Draft standards consultation: Specialist Community Public Health Nursing, Community Specialist Practice Qualifications, and associated programme standards

Consultation findings

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Final Report

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Acronyms

AEI	Approved Educational Institution
CCN	Community Children's Nursing/Nurse
CLDN	Community Learning Disabilities Nursing/Nurse
CMHN	Community Mental Health Nursing/Nurse
CSPQ	Community Specialist Practice Qualification
CYP	Children and Young People
DN	District Nursing/Nurse
GPN	General Practice Nursing/Nurse
HEI	Higher Education Institution
HV	Health Visiting/Visitor
NMC	Nursing & Midwifery Council
Ofsted	Office for Standards in Education, Children's Services and Skills
OHN	Occupational Health Nursing/Nurse
QAA	Quality Assurance Agency for Higher Education
RPHN	Registered Public Health Nursing/Nurse
SCPHN	Specialist Community Public Health Nursing/Nurse
SN	School Nursing/Nurse
SPQ	Specialist Practice Qualification

1. Executive summary

Introduction and background

1. The Nursing and Midwifery Council (NMC) is the professional regulator of nurses and midwives across the UK, and for nursing associates in England. As part of its role, the NMC has a responsibility, amongst others, to set out and review its standards of proficiency and education and training to ensure consistent and high standards of care.

2. On registering as a nurse or as a midwife with the NMC, registrants can undertake an NMC-approved course to become a specialist community public health nurse (SCPHN) for a public health role, including working as a health visitor (HV), an occupational health nurse (OHN), a school nurse (SN), and/or registered nurses can gain an NMC-approved specialist practice qualification (SPQ).

3. In January 2020, following the Council's decision, the NMC announced its intention to develop new standards of proficiency for three areas of Specialist Community Public Health Nursing (SCPHN) practice:

- Health Visiting (HV),
- Occupational Health Nursing (OHN), and
- School Nursing (SN).

4. At that time, the NMC also announced that it would begin to scope out the content for a new Specialist Practice Qualification (SPQ) standard of proficiency in community nursing, along with associated programme standards for both SCPHN and SPQ. The initial proposal was for one set of standards of proficiency that would be applicable to all five existing areas of specialist community nursing practice for which NMC-approved SPQs are already available. The current community roles are:

- Community Children's Nursing (CCN),
- Community Learning Disabilities Nursing (CLDN),
- Community Mental Health Nursing (CMHN),
- District Nursing (DN), and
- General Practice Nursing (GPN).

5. Following extensive stakeholder engagement in 2020, NMC agreed to retain these five existing SPQs and proposed a new one to accommodate other existing community nursing roles for which there is no SPQ, and any new community roles which may emerge in future. The new qualification would be based on the same core standards of proficiency, but with enhanced programme standards to describe the programme requirements that lead to each annotation.

6. Following the pre-engagement activities between June and October 2020, the NMC co-produced three sets of draft standards with key stakeholders and subject matter experts for a full public consultation:

- Standards of proficiency for specialist community public health nursing (SCPHN),
- Standards of proficiency for community nursing specialist practice qualifications (SPQs), and
- Standards for post-registration education programmes.

7. A nationwide consultation on these draft standards was held from April to August 2021 and Pye Tait Consulting was commissioned to assist with managing the consultation survey and its analysis.

Research aim

8. The aim of the consultation was to gather feedback on the three sets of draft standards to identify where there is consensus, and what improvements and revisions may be required prior to their finalisation. Besides the main consultation questions, the responses to which were predominantly positive and for which the extent of agreement is clearly illustrated through charts, we also identified the reasoning behind the relatively small number of suggested improvements and revisions through the provision of additional questions seeking comment from those who are in disagreement with any element of the three sets of drafts standards. The qualitative analysis sections in this report therefore are not intended to show balance between support and challenge, but to illustrate the relatively small number of dissenting opinions.

9. The main research questions focused on whether the standards reflect the key knowledge and skills each specialist nurse needs to have at the point of registration or annotation of their award, and key features, such as student selection and admission, curriculum and programme structure and supervision and assessment, of post-registration programmes for SCPHN and SPQ.

10. Complementary qualitative research with the public sought to establish the extent to which the draft standards are clear and understandable to a wide range of people including nursing professionals and members of the public, and understand the extent to which the draft standards are perceived as ambitious, inclusive and appropriate for all four nations of the UK.

Method

11. The method comprised two core strands.

- Online surveys - Three versions were developed: one to gather views from health and social care professionals and organisations; one to gather views from members of the public, and one “easy read” version for the public was also available.
- Focus groups - A series of focus groups and in-depth interviews with members of the public and from “seldom heard” groups of the population. Pye Tait Consulting derived a sampling strategy to ensure a cross-section of participants.

12. The consultation, incorporating the associated fieldwork, ran for 16 weeks from 8th April to 2nd August 2021, four weeks longer than the customary length of consultation to enable wider participation.

Response patterns

13. In total, 2,363 responses were received to the online consultation, of which 2,282 responses were from individuals, including 473 responses from members of the public, and 81 from organisations. In addition, a total of 73 offline (a mix of individuals and organisations) responses in the form of letters or statements were received. The profile of the final consultation sample, including by nation, age and other characteristics, is provided in section 2.5.

14. Qualitative research comprised 11 focus groups and 49 individual depth interviews. Key population groups that the NMC identified for focus in the separate qualitative research were:

- young people/children,
- parents/carers,
- members of the public who use/have used the services of SCPHN and SPQ professionals, and
- seldom heard.

High level findings

15. The overarching conclusion from all audiences is that the three sets of draft standards are welcomed and largely fit-for-purpose and that the majority of respondents are positive and supportive.

16. In relation to SCPHN, there were 1,130 responses. Seventy five percent (848) agree that the draft core and field specific standards of proficiency reflect the specialist knowledge, skills, and attributes necessary for all SCPHN registrants.

17. In relation to SPQ, there were different numbers of responses for each of the seven Platforms. Views on the applicability of seven Platforms to the five specialist community fields of practice range from 72% (660) agreement with the proficiencies expressed in platform 5 (n=917) to 88% in agreement (905 and 902) for the standards in platforms 2 and 3 (n=1,208 and n=1,025).

18. For SPQ, there are issues of detail and areas which some respondents would like to see improved or enhanced. Common themes among those who disagreed and submitted comments were in relation to a perceived requirement for field specific standards for each SPQ field of practice, and for standards to contain more advanced terminology.

19. In response to questions on post-registration programme standards for both SCPHN and SPQ, at least 67% (718) are in agreement with most of the proposals.

20. Areas of disagreement with the proposals for programme standards centred on length of programme, and period of consolidated practice. For SCPHN, 31% (351 of 1,132 responses) and for SPQ 24% (265 of 1,105 responses) disagreed with proposals to not specify a duration within the post-registration programme standards. Just over 34% (380) also disagreed with the proposal to not specify a period of consolidated practice for SCPHN programmes (n=1,119).

21. The following specific conclusions are summarised across the three sets of standards as follows, along with a summary of views from the public.

Draft standards of proficiency for SCPHN

60% (1,137) of a total of 1,890 respondents chose to respond to some or all questions on SCPHN[1]

22. There are high levels of agreement that the draft core and field specific standards for HV, OHN and SN meet the proficiency requirements – with average levels of agreement at 83%, 78%, and 83%, respectively.

[1] All percentages in this section relate to those who responded to SCPHN questions.

23. The main area of disagreement in relation to the standards of proficiency was in relation to prescribing. For HV, 47% (450/959 respondents), believe a prescribing element should be a mandatory integrated programme requirement. This drops to just over a third for the OHN at 37% (296/801) and 33% (275/833) for SN.

24. There is an even split as to whether the V100 or V300 is most appropriate with just over half believing the V100 level is most appropriate for the SN and HV routes at 59% (318/539) and 54% (382/708) respectively. A similar proportion, 55% (270/491), believe the V300 level is most appropriate for the OHN route.

25. Respondents were asked whether the Registered Public Health Nursing (RPHN) qualification should be retained. While 45% (469) of individuals agreed that it should, organisations are evenly split with 32% (18) saying it should be retained and 36% (20) thought it should not (n=56). There is generally a high degree of ambivalence around this topic with 41% (452) of all respondents being unsure (n=1103). Concern is raised that retaining this qualification may result in confusion among professionals and the public.

26. There is broad support (63%, 286/454) that these draft core standards can be applied to other public health nursing roles. Among those who were uncertain (27%), concerns are that the standards might need to be more role specific.

Draft standards of proficiency for SPQ

62% (1,177) of a total of 1,890 respondents chose to respond to some or all the questions on SPQ[2]

27. Responding to the questions for each of the Platforms proposed for SPQ, between 72% and 88% (660 to 905) of respondents agree that the proficiencies within each of the seven Platforms is applicable to each community field of practice. This suggests that the draft standards are reasonably well received by the majority of respondents.

28. From those disagreeing, most commonly between 5% to 7%, between 64 and 94 comments were received from a mix of individuals and organisations for each of Platforms 1 to 7 about the applicability of the standards. Of those specific comments, several themes emerged, of which the main theme is that the Platforms – as they stand – are too broad. Those respondents would like to see more field specific standards to reflect what they regard as the specialist aspects of each SPQ role.

29. Overall, 48% (552) support the development of a skills annex, however a quarter disagree and just over a quarter are unsure (n=1,149).

30. In relation to prescribing, there is stronger feeling that this should be mandated rather than optional but it is not clear-cut across all five areas of SPQ. Nearly three quarters, 73% (739), of respondents believe a prescribing element should be a mandatory integrated programme requirement for the DN route, while 66% (581) agree for the GPN route. This falls to just over half, 51%, supporting a mandatory prescribing element for the CMHN (417) and CCN (426) routes. For CLDN, 42% (335) respondents agree. Seven percent (56) of respondents believe that this is not necessary for any of the five routes.

31. Of the two levels, V300 level is preferred for all routes. Justification for this is largely that V300 is more suitable as it caters for the more complex autonomous care and associated prescribing

[2] All percentages in this section relate to those who responded to SPQ questions.

practice required at this level, as opposed to V100 which some perceive as being either outdated, or offering insufficient scope.

32. In total, 1,139 people responded to questions about the proposed additional community SPQ. Over two thirds 68% (775) agree the NMC should seek to extend these standards for other community roles without a community nursing specialist practice qualification. Sixty four percent (775) agree that the draft standards are appropriate for nurses in other community settings with 13% (148) not agreeing.

33. There are high levels of agreement in relation to: the proposed new SPQ annotation (71%), referring to these qualifications as SPQs (73%), and for NMC to regulate these (88%). This suggests these proposals are well-received.

Draft standards for post-registration education programmes

1,178 respondents responded to these questions (62% of total)[3]

34. For both SCPHN and SPQ, there are good to high levels of agreement with the proposals around student selection and admission (83% and 77%, respectively).

35. For both SCPHN and SPQ, there is also agreement that the draft standards will allow providers to be creative and innovative, and to design a curriculum that supports students (67%+).

36. There are good levels of support for the proposals around supervision and assessment: 87% for SCPHN and over 80% for SPQ. Taken together, these aspects of the draft standards have been well-received.

37. There is however a stronger feeling that course duration should be specified. Thirty one percent (351) disagree or strongly disagree with the SCPHN proposals to not specify the duration programme length (n=1,132). There is a slightly lesser feeling for programme length with regard to SPQ, where just under 24% (265) disagree or strongly disagree with the proposal (n=1,105).

38. Forty eight percent (509) of respondents agree or strongly agree with the proposed approach (SCPHN) not to stipulate the requirement to have a specified period of consolidated practice within the draft standards (n=1,119). This drops to 47% (516) for SPQ (n=1,098).

39. Concerns by those disagreeing were about a potential adverse impact on quality and outcomes.

Views from the public on the draft standards for SCPHN and SPQ (n=473)

40. There are high levels of agreement with the intentions of the draft standards for each SCPHN area (90%+), with 75% being supportive of the prescribing element.

41. There is support for retaining the RPHN qualification (55% agree), but there are high levels of uncertainty as the public feel uninformed on this topic. Similar levels of support are seen for the RPHN prescribing element (65% agree).

[3] All percentages in this section relate to those who responded to associated programme standards questions.

42. There is a warm reception (71% agree) to the proposed new specialist practice qualification for nurses in other community fields, although many feel insufficiently informed to comment.

43. There are high levels of agreement (90%+) with intentions of draft specialist community nursing standards.

44. There are good levels of agreement that the draft standards for specialist community nursing could be extended to other roles (83% agree).

45. The structure, format and layout of both sets of standards are well received by the majority of focus group members and interviewees, although the language is noted to be “heavy going” in places.

46. The majority of these same participants feel their current and future needs will be met by the draft standards. Concerns are raised how they will be regulated in practice and how nurses will be monitored.

47. Again, these participants feel that the draft standards reflect what specialist community nurses need to know and do, but a few would like more detail about expectations for specific roles (see section 6.2.3 for details).

48. The public feel more emphasis is required on specialist community nurses’ all-round knowledge/experience, and mental health training/awareness was mentioned many times in various settings. A small minority, particularly seldom heard sections of the population, note they have had experience of being treated “unfairly”, or being judged, by specialist community nurses.

2. Introduction

2.1 About the NMC

The Nursing and Midwifery Council (NMC) is the professional regulator of nurses and midwives in the UK, and for nursing associates in England. As part of its role as a regulator, the NMC has a responsibility, amongst others, to set out and review standards of education and training to ensure consistent and high standards of care.

49. The role of the NMC involves:

- promoting high education and professional standards for nurses and midwives across the UK, and nursing associates in England,
- maintaining the register of professionals eligible to practise, and
- investigating concerns about nurses, midwives and nursing associates (something that affects less than 1% of professionals each year).

50. The NMC has a statutory obligation to consult on changes to various aspects of their work, including, but not limited to, changes to their standards, the registration fee, and amendments to the structure of the register.

2.2 About this consultation

51. On registering as a nurse or as a midwife with the NMC, registrants can undertake an NMC-approved course to become a Specialist Community Public Health Nurse (SCPHN) for a public health role, including working as a health visitor (HV), occupational health nurse (OHN), or school nurse (SN). Nurses can also gain an NMC-approved Specialist Practice Qualification (SPQ), for example, in community children's nursing (CCN), community learning disabilities nursing (CLDN), community mental health nursing (CMHN), district nursing (DN) or general practice nursing (GPN).

52. The NMC programme to review all of its education standards began in 2016. The post-registration community specialist practice standards are the final part of this programme, and are the oldest of NMC standards. The ambition of the NMC is to update, modernise and streamline the standards and reflect the current vision for public health and community nursing services across the four countries of the UK to meet the needs of people and communities.

53. In January 2020, the NMC announced its intention to develop new standards of proficiency for SCPHN, to include core standards, and where required, field specific standards of practice for:

- Health Visiting (HV),
- Occupational Health Nursing (OHN), and
- School Nursing (SN).

54. At that time, the NMC also announced that it would begin to scope out the content for a new SPQ standard of proficiency in community nursing, along with associated programme standards for

both SCPHN and SPQ. The initial proposal was for a SPQ standard of proficiency that would cover the five existing areas of specialist community nursing practice for which NMC-approved SPQs are already available. The current community roles are:

- Community Children's Nursing (CCN),
- Community Learning Disabilities Nursing (CLDN),
- Community Mental Health Nursing (CMHN),
- District Nursing (DN), and
- General Practice Nursing (GPN).

55. Following extensive stakeholder engagement in 2020, NMC agreed to retain these five existing SPQs and proposed a new one to accommodate other existing community roles for which there is no SPQ, and any new community roles which may emerge in future. Each SPQ, including the proposed new one, would be based on the same core standards of proficiency, but with enhanced programme standards to describe the programme requirements to lead to each annotation.

2.2.1 Pre-engagement activities

56. To ensure that the draft standards were shaped by a diverse range of voices and perspectives, the NMC undertook a set of engagement activities in the summer and autumn of 2020. Three different approaches to gathering feedback from nursing professionals, stakeholders, educators, and advocacy groups were employed by the NMC via: 1) 39 online webinars/roundtables and discussion groups, 2) 252 virtual postcard responses, and 3) a dedicated mailbox to which any member of the public, including professionals, could send queries, questions, or views on topics of their choosing.

57. Following these activities, a thematic analysis of the engagement activities was undertaken by Pye Tait Consulting. The report outlines the key themes arising from this pre-consultation engagement.[4]

58. Six common themes frequently emerged from the online events, virtual postcards, and email responses when discussing what was needed for future SCPHN and SPQ practitioners and these were considered for each set of new draft standards. These six themes were:

- advanced communication skills,
- collaborative working,
- leadership,
- prescribing,
- public health,
- safeguarding.

59. Many more themes emerged beside these, reflecting the wide variety of specialist knowledge and skills required by SCPHN and SPQ practitioners.

60. Building on this pre-consultation activity, the NMC co-produced three sets of draft standards for a full public consultation:

[4] Pye Tait Consulting, 2020, Themes from pre-consultation stakeholder engagement for the post registration standards review; post-registration-review---pye-tait-report-pre-consultation-engagement-themes-november-2020.pdf (nmc.org.uk)

- Standards of proficiency for specialist community public health nursing (SCPHN),
- Standards of proficiency for community nursing specialist practice qualifications (SPQs), and
- Standards for post-registration education programmes.

61. A nationwide consultation on the draft standards was held from April to August 2021 and Pye Tait Consulting were commissioned to assist with managing the consultation survey and its analysis. In order to ensure the voices of key groups within the population were represented in the consultation, Pye Tait Consulting conducted a separate qualitative research exercise with members of the public during this same timeframe.

2.3 Aim and objectives

62. The aim of the consultation was to gather feedback on the three sets of draft standards to identify where there is consensus, and what improvements and revisions may be required prior to their finalisation. Besides the main consultation questions, where the extent of agreement is clearly illustrated through charts, we identified the reasoning behind suggested improvements and revisions through additional questions seeking comment from those who are in disagreement with any element of the three sets of drafts standards. The qualitative analysis sections in the report therefore are not intended to show balance between support and challenge but to illustrate the dissenting opinions.

63. The main research questions focused on whether the standards reflect the key knowledge and skills for registration as SCPHN or for NMC-approved recordable community SPQs, and key features such as student selection and admission, curriculum and programme structure and supervision and assessment, of the programme standards for SCPHN and SPQ.

64. The qualitative research with the public sought to establish the extent to which the draft standards are clear and understandable to a wide range of people including nursing professionals and members of the public and understanding the extent to which the draft standards are perceived as ambitious, inclusive, and appropriate for all four nations of the UK.

2.3.1 Report structure

65. As explained in the methodology, this report is based on the consultation and the key findings from the qualitative research. The survey instrument was structured in such a way to ask questions about each of the three sets of standards. Respondents were invited to participate in only the sections in which they had interest; therefore, respondents could skip or complete certain sections as they wished. This results in different base numbers per section, as well as per question. Each chapter therefore presents at the start an accurate picture of the final numbers responding to each section.

66. Chapter 3 sets out views and feedback received to the draft standards of proficiency for specialist community public health nursing (SCPHN). Chapter 4 outlines feedback received to the draft standards of proficiency for community nursing specialist practice qualifications (SPQs). Chapter 5 provides an overview of feedback on the draft standards for post-registration education programmes. These three chapters present feedback from professionals and organisations to the

online survey, as well as offline responses. The term "respondents" refers to this cohort as a whole, unless otherwise specified.

67. Chapter 6 outlines feedback from members of the public on the draft standards for SPQ and SCPHN. Chapter 7 contains conclusions. A series of appendices contains more detailed information about the achieved sample's profile, a list of responding organisations, feedback suggested to be missing or requiring more emphasis in the draft standards, and the topic guides used for the qualitative research with the public.

2.4 Methodology

68. The methodology comprised two core strands.

- Online surveys - Three versions of the online survey were developed by the NMC, in consultation with Pye Tait Consulting, to reflect the different stakeholder audiences who could engage with the consultation: one to gather views from health and social care professionals and organisations; one to gather views from members of the public, and one "easy read" version for the public was also available.

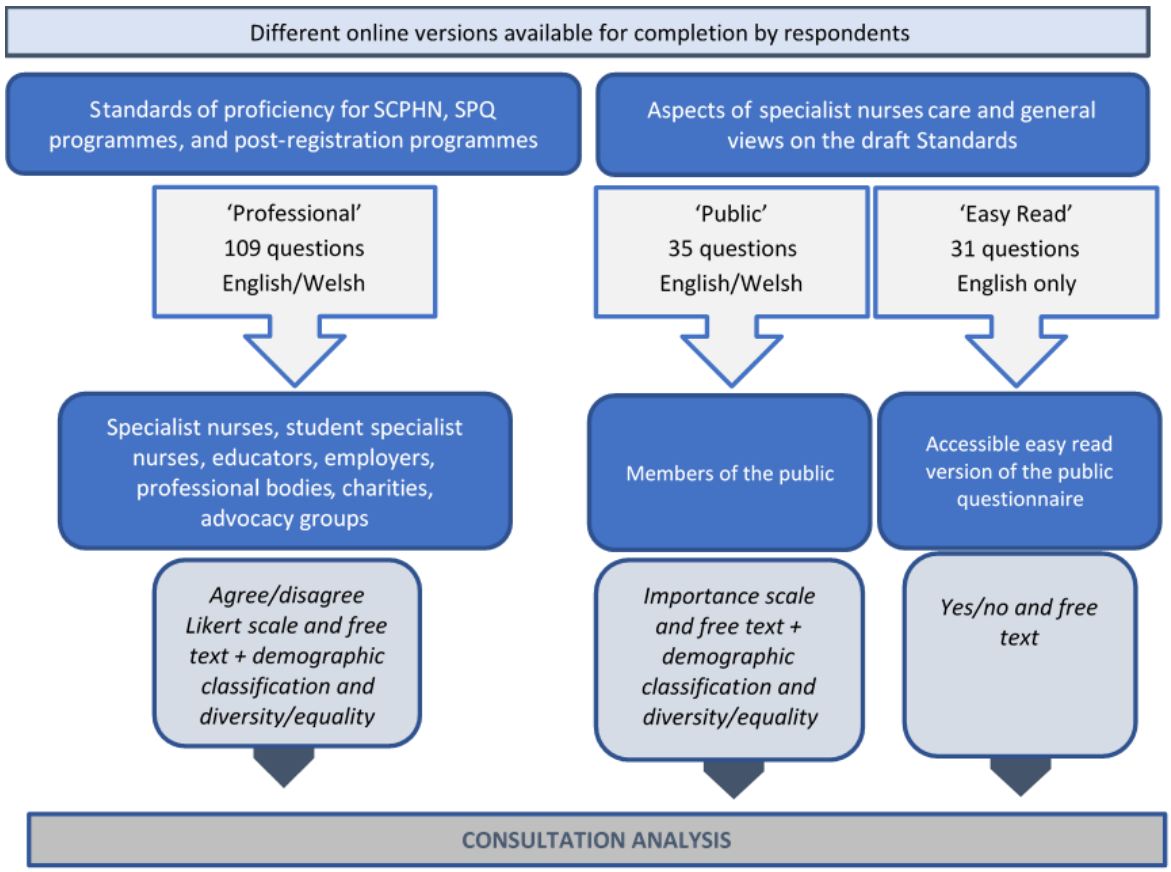
- Focus groups - A series of focus groups and in-depth interviews with members of the public and from "seldom heard" groups of the population. Pye Tait Consulting derived a sampling strategy to ensure a cross-section of participants in a separate activity of qualitative fieldwork.

