–2019.

Our achievements since 2015

We have maintained a strong performance across our core regulatory functions, and we're pleased that the Professional Standards Authority reviews of our performance recognise this.

We have continued to strengthen the way we regulate. Changes we have made include:

- introducing a **new Code** of professional standards of practice and behavior for nurses and midwives, which is the cornerstone of good nursing and midwifery care
- introducing **revalidation**, which enables nurses and midwives to demonstrate they continue to practise safely and effectively
- making strong progress on our **education strategy**, a four year strategic project involving extensive consultation, to make sure our education standards equip the nurses and midwives of the future
- expanding **NMC Online**, a way for nurses and midwives to interact with us more easily
- introducing the **Employer Link Service** to help employers refer the right cases to us
- securing legislative changes to strengthen **midwifery regulation** and meet our moral commitment to support transition to new clinical supervision arrangements across the four countries
- securing legislative change to allow us to deal with **fitness to practise** cases more effectively and efficiently
- progressing the two year strategic project to become the regulator for **nursing associates** from 2019
- introducing new ways for nurses and midwives trained outside the UK to demonstrate their **English language capability**
- initiating our new **People Strategy** to build a culture where everyone who works here feels valued and proud to work at the NMC.

Strategic context

The wider picture

Our corporate plan needs to be agile and responsive to the fast moving environment we operate in.

- Rising economic and performance pressures on the health and social care sectors
- Changes in the need for care, and how and where care is delivered
- The changing political landscape, in particular the potential implications of Brexit. Five percent of nurses and midwives registered with us were first registered in an EEA country
- Possible regulatory reform. We, together with other regulators, have long pressed for modernisation of our legislation. We responded to the Government's consultation in January 2018 and look forward to continuing to help shape and influence the future of health regulation
- Strategic collaboration. We will continue to develop the potential to share activities and functions with other regulators where it makes sense to do so and can offer enhanced public protection.

Regulation of four countries

As a UK wide regulator, we regulate nurses and midwives across England, Scotland, Wales and Northern Ireland.

Strong relationships with each of the devolved administrations make sure that we are always improving our knowledge of the frameworks that are in place and how these interact with regulation.

Nursing associates

At the end of 2016 the Secretary of State for Health asked us to regulate nursing associates in England and our Council agreed to this request.

The government's intention is that nursing associates will deliver care, freeing up registered nurses to focus their skills and knowledge on complex clinical duties and to take a lead in decisions on the management of patient care. This new role is designed to bridge the gap between healthcare assistants and registered nurses in England.

We will continue our work with the nursing profession, stakeholders and partners so that we are ready to register the first new nursing associates in early 2019.

An overview of our priorities for 2018–2019

We have six specific priorities for 2018–2019 that focus on taking forward major programmes of work, while continuing to deliver our core regulatory functions. Delivery commitments for these are stated on pages 5–6 but they are summarised here. Our six priorities are:

Education

Modernising the standards of education and training for nurses and midwives.

Nursing associates

Regulating nursing associates from January 2019.

Fitness to practise

Setting a new strategic direction for fitness to practise to deal with cases more effectively and efficiently.

Overseas registration

Improving the efficiency of our processes and updating routes onto the register to take account of our new education standards and the introduction of nursing associates, for all overseas applicants.

An effective organisation

Continually improving the way we work, with a focus on investing in our people and technology.

Core regulatory performance

Building on and maintaining our current strong performance and quality.

Engaging with our stakeholders to make sure we understand patient and public perspectives and equality, diversity, and inclusion in our work.

Our delivery commitments 2018–2019

Strategic priority 1: Effective regulation

Education

By 31 March 2019 we will have:

Nursing

- implemented the new standards of proficiency for the Future Nurse.

Midwifery

- drafted the new standards for the Future Midwife in readiness for public consultation.

Nursing and midwifery education quality assurance

- implemented our new approach to quality assurance of education institutions.

Nursing associates

By 31 March 2019 we will have:

- opened the register for the first nursing associates.

Overseas registration

By 31 March 2019 we will have:

- reviewed and started to introduce a new approach to register nurses and midwives from outside the UK.

Fitness to practise

By 31 March 2019 we will have:

- set a new strategic direction for fitness to practise, taking account of the views of the public, patients, and other stakeholders.
- piloted changes aimed at:
 - improving public protection by resolving cases at the earliest opportunity
 - improving the experience of people involved in cases
 - improving efficiency and reducing the number of full hearings we hold.