69. Due to the impact of Covid-19 pandemic on the community and public health and wider health and social care workforce sector and workforce, the consultation period ran for longer than previously held 12-week consultations, running for 16 weeks from 8th April 2021 to 2nd August 2021.

2.4.1 Quantitative research

70. The questionnaires were created using SNAP software and hosted by Pye Tait Consulting with direct links on the NMC's website. In addition to the online survey questionnaires, downloadable versions were available which respondents could choose to complete and return by email. Consultation respondents were able to download the draft standards from the NMC's website prior to completing the survey.

Figure 1 Methodological approach to the online consultation



71. The online consultation for professionals was structured into five parts:

    A. About you
    B. SCPHN: Draft standards of proficiency
    C. Community nursing SPQ: Draft standards of proficiency
    D. Standards for post-registration programmes: SCPHN and SPQ programmes
    E. Diversity monitoring

72. Respondents could choose either to complete or skip over sections B, C, D or E. Therefore the number of respondents to each section differs. The total number of respondents per section is confirmed in each section (B through to E) in the report. Within section B, there were three sub-sections (among others) relating to HV, OHN, and SN, which respondents could choose either to complete or skip over.

73. The style and approach of the questionnaire was discussed at length in view of the three sets of standards to be consulted upon. Earlier in 2021, the draft questions were piloted with professionals in different roles and members of the public. A decision was taken to focus on finding out what issues professional respondents to the survey had with the standards and therefore the questionnaire provided opportunities for those wanting to explain their concerns.

74. Open comment boxes were provided, therefore, for those who chose 'disagree' or 'strongly disagree' in a rated style question. In previous such consultations, where open comment boxes were available for agree or disagree choices, it was noted that often those ticking 'agree' went on to provide commentary that suggested they disagreed with the subject of the question, thus making it hard to determine their actual stance. Final comment boxes were provided elsewhere in the questionnaire.

75. Some respondents ticked these options to activate the comment box but were actually in agreement and wished to note their support further. This is noted at various points through the report and does suggest that, on occasion, the levels of disagree/strongly disagree are slightly higher than they would necessarily be. However, despite these instances, charts derived from the quantitative questions have not been altered to reflect the small number of such counter comments.

76. To promote the consultation, the NMC developed a social media and stakeholder engagement strategy to run alongside a programme of events, across the four countries of the UK. Through these channels the NMC directed people towards the online consultation survey. These events included:

- webinars (12) focusing on the review of the post-registration standards, covering the NMC's work to date and the content of the draft standards,
- nine drop-in sessions with the NMC team to answer questions about the consultation and the draft standards,
- discussions with post-registration and pre-registration students, and
- a series of 32 external meetings and events to discuss the consultation in detail with various stakeholder organisations.

77. To boost responses from members of the public to the online consultation, the public survey was circulated via a third-party panel provider specialising in public engagement for research.

78. Consultation responses were monitored by Pye Tait Consulting on a weekly basis to identify the demographic profiles of respondents. This monitoring enabled the identification of under-representation of any segments of the population and targeting activities by the NMC.

2.4.2 Qualitative research

79. Qualitative research comprised 11 focus groups and 49 individual depth interviews that took place during June and July 2021 resulting in contact with a total of 126 research participants.

80. The key population groups the NMC identified for specific focus in the separate qualitative research were:

- young people/children,
- parents/carers,
- members of the public who use/have used the services of SCPHN and SPQ professionals, and
- seldom heard.

81. Prior to the consultation going live, Pye Tait Consulting derived a sampling strategy to ensure a cross-section of participants, based on gender, nation, location (rural/urban), sexuality, ethnicity and population group. The detail of the achieved sample is contained in Appendix A: Respondent profile.

82. Depth interviews were conducted remotely using telephone or video interviews, while focus groups were held virtually. Two focus groups were replaced with depth interviews during the course of the fieldwork, as some population groups felt more comfortable speaking in a one-on-one setting.

83. Respondents were sent an information pack ahead of the focus groups and interviews with details of the new draft standards and were tasked to read this material beforehand.

84. The duration of the focus groups was 1.5 hours, and the average length of the depth interviews was 45 minutes. A small cash incentive was provided to all respondents to compensate them for their time attending the groups/interviews and completing the required pre-reading.

85. Copies of the topic guides used in the focus groups and depth interviews, developed in consultation with the NMC, can be found in Appendix C: Topic guides.

2.4.3 Analysis of the quantitative and qualitative research

86. A top-level analysis of the quantitative survey findings was undertaken, and cross-tabulation analyses were also conducted, including by:

- individual vs organisation,
- nation,
- type of individual,
- SCPHN field of practice,
- SPQ field of practice, and
- key demographic characteristics (age, gender, ethnicity).

87. Where differences exist, these have been explicitly discussed in the main body of this report.

88. It is important to note the following.

- Not all respondents answered all questions. At the start of each section and for each question the base number (n=) is indicated.
- Every question in the professional survey could be answered by any professional. This means that if a question asked about applicability, for example, of the standards to a particular area of practice, say SCPHN HV or SPQ DN, it was not restricted to a SCPHN HV or SPQ DN to respond, any individual or organisation could respond if they so chose.
- In order to analyse and report on the consultation, open question responses were manually analysed noting, as above, which were individuals, organisations, offline responses and their location. These facts were recorded to help identify frequencies for each of the emerging issues.
- Throughout this report, following the analysis of the closed questions, the focus of the analysis of the open questions is on presenting the main views submitted by respondents.

However, in considering the findings of the analysis, it is important to bear in mind that views gathered through an open consultation exercise are the views of those who have chosen to respond.

- The respondent profile by SCPHN area largely mirrors the proportions on the registrant profile for HV at 56%, (273), SN at 23% (112) followed by OHN at 19% (93). Similarly, this applies to the SPQ area where the bulk of the responses were from DN at 60% (223) followed by GPN at 12% (46) and CCN at 12% (45) with the remaining roles at 6% or less. The respondent profile compared with the register is provided in the Appendices (see charts A3 and A4).
- Clearly, views of organisations are important and although recorded as one response the organisation does represent multi-membership which needs to be given due weight, but this does not diminish the importance of individual responses.
- Where we discuss national trends at various points in the report, this is for individual respondents only, as the cross-tabulation analysis links to the question on location of individual respondents, unless specified.

89. Note that some charts in this report may not add to 100% due to rounding.

2.5 Overview of sample profile

2.5.1 Quantitative survey

90. In total, 2,363 responses were received to the online consultation. Of those, no responses were received in Welsh and 11 responses were received to the easy-read public version. The table below provides a breakdown of all the responses by type of respondent, of which 2,282 responses are from individuals and 81 from organisations.

Figure 2 Breakdown of responses to the consultation

Respondent types	Number of responses	% of responses
Total numbers of respondents	**2,363**	**100%**
Individuals		
SCPHN professionals	497	21%
SPQ professionals	371	16%
Registered nurse (without SCPHN or SPQ)	700	30%
Registered midwife (without SCPHN)	26	1%
Other health and social care professionals	215	9%
Organisations (see also table below)	81	3%
Sub-total – all professionals – individuals and organisations	1,890	80%
Members of the public (reported on separately in chapter 6)	473	20%

Figure 3 Breakdown of organisation responses

Organisations[5] - descriptions of the responding organisations as selected by the responding organisation (a multi-response question)		
	Nos	**%**
Employer of doctors, nurses, midwives and/or nursing associates and/or allied health and social care professionals	32	40%
Education provider	27	33%
Professional organisation or trade union	18	22%
Government department or public body	8	10%
Consumer or patient organisation or charity or advocacy group	8	10%
Regulatory body	2	2%
Other	4	5%

91. A list of all those organisations responding to the consultation is provided in Appendix B. In addition, a total of 73 offline responses were received from organisations and individuals including professionals and members of the public.

92. A brief overview of the respondent profile of the achieved sample is outlined below. A detailed breakdown of the respondent profile can be found in Appendix A, along with a comparison to the overall NMC registrant population.

- Nation: The bulk of the individual respondents to the professional consultation reside in England (76%). Some 12% are based in Scotland, while 7% are based in Wales and 5% in Northern Ireland. The register profile for the UK matches this well with England 81%, Scotland 10%, Wales 5% and Northern Ireland 4%. Please note some 25,000 registrants live abroad and are not included in this UK breakdown. Around 1% of the total number of responses to the consultation came from overseas registrants.

- Nation (organisations): Over half of responding organisations represent or work in England (52%), while a third do so UK wide (35%). Some 14% represent or work in Scotland, 10% in Wales, 7% in Northern Ireland, with 11% doing so outside the UK.

- Age: The age profile for respondents to the professional survey reflects a middle to older age range: 63% are within the 40-59 year-old age groups. The public in contrast have a younger age profile: 46% are aged 40 or under.

- Gender: Females represent the largest majority of professional respondents (91%) and public respondents (59%).

- Ethnic profile: Around 80% of all respondents – both professional and public respondents – are white British (encompassing English, Northern Irish, Scottish or Welsh) and 5% are Black, African, Caribbean or black British: African.

[5] Note that the unique number of organisations responding is 81, but the various types of organisation add up to over 81 - organisations could choose to select more than one organisation type.

- Public: Most describe themselves as members of the public (82%) while others are carers or family members of someone receiving care (18%).

2.5.2 Qualitative research

93. Some 77 individuals participated in the 11 focus groups, with an average of 7 participants in each group. In addition to the groups, 49 individual depth interviews were conducted. The demographic profile of participants is detailed below.

Figure 4 Breakdown of focus group audiences and depth interviews with a varying total number of attendees

Groups	By Life stage
Group 1	Young people (age 16-20)
Group 2	Young people (age 16-20) using Mental Health services
Group 3	School children (age 12-16)
Group 4	Parents with children age 4-16
Group 5	Parents with children age <4
Group 6	Carers
Group 7	People of working age
Group 8	People with long-term illnesses
Group 9	Refugees/asylum seekers
Group 10	People with learning disabilities and/or autism
Group 11	Older people (age 75+)

94. Participants for each group were recruited to reflect a diverse mix of gender, sexual orientation, ethnicity, UK nations, and urban/rural home addresses. Further detail is provided in Appendix A.2.

95. The 49 depth interviews were completed with key population groups of interest. The next table shows the total number of interviews conducted by participant group.

Figure 5 Breakdown of in-depth interview audiences

Depth interviews	No. of interviews
Young people aged 16-20	3
Young people aged 16-20 using Mental Health services	2
School children aged 12-16	2
School children aged 12-16 using Mental Health services	3
Parents with children aged 4-16	3
Parents with children under 4	4
Carers	3
People of working age	2
Parents with school children	2
People in social care/care homes	7
Health visitor service users	2
People with long-term illnesses	2
Travellers	6
People with learning disabilities/autism	2
Homeless	2
People with physical disabilities	2
Older people 75+	2
Total	**49**

Further details of participant demographic profiles can be found in Appendix A.1.2: Respondent profile.

3. Views on Specialist Community Public Health Nursing (SCPHN)

96. This chapter presents the feedback received from professionals and responding organisations concerning the draft standards of proficiency for Specialist Community Public Health Nursing (SCPHN). **Around 60% (1,137) of all respondents chose to answer at least one question in this section. This constitutes almost three quarters 73% (59) of responding organisations and 60% (1,078) of responding individuals to the survey as a whole**. This section also incorporates the analysis of the responses received offline to the NMC mailbox.

97. The total number of responses described in this chapter varies as questions for each section of the survey were voluntary and open to all to respond as they choose. There is therefore an imbalanced representation of views across HV, OHN and SN due to the varied number of respondents.

Figure 6 Number of responses to SCPHN section

Total responses to the whole consultation by type	N	Total responses to questions about SCPHN as reported on in this chapter	N	Percentage of all respondents by type
Individuals	1,809	Individuals	1,078	60%
Organisations	81	Organisations	59	73%
Total	1,890	Total	1,137	60%

Key findings for Chapter 3 – SCPHN

- There is 75% (848) agreement that the SCPHN core and field standards of proficiency reflect the specialist knowledge, skills, and attributes necessary for all SCPHN registrants (n=1,130).
- There are also high levels of agreement that the draft core and field specific standards for HV, OHN and SN meet each of the six spheres of influence.
- Prescribing element: a slight lean towards this being optional (41% to 48%) over mandatory (33% to 47%), and there is an even split as to whether the V100 or V300 is most appropriate.
- While 44% (485) of individuals feel that the Registered Public Health Nursing (RPHN) qualification should be retained (n=1,103), organisations are evenly split: 32% (18) yes and 36% (20) no (n=56). Generally, there is a high degree of ambivalence around this topic.
- There is broad support that these draft core standards can be applied to other public health nursing roles.
- Respondents largely see these qualifications as role descriptions and not as knowledge and skills that require regulation, but which are common to many roles.

98. The NMC's draft standards of proficiency are intended to specify the knowledge, skills, and attributes that registered nurses and midwives go on to achieve in order to support and care for

people, communities and populations across all ages as SCPHNs. The NMC's intent is that they reflect what the public can expect SCPHN health visitors, occupational health nurses, and school nurses to know and be able to do in order to lead, collaborate, promote health and wellbeing, and protect and prevent ill health. Both registered nurses and midwives can pursue a SCPHN qualification.

99. The SCPHN standards of proficiency comprise:

- core standards of proficiency that apply to all fields of SCPHN practice, and
- SCPHN field-specific standards of proficiency that apply to each field of practice (health visiting (HV), occupational health nursing (OHN), and school nursing (SN).

100. These are grouped under six headings which have been called 'spheres of influence' for SCPHN practice.

1. Autonomous specialist community public health nursing practice.
2. Evidence-based, data driven specialist community public health nursing practice.
3. Promoting human rights and tackling inequalities.
4. Population health in relation to people of all ages.
5. Advancing public health services.
6. Leadership and collaboration.

101. Note: Unless otherwise specified throughout this chapter, individuals and organisations make similar points, i.e. there is no clear trend to distinguish between individual versus organisation responses.

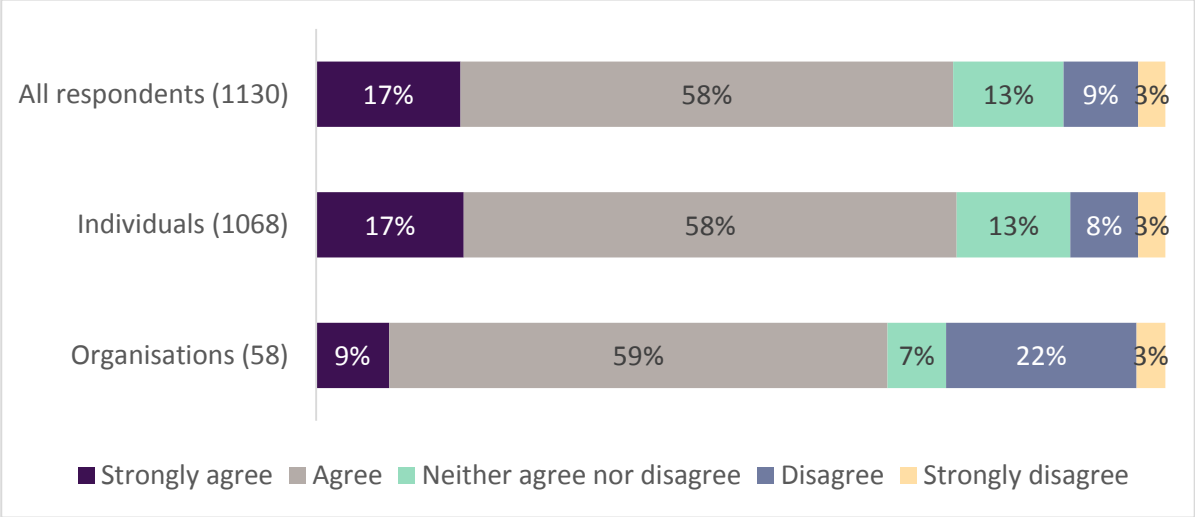
3.1 Core and field specific standards of proficiency

102. Respondents choosing to answer questions on SCPHN were, firstly, asked the extent to which they agree that the draft core and field specific standards of proficiency adequately reflect the specialist knowledge, skills, and attributes necessary for all SCPHN registrants. Some 1,130 respondents answered this question.

103. Respondents were then asked if they wished to respond to questions on health visiting (HV), occupational health nursing (OHN) and school nursing (SN). Varying numbers answered questions on each of the three fields of SCPHN practice. Those bases and their views are described in each of sections 3.2, 3.3, and 3.4 respectively.

104. Appendix D provides more detail on topics suggested as additional content/added emphasis for the SCPHN standards.

Figure 7 Whether the draft core and field specific standards of proficiency adequately reflect the specialist knowledge, skills, and attributes necessary for all SCPHN registrants



105. The majority - 75% (848 individuals and organisations) - of respondents agree or strongly agree that the draft core and field specific standards adequately reflect the specialist knowledge, skills and attributes necessary for all SCPHN registrants (n=1,130).

106. Twelve percent (136) of all respondents to this question disagree or strongly disagree (n=1,130), while one in four organisations - 25% (15) - disagree or strongly disagree that the draft core and field specific standards of proficiency adequately reflect the specialist knowledge, skills, and attributes necessary for all SCPHN registrants (n=58).

107. Of the 12% (136) of individuals and organisations disagreeing or strongly disagreeing 110 provided further comment.[6] The analysis is summarised below.

108. Of those comments:

a. around 36 note that they would like to see more role-specific detail in the standards, reflecting different skills and attributes of each role,
b. a further 31 believe that a particular topic or area of study could have more emphasis in the draft standards, or mention a topic that is felt to be missing such as safeguarding, prevention or mental health,
c. eighteen say the standards are too generic or ambiguous to adequately reflect SCPHN roles, and that they could be clearer, and
d. about 13 believe the standards are too ambitious, particularly in relation to aspects of management.

109. Prescribing is regularly mentioned and is covered in full for SCPHN in section 3.5.

[6] Note: As the first open-ended question in the survey, many comments received here did not answer the question but instead focused on specific aspects of the consultation that were asked about at a later stage, for instance around prescribing.

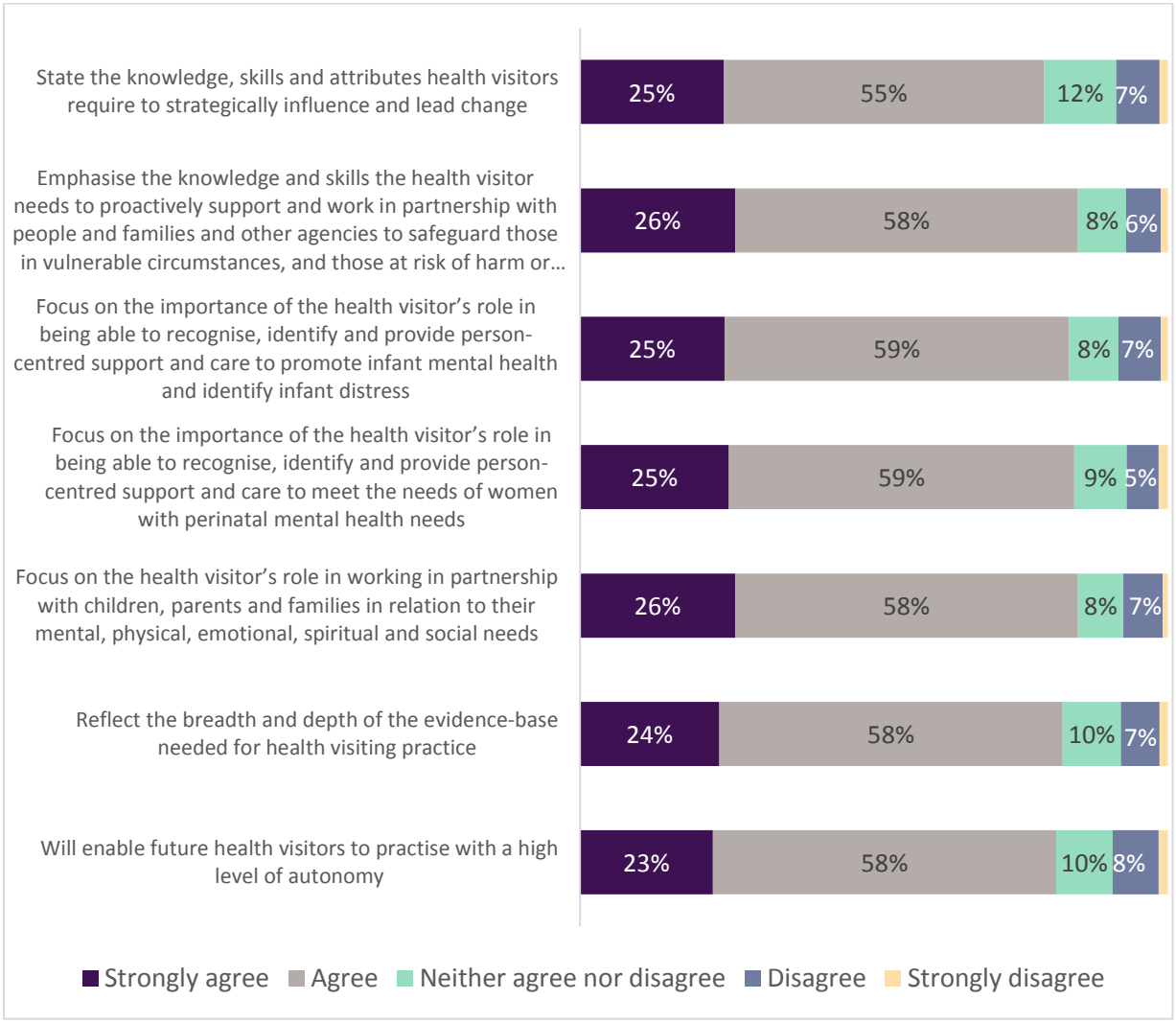
3.2 Health visiting (HV)

Figure 8 Responses to HV section

Total responses to the section on SCPHN by type	N	Total responses to questions about HV as reported on in section 3.2	N	Percentage of all SCPHN respondents by type
Individuals	1,078	Individuals	533	49%
Organisations	59	Organisations	46	78%
Total	1,137	Total	579	51%

110. Respondents were asked their opinion regarding the extent to which the draft core and health visiting field specific standards achieve each of the six spheres of influence. The table above indicates the proportions answering questions on health visiting.