Maintaining core regulatory performance

Throughout 2018–2019 we will:

- maintain strong performance against our key targets for registration and fitness to practise

- continue to monitor our customer service and deliver changes as a result of customer feedback.

Strategic priorities 2–4: Use of intelligence, collaboration and communication, an effective organisation

An effective organisation

By 31 March 2019 we will have:

- invested in replacing outdated IT systems and delivered ICT solutions to improve our efficiency and support our staff and the people we regulate.
- developed our accommodation strategy to better use our buildings and deliver long term cost savings
- strengthened our organisational capacity and capability through improvements to:
 - recruitment
 - induction
 - management development
 - employee engagement.
- continued to fulfil our commitments to equality, diversity and inclusion as set out in our strategic framework and action plan.

- END -

Draft KPIs and targets for 2018–2019

Corporate KPIs

Corporate KPI	Year to Date Actual (at Jan 2018)	2018–2019 target	Rationale
KPI 1: % of initial UK registration applications completed within 10 days	97.8%	95%	No target changes proposed because the target is challenging within current resource availability.
KPI 2: % of standard UK registration applications completed within 30 days	99.6%	99%	No target changed proposed because the target is challenging within current resource availability.
KPI 3: % of EU/Overseas registration applications assessed within 60 days	98%	90%	No target changes proposed for 2018–2019 as the impact of the English language changes introduced in November 2017 and the overseas review happening in 2018 is largely unknown.
KPI 4: % of interim orders imposed within 28 days of opening the case (year to date)	89%	80%	<p>No target changes proposed.</p> <p>The rolling 12 month average has averaged 90% but there is little tolerance in the measure for unexpected events or fluctuations. The screening team which carries out the interim order function is at full capacity, and are reliant on the hearings function to accommodate new applications.</p> <p>The median time taken to impose interim orders is currently 26 days so an increase, however brief, in demand which breaches capacity constraints in either team will impact on our performance.</p>
KPI 5: Proportion of FtP cases concluded within 15 months of being opened	78%	80%	<p>No target changes proposed for the first six months of 2018–2019.</p> <p>Our timeliness pathway is a clear plan to progress older cases from our caseload. Until it is successfully delivered there will be fluctuation in</p>

			<p>the percentage of cases concluding within 15 months.</p> <p>We will review progress at the mid-point in the year to assess whether a more challenging target is achievable.</p>
--	--	--	--

Additional performance data reported to Council

Performance measure	Year to Date Actual at Jan 2018	2018–2019 target	Rationale
Call attempts handled: % of call answered	90.7%	90%	<p>No target changes proposed.</p> <p>Introduction of a new telephony system could provide tools that improve performance in the longer term. However, more detail is required from the IT strategy to understand how we can increase performance before targets are increased.</p>
<p>Customer satisfaction:</p> <p>a. % of customers highly satisfied/satisfice with the service received (FtP / Registration & Revalidation)</p> <p>b. % of customers who strongly agreed/agreed that NMC made it easy for them to manage their issue (FtP / Registration & Revalidation)</p>	<p>75.3%</p> <p>70.4%</p>	<p>75%</p> <p>70%</p>	<p>No target changes proposed as further exploration is needed to determine what customer improvement work is required to improve performance.</p> <p>We have committed to reporting at May 2018 Council the reasons for customer dissatisfaction alongside satisfaction.</p> <p>We will continue to increase survey response rates within FtP.</p>
Revalidation: % of revalidation rates (of those due to revalidate) for the whole register and by each country	91.8% (Average Oct– Dec 2017)	No target – continue to monitor the trend	We will continue to monitor the trend as part of the first 3-year cycle of revalidation to assure that rates remain within previous renewal rates.
People: % of staff turnover	23.1% (Dec 2017)	<25%	<p>New target. We will continue to monitor turnover rates, with a focus on new starters (see below).</p> <p>It's anticipated that improvement initiatives being delivered in 2018–2019 will lead to reductions in turnover in the medium to long term.</p>

Performance measure	Year to Date Actual at Jan 2018	2018–2019 target	Rationale
People: % of new starters with less than 6 months service leaving	New measure	<25%	As requested by the Council we will have a particular focus on understanding and tackling why new starters are exiting the organisation within 6 months.
Quarterly updates against corporate commitments	N/a	Traffic light rating against delivery of milestones in corporate plan	We will continue to report against the corporate commitments detailed within the 2018–2019 corporate plan on a quarterly basis.