Figure 9 Whether the draft core and HV field specific standards achieve each sphere of influence



Base: variable from 570 to 575 respondents.

111. The majority of respondents concur, with approximately four in five or 80% (460) respondents agreeing or strongly agreeing with each statement (n=575). Respondents are most in agreement that the draft standards emphasise the knowledge and skills HVs need, and that they focus on the HV's role in working in partnership - both 85% (489, n=575). Two organisations responding offline support the focus on mental health and how the draft standards will enable HVs to work autonomously and develop a person-centred approach in their practice.

112. For each of the six spheres of influence, fewer than 10% (58) of the 575 respondents disagree or strongly disagree that the draft core and health visiting field specific standards reflect these.

113. Respondents disagreeing or strongly disagreeing with any statement were provided with the opportunity to comment on what they believed was missing from the draft standards for HV, and 74 comments were received.

114. Of those 74 comments:

a. around 12 feel the draft standards are too abstract and require more explicit detail relating to the specific role of health visitor, but do not add further comment,
b. others go into more detail about what specific topics they would like to see greater emphasis on in HV. Topics suggested for greater focus include:
   - child development (13),
   - prevention and public health (11),
   - mental health (11),
   - safeguarding (10), and
   - joined up working with multiple agencies and/or professional roles (13).
c. seven would like to see better recognition of the potential that health visitors have to drive change from a strategic and leadership perspective

3.3 Occupational health nursing (OHN)

115. **Some 24% (268) of all SCPHN respondents chose to answer questions about OHN, including 32% (19) of all SCPHN responding organisations**.

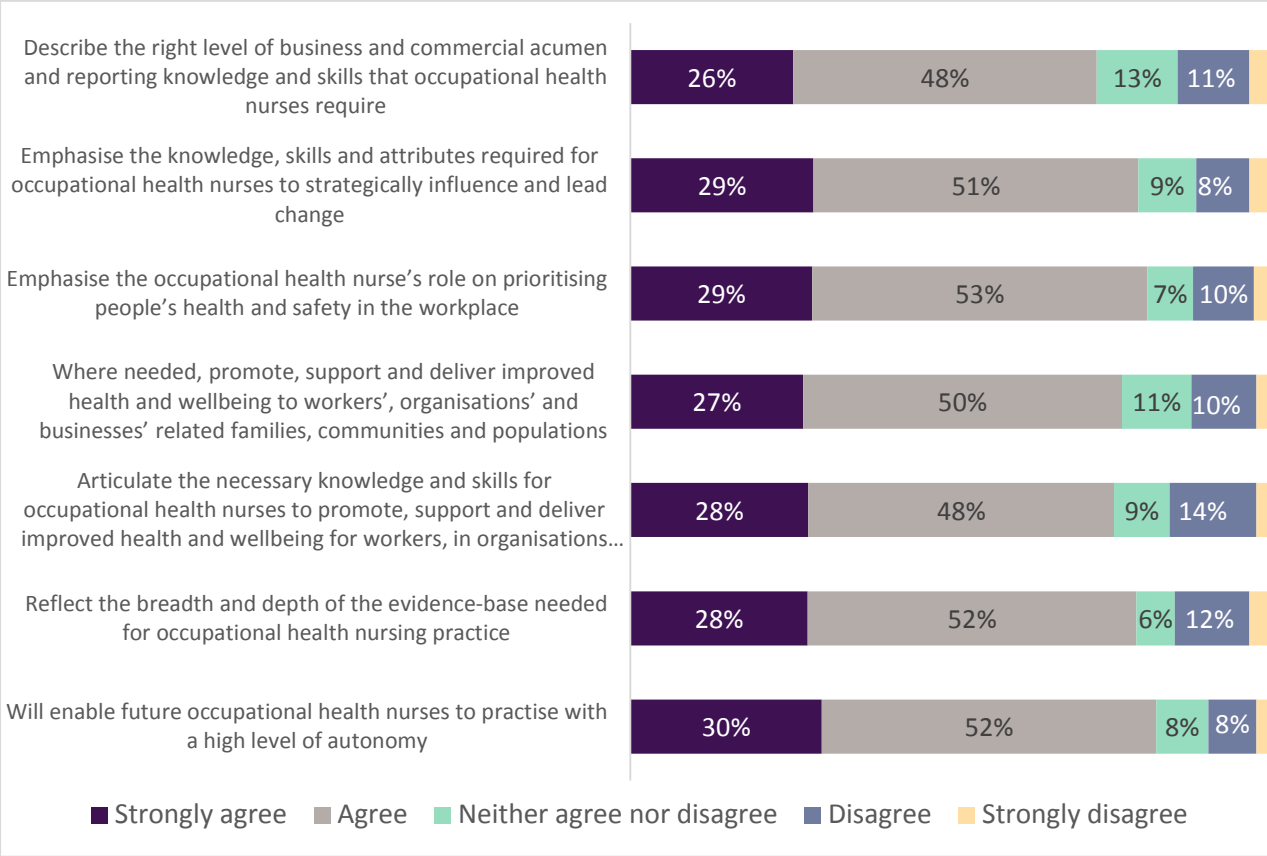
Figure 10 Responses to OHN section

Total responses to the section on SCPHN by type	N	Total responses to questions about OHN as reported on in this section	N	Percentage of all respondents by type
Individuals	1,078	Individuals	249	23%
Organisations	59	Organisations	19	32%
Total	1,137	Total	268	24%

116. Respondents were asked their opinion regarding the extent to which the draft core and OHN field specific standards achieve each of the six spheres of influence. Broadly, the majority of respondents concur, with approximately three quarters of respondents (around 200) agreeing or strongly agreeing with each statement. Respondents are most in agreement that the draft standards emphasise the knowledge and skills OHNs need for prioritising people's health and safety

in the workplace, and that they will enable OHNs to practice with a high degree of autonomy (both 82%).

Figure 11 Whether the draft core and OHN field specific standards meet each sphere of influence



Base: variable from 263 to 267 respondents.

117. For each of the six spheres of influence, between 10% (26) and 16% (42) of the 267 respondents answering this question disagree or strongly disagree that the draft core and OHN field specific standards reflect these.

118. Respondents disagreeing or strongly disagreeing with any statement were provided with the opportunity to comment on what they believed was missing from the draft standards for OHN, and 41 comments were received.

119. Of these 41 comments 24 are from current OHNs. It should also be noted that five respondents (three individuals and two organisations) ticked "disagree" to all options to activate the comment box but are actually in agreement and wished to note their support further. These respondents believe the standards are relevant and sufficiently future focused.

120. Of those disagreeing:

a. fourteen respondents say they would like more emphasis on links with the workplace such as the ability to assess workplace environments and hazards as well as develop relationships with employers and understand workplace laws. They argue that managing and balancing the risk for the employer as well as for

individuals is an important aspect of the OHN role and so needs to be covered by the standards, and

b. ten believe that the standards need to be more specific to the role of OHN and other respondents would like to see more practical, clinical aspects covered, including:
   - health surveillance (mentioned by 8),
   - audiometry (3),
   - spirometry and other respiratory screening (3),
   - mental health (5), and
   - case management (5).

3.4 School nursing (SN)

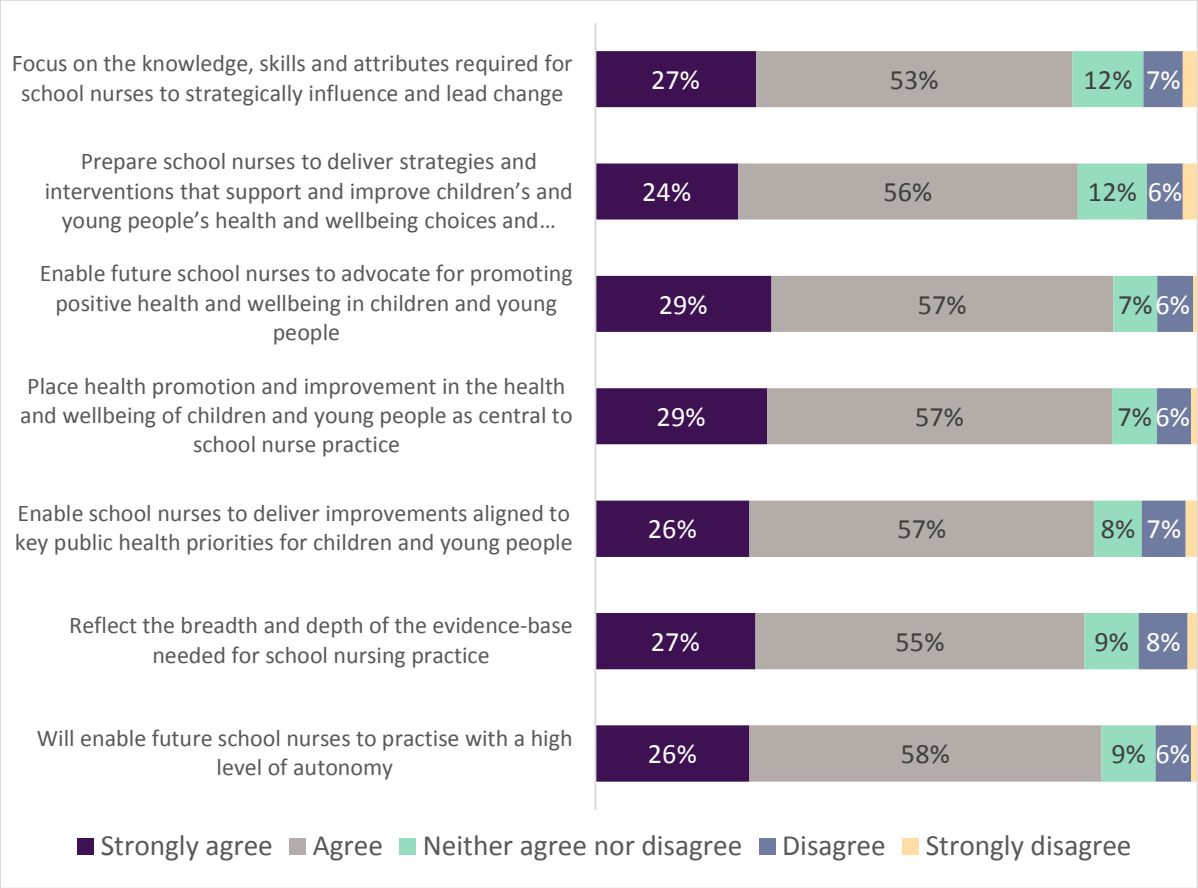
121. **Some 362 respondents (19%) chose to answer questions about SN, including 52% (42) of all responding organisations**.

Figure 12 Responses to SN section

Total responses to the section on SCPHN by type	N	Total responses to questions about SN as reported on in this section	N	Percentage of all respondents by type
Individuals	1,078	Individuals	320	30%
Organisations	59	Organisations	42	71%
Total	1,137	Total	362	32%

122. Respondents were asked their opinion regarding the extent to which the draft core and SN field specific standards achieve each of the six spheres of influence. The majority of respondents concur, with between 80% (286) and 86% (307) agreeing or strongly agreeing with each statement (n=357). Respondents are most in agreement that the draft standards place health promotion and improvement as central to the SN role and that the standards will enable future SNs to advocate for promoting positive health and wellbeing at 86% (307, n=357).

Figure 13 Whether the draft core and SN field specific standards meet each sphere of influence



Base: variable from 351 to 357 respondents.

123. For each of the six spheres of influence, between 7% (25) and 10% (36) of the 357 respondents disagree or strongly disagree that the draft core and school nursing field specific standards reflect these.

124. Respondents disagreeing or strongly disagreeing with any statement were provided with the opportunity to comment on what they believed was missing from the draft standards for SN, and 45 comments were received.

125. Of the 45 comments, 19 are from current SNs. Six respondents (two organisations and four individuals in England, three of whom are nurses with an SPQ annotation) ticked "disagree" to all options to activate the comment box but are in agreement with this question. These respondents believe the standards are relevant and sufficiently future focused.

126. Of those disagreeing:

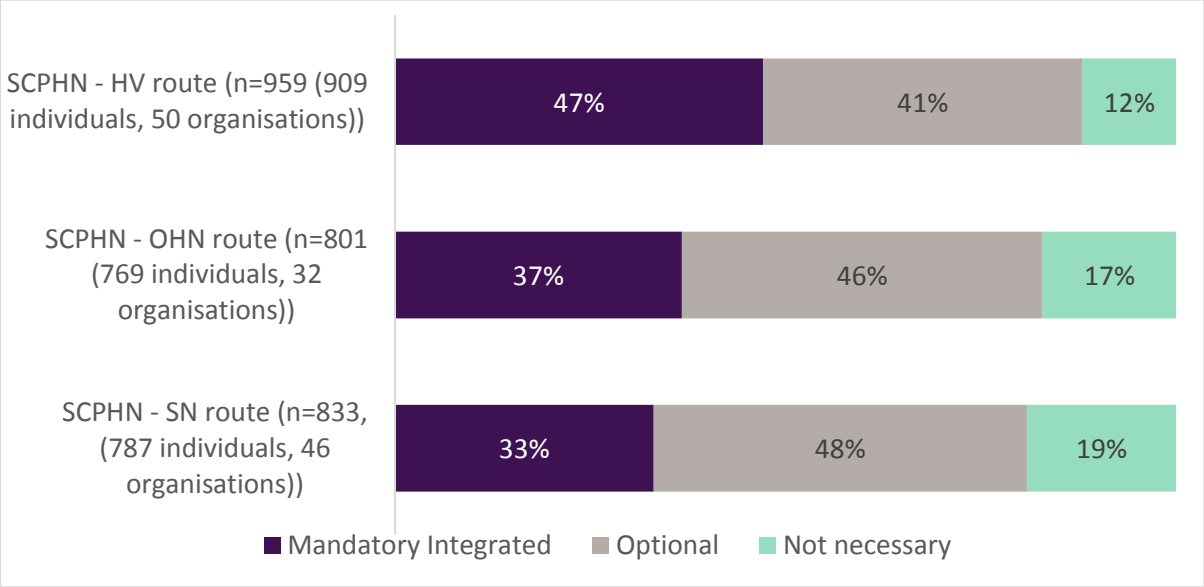
a. around 10 respondents state that they believe the draft standards need to relate more specifically to school nursing; others are concerned that their perception is of a lack of clarity in the standards meaning commissioners will interpret the standards differently. The impact of this, they believe, could result in a loss of service – this point is beyond the direct remit of the NMC,

b. other respondents mention topics that they would like to see covered in more detail. These include:
   - safeguarding (mentioned by 4 respondents),
   - joined up working with other professionals (4),
   - child development and wellbeing (3),
   - leadership (3), and
   - mental health (2).

3.5 Prescribing practice (SCPHN)

127. There is currently a mixture of approaches with regard to the inclusion of prescribing modules within existing NMC-approved SCPHN programmes, with many including the V100 prescribing programme. Respondents were asked their opinion regarding whether a prescribing element should be a mandatory integrated or optional element, or not required at all, for each SCPHN route.

Figure 14 Whether prescribing element should be a mandatory integrated programme requirement, should be an optional requirement, or is not necessary for the role/s of the SCPHN programmes' fields of practice routes



128. Nearly half of all respondents (47%, 450) believe a prescribing element should be a mandatory integrated programme requirement for the HV route, while this drops to around a third for the OHN (37%) and SN routes (33%) (296 and 275 respectively). Fewer than one in five respondents (19%, 158) believe that a prescribing element is not necessary for any of the three routes.

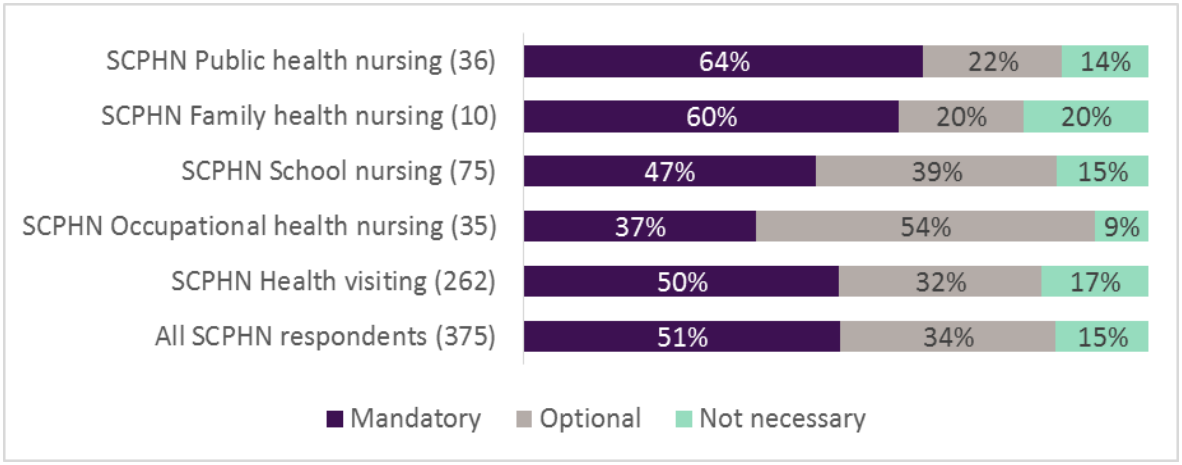
129. As mentioned earlier, all questions are open for answer by all respondent groups. For the question on prescribing practice for SCPHN a cross-tabulation analysis was undertaken to review overall findings according to SCPHN current areas of practice. The analysis reveals some variation between the area of practice respondents are currently working in or studying and their views on prescribing. These are illustrated in the charts that follow.

130. Respondents describing themselves by a specific SCPHN area have commented on the prescribing element by the five different field of practice routes and the highlights are illustrated in the separate charts and described below.

131. For the HV route, 63% (22) of 35 respondents describing themselves as SCPHN 'OHN' believe a prescribing element should be optional or is not necessary. But of those 262 describing themselves as SCPHN HV it is split between 50% (131) saying prescribing is mandatory, to 49% (128) believing a prescribing element should be optional or is not necessary.

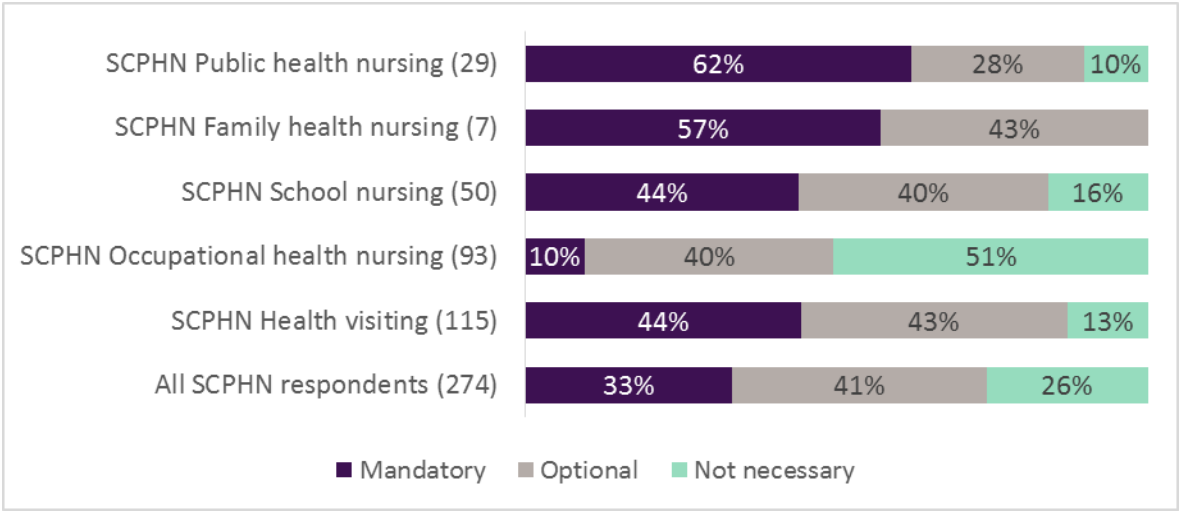
Figure 15 Whether the prescribing element should be mandatory, optional, or is not necessary for the role/s of the SCPHN programmes' fields of practice routes, by individuals per SCPHN area

Whether prescribing should be included in the SCPHN HV route – by type of respondent



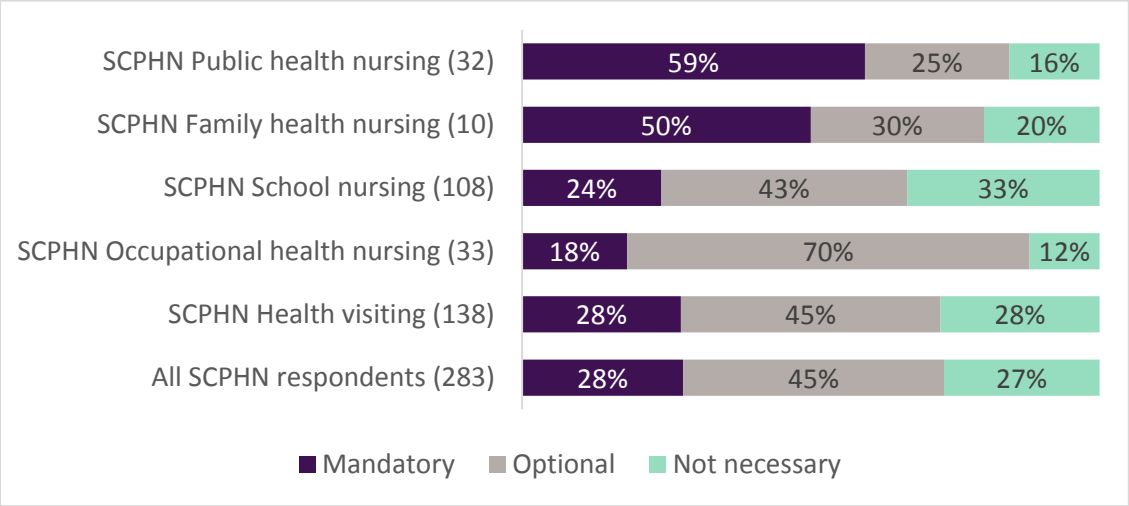
132. Of the 93 respondents describing themselves as SCPHN 'OHN' in this question about the OHN route, 10% (9) believe a prescribing element should be a mandatory integrated requirement, in fact 51% (47) believe it is not necessary. These choices vary considerably to other SCPHN groups. For example, the majority, 62% (18), of the 29 self-describing SCPHN 'public health nursing' respondents feel that the prescribing element should be mandatory.

Whether prescribing should be included in the SCPHN OHN route – by type of respondent



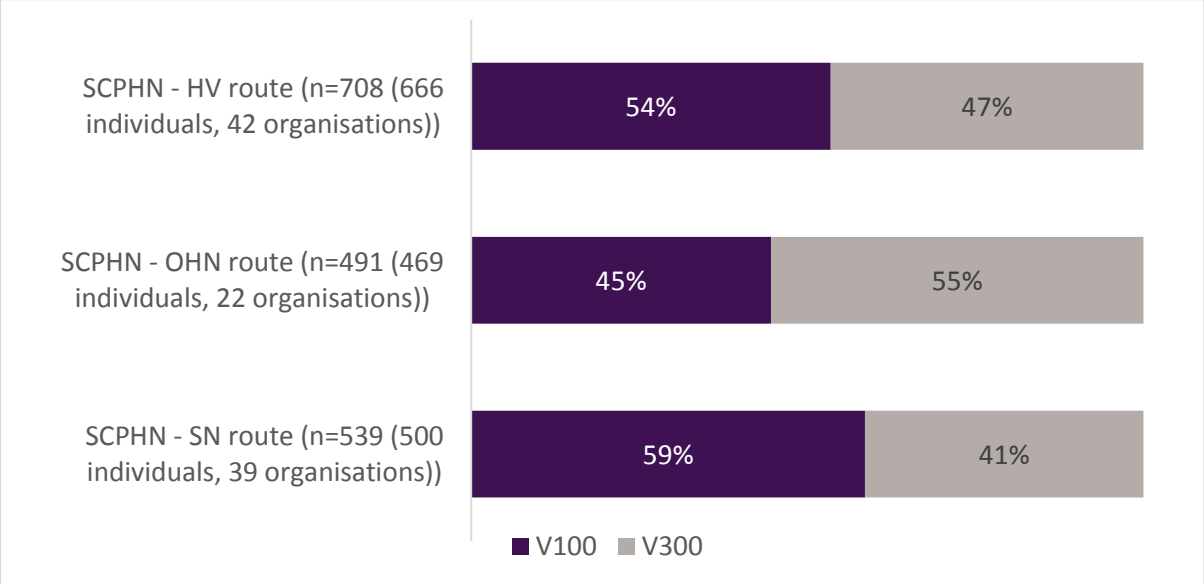
133. Further, between half 50% (5) and nearly two thirds 64% (23) of SCPHN 'public health nursing' and SCPHN family health nursing respondents (note these are small respondent numbers as there are low numbers on the register overall) believe that prescribing should be mandatory for HV, OHN, and SN routes.

Whether prescribing should be included in the SCPHN SN route – by type of respondent



134. Respondents were asked for their opinion on which level of prescribing qualification – either the V100 or V300 – they believe is most appropriate for each of the SCPHN programmes' field of practice routes. Respondents are somewhat split in their response, with just over half believing the V100 level is most appropriate for the SN and HV routes at 59% (318) and 54% (382) respectively. A similar proportion believe the V300 level is most appropriate for the OHN route (55%, 270).

Figure 16 Which level of prescribing qualification is most appropriate



135. Respondents were subsequently provided with the opportunity to explain their rationale for their views on the prescribing element, and 617 provided comment, with over half coming from those registered or studying towards SCPHN. Note, not all give reasons for all their responses.

For example, some only give reasons for their V100/V300 choice; some focus only on reasons for their optional/mandatory/not necessary choice; and some only give answers in relation to one of the roles (usually their own profession).

136. **Mandatory: of those commenting, 38% (229)** explain why they feel mandatory is the best option.

a. Prescribing would have clinical benefits for the relevant client group and therefore can improve health outcomes. Having this element would help the individual to meet the needs of their patients more effectively and through training, it provides nurses with a good level of knowledge and understanding. Some comment that prescribing is a core part of SCPHN, and that all such nurses should have this ability (200+).
b. Those who are health visitors often give specific medication which may be useful to their patients, such as prescribing (specialised) milk, reflux treatment, oral thrush medication and contraception (75).

As a HV and trained in CMPA, I find it frustrating to request a GP to prescribe infant formula and have to explain which one to prescribe - when as a HV, I would complete an allergy focused assessment, decide on the most appropriate formula and negotiate this contract with a parent, then have to go through the GP to prescribe, as a V100 qualification does not allow this.

Registered nurse with SCPHN

c. These professionals are best placed to provide support as they tend to have more contact and so are able to build a rapport with patients and/or families. More holistic support is provided if a patient has all their needs met through one appointment, rather than being signposted to other services. Respondents note this is particularly important when working with more disadvantaged patients who may be less likely seek help elsewhere or access primary care, such as financially deprived people or those in rural areas (87).
d. It alleviates pressure on GPs, primary care, and the wider health and social care system if SCPHNs are able to prescribe. Not only could patient time be saved, but also – respondents argue – this approach could also decrease waiting times, improve early intervention, facilitate faster treatment solutions, and decrease costs (76).
e. As SCPHNs are professionals in their own right, respondents believe that prescribing should be part of their specialist role as a way to establish their independence and allow for more autonomous practice (45).
f. Meanwhile, one in ten note that roles are likely to evolve and expand over time to include prescribing, so it would be prudent to include it now to ensure SCPHN is able to move forward and is fit for the future (21).

137. **Optional**: **of those commenting, 42%** (**257)** explain why they feel prescribing should be optional although to note such responses often cover similar reasoning as described by both the mandatory and not necessary respondents. The reasons for choosing optional are explained below.

a. Respondents raise a concern that lack of practice might affect competency levels and opportunities to learn for students (101).

b. The clinical benefits that prescribing can have for their patient group, such as useful in their role and have the knowledge to support their clients in gaining access to medication (78).
c. The ability to prescribe in practice can be limited by the employing Trust, Health Board, local authority, or workplace, meaning that a prescribing element will be applicable for some, but not for all SCPHN (56).
d. Prescribing is not used by all or can vary between roles (52).
e. The medication they are able to prescribe, largely under V100, is available to patients over the counter, and refer to initiatives such as the pharmacy first scheme or 'minor ailment scheme' which encourages patients to access local pharmacies as their first point of contact (48).
f. The prescribing element is so large and demanding that it would detract from other important elements of the course. Some argue that the course time should be extended if it is to be included as it would be challenging within the current timeframe, while others believe it should be an optional standalone course after or before completing the SCPHN (46).
g. Support needs to be put in place in order to make prescribing viable and sustainable within their practice (e.g. through capping caseloads or ensuring safe governance through robust supervision and clear guidance (32).
h. SCPHN roles are well-placed to prescribe for their client as they have more contact, and so can provide the patient with a more streamlined and holistic approach to their care (18).
i. Prescribing can help relieve pressure from primary care and wider services (16).
j. Including prescribing will help to 'futureproof' the role as it grows and changes in time (13).

138. **Not necessary**: **of those commenting, 20%** (**124)** explain why they feel prescribing is not necessary.

a. There is not much use for it, and there is concern therefore that nurses would be unable to maintain accepted levels of competency. Furthermore, these respondents note there is limited opportunity for students to observe the practice in training. There is an even spread among HV, OHN, and SN respondents commenting here (100).
b. OHN respondents state prescribing is never or rarely used, with several respondents basing this on their years of practice (60) and for OHN, and HV, prescribing falls into a medical model of practice to treat and diagnose patients, whereas public health roles tend to follow a social model of preventing ill health by empowering and advising patients (34).
c. The medication they can prescribe is limited and is accessible over the counter at local pharmacies or through the patient's GP (29).
d. The capacity to prescribe is often dictated by the employing trust or workplace (19).

139. **V100**: **Some 114 respondents** provide comment for why the V100 level is most appropriate:

a. It is the most appropriate level of prescribing for the SCPHN programmes' field of practice and is sufficient for the role requirements. These respondents feel that there is little or no need for a V300 level to be completed as it would not be used effectively. These respondents also note that the lack of use at any higher level could compromise competence and maintaining these skills (67).
b. Prescribing is beneficial for their client group and will meet their needs adequately as this includes the most commonly used medication generally required. A small number note that, if more complex assessment and diagnosis is required, then referring back to primary care is possible and sometimes preferred (41).
c. The more intensive V300 level is too demanding and time consuming to benefit these roles (37).
d. The V300 level should still be an optional progression if wanted or needed by the individual (27).

140. **V300**: **Some 162 respondents** provide comment for why the V300 level is most appropriate:

a. It has clinical benefits for patients and the V300 level would be useful in practice as it would provide better outcomes for patients, with treatment and service delivery being improved (88).
b. This higher level would be more beneficial than the V100 which is perceived to be of little use. These comparisons usually highlight the broader range of medication available by the V300 and the limitations of the V100 medication which can usually be obtained over the counter (61).
c. The V300 would help to ease some of the burden on GP practices and wider primary care services – this point was mostly made by HV respondents and those discussing HV. These respondents further argue that the V300 qualification would allow SCPHNs to tackle multiple health needs during one appointment, reducing unnecessary GP appointments and streamlining services for patients (57).
d. The varying use and requirements across roles and Trusts, Health Boards, and local authorities (18).
e. This level of prescribing will help to 'futureproof' the role as it grows and changes in time.

This is a future focussed piece of work where all registered nurses will be prescribing within their scope of practice in future. There is therefore an argument to be made for this being mandatory, but it needs to be a managed transition.

Consumer or patient organisation or charity or advocacy group

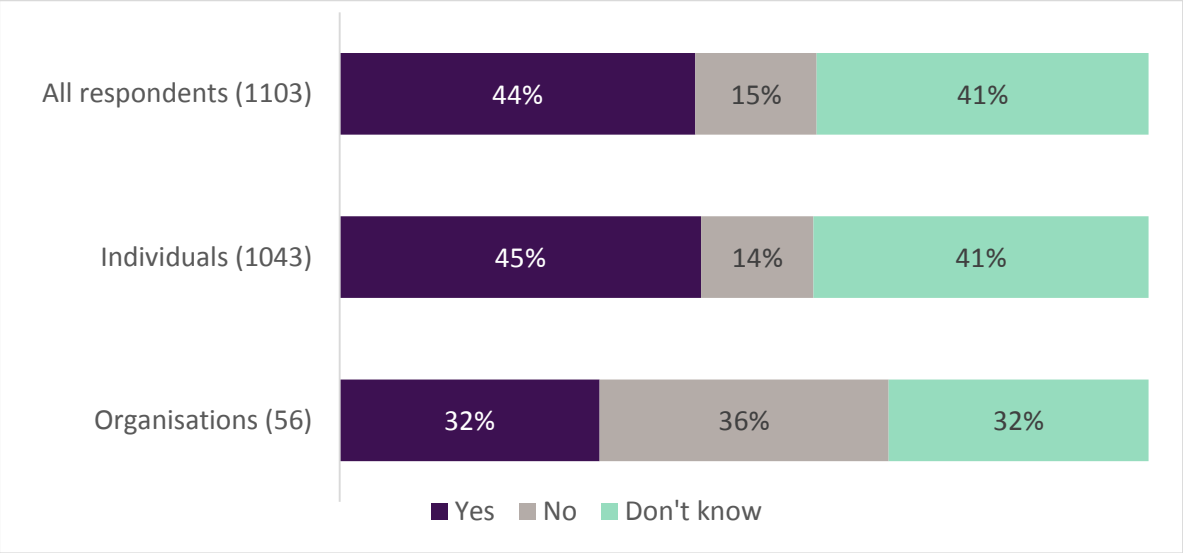
3.6 Registered public health nursing (RPHN) qualification

141. As well as the existing field specific SCPHN qualifications, the NMC also has a broader registered public health nurse (RPHN) qualification. The NMC is aware that there are some public health nursing roles that exist currently which it does not regulate and that more may emerge, especially as a result of the impact of the Covid-19 pandemic. The NMC therefore wished to test whether it should consider retaining the RPHN qualification for those roles and if so whether the knowledge, skills and attributes described in the draft core SCPHN standards would be applicable.

3.6.1 Retention of the RPHN qualification

142. Respondents were asked whether the NMC should retain the SCPHN RPHN qualification for public health nursing roles other than HV, OHN, and SN.

Figure 17 Whether the NMC should retain the SCPHN RPHN qualification for public health nursing roles other than HV, OHN, and SN



143. Just under half of individual respondents at 45% (469) believe that the RPHN qualification should be retained. While a similar proportion 41% (427) are unsure - a minority 14% (146) believe it should not be retained (n=1,103). This trend is broadly reflected across all four UK nations apart from Wales, where just over a quarter (28%) believe the RPHN qualification should be retained, while 55% are unsure (n=78).

144. The weight of feeling among organisations differs to individuals. Over a third of organisations - 36% (20) - believe the RPHN qualification should not be retained – a slightly lower proportion at 32% (18) believe it should be retained. Remaining organisations - 32% (18) - are unsure (n=56).

145. Respondents believing that the RPHN qualification should not be retained were asked to provide a rationale for their response, and 123 provided comment (104 individuals, 18 organisations and one other). Sixty of the individuals described themselves as registered/studying SCPHN, and 10 for SPQ and the rest are a mix of educator, employers, midwives, organisations amongst others.

146. Of the 123 comments received, the bulk suggest that retention of the qualification expands the potential for confusion.

a. Holding multiple qualifications could cause confusion for the public, as well as professionals as it is already difficult for patients to understand the difference between nursing roles. Blurred boundaries could lower existing high standards and reduce quality, ultimately affecting patient safety. Some also note that employers may not be able to distinguish between roles and specialities and one mentions the potential for confusion with the Public Health Practitioner qualification (80).

There is member concern that it is not identifiable within a specific field of practice and whether there is a need for it. Members feel that the three SCPHN fields offer public health expertise across specialist areas and that public health is incorporated into all other fields of nursing. The option also exists for registration through the UK Public Health Register.

Professional organisation or trade union

b. SCPHN should be restricted to HV, OHN and SN only. There is a perception that these roles have value by having their own clearly defined qualification, and that adding more roles could dilute or devalue their specialism (30).
c. RPHN is a separate, though somewhat generic, qualification, and so should be separate to SCPHN specific specialisms (25).

RPHN can be a confusing term in relation to the SCPHN title. The NMC has developed the draft standards to have field specific standards under the spheres. It is therefore difficult to see where RPHN sits as there are no field specific standards and the core standards would probably not cover all knowledge, skills and attributes required.

Educator

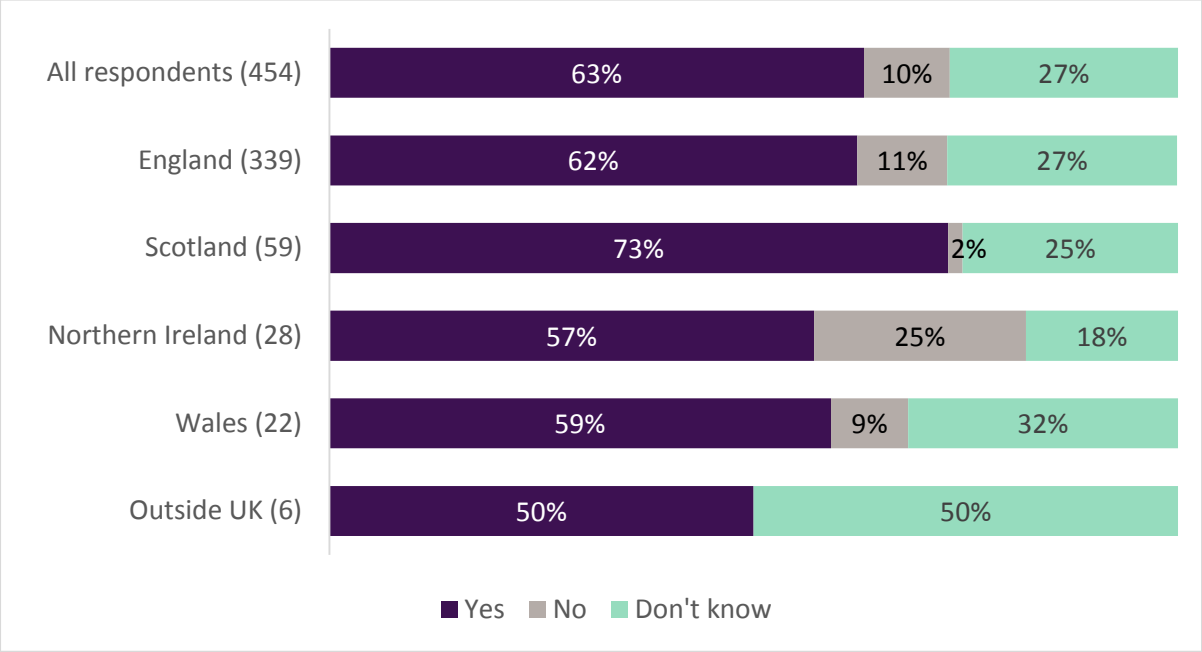
d. The SCPHN RPHN qualification is not needed due to lack of demand, or because SCPHN already covers the required element of the course (5).

3.6.2 Appropriateness of draft core SCPHN standards to other public health nursing roles

147. Those 485 (44%, n=1,103) respondents who indicated that the NMC should retain the SCPHN RPHN qualification (see section 3.6.1) were then asked whether they thought the draft core SCPHN standards would be appropriate for other public health nursing roles. Whilst not all the 485 respondents answered the follow-on question, 63% (286) of those respondents who did (n=454) agree that it would be appropriate to do so. A similar level of agreement is seen among both individuals and organisations.

148. Across the four nations, there is particularly high level of agreement among individuals in Scotland 73% (43), while Northern Ireland respondents show the highest level of disagreement at 25% (7) of all four nations.

Figure 18 Whether the draft core SCPHN standards would be appropriate for other public health nursing roles, by nation



149. The 10% (45) disagreeing that the draft core SCPHN standards would be appropriate for other public health nursing roles were asked to explain their rationale, and 35 respondents provided comment as explained below.

a. The standards need to be more role specific, that each role requires support for different groups in the community and that the standards should be tailored for each group that the public health nurse would be caring for (20/35).
b. The standards for RPHN should cover wider population health or elements of epidemiology, such as infectious diseases and their control (10/35).
c. Other suggestions, with one or two mentions each, refer to:
   - mental health,
   - older people,
   - community children's nursing, and
   - health promotion.

3.6.3 Potential consequences

150. Respondents were asked if there are any unintended consequences of retaining an option for the SCPHN RPHN qualification, and 292 responses (265 individuals, 25 organisations and two others) were received. Many of the comments resonate with those described above in section 3.6.1.

151. Of the 292 comments, the potential consequences of retaining the SCPHN RPHN qualification are explained as:

a. blurring the boundaries between roles and specialities (71), and

b. causing confusion for the public in terms of distinguishing between nurses. Respondents feel that this could lower the value of some specialisms through the inclusion of the SCPHN as a broader qualification (48).

My concern would be that it would detract from the SCPHN role and dilute the public's understanding of these roles. There would need to be comprehensive guidance on what the role is and what they are able to undertake. There would need to be distinct definitions.

Educator

152. However, just under 20% (58) of the 292 respondents confirm their view that the SCPHN RPHN qualification should be retained and that there are no unintentional consequences. They explain:

a. the RPHN provides a broader scope in terms of dealing with community needs as a whole, rather than focusing on children or just on working adults (25/58), and
b. it is useful to fill other public health role gaps or emerging roles in future with suggestions that there are some common aims across the standards which could also be applicable to other areas of public health (18/58). Examples of these include: being able to do more work at community level with families; to tackle the obesity challenge; to work with all age groups; to respond to pandemic/Covid; to work with people facing homelessness; and to provide mental health support in the community.

Without the RPHN option the SCPHN qualification becomes an exclusive qualification that rules out any innovations. The RPHN could work with the homeless, mental health programmes aimed at the public without GP referral.

Registered nurse

153. Around one in seven (40) of the 292 respondents note they are unsure what the role of a RPHN is, or that they had not heard of this, and so were unable to comment.

4. Views on Specialist Practice Qualifications (SPQ)

154. This chapter presents the feedback received from professionals and responding organisations, and the responses received offline concerning the draft standards of proficiency for community nursing Specialist Practice Qualifications (SPQs).

155. The total number of responses described in this chapter varies as questions for each section of the survey were voluntary and open to all to respond or not as they chose. For example: total responses to the individual questions on the Platforms range from 871 to 1,042.

Figure 19 Number of responses to SPQ section

Total responses to the whole consultation by type	N	Total responses to questions about SPQ as reported on in this chapter	N	Percentage of all respondents by type
Individuals	1,809	Individuals	1,121	62%
Organisations	81	Organisations	56	69%
Total	1,890	Total	1,177	62%

Key findings for Chapter 4 – SPQ

- Findings are presented from **62% (1,177) of all respondents who chose to answer at least one question on SPQ. These 1,177 constitute 62% (1,121) of all responding individuals (n=1,809) and 69% (56) of all responding organisations (n=81).**
- There is broad and positive support for each of the seven Platforms regarding applicability to each community field of practice. The responses to the five specialist community fields of practice range from 72% (660) for Platform 5, the lowest level of agreement (n=917), to 88% in agreement (905 and 902) for Platforms 2 and 3 (n=1,208 and n=1,025).
- While there is support at 48% (552), there is no overwhelming appetite for a skills annex (n=1,149).
- Prescribing element: overall there is stronger feeling that this should be mandated rather than optional with particularly strong support for this in District Nursing 73% (739) and General Practice Nursing 66% (590), and just over 51% (426 and 417 respectively) for Children's Nursing and Mental Health Nursing. However, for Learning Disabilities Nursing 52% (415) prefer the optional route (n=798 to 1,012). The V300 level is preferred across all fields of practice.
- Sixty-eight percent (775) support the proposal that the SPQ standards should be extended to other community roles which do not currently have a community nursing specialist practice qualification (n=1,139). Further, there is support by 64% (726) that the draft standards are appropriate for nurses in other community settings (n=1,134).
- Seventy-one percent (810) agree with the proposal by the NMC to use these forms of annotation: Community Nursing SPQ (CCN), Community Nursing SPQ (CLDN), Community

Nursing SPQ (CMHN), Community Nursing SPQ (DN), Community Nursing SPQ (GPN), and Community Nursing SPQ (CSPQ) [see section 4.4].