Council

Audit Committee report

Action: For information.

Issue: Reports on the work of the Audit Committee.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: None.

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Secretary: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Chair: Marta Phillips

- Context:**
- 1 Provides a report to Council following the Audit Committee meeting on 28 February 2018.
 - 2 In keeping with good practice, the Committee met with the NMC's External Auditors (haysmacintyre) and the National Audit Office (NAO) without the Executive team present. There are no issues of concern to report.

- Four country factors:**
- 3 Four country factors are taken into account by the Audit Committee, where applicable.

Discussion: Internal Audit work programme 2017–2018 progress update

- 4 The Committee considered an update on progress on the Internal Audit work programme 2017–2018. Two programmed reviews had been completed since the Committee's last meeting: on programme management and payroll. The Committee was pleased to note the findings of these reports were, in the main, positive with some areas for improvement.
- 5 Two additional reviews had been requested by the Executive: the review of an error processed by the software application that supports the Register; and a review of financial accruals in the Fitness to Practise directorate following the introduction of new processes.
- 6 The software application processing error occurred over the New Year period. While the risk to public protection arising from the event has been assessed as extremely low, the Internal Audit report identified some recommendations in relation to incident management, communication and IT processes. The Committee considered the significance of this incident and sought assurance that a cross-organisational approach was in place to deliver the outcomes needed. All immediate issues have been resolved and the remaining follow up work will be completed by the end of March 2018.

Internal Audit strategy 2018–2021 and annual work plan 2018–2019

- 7 The Committee approved the Internal Audit strategy and work plan developed by RSM, who will take on responsibility for Internal Audit from April 2018. These took into account both organisational priorities and key risk areas.
- 8 The Committee approved the Internal Audit charter setting out the roles and responsibilities of the NMC and RSM and the standards which will underpin the delivery of the service by RSM.
- 9 The Committee welcomed RSM's plans to ensure internal audit reviews add value rather than simply confirming issues already known to management, for example the illustration of best practice from

across the NMC or identified elsewhere.

Cyber security – Risk management and assurance

- 10 The Committee received a report on cyber security issues together with an update on steps to mitigate the risks identified in the Infrastructure and Capability Internal Audit review of September 2017.
- 11 The Committee noted that risks identified by Internal Audit have been addressed and account taken of National Audit Office (NAO) guidance in considering the overall approach to cyber security.
- 12 The Committee asked for some further analysis against the questions raised in the NAO guidance. This will be brought back to the Committee's June meeting.

Risk Management update

- 13 The Committee received an update report on risk management processes and procedures including proposals for future assurance reviews at directorate level. The Committee asked for further thought to be given to looking at cross-organisational assurance reviews.
- 14 The Committee received a presentation on risks, mitigations and sources of assurance in relation to the Education, Standards and Policy directorate. The Committee noted that since 2016 there had been a shift in the work of the directorate from mainly routine activities such as the quality assurance of approved programmes of education to taking forward very significant strategic programmes such as the Future Nurse and Midwifery Standards; Education framework and Quality Assurance; and Nursing Associates. The risks and issues identified reflected this accurately.

External Audit and NAO plans for the audit of the accounts for the year ended 31 March 2018

- 15 The Committee approved the arrangements proposed by the External Auditors and the NAO for the external audit and certification of the NMC's annual accounts for the year ending 31 March 2018. The Committee noted the outcome of the interim annual audit visit and the arrangements in place to deliver the year-end work.
- 16 The arrangements proposed reflected some changes of approach due to revised auditing requirements, which would affect the content and structure of audit reports.

Update on Procurement and Single Tender Actions

- 17 The Committee considered a report on procurement, including Single Tender Actions (STAs) approved since the last meeting.
- 18 The Committee is monitoring progress in relation to procurement due

to it continuing to be an area of concern. A number of improvements are in hand to improve performance in this area but there remains significant work to be done.

- 19 The Committee scrutinised the STAs from the period April 2017 to February 2018. The Committee continues to monitor cumulative single tender actions to enable the identification of any trends and ensure that any such activity is defensible and not adding any risk to the NMC's operations.