- In consideration of whether the term 'specialist' remains appropriate, and being mindful of future commitments, the NMC requested a view on whether these qualifications should be continued to be referred to as 'SPQs'. Seventy three percent (834) agreed they should (n=1,143), and that NMC should continue to regulate these qualifications (88%, 1,010, n=1,148).

4.1 Views on Platforms

156. Regulatory standards of proficiency describe what a registered nurse needs to know and be able to do to join the register for the first time as a registered nurse. For a post-registration qualification, the NMC intends that the draft standards should surpass the knowledge and skills described by the standards of proficiency for registered nurses.[7] In order to demonstrate this, the NMC has organised the draft standards of proficiency for SPQ into seven Platforms to align with the organisation of the pre-registration nursing proficiency standards.

157. These seven Platforms are as follows:

1. Being an accountable and autonomous professional.
2. Promoting health and preventing ill health.
3. Assessing people's abilities and needs, and planning care.
4. Providing and evaluating evidence-based care.
5. Leading and managing teams.
6. Leading improvements in safety and quality of care.
7. Care co-ordination and system leadership.

158. For each Platform, respondents were asked whether they think the standards in that Platform are applicable to each of the five community fields of practice:

- Community children's nursing (CCN),
- Community learning disabilities nursing (CLDN),
- Community mental health nursing (CMHN),
- District nursing (DN), and
- General practice nursing (GPN).

159. The response to the closed questions on the seven Platforms has been collated by the five fields of practice as portrayed in the following table. The response was positive: views on the applicability of seven platforms to the five specialist community fields of practice range from 72% (660) in agreement for platform 5 for GPN (n=917) to 88% in agreement (905 and 902) for platforms 2 and 3 (both for DN) - (n=1,208 and n=1,025).

[7] https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/

Figure 20 Positive responses by area of practice to each individual question on each Platform – 'are the standards applicable?'

Field of Practice *	YES by % / number						
Platform N=base	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Community children's nursing (CCN)	**80%** 736 N=920	**82%** 737 N=899	**81%** 726 N=896	**83%** 739 N=890	**75%** 668 N=891	**81%** 721 N=890	**77%** 685 N=889
Community learning disabilities nursing (CLDN)	**78%** 697 N=894	**80%** 702 N=878	**80%** 700 N=875	**81%** 706 N=871	**74%** 645 N=872	**80%** 698 N=872	**76%** 660 N=869
Community mental health nursing (CMHN)	**79%** 714 N=904	**81%** 724 N=894	**81%** 718 N=887	**81%** 714 N= 881	**73%** 646 N=885	**79%** 658 N=833	**76%** 670 N=882
District nursing (DN)	**87%** 907 N=1042	**88%** 905 N=1028	**88%** 902 N=1025	**87%** 887 N=1020	**85%** 874 N=1028	**87%** 888 N=1021	**85%** 865 N=1018
General practice nursing (GPN)	**82%** 776 N=946	**84%** 782 N=931	**81%** 750 N=926	**84%** 769 N=915	**72%** 660 N=917	**81%** 745 N=920	**75%** 684 N=912

*the questions relating applicability of the standards for each Platform to each field of practice were open to all respondents to comment on. The question encouraged respondents to answer for the fields of community practice they felt best placed to answer. In other words, the questions, for example, on CCN draft standards of proficiency were not just answered by CCN respondents.

160. Commenting on the draft standards as a whole, two organisations responding offline believe the language contained within the Platforms to be "*too medically focused and needs to be better aligned with the approach, thinking and practice of adult social care nursing*".

161. Unless otherwise specified throughout this chapter, there were no differences in level of agreement or nature of comments between individuals and organisations.

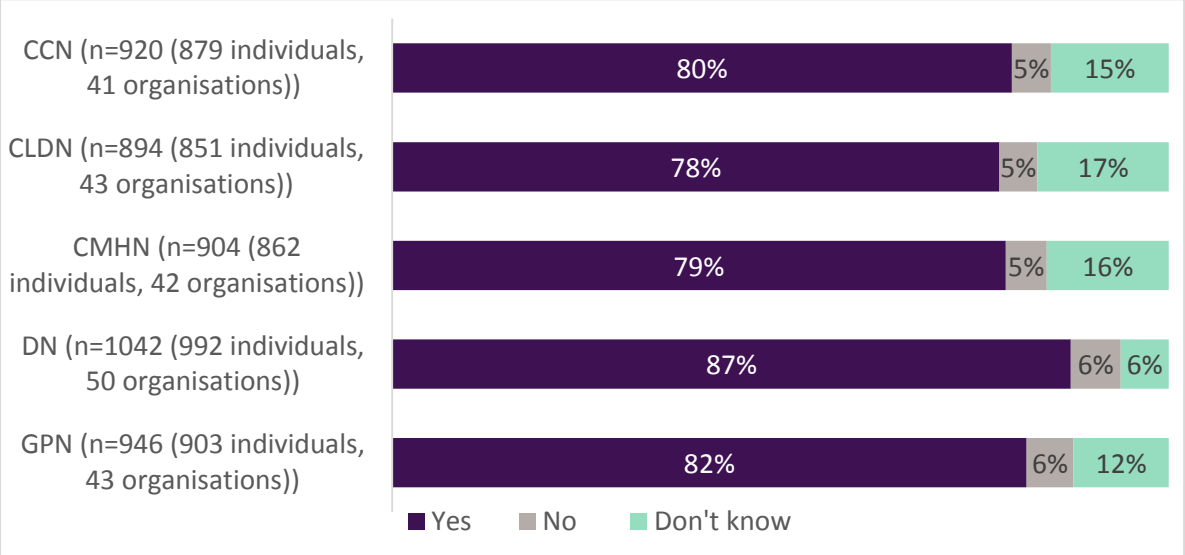
162. Section 4.1.8 contains feedback received relating to the need for field specific standards – this topic was raised by respondents throughout this section on the Platforms of the consultation.

4.1.1 Platform 1: Being an accountable and autonomous professional

163. Respondents largely agree ('yes') that the standards in Platform 1 are applicable to each of the five specialist community nursing fields of practice, with levels of agreement varying between 78% (697) for CLDN (n=894) to 87% (907) for DN (n=1,042).

164. Respondents who disagree that the standards are applicable to one or more roles were asked to comment on why they selected 'no'. Altogether 80 respondents provided comments (72 from individuals and 8 from organisations) across Platform 1.

Figure 21 Whether standards in Platform 1 are applicable to each community field of practice



165. A theme emerged in Platform 1 as many chose this first question to highlight a perceived lack of specific standards for each specialised nursing role. The concerns of around 22 responses are that the provided platforms are too broad to comment on the accountability and autonomy. The respondents want to see more bespoke standards that reflect the specialist aspects of the SPQ roles. Examples of these are highlighted below.

a. Around 10 DNs believe being accountable and autonomous is more vital for DN than it is for the other SPQ nurses, with a view that this is currently under-described in Platform 1. DNs should be required to have a higher level of independence, knowledge, and adaptability to unforeseen barriers in patient care than the other practitioners due to the fact DNs administer care in residential and care homes or the lone working aspect of the DN role.
b. Five CCNs comment that the CCN role is highly complex and takes a significant amount of training to work with complex children and be autonomous in such a

field. They believe the current content in Platform 1 is at an insufficiently advanced level to cover their responsibilities effectively.

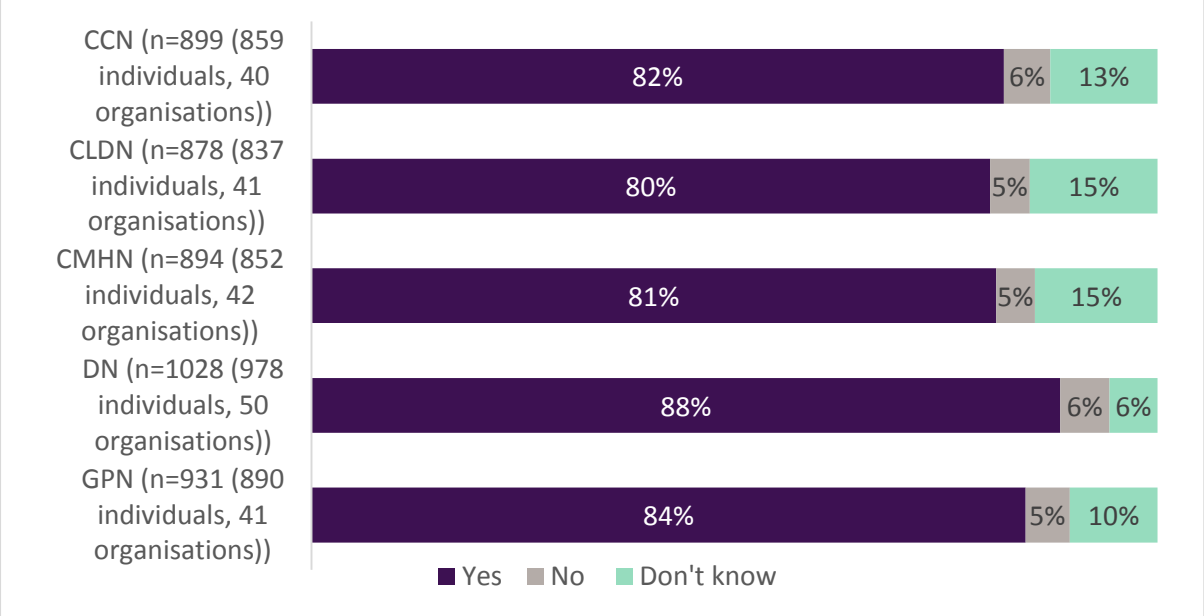
c. Six GPNs believe they should not be expected to conform to as high a level of autonomy or accountability as DNs, due to the fact the GPNs have access to a team of peers to consult for advice and that they have no need to be autonomous when there are multiple others, such as GPs/Senior Colleagues/Nurse Practitioners to provide expertise.
d. A single comment was that for more complex needs such as mental health and learning disabilities, there should not be a requirement to be independent and autonomous, as external advice or help may be more appropriate.

4.1.2 Platform 2: Promoting health and preventing ill health

166. Respondents largely agree that the standards in Platform 2 are applicable to each of the five community fields of practice, with levels of agreement varying between 88% for DN (905) to 80% for CLDN (702).

167. Of those respondents who disagree that the standards are applicable to one or more roles for Platform 2, 69 respondents provided comments, of which 10 were from organisations.

Figure 22 Whether standards in Platform 2 are applicable to each community field of practice



168. Their views are summarised below.

a. Around 20 comments suggest the core standards reflect a lower level of practice than is anticipated for practitioners, requesting role-specific standards may be required to accomplish this pointing out that differences between each of the SPQ specialised nurses are not adequately distinguished, due to the proposed standards being too generic. The respondents worry that this may cause specialist

skills to be lost or misused. In particular, DNs (seven) and a GPN say they need a wide knowledge base of all age groups to provide adequate care to all.

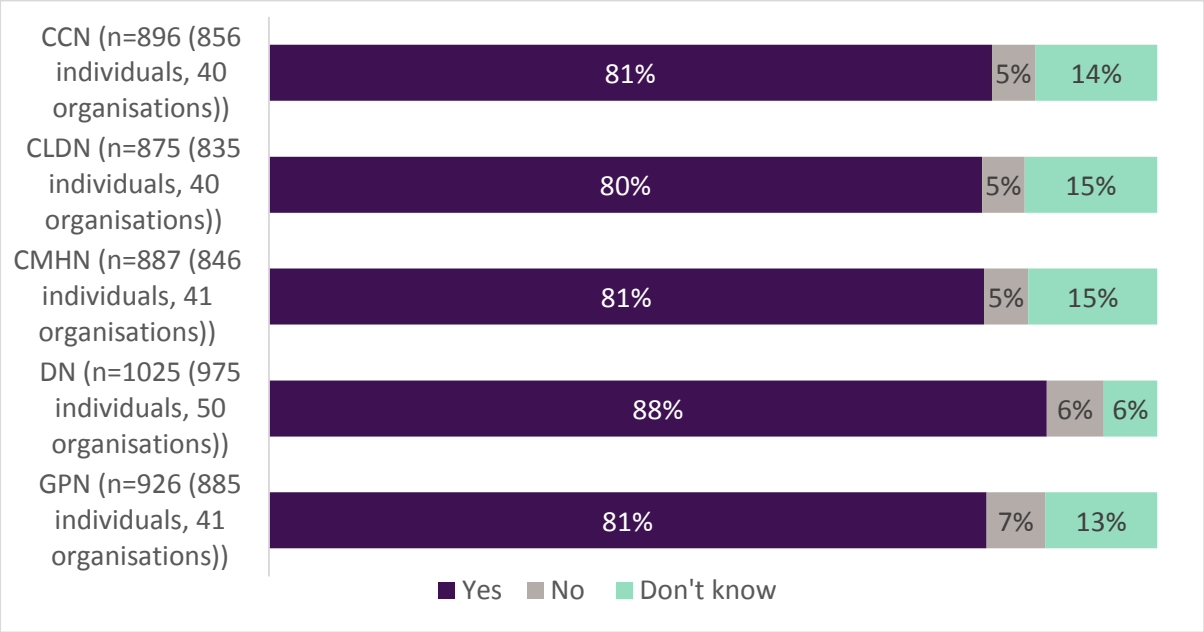
b. In addition, seven CCNs say there is a significant lack of focus on promoting health and preventing ill health specifically for children, and the standards neglect to highlight the complexities of working with children and young people.
c. Two other CCNs put forward the alternative view that as CCNs will be required to deal with difficult cases in the home environment such as complex childhood illnesses, health promotion is therefore not a priority at all.

4.1.3 Platform 3: Assessing people's abilities and needs, and planning care

169. Respondents largely agree that the standards in Platform 3 are applicable to each of the five community fields of practice, with levels of agreement varying between 88% (902) for DN (n=1,025) to 80% (700) for CLDN (n=875).

170. Of those respondents who disagree that the standards are applicable to one or more roles for Platform 3, 77 respondents provided comments, of which 12 were from organisations.

Figure 23 Whether standards in Platform 3 are applicable to each community field of practice



171. From those disagreeing with the applicability of the standards described for Platform 3, the reasons - in some cases by the respondents' field of practice - are summarised below.

a. The platforms are too generic for the specialities required from each of the SPQ roles; bespoke standards need to be in place, as the platforms currently fail to recognise the individual requirements that each of the fields need in order to plan care effectively in high-risk environments. Issues raised are around assessing the needs of an ill child, and being in highly complex and situations, often involving mental health or learning disabilities (25/77).

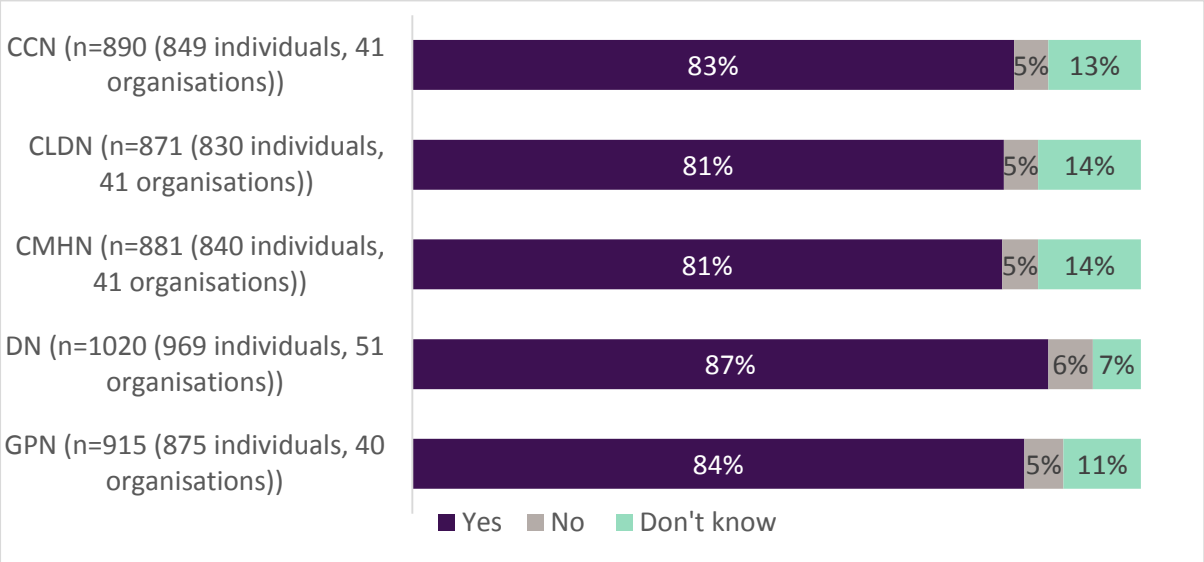
b. Eleven DN say there is insufficient emphasis on how important it is for DNs to be capable of assessing peoples' needs to an advanced level in Platform 3, for example on a DN's capability to conduct a holistic physical assessment that has potential to prevent hospital admissions, or playing a role in safeguarding decisions within high risk environments when planning care. A further 10 respondents from across the areas of practice say the platforms are too low level, not describing the advanced details needed to ensure high quality of care and patient assessment.

4.1.4 Platform 4: Providing and evaluating evidence-based care

172. Respondents largely agree that the standards in Platform 4 are applicable to each of the five community fields of practice, with levels of agreement varying between 87% (887) for DN to 81% (714) for CMHN and (706) for CLDN.

173. Of those respondents who disagree that the standards are applicable to one or more roles for Platform 4, 67 responses were received, of which 11 were from organisations.

Figure 24 Whether standards in Platform 4 are applicable to each community field of practice



174. Reasons for disagreeing are summarised below.

a. The platforms are not specialised enough to reflect the complex nature of the roles of SPQ nurses, and therefore the specialisms could be lost (5/67).
b. An alternative view is that for evidence-based care, the nursing fields should be generalised, and only go into specialisms for specific cases such as child healthcare or mental health. All care should be evidence-based (2/67).
c. For evidence-based care to be fully implemented, there needs to be a stronger emphasis in Platform 4 on the background research required (3/67), also required for DN (1/67).

d. The capability to work with and provide evidence-based care for CYP is as important for the GPN, CLDN and CMHN. There is also a perceived lack of content within these standards that relate to mental health issues and evidence-centric care (3/67).
e. Four DNs say the Platforms need to reflect a greater emphasis on how the DN field is evolving in its complexity as DNs need to be able to adapt to situations effectively and have a strong knowledge base to effectively provide evidence-based care.

People that previously would have been managed in a hospital setting are now being managed at home and a variety of other settings by District Nurses. This requires DNs to have excellent knowledge and clinical skills in a variety of conditions.

Registered nurse

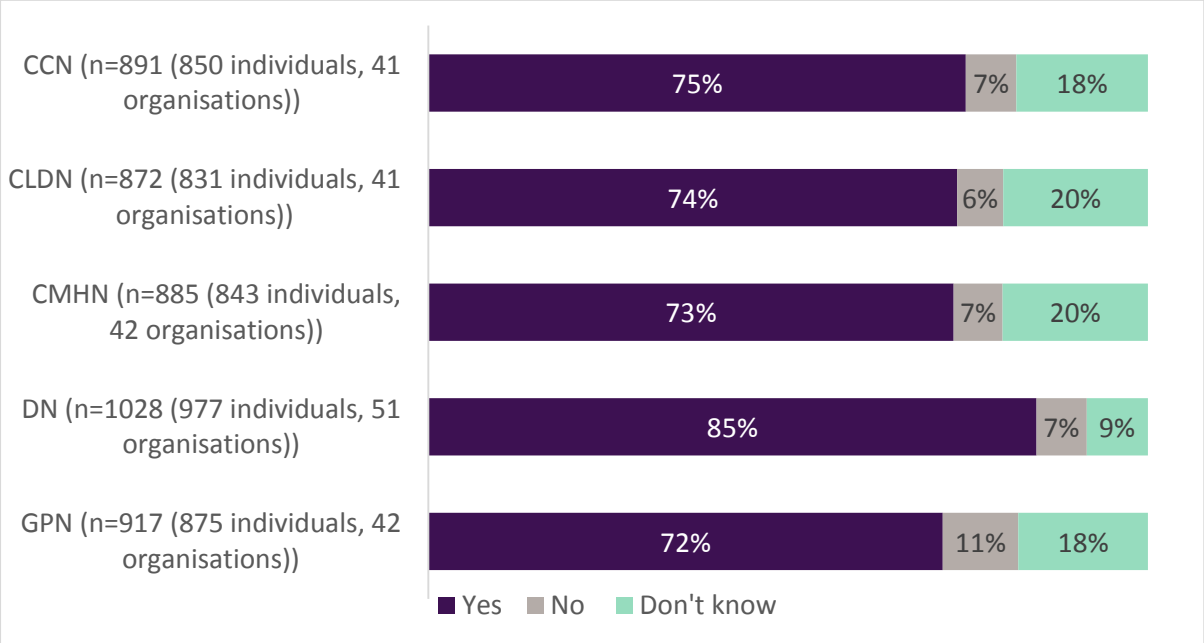
f. Four CCNs point to a lack of reference to evidence-based care for CYP. These respondents state that the knowledge and skill base required to treat younger people is more discrete and specific than other SPQ fields that primarily involve adult care.

4.1.5 Platform 5: Leading and managing teams

175. Respondents largely agree that the standards in Platform 5 are applicable to each of the five community fields of practice, with levels of agreement varying between 85% (874) for DN to 72% (637) for GPN. Overall, levels of agreement are lower for this Platform than for the others, but still remain high at over 70% for all SPQs.