Serious event and data breaches report

- 20 The Committee considered a report on SERs and data breaches during the period September 2017 to January 2018.
- 21 The Committee was pleased to note that themes emerging from serious events were being identified and addressed, in particular through process change; and staff induction and training programmes.

Progress on Internal Audit recommendations

- 22 The Committee continues to monitor progress on clearing internal audit recommendations from previous audits. The Committee was pleased to note there had been a marked improvement in implementing Internal Audit recommendations. Progress on the three outstanding overdue recommendations will continue to be monitored by the Committee.

Whistleblowing

- 23 The Committee noted there had been no whistleblowing issues raised since the Committee's last meeting.
- 24 The Committee was pleased to note that training to support frontline managers will be rolled out from April 2018, as part of the management development programme.

Annual review of External Audit effectiveness for the year to 31 March 2018

- 25 The Committee considered the report on the review of effectiveness of the external auditors and NAO and is satisfied that good service is being provided.

Public protection implications:

- 26 None.

Resource implications:

- 27 None.

Equality and diversity implications: 28 None.

Stakeholder engagement: 29 None.

Risk implications: 30 None.

Legal implications: 31 None.

Council

Council appointments

Action: For information.

Issue: Confirms Council appointments and Committee membership for 2018–2019.

Core regulatory function: All regulatory functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: None.

Annexe: The following annexe is attached:

- Annexe 1: Proposed Council Committee membership 2018–2019.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the assistant director named below.

Author: Pernilla White
Phone: 020 7681 5477
pernilla.white@nmc-uk.org

Secretary to the Council: Fionnuala Gill
Phone: 020 7681 5442
fionnuala.gill@nmc-uk.org

- Context:**
- 1 The Council's Standing Orders (paragraph 4.3.4) authorise the Chair of the Council to make appointments to Council Committees. The Chair also determines the appointment of the Vice-Chairs and other Council appointments.
 - 2 After discussions with Council members, the Chair has confirmed appointments for 2018-2019 in relation to the roles below, recognising that the new Chair of the Council may wish to make adjustments at an appropriate time during 2018-2019.
 - 3 The roles covered are:
 - 3.1 Vice-Chair appointments.
 - 3.2 Remuneration and Audit Committee membership.
 - 3.3 Midwifery Panel.
 - 3.4 NMC Trustee: General Nursing Council for England and Wales Trust.
 - 4 All appointments are consistent with members' current terms of office on the Council.
 - 5 In addition, following an open competitive recruitment exercise, appointments have been made to the Appointments Board, which is comprised entirely of non Council members.
 - 6 All Council appointments are set out at **annexe 1**.
- Four country factors:**
- 7 Four country considerations are one of the factors taken into account in balancing roles across the Council (see paragraph 11.5 below).

Discussion: Vice Chair appointments

- 8 The Council currently has two Vice Chairs, Anne Wright (lay member) and Maura Devlin (registrant member). The Vice Chairs are responsible amongst other things for conducting the annual appraisal of the Chair and presiding as acting Chair should the Chair need to withdraw from a meeting or be unexpectedly absent.
- 9 In the event of the Chair of the Council being absent from a meeting, the Council Constitution Order (and Standing Orders) provide for the Council to nominate a member to preside. As agreed by the Council, the normal expectation is for the Council to nominate a Vice Chair to preside in the event of the Chair being unexpectedly absent from a meeting or should the Chair need to withdraw from part of a meeting due to conflict of interest.
- 10 To ensure continuity, it has been agreed to continue with the current

Vice Chair appointments for 2018-2019.

Remuneration and Audit Committee

- 11 In November 2015, the Council agreed the following set of principles to inform Council Committee appointments:
 - 11.1 Committee appointments should be informed by an agreed skills matrix and aim to optimise individual member skills, experience, interests and expertise.
 - 11.2 Committee members should be appointed for a specified term of office, usually two to three years.
 - 11.3 Committee membership should be reviewed annually and refreshed regularly, whilst also maintaining appropriate continuity and avoiding unnecessary disruption.
 - 11.4 Where possible Committee appointments should aim to distribute responsibilities evenly amongst members, in any given year and over terms of office, and to spread the opportunities to chair Committees.
 - 11.5 Committee appointments should seek to balance factors including diversity, registrant and lay members and four country representation, where possible.
- 12 Taking account of the above factors and discussions with members, changes have been made to membership of the Audit and Remuneration Committee for 2018-2019 as shown in **annexe 1**.