176. Of those respondents who disagree that the standards are applicable to one or more roles for Platform 5, 94 comments were received, of which 13 were from organisations.

Figure 25 Whether standards in Platform 5 are applicable to each community field of practice



177. Reasons for disagreeing are summarised below.

a. Leadership is not applicable for most nurses, and it should not be a mandated requirement as part of the qualification. Most SPQ nursing roles specifically work in teams or large groups – collaboratively or individually – so there are rarely opportunities in which they can take a managerial or leadership role, nor is it seen as essential to their job as a nurse or in delivery of care (31/94), of which 11 are GPNs.

I don't believe every nurse needs to lead a team. I believe some nurses are better as being part of a team and focusing on patient care rather than leadership.

Registered nurse

b. An alternative view is that the emphasis on leadership needs to be strengthened for DN, and Platform 5 should be specifically tailored to fit the requirements for DN. The need to manage teams and risk within the community is seen as prominent by this group of respondents (seven DNs).

This level of responsibility, complexity, and autonomy in relation to both patient care, team management and leadership is rarely seen in other areas of nursing at this level of practice.

Professional organisation or trade union, Wales

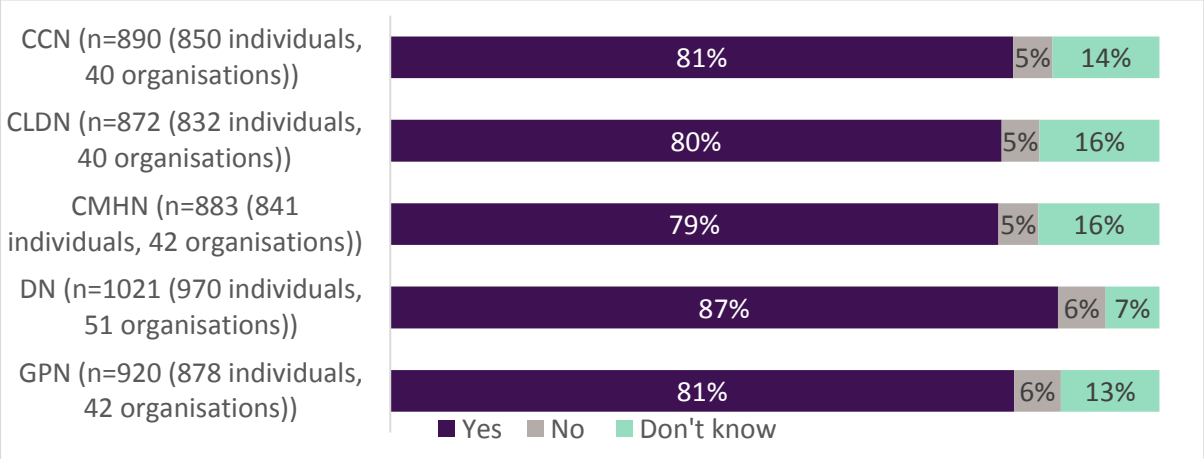
c. The CCN workforce is a relatively new discipline, and thus requires leadership skills to incorporate the voice of the CYP in leading and developing services (3/94).

4.1.6 Platform 6: Leading improvements in safety and quality of care

178. Respondents largely agree that the standards in Platform 6 are applicable to each of the five community fields of practice, with levels of agreement varying between 87% (888) for DN to 79% (658) for CMHN.

179. Of those respondents who disagree that the standards are applicable to one or more roles for Platform 6, a total of 64 responses were received, of which 7 were from organisations.

Figure 26 Whether standards in Platform 6 are applicable to each community field of practice



180. Reasons for disagreeing are summarised below.

a. The standards expressed in Platform 6 are too generalised, and therefore are at risk of losing the specialities, for example of providing the complexities required to provide safe, high quality care for CYP, as they are too vague or broad (48/64, of which 12 are DNs).
b. Not all specialist roles require leadership skills. Whilst leading improvements in safety and quality of care is important, several specialist nurses work as a part of a team rather than autonomously and as such are not required to lead. There is concern about unwarranted pressure on the nurses (15/64).

This platform is not specific enough to recognise the role of the District Nurse in leading new models of working that are often multi-professional. This requires vast leadership skills and effective change management skills. There needs to be more emphasis on the importance of using the clinical governance agenda to further their service, specifically with regards to the complexity, unpredictability and risk that DNs face when leading on improvements and how this relates to the management of significant caseloads (not seen in other services/teams).

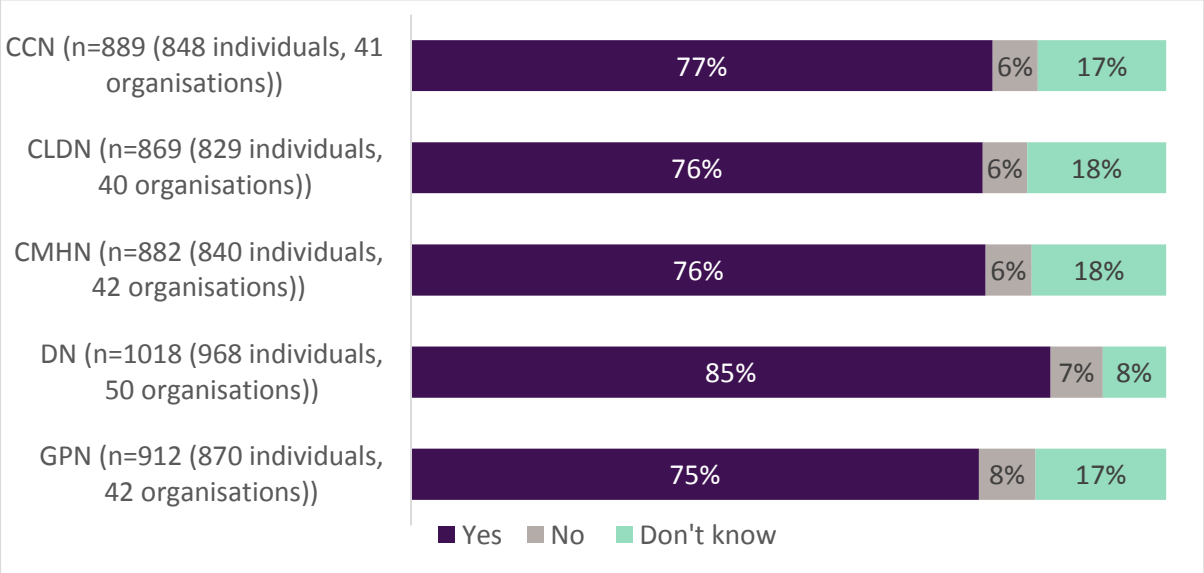
Professional organisation or trade union

4.1.7 Platform 7: Care co-ordination and system leadership

181. Respondents largely agree that the standards in Platform 7 are applicable to each of the five community fields of practice, with levels of agreement varying between 85% (865) for DN to 75% (662) for GPN.

182. Of those respondents who disagree that the standards are applicable to one or more roles for Platform 7, a total of 82 responses were received, of which 10 were from organisations.

Figure 27 Whether standards in Platform 7 are applicable to each community field of practice



183. Reasons for disagreeing are summarised below.

a. The standards listed in Platform 7 are too generic, broad and low level for care co-ordination and system leadership to be implemented effectively without compromising the quality of care. Public safety may be at risk if these SPQ specialisms are diluted by generalised standards (17/82).
b. Some specialist community nursing roles do not require leadership-based skills, therefore mandating these is not necessary as the skills will not be utilised or will already be encompassed in the existing regulations for registered nurses (11 including six GPNs/82).

> *These are applicable, but are not necessary as additional regulations…they are encompassed in the existing regulations that apply when you join the NMC register which allows for development of practice to enhanced, specialist, or advanced levels.*
>
> Educator, England

c. The standards outlined in Platform 7 are not specific enough to account for the complexities involved in DN, especially regarding coordinated care for multiple different environments within the community. These include vulnerable adult care, end of life care, caseload management, organisation coordination, adaptation to changing circumstances and safeguarding of high-risk patients (16 DNs/82).
d. There is a lack of specific standards highlighted in Platform 7 that directly influence or refer to CCN, for example no direct mention of child-centric coordinated care nor any reflection of the advanced practice required of CCNs (4 CCNs/82).

4.1.8 Field specific standards

184. There was no specific question within the consultation regarding the need for field specific standards for SPQ. The consultation asked questions about whether the standards of proficiency are the right ones, their applicability to each of the current fields of community practice, and whether any additional standards are needed.

185. The preceding sections 4.1.1 to 4.1.7 present the positive responses to the research questions as well as specific concerns raised by respondents disagreeing. Between 64 and 94 comments were received for each of Platforms 1 to 7 from a mix of individuals and organisations detailing concerns on why they disagree with the applicability of the standards.

186. Within the above, between 20 to 30 comments were received per Platform relating to the perceived generic nature of the draft standards and a resulting need for, and expectations of, field specific standards.

187. This view was based on a perceived requirement for field specific standards to be developed for each specialist nursing role.

188. Typically, those respondents who disagreed with the applicability of the standards and went on to provide further comment, argue that the Platforms – as they stand – are too broad and that they would like to see more field specific standards to reflect the specialist aspects of each SPQ role.

Suggestions include a view that Platforms 1-7 should follow the same format and level of specificity that spheres A-F exhibit within SCPHN.

189. They further argue that the draft Platforms currently fail to recognise the individual requirements that each SPQ field needs and call for field specific standards. Many of these respondents, however, do not go on to suggest what these might incorporate. Underpinning this, many of the comments imply a belief that the standards are there to describe a particular role, whereas their purpose is fundamentally to describe the knowledge and skills required at a particular level of practice.

> *My principal concern is that there is an assumption that these roles are all similar in nature and that there are proposed to be no field-specific ('bespoke') standards of proficiency for individual specialist areas of nursing.*
>
> Registered nurse

> *These are very generic standards and do not reflect the challenge and specialist knowledge needed for each of the professions. I think that if the standards are too broad then the specialist knowledge needed will be lost and that will lose the benefit of having the specialist practice title, as those completing it will not be fully equipped to deal with their specific profession where the clients and circumstances are so varied and complex.*
>
> Registered nurse with a community SPQ annotation

190. These same respondents, as described above, put forward a concern that a one size, generic approach does not fit all, and that the standards could not be implemented effectively without compromising quality of care or patient safety. Several note that public safety may be at risk if these SPQ specialisms are diluted by generalised standards.

191. Suggestions of standards were offered, examples of which are included in Appendix D, however, many of the comments did not identify any discrete specifics for each speciality that are not already incorporated in the pre-registration standards.

192. A small number of respondents (fewer than 10) on the other hand, specifically comment that advanced generic, broad standards that cover the patient's assessment needs could be beneficial to care. They note that such standards could cover all groups, then the core nursing skills would be applicable to all, thus allowing for easier access to care. Some further believe that the nursing fields should be generalised and should only go into specialisms for specific cases such as child health and social care or mental health, justifying this by noting that all care should be evidence-based.

> *There should not be specific nursing fields, just generic nursing and then specialist courses in child, MH, learning disabilities and adult nursing, depending on the registrants' interests and the needs of the department in which they serve.*
>
> Educator

193. Around two in three - 64% (47) - of the 73 offline responses received via the NMC mailbox were templated responses, i.e. broadly similar letters which refer specifically to the draft standards of proficiency for community nursing SPQ.

194. The templated letter argues that there should be a set of field specific standards that are bespoke for each SPQ area. Of these 47, three quarters note that having the same standards for all SPQ areas could lead to:

- greater variation in practice,
- the NHS being unable to deliver on national policy requirements, and
- widespread variation in courses offered by Approved Educational Institutions (AEIs) that may introduce unwarranted variation in care provision.

195. However, while arguing that field specific standards are required, none of these offline templated responses identified additional specific standards that were perceived to be missing.

196. Some organisations (around seven) responded both offline and via the online survey, raising these concerns on both occasions.

197. Four offline responses from organisations (one of which also responded online) raise detailed concerns about the draft standards and the perceived need for bespoke field specific standards to replace these. Their concerns largely echo those points made by respondents to the online consultation described earlier in this sub-section.

4.2 Skills annex

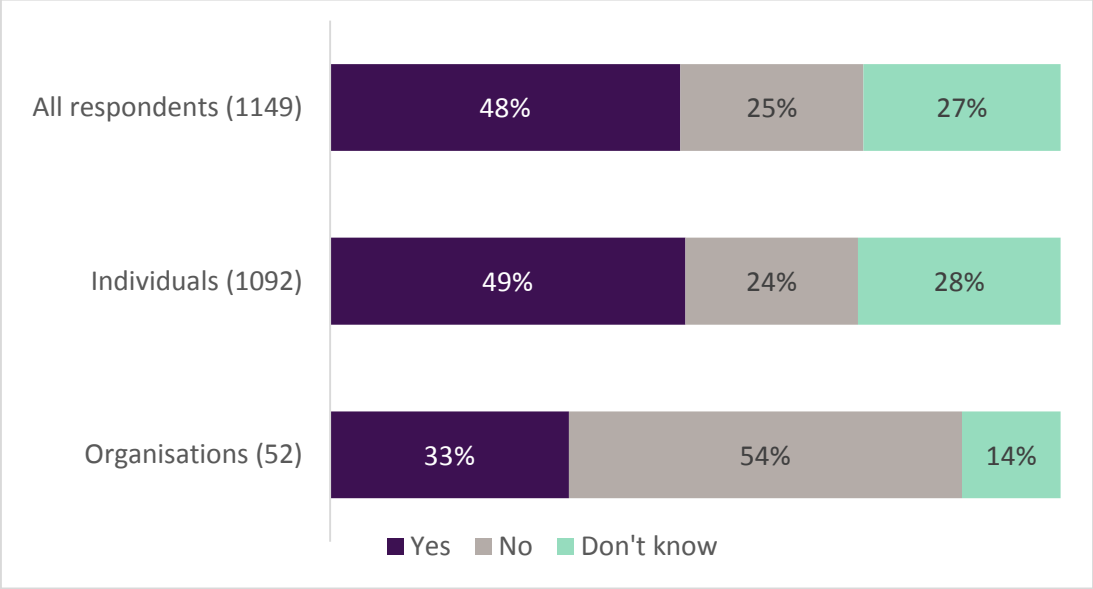
198. In its standards of proficiency for registered nurses,[8] the NMC included a skills annex which identifies the skills and procedures that nurses are required to demonstrate in order to successfully complete their programme. During the pre-consultation engagement that the NMC undertook regarding the post-registration standards, the feedback received indicated to the NMC that this was not necessary for these draft community SPQ standards. However, this consultation sought views from professionals and organisations on this topic.

199. The question was in two parts: respondents were firstly asked whether they think there is a requirement for an annex to detail the specific skills and procedures required to underpin the proficiencies, and then, secondly, if they answered yes, could they provide examples of potential content. These are provided in Appendix D.

200. Just under half, 48% (552), believe that there is a requirement, while a quarter disagree, and a quarter are unsure. A smaller proportion of organisations agree that a skills annex is required (33%) compared to individuals (49%). There is no notable difference by nation.

[8] https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/

Figure 28 Whether there is a requirement for an annex to detail the specific skills and procedures required to underpin the proficiencies



201. Of those responding to this question, 354 respondents, including 99 DNs, provide comment on why they think there is a requirement for an annex to detail specific skills and procedures.

a. This annex should be specific to each SPQ field so that individuals can adequately demonstrate required competences in their area. This would reduce overall risk to public protection as it provides an indication of nurses' competence (74, including 15 organisations).

This should be more than an annex - it requires specific standards to each professional role and not something simply to note or provide as additional guidance. The standards need to be robust and tailored to each profession, recognising contemporary workforce needs and the specialist skills required in each professional field.

Education provider

b. General core skills could apply to each SPQ area, which might include advanced soft skills, including in-depth communication and psychosocial skills to assess patients, organisation of caseloads and management of complex patients, supporting the patient, leadership and autonomy, and complex care regarding bereavement and terminal illness (87, including 33 DNs).
c. Clinical assessment skills should be incorporated. These skills include (but are not limited to) pain management, long term illness care, treatment planning, medical administration (e.g. IV, syringe based medication etc), ventilation care, catheterisation, skin care and dermatology, and wound care and assessment. Many of these skills are suggested to be specifically important to DN (101, including 28 DNs).

I think there needs to be a higher level of clinical skills within the SPQ for district nursing especially at the minute as primary care is leading the way.

Registered nurse with a community SPQ annotation

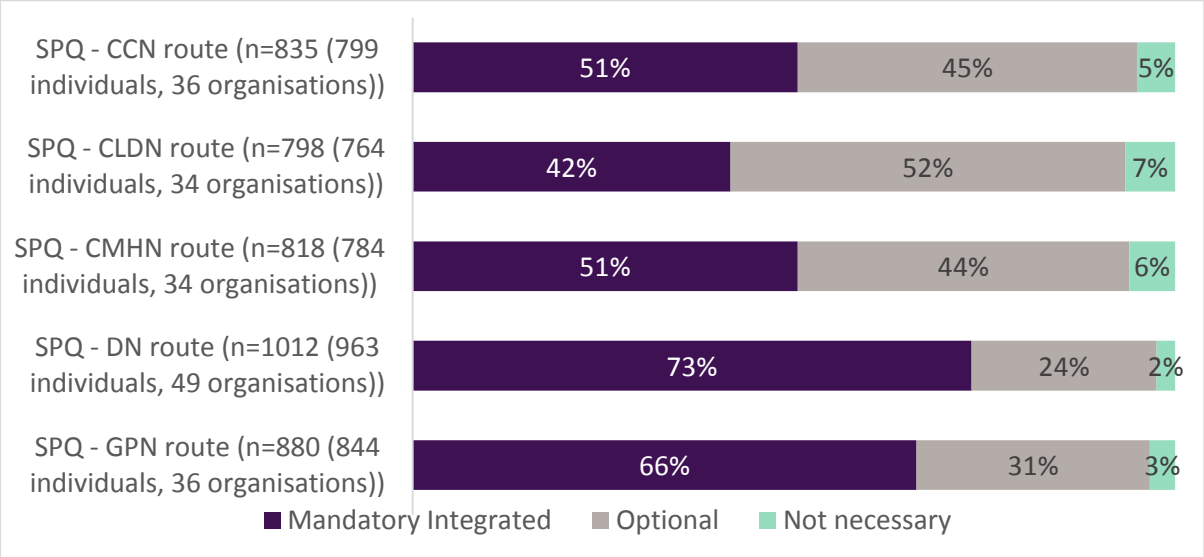
d. End of life care might be included in an annex, as it is important for example DNs and CCNs have skills in administering terminal care relating to older people and for children with life-limiting illnesses (31).
e. Specifically, CLDN and/or CMHN areas of practice require skills in very complex physical/mental examinations and assessments for a range of patient ages (infancy to adulthood) because of their direct focus on issues that other community nurses may not come across, such as complex communication issues, anxiety and depression, eating disorders, autism and patients with sensory issues that may impede care (25).
f. The skills that should be incorporated in any annex relating to GPN, include cervical screening, immunisation in both adults and children, sexual health, managing long term conditions, planning effective and complex health and social care (21).

4.3 Prescribing practice (SPQ)

202. There is currently a mixture of approaches relating to the inclusion of prescribing modules within existing NMC-approved community SPQ programmes. Some include a V100 community formulary prescribing qualification, some include a V300 independent/supplementary prescribing qualification, and some do not include a prescribing qualification at all.

203. Respondents were asked their opinion regarding whether a prescribing element should be a mandatory integrated or optional programme requirement, or not required at all, for each SPQ field of practice route.

Figure 29 Whether a prescribing element should be a mandatory integrated or optional programme requirement, or not required at all, for each SPQ field of practice route



204. Nearly three quarters, 73% (739), of respondents believe a prescribing element should be a mandatory integrated programme requirement for the DN route, while 66% (581) agree likewise for the GPN route.

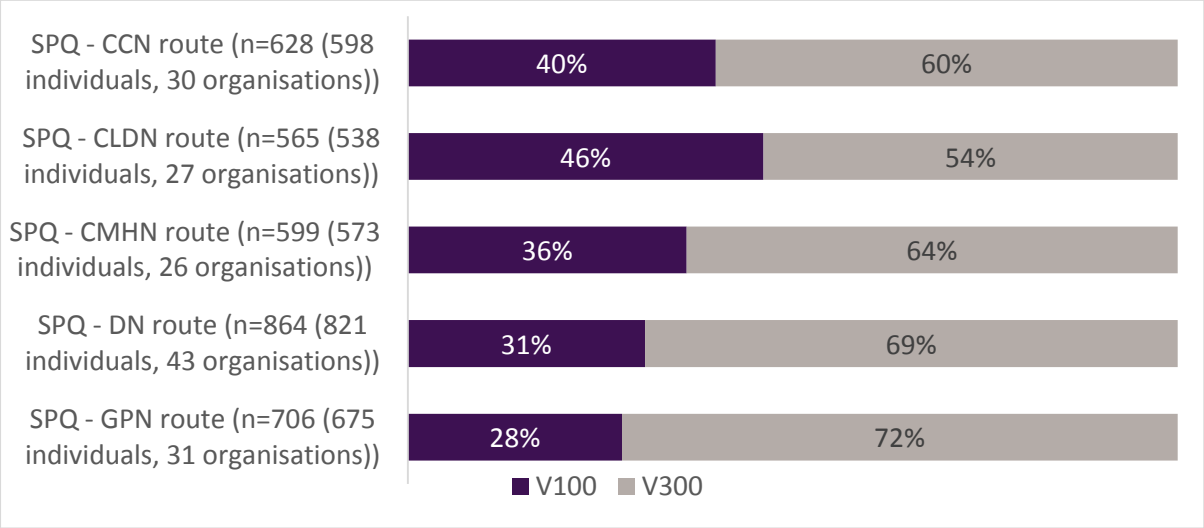
205. For remaining roles, opinions are less clear cut, with around half, 51% (417 and 426 respectively), supporting a mandatory prescribing element for CMHN and CCN routes, and below this at 42% (335) for CLDN. Remaining respondents generally believe a prescribing element should be optional for each field of practice route, and no more than 7% (56) of respondents believe that this is not necessary for any of the five routes.

206. In the main (over half of 31 to 37) respondents from Northern Ireland are more inclined towards an optional prescribing element, with 12 believing it should be mandatory. Levels of agreement/disagreement in the other nations are similar to the overall picture.