Midwifery Panel

- 13 Whilst the Midwifery Panel is not a Council Committee, its current membership includes two Council members, Anne Wright and Lorna Tinsley. Both have agreed to continue to be members of the Midwifery Panel for 2018-2019.

Appointments Board

- 14 The Appointments Board is a discretionary Committee established by the Council to ensure appropriate separation of responsibilities between the Council and the appointments and oversight of Fitness to Practise Committee (panel) members and Legal assessors. For this reason, it is comprised entirely of non Council members.
- 15 Following an open competition, two new members of the Board were appointed from 1 March 2018 and a new Board Chair appointed to succeed Belinda Phipps whose terms ends in August 2018. Further details are included in the separate Chair's action on the agenda.

NMC Trustee: General Nursing Council for England and Wales Trust

16 From 1 May 2018, Robert Parry will be the NMC Trustee on the General Nursing Council for England and Wales Trust, replacing Maureen Morgan whose terms of office as a Council member ends on 30 April 2018.

Public protection implications:

17 None.

Resource implications:

18 There are no resource implications arising from this paper.

Equality and diversity implications:

19 Equality and diversity impacts and the NMC's obligations under the Equality Act 2010 are taken into account in Council appointments.

Stakeholder engagement:

20 None.

Risk implications:

21 Regular review of Council roles and Committee appointments are consistent with good governance and mitigate against any governance risks.

Legal implications:

22 Under Standing Order 4.3.4, the Chair of the Council has delegated authority to make appointments to Council Committees.

Council/Committee appointments 2018–2019

Vice Chair (Two Council members)	Term
Anne Wright (lay member)	Vice Chair since November 2015
Maura Devlin (registrant member)	Vice Chair since November 2015

Remuneration Committee (Three Council members)	Term
Karen Cox (Chair) (registrant member)	1 April 2018 to 31 March 2019 (Committee member since 1 January 2016, Chair from 1 April 2018)
Maura Devlin (registrant member)	1 April 2018 to 31 March 2019 (Committee member since 1 January 2016)
Sir Hugh Bayley (lay member)	1 April 2018 to 31 March 2019

Audit Committee (Three Council members)	Term
Marta Phillips (Chair) (lay member)	1 April 2018 to 31 March 2019 Independent Chair 1 June 2016 to 30 April 2017 Council member Chair from 1 May 2017
Maureen Morgan (registrant member)	1 April 2018 to 30 April 2018 Committee member since 1 January 2016
Robert Parry (registrant member)	1 April 2018 to 31 March 2019 Committee member since 1 January 2016
Derek Pretty (lay member)	1 April 2018 to 31 March 2019 Committee member since 1 January 2017

Midwifery Panel (Two Council members)	Term
Anne Wright (lay member)	Member since November 2015
Lorna Tinsley (registrant member)	Member since November 2015

NMC Trustee, General Nursing Council for England and Wales Trust	Term
Robert Parry (registrant member)	From 1 May 2018

Appointments Board (Five non Council members)	Term
Belinda Phipps (Chair)	3 August 2015 to 3 August 2018
Jane Slatter (Chair designate)	6 August 2018 to 5 August 2021
Fiona Whiting	3 August 2015 to 3 August 2018
Frederick Psyk	1 September 2016 to 31 August 2019
Angie Loveless	1 March 2018 to 28 February 2021
Clare Salters	1 March 2018 to 28 February 2021

Council

Chair's action taken since the last meeting of the Council

- Action:** For information.
- Issue:** Reports action taken by the Chair of the Council since 31 January 2018 under delegated powers in accordance with Standing Orders.
- There has been one Chair's action to authorise three appointments to the Appointments Board.
- Core regulatory function:** Supporting functions.
- Strategic priority:** Strategic priority 4: An effective organisation.
- Decision required:** None.
- Annexes:** The following annexe is attached to this report:
- Annexe 1: Chair's action – Authorisation of three appointments to the Appointments Board.
- Further information:** If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Secretary: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Chair's Action

Under NMC Standing Orders, the Chair of the Council has power to authorise action on minor, non-contentious or urgent matters falling under the authority of the Council (Scheme of Delegation, paragraph 4.6). Such actions shall be recorded in writing and passed to the Secretary who maintains a record of all authorisations made under this paragraph. The Chair is required to report in writing, for information, to each Council meeting the authorisations which have been made since the preceding Council meeting.