207. In contrast, organisations are more inclined than individuals to state that a prescribing element should be mandatory, with 56% (CLDN), 64% (CCN), 65% (CMHN), 75% (GPN) and 84% (DN) of these respondents agreeing with this (note: 34 to 49 organisation respondents).

208. Respondents were also asked for their opinion on which level of prescribing qualification – either the V100 or V300 – they believe is most appropriate for each of the SPQ programmes' field of practice routes. For all roles, respondents believe the V300 level is more appropriate than the V100 level, although the extent of agreement ranges from 72% (508) for GPN and 69% (596) for DN, to a nearer even split for CLDN with 54% (305) favouring the V300 level. Over 85% of organisations believe the V300 level is most appropriate for each route.

Figure 30 Which level of prescribing qualification is most appropriate



209. For each SPQ area, respondents from any area of practice were able to explain their choice of selection and these views are detailed below per area of practice.

210. **CCN (308 total responses):**

In favour of V300 = 69% of those commenting (214/308)

211. The 214 respondents providing further commentary argue that the V300 qualification is the most appropriate for CCN. Of these, nearly half (102) note that it is highly important for CCNs to have the qualifications necessary to prescribe care, treatment and medication to potentially complex children and young people (CYP) patients in the community. They argue that the skills required to meet patients' needs vary significantly, and thus a V300 level is required. Some go further and state that prescriptions should be easily managed by CCNs, without the necessity for patients to visit a GP or hospital. They note the importance of providing quick and effective treatment within patients' homes that is beneficial to both patient and their family/carer.

212. **Other comments in favour of V300 for CCN:**

a. V100 is outdated and limits the prescribing capabilities of the nurse (35/214).
b. Autonomy is a vital component to CCN and this level provides more opportunities for CCNs to be independent and autonomous (without the need for external teams or GPN input) in the treatment that can be provided (21/214).

In favour of V100 = 31% of those commenting (94/308)

213. A total of 94 of those commenting, in contrast, believe the V100 qualification is sufficient to provide care to a child, and that it should potentially be an essential mandated standard for CCN. It is regarded by these respondents as a basic requirement and will adequately benefit children in their care, especially those with complex issues, and that it will equip nurses with the knowledge and skills to treat mild ailments, provide basic drug prescriptions, risk assessment, leadership, and the capability to respond quickly to the patient and the patient's family. V300 could be an optional path if/when nurses specialise in their role.

214. **Other comments on V100 from the same set of 94 responses:**

a. CCNs with V100 would potentially be able to prescribe some low-level medication, thus bypassing some of the need for lengthy GP appointments or hospital visits. This overall would lead to easier and more efficient treatment for patients due to the higher level of autonomy and control that the V100 provides, however, respondents acknowledge there should be a limit to CCNs prescribing without the consultation of a GP (25/94).
b. V300 is too niche or difficult which may dissuade nurses from specialising in certain fields. With more advanced health and social care professionals available, there is no need for CCNs to obtain V300, as it will not be necessary for the treatment they will provide (19/94).

215. **CLDN (246 total responses):**

In favour of V300 = 65% of those commenting (159/246)

216. In total, 159 of the 246 responses argue that V300 is an absolute requirement, that CLDNs should be able to prescribe basic and more complex care to their patients, including prescriptions

of antiepileptics and antipsychotics, to ensure that patients receive the best possible care efficiently, without the need to book a GP appointment. These respondents also note that this is essential for patients who may not have easy access to alternative health and social care, such as members of the public with severe learning disabilities.

In favour of V100 = 35% of those commenting (86/246)

217. In total 86 of the 246 responses are in favour of the V100 level as they see it as an adequate level of qualification to treat patients with learning disabilities. V100 is a sufficient level to account for the amount of prescribing required as the medicine prescribed should be done specifically through a general practitioner or a doctor, making the need to have this skill superfluous.

218. **CMHN (266 total responses):**

In favour of V300 = 74% of those commenting (197/266)

219. Around three quarters (197) of those providing comment indicate the V300 is most suitable, arguing that this higher level is required to ensure sufficient autonomy. If CMHNs have this ability to prescribe, then the care patients receive will be efficient, received without delay and avoid unnecessary GPN or doctor appointments. Other comments are:

a. the V100 qualification would be too simplistic to effectively care for the complex needs of mental health patients. The skills required (advanced communication, prescribing complex medications, psychological skills, dealing with sensitive issues such as eating disorders and depression, etc) are too advanced and also medications may be incredibly specific and require highly specialised knowledge to be prescribed safely (39/197).

In favour of V100 = 26% of those commenting (69/266)

220. These respondents outline how the V100 level is sufficient to provide the care expected of and required by CMHN. Respondents note that this is an essential, starting qualification that ensures a level of autonomy and competence to prescribe efficient care in low level medicine prescription, family care, psychological care and trauma care.

221. **DN (528 total responses**):

In favour of V300 = 70% of those commenting (371/528)

222. The V300 is regarded to be most suitable. The V100 is considered to be limited, outdated and lacking sufficient detail to cover the broad and complex specialities required of a DN – examples provided include palliative care, end of life care, antibiotic prescription, complex diagnosis of conditions, and working in complicated housing situations safely in order to prevent hospitalisation. Other comments are:

a. this field requires the highest level of autonomy of all SPQ fields. These respondents note that, as DNs work independently in the households of patients with complicated diagnoses to provide treatments quickly, they need to be highly professional and autonomous. They therefore argue that, with the complicated skill sets required, this can only be achieved with V300. This cohort of respondents also mention that, as a consequence of this, DNs can reduce the

stress of GPs by alleviating some of the need for patients to receive appointments for medication prescription and ailment care (123/371 - many of whom are DNs).

In favour of V100 = 30% of those commenting (157/528)

223. These respondents outline how the V100 level covers different aspects of the DN role, including basic health and social care and broad treatment of mild ailments, that would help avoid a visit to a GP. These respondents argue that the V300 level is an unnecessary qualification because the broad nature of DN means it is rarely used and therefore V300 should be optional, to minimise DN caseload and stress. Other comments are:

a. DN is an independent role in the community and that autonomy is vital. The V100 is a high enough level to provide sufficient autonomy, with the benefit that patients can receive care and prescriptions in their home efficiently and without delay (23/157).

224. **GPN (359 total responses):**

In favour of V300 = 80% of those commenting (287 of 359)

225. These respondents see the V300 as more appropriate for GPNs when prescribing care. They refer to the complex base knowledge of medications that the GPN requires to prescribe care efficiently and effectively, with mention specifically to vaccine administration, contraceptives, steroid creams, niche antibiotics and chronic disease treatments. Respondents note that the V100 qualification would not adequately meet these requirements. Other comments are:

a. the breadth and variety of different conditions and individuals requires a higher level of competency that only the V300 qualification can provide. GPN will treat a diverse range of different ailments and requires the knowledge and skills to prescribe the correct care (28/287).

In favour of V100 = 20% of those commenting (72 of 359)

226. The V100 is seen as an essential minimum level of practice to ensure that GPN have the required skills needed to prescribe medication and appropriate treatment. A small number (15) believe V100 should be mandated with the V300 level being an optional progression for practitioners wishing to advance and specialise. As GPNs work in large teams of health practitioners, there is less need to have the higher levels of autonomy associated with V300. Respondents argue that GPN is a part of an integrated workforce, so prescribing care can be managed by others if required.

4.4 Proposal for an additional community SPQ

227. This consultation also sought views on the addition of one more annotation with a title of "community specialist practitioner" – this would be in addition to the five existing community SPQ annotations (CCN, CLDN, CMHN, DN, and GPN). The NMC's rationale for this is that a range of new roles now exist in community health and social care which require increasing levels of autonomous

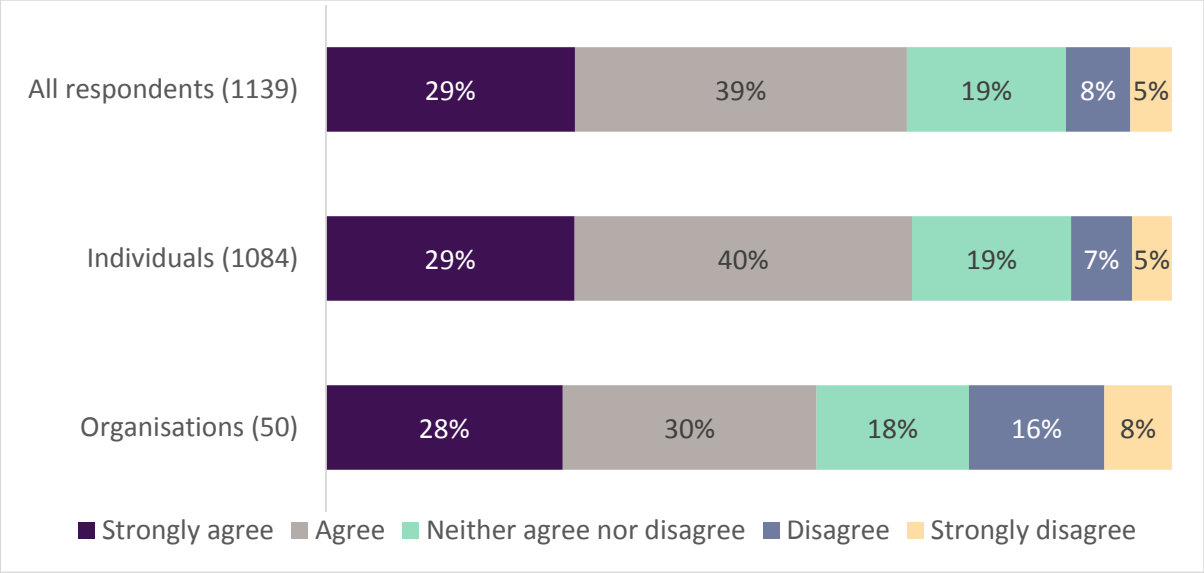
practice and leadership (for example, social care, hospital at home, intermediate care, offender health) for which no NMC community specialist practice qualification exists.

228. This consultation therefore sought views on whether an additional community SPQ is necessary, and if so, whether the knowledge, skills and attributes described in the draft SPQ standards would be applicable for other community nursing roles (assuming that educational providers are able to demonstrate that they could construct an appropriate programme to ensure that the standards are taught within an appropriate context).

4.4.1 Necessity for an additional community SPQ

229. Respondents were asked whether the NMC should seek to extend these standards for other community roles which do not currently have a community nursing specialist practice qualification (SPQ). Over two thirds 68% (775) of all respondents agree or strongly agree with this, while some 13% (148) disagree or strongly disagree (n=1,139). Fifty-eight percent (29) of organisations agree or strongly agree, while 24% (12) disagree or strongly disagree. Two organisations responding offline and agreeing with this proposal note that, with this inclusion, community roles would be regulated and monitored more heavily to ensure public safety and overall competency, and further that it may offer career development paths for registered nurses.

Figure 31 Whether the NMC should seek to extend these standards for other community roles which do not currently have a community nursing specialist practice qualification (SPQ)



230. Respondents disagreeing or strongly disagreeing that the NMC should extend the standards to other community roles that do not currently have a nursing specialist practice qualification were provided with the opportunity to explain their reasoning, and 103 responses were received. The main points from their responses are detailed below.

a. Extending these standards to include other community roles may lead to confusion, both for members of the public and nursing practitioners. Having multiple additional roles and qualifications would be difficult to distinguish between, and would become meaningless to the layperson, ultimately making it harder to reach the required standard of care (13/103).

This will further confuse the public - what exactly does "practitioner" mean? A nurse is a nurse, it is a protected job title, the use of community practitioner is ambiguous and will likely cause confusion.

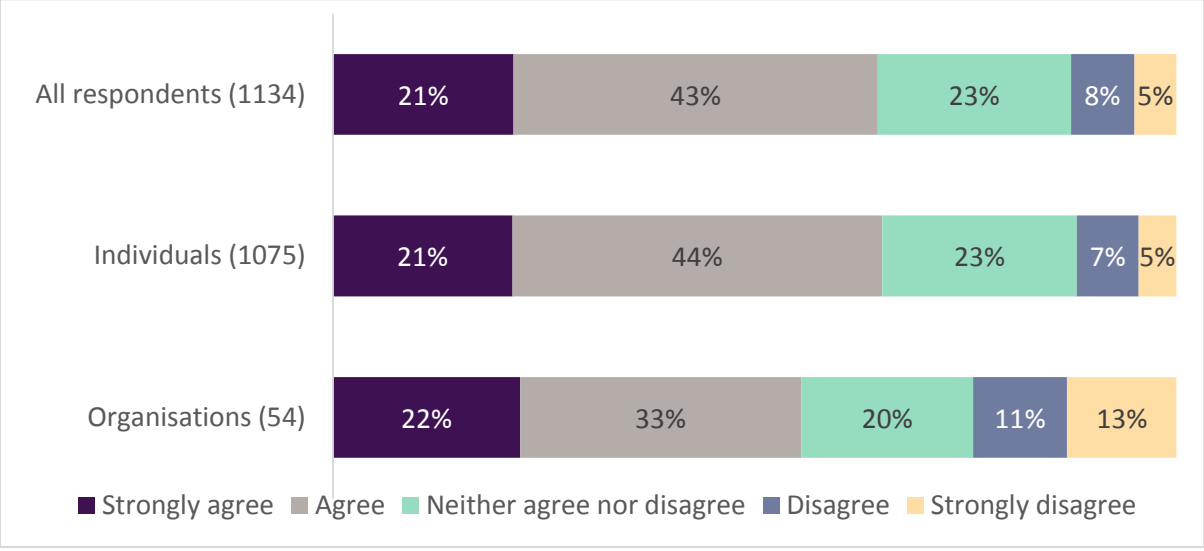
Registered nurse with a community SPQ annotation

b. It would greatly devalue the roles of nurses in existing SPQ fields. There is a danger that current role specialities may become diluted, leading to too "broad" a range of nurses. The distinction between nurses may become blurred to such an extent that the public risk receiving a lower standard of health and social care (12/103).
c. By extending the standards to cover more community roles, there may be an adverse effect on current nurses, and adding specialities could increase stress and pressure with negative impacts such as deterring take-up of SPQs in the future. This may, inadvertently, lead to recruitment difficulties, reduced employment opportunities and reduced ability for nurses to alter professions (9/103).
d. The SPQ annotations should not be fully expanded, but there should be an exception for specific specialist nurses, suggesting that care home/hospice nurses, homeless and inclusion health nurses, adult social care nurses, and prison and criminal justice nurses should be of the few included (6/103).

4.4.2 Appropriateness for nurses practising in other community settings

231. Respondents were asked whether the draft SPQ standards are appropriate for nurses who practise in other community settings. Around two in three, 64% (726), respondents agree or strongly agree they are appropriate in these instances, while some 13% (147) disagree or strongly disagree. Just over half of organisations, 55% (29), agree to some extent, while around a quarter, 24% (13), disagree or strongly disagree.

Figure 32 Whether the draft SPQ standards are appropriate for nurses who practise in other community settings



232. Respondents disagreeing or strongly disagreeing that the draft SPQ standards are appropriate for nurses who practice in other community settings were provided with the chance to explain their reasoning, and 104 responses were received. Their views are summarised below.

a. The standards do not adequately define the specifics of each of the specialist roles in the community. They are too generic and broad. This approach will not work as each role within the community is unique and has differing areas of expertise (43/104).
b. The standards should cover more advanced topics to ensure that the complexities involved in specialist community roles are adequately described and understood. Examples such as children's home nurses versus care home nurses, mental health nurses, learning disabilities nurses, disease specific nurses, health inclusion nurses, social care nurses, and nurses working with chronic and complex conditions such as eating disorders (24/104).

The standards are not appropriate for all nurses who practice in other community settings as they do not reflect the proficiencies (what nurses need to know and be able to do by the end of the programme) that are specific to the specialist field of practice.

Professional organisation or trade union

The NMC should seek to extend the standards and include field specific standards with annotations for at least two other specialist fields of community specialist practice: Homeless and Inclusion Health and Adult Social Care Nursing. These are very well established high-risk, nurse-led services delivered within the community setting and specific standards of proficiency are required in addition to core/shared standards to prepare the nurses to lead and manage the teams and services in these settings within the SPQ. In addition, consideration should be given to the annotation of Criminal Justice Nursing (to include the Prison Nursing service) and Hospice Nursing.

Professional organisation or trade union

4.4.3 Potential consequences

233. Respondents were asked if there are any unintended consequences to the proposal for a new community SPQ qualification, and 399 responses were received, many of which are very similar to points made earlier and some of which are out of scope of the NMC's remit.

a. The main perceived consequence will be the generalisation of the role "community specialist practitioner" causing a dilution of specialist skills and knowledge in specific nursing areas, such as care home and hospice work, as the skills required may be diminished or overlooked in training (107/399).
b. The new title is not clear on what responsibilities it will contain, making it difficult for the public to ascertain what care they need or will receive from this new community specialist practitioner. There is concern that the safety and protection of the public will be at risk because of this (44/399).
c. A generalised SPQ will undermine the role that DNs undertake within the community by potentially causing duplications in patient visits, confusion in the public regarding the differences in practice, and put the role of DN at risk if a new SPQ claims to cover more specialities (35 DNs/399).

In terms of recognition, it will make it difficult for the public and other professionals to recognise what a generic community SPQ actually means, may cause issues in terms of validating programmes and in terms of HEIs being able to financially run them - not having enough students on a generic SPQ programme.

Educator

d. Two organisations note that the proposed SPQ should contain field specific routes, as opposed to a generalised title, to mirror the approach to the SCPHN qualification.
e. Training providers, such as AEIs, HEIs, and universities, may struggle to facilitate the new community specialist role as there will be no supervisors available to provide training, there will be no example standards to follow, and education providers will struggle to train student nurses in every specialism required when the spread of roles has the potential to be so broad. Due to the generalised nature of this SPQ, there is potential for non-uniform training programmes across providers as there is no base programme to develop (39/399).
f. It may unintentionally create barriers for nurses who wish to transition between roles (17/399).

4.5 Recording qualifications

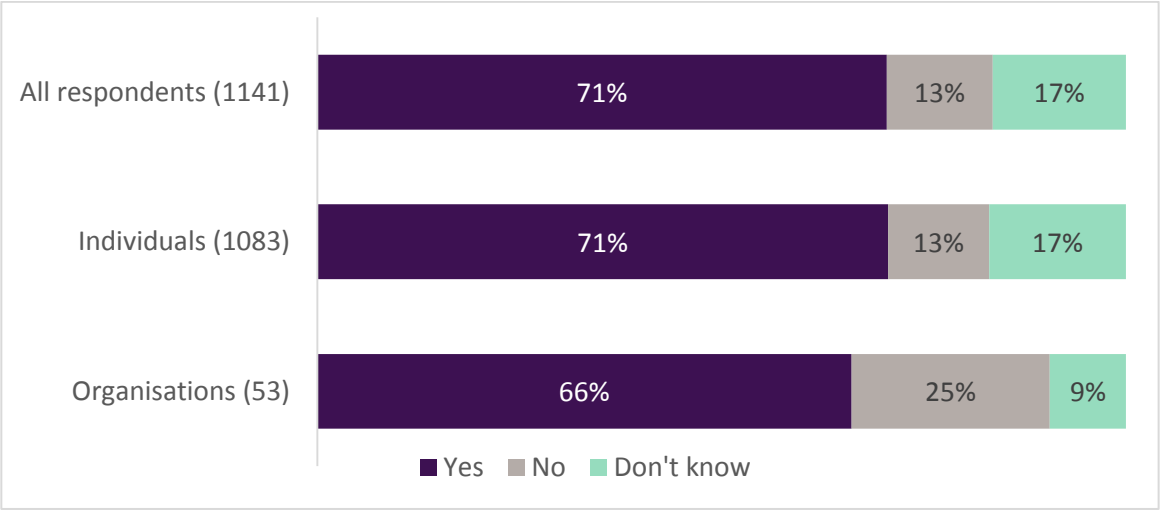
4.5.1 Annotation

234. When an individual has gained the community SPQ, it is annotated next to their name on the register. The NMC proposed that the additional annotation for these qualifications would be:

- Community Nursing SPQ (CCN),
- Community Nursing SPQ (CLDN),
- Community Nursing SPQ (CMHN),
- Community Nursing SPQ (DN),
- Community Nursing SPQ (GPN), and
- Community Nursing SPQ (CSPQ) – see section 4.4 for a discussion on a proposed additional community SPQ.

235. Respondents were asked whether they believe these forms of annotation are appropriate for all six SPQs. Nearly three quarters, 71% (810), of respondents agree they are appropriate, with similar levels of agreement across all four UK nations (n=1,141). Organisations had a slightly lower level of agreement at 66% (35) than individuals at 71% (769) and almost twice the level of disagreement at 25% vs 13%.

Figure 33 Whether these forms of annotation are appropriate for all six SPQs



236. Of the 148 respondents disagreeing with this suggestion, 126 gave their rationale. Of those respondents disagreeing, many view this as an unnecessary change. Their views are summarised below.

a. The format suggested would lead to confusion amongst both nurses and members of the public. The proposed titles would not be understood as the initials have little clarity. SPQ roles would not be adequately described via this generalisation, for example GPN is not equivalent to DN. Some suggested alternatives to the annotations, for instance include writing out the specialities in full (52/126).
b. This generalisation neglects to refer to a selection of other specialist nurses. Examples are care home and social care nursing, mental health nursing and learning disabilities nursing that relate directly to childcare and families, inclusion health (homeless care), and criminal justice care (28/126).
c. DNs note in particular their title should remain the same due to the complexity of their work in comparison to an average community nurse. These respondents believe the title of their role should be directly acknowledged, rather than grouped as a community nursing SPQ (14/126).
d. Confusion about the CSPQ role, as the description is overly vague with a lack of specifics required to accurately define the requirements of the role (7/126).

These are unclear and inconsistent - CSPQ is an 'SPQ' but does not contain 'nurse' and others may, by contrast, be seen as not specialist. 'DN' is also frequently misunderstood in my experience - often assumed to refer to a midwife. Employers would need to check the Register very carefully to avoid mistakes e.g. CLDN contains DN and the public would be very confused by these annotations I think.