Each Chair's action must set out full details of the action that the Chair is requested to authorise on behalf of the Council.

Requested by: Fionnuala Gill Secretary to the Council	Date: 20 February 2018
--	----------------------------------

The Council has established the Appointments Board as a discretionary committee. The remit of the Appointments Board is:

"To assist the Council in connection with the exercise of any function or process relating to the appointment of Panel Members and Legal Assessors."

Given this remit, the Chair and all members of the Board are lay members.

A selection panel chaired by Council member Lorna Tinsley was convened to oversee a recruitment and selection process for a Chair and two members of the Appointments Board.

Following an open competitive recruitment process the Panel makes the following recommendations for appointment:

1. Jane Slatter – Chair (effective from 6 August 2018 to 5 August 2021)
2. Clare Salters – Member (effective from 1 March 2018 to 28 February 2021)
3. Angie Loveless – Member (effective from 1 March 2018 to 28 February 2021)

Under NMC Standing Orders, paragraph 4.2.6, the Chair is requested to authorise the above appointments on behalf of the Council.

Signed



(Chair)

Date 20 February 2018

Appointments to the Appointments Board

Action: For decision.

Issue: Appointments to the Appointments Board.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: The Chair is requested to appoint the following to membership of the Appointments Board:

- Jane Slatter – Chair (effective from 6 August 2018 to 5 August 2021).
- Clare Salters – Member (effective from 1 March 2018 to 28 February 2021).
- Angie Loveless – Member (effective from 1 March 2018 to 28 February 2021).

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Mary Anne Poxton
Phone: 020 7681 5440
maryanne.poxton@nmc-uk.org

Assistant Director: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

- Context:**
- 1 The Council has established the Appointments Board as a discretionary Committee to assist the Council in connection with the exercise of any function or process relating to the appointment of Fitness to Practise Panel Members and Legal Assessors.
 - 2 In accordance with Standing Orders, the Board comprises a Chair and four members, all of whom are lay, partner members.
 - 3 Two Appointments Board members' second terms of office came to an end in January 2018 thereby creating two vacancies on the Board. The Chair role will become vacant when the current Chair's term of office comes to an end on 3 August 2018.
 - 4 An open, competitive recruitment process was conducted to fill the vacancies.
- Four country factors:**
- 5 The roles were open to lay candidates from any of the four countries of the UK.
- Discussion**
- 6 A Selection Panel was established to oversee a rigorous recruitment and selection process. The Panel consisted of:
 - 6.1 Lorna Tinsley, Chair of the Selection Panel.
 - 6.2 Derek Pretty, member of the Selection Panel.
 - 6.3 Radhika Seth, Independent Panel member.
 - 7 Although not bound by it, the Panel had regard throughout the process to the good practice guidance issued by the Professional Standards Authority, that appointments should be based on four key principles: merit, fairness; transparency and openness; and inspiring confidence.
 - 8 A broad advertising strategy was put in place designed to attract high calibre candidates with the range of skills to meet the competencies from the four countries of the UK and underrepresented communities.
 - 9 The Panel was impressed with the high calibre of candidates and is confident that the recommended candidates meet the full range of required competencies and bring a broad range of relevant skills and experience to the Board.
 - 10 Recommendation: The Chair is recommended to appoint the following to membership of the Appointments Board:
 - 10.1 Jane Slatter – Chair (effective from 6 August 2018 to 5 August 2021).

10.2 Clare Salters – Member (effective from 1 March 2018 to 28 February 2021).

10.3 Angie Loveless – Member (effective from 1 March 2018 to 28 February 2021).

Public protection implications:

11 None.

Resource implications:

12 Allowances and expenses for Partner members are provided for within the Governance budget.

Equality and diversity implications:

13 An equality analysis was undertaken of our member recruitment processes to inform the design of the advertising strategy, and the recruitment and selection process. To make sure we are treating candidates fairly, we monitor diversity at all stages of the selection process.

Stakeholder engagement:

14 Not applicable.

Risk implications:

15 None.

Legal implications:

16 None.