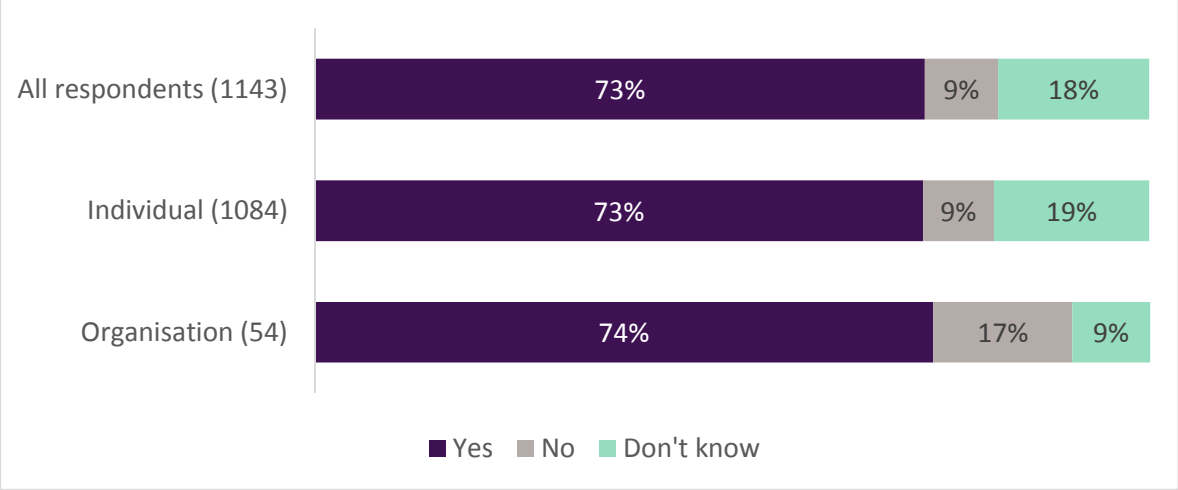
Registered nurse with a community SPQ annotation

4.5.2 Retaining the term "specialist"

237. In pre-consultation engagement, concern was raised about the potential for different interpretations of the term 'specialist', and from a regulatory point of view, this term is no longer considered contemporary. This consultation sought to form a bridge to future work that the NMC has committed to on whether the regulation of advanced practice is needed, and this means that the NMC cannot use the word 'advanced' within this qualification at this time.

238. On this basis, respondents were asked whether the NMC should continue to refer to these qualifications as SPQs. Nearly three quarters, 73% (834), of respondents agree that they should still be referred to as SPQs, with similar levels of agreement across all four UK nations (n=1,143). Organisations had a similar level of agreement 74% (40) to individuals 73% (791) but almost twice the level of disagreement at 17% (9) vs 9% (92) – remaining respondents are unsure.

Figure 34 Whether the NMC should continue to refer to these qualifications as SPQs



239. Of the 103 respondents disagreeing with this suggestion, 69 substantive comments were received on an alternative title. These views are summarised below.

a. The term "specialist" is misleading or has lost the meaning and value associated with it (16/69).
b. Alternatives are "advanced practice", "advanced specialist practitioner" or "enhanced training DN" (13, of which 7 are DNs).
c. ''Community nursing practitioner qualifications" may be more self-explanatory and reduce any misunderstanding (10/69).
d. The word "specialist" in SPQ could be negated. Better to use "DN qualification" or "DNQ" as a simplistic and preferable alternative, as this is more direct and will avoid any confusion between different SPQ roles (5/69).
e. The word "specialist" is due to a lack of consistency across nursing, in which some roles may have the title "specialist" without the prerequisite of an SPQ (5/69).
f. The term is complicated and better to use words such as "enhanced", "independent", "consultant" or "advanced" instead, with specific mention of "advanced community practitioner" (1/69).

"Specialist" does not work for advanced generalist roles. Advanced is the only word to describe a higher level of practice, which needs to apply whatever the setting or care group.

Registered nurse

There are many 'specialist' Community Learning Disability Nurses (for example) who have not got an SPQ. There remains a need for regulation I believe, but removal of the word 'specialist' would also indicate perhaps that it is not a necessity.

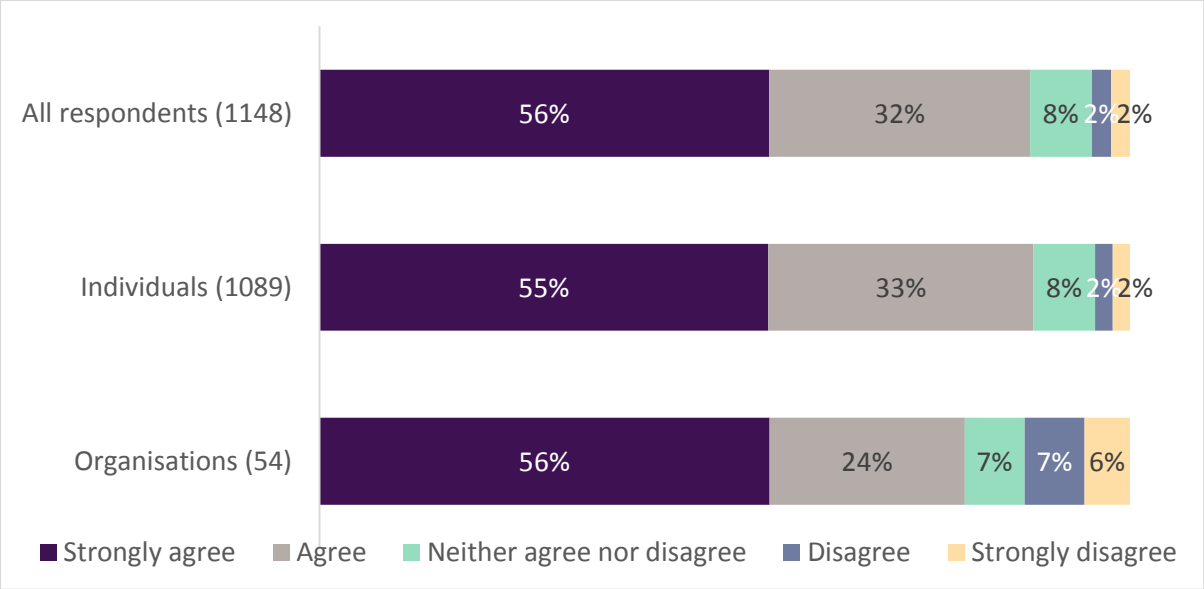
Educator

4.5.3 Regulation of community SPQs

240. During the pre-consultation engagement, some stakeholders queried whether the regulation of community SPQs is necessary. To this end, this consultation asked respondents whether they agree that the NMC should continue to regulate new standards, programmes, and qualifications in community nursing.

241. There is a high level of agreement that regulation should be continued, with 88% (1,010) agreeing or strongly agreeing (n=1,148). Four percent (46) of all respondents disagree or strongly disagree, and among organisational responses this rises to 13% (7). Three organisations providing an offline response explain that they support this proposal as this regulation ensures a high level of accountability, autonomy and knowledge that will protect the public and give them confidence in the quality of their care.

Figure 35 Whether the NMC should continue to regulate new standards, programmes, and qualifications in community nursing



242. Those 46 disagreeing were asked to explain their rationale, and 40 responses were received. Their views are summarised below.

a. The NMC as the governing body gives cause for concern, it is out of touch and underestimates the specialist skills required, and therefore should hand over regulating community nursing elsewhere (10/40).
b. There is no need for this regulation, nurses are already registered with the NMC and will have already accepted accountability and be practising safely. Additionally, bodies such as Quality Assurance Agency for Higher Education (QAA) and the Office for Standards in Education, Children's Services and Skills (Ofsted) are continually quality assuring programmes and qualifications to monitor nurses and believe that additional scrutiny is not needed (9/40).
c. Regulation for community nursing may make it more difficult for nurses to change specialties and make altering career paths increasingly difficult (2/40).

I would have more faith in an alternative organisation to regulate community nursing standards and believe such an organisation would be more representative and inclusive of the community nursing disciplines in question.

Registered nurse with a community SPQ annotation

All nurses and midwives are accountable at the point of registrations. Therefore, we do not believe that the NMC is required to regulate post registration qualifications.

Educator

4.6 Other considerations

243. Respondents were given a chance to add final comments about any part of the proposed SPQ standards, and 389 responses were received. Many of the comments raised points that respondents had already made earlier in the consultation, and which have been explained in the appropriate sections. Some suggestions include aspects of the standards that are potentially missing, and these are included in Appendix D. A different point to those arising before is noted here.

a. Some respondents believe that the new proposed standards are intended to be compulsory for all nurses working in health or social care in the community, which is not the case. These respondents, concerned about the welfare of existing nurses, went on to suggest that a large number of nurses will require more support to meet these standards as the nurses are overworked and lack the energy (due to the effects of Covid-19) to complete more qualifications (32/389).

5. Views on post-registration programme standards: SCPHN and SPQ programmes

244. This chapter presents the feedback received from professionals and responding organisations concerning the draft standards for post-registration programmes: Specialist Community Public Health Nursing (SCPHN) and Specialist Practice Qualifications (SPQ). **Around 62% (1,178) of all respondents chose to answer this set of questions including 69% (56) of all responding organisations.** This section also incorporates the analysis of the responses received offline to the NMC mailbox. Again, as before, the total number of responses described in this chapter varies from question to question and the sample size for the four nations varies accordingly (England - 76%, Scotland - 12%, Wales - 7% and Northern Ireland - 5%).

Figure 36 Number of responses to section on SCPHN and SPQ programme standards

Total responses to the survey by type	N	Total responses to questions about programme standards as reported on in this chapter	N	Percentage of all respondents by type
Individuals	1,809	Individuals	1,122	62%
Organisations	81	Organisations	56	69%
Total	1,890	Total	1,178	62%

245. These draft standards include content relating to entry requirements and entry routes, curriculum, practice learning, supervision and assessment requirements and information on the award, registration and recording of these post-registration qualifications.

Key findings for Chapter 5 – programme standards

- **Around 62% (1178) of all individuals responded to this set of questions plus 69% (56) of all responding organisations (n=1,809 and n=81, respectively).**
- There is strong agreement - 83% (924) with the SCPHN proposals around student selection and admission and 77% (868) agreeing or strongly agreeing with the SPQ proposals (n=1141 and 1128, respectively).
- There is also agreement: 67% (525) agree or strongly agree, while some 11% (86) disagree or strongly disagree that the draft standards will allow providers to be creative and innovative, and to design a curriculum that supports students (n=1071).
- There is however a stronger feeling that course duration should be specified as just under one in three - 31% (351) - disagree or strongly disagree with the SCPHN proposals to not specify the duration programme length (n=1132). There is a slightly lesser feeling for programme length with regard to the SPQ, where just under 24% (265) disagree or strongly disagree (n=1,105).
- Good levels of support exist for the proposals around supervision and assessment - typically over 80% (978 and 918, n=1124 (SCPHN), and n=1107 (SPQ)).

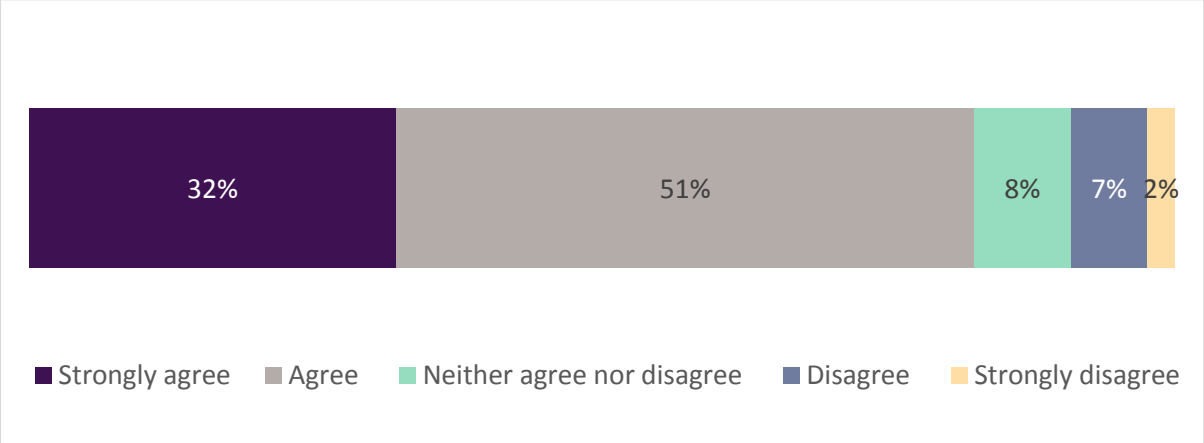
5.1 Student selection and admission

5.1.1 SCPHN – programme entry

246. The NMC is proposing that Level 1[9] NMC registered nurses and midwives can be considered for entry to a SCPHN programme, as long as the applicant is capable of safe and effective practice at a level of proficiency for the intended field of SCPHN practice.

247. The consultation explored the extent of agreement with this proposal. The majority of respondents agree with this proposal, with 83% (924) agreeing or strongly agreeing and less than 10% (103) disagreeing or strongly disagreeing. Similar patterns in response are seen between individuals and organisations, and between respondents from the four UK nations.

Figure 37 Whether Level 1 NMC registered nurses and midwives can be considered for entry to a SCPHN programme



Base: 1141 respondents.

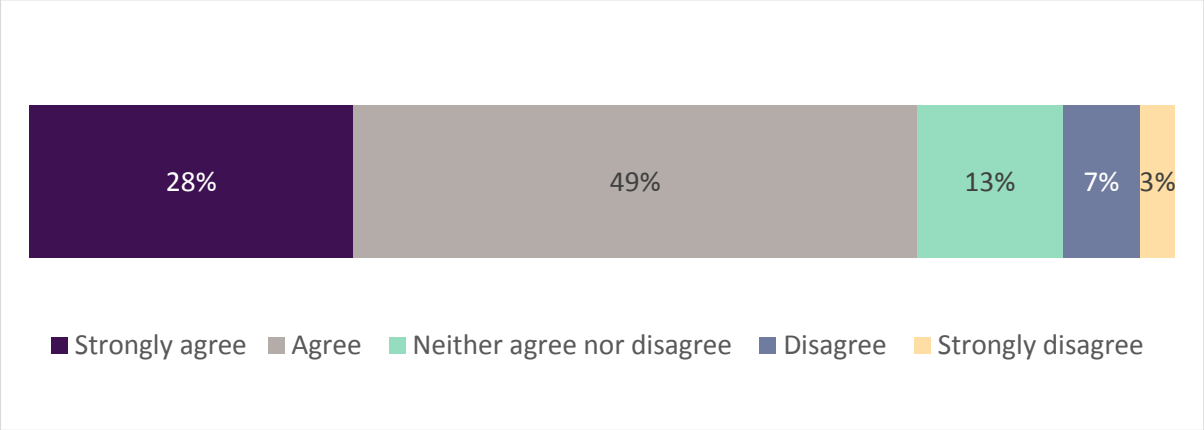
5.1.2 SPQ – programme entry

248. The NMC is further proposing that, in line with entry to existing SPQs, Level 1 NMC registered nurses[10] can be considered for entry to a community SPQ programme that leads to the new proposed SPQ in other intended fields of community nursing practice, as long as the applicant is capable of safe and effective practice at this level of proficiency.

249. The consultation explored the extent of agreement with this proposal. The majority of respondents agree with this proposal, with 77% (868) agreeing or strongly agreeing and 10% (113) disagreeing or strongly disagreeing. Similar patterns in response are seen between individuals and organisations, and between respondents from the four UK nations.

[9] The Level 1 registered nurse title is set out in NMC legislation - 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).
[10] The parts and entries order state that SPQs listed are for first level nurses.

Figure 38 Whether Level 1 NMC registered nurses can be considered for entry to a community SPQ programme that leads to the new proposed SPQ in other intended fields of community nursing practice



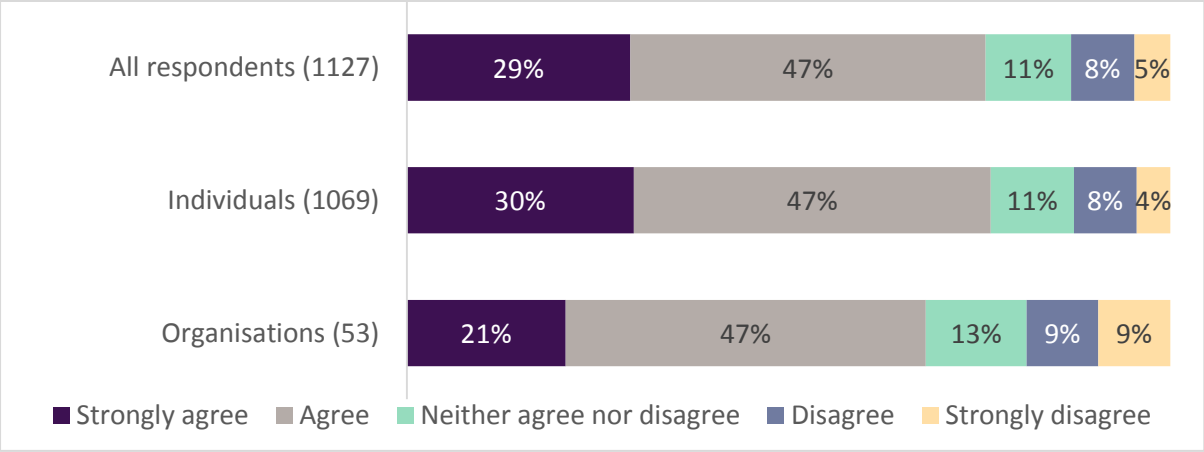
Base: 1128 respondents.

250. In the published nursing and midwifery standards, the NMC set a minimum degree level requirement for pre-registration qualifications. To surpass this, the draft programme standards for post-registration programmes indicate that the minimum academic level for SCPHN and SPQ is to be postgraduate level. The NMC propose that this will give flexibility for Approved Education Institutions (AEIs) across the UK to determine the academic credits for their curricula and programme outcomes.

5.1.3 SCPHN – minimum levels

251. The consultation explored respondents' views on this proposal for SCPHN programmes, to which 76% (857) agree or strongly agree. Respondents in Scotland agree particularly strongly (89% agree or strongly agree), while organisations have a slightly higher level of disagreement than individuals (18% vs 12%).

Figure 39 Whether the draft programme standards should indicate that the minimum academic level for SCPHN should be postgraduate level



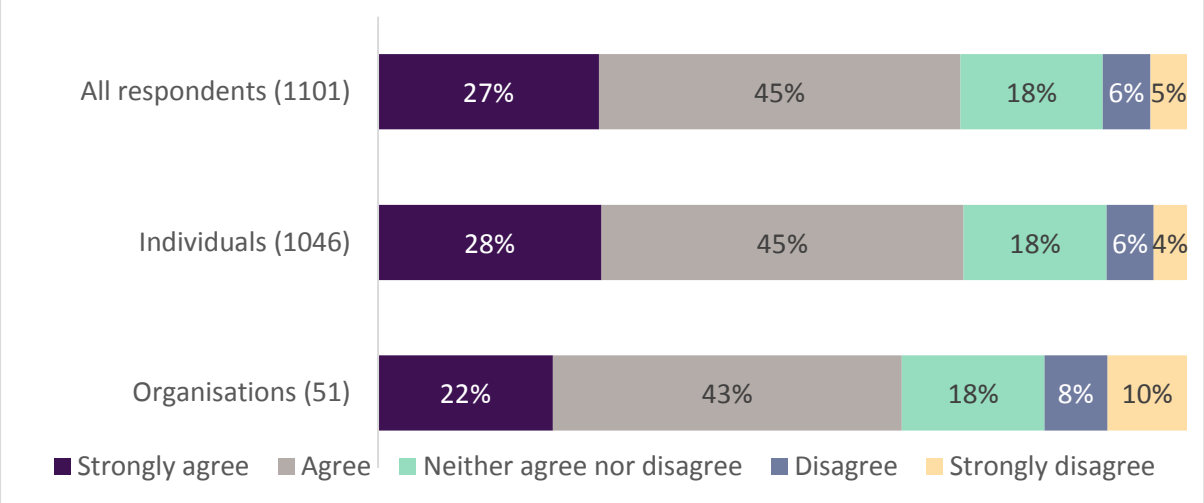
252. Of the 13% (147) respondents disagreeing or strongly disagreeing, 120 provided their rationale. For context, it should be noted that, while these programmes are at postgraduate level, a degree is not necessarily required to enter these programmes, nor do the NMC draft standards indicate that a degree is needed for entry to a programme. Their views are summarised below.

a. The academic nature of degrees and assignment writing may put some people off accessing the qualification which may adversely impact on diversity in this area, thus being unfair to registered practitioners with relevant experience but a diploma qualification (or lower). Recognition of experience is highly valued, and older nurses with a wealth of experience could be put off this career pathway if degrees are valued over skills (40/120).
b. AEIs have the flexibility to determine the academic credits for their curricula and programme outcomes. Whilst the programme length and credits should be clearly stipulated to ensure uniformity in quality and to avoid inequality, organisations tend to agree with the level being postgraduate (17/120).
c. Although not within the NMC's remit, there are other implications such as exacerbating skills shortages in certain nursing roles, with a concern that this perceived exclusion could also prevent individuals from progressing in their careers (15/120).
d. Similarly not within the NMC's remit, the potential financial impact of this proposal for individuals, especially where workplaces are not supportive or bursaries are unavailable, and the lack of pay increase upon completion could lead to inequalities (7/120).

5.1.4 SPQ – minimum levels

253. The consultation also explored respondents' views on the NMC's proposal for SPQ programmes that the minimum academic level is postgraduate level. Overall results are shown in the table below, with 72% (793) either agreeing or strongly agreeing. Respondents in Wales (n= 78 individuals) agree slightly less strongly, 58% (45) agree or strongly agree, and have a higher degree of ambivalence - 26% (20) - answer neither agree nor disagree. Responses from other nations are similar to the overall picture.

Figure 40 Whether the draft programme standards should indicate that the minimum academic level for SPQ should be postgraduate level



254. In total 85 responses were received from the 11% (121) disagreeing as shown above. Very similar themes were presented as for SCPHN. And, as before, a degree is not necessarily required to enter these programmes nor do the NMC draft standards indicate that a degree is needed for entry to a programme.

a. This approach could exclude individuals for example, that having a degree may be a significant barrier for many nurses who are qualified to diploma level stage. Experience and examples of nurses who are 'brilliant at their jobs' without being qualified to a degree or postgraduate level is important. There is a perceived impact on diversity (45/85).
b. AEIs have the flexibility to determine the academic credits for their curricula and programme outcomes (12/85).

5.2 Curriculum and programme structure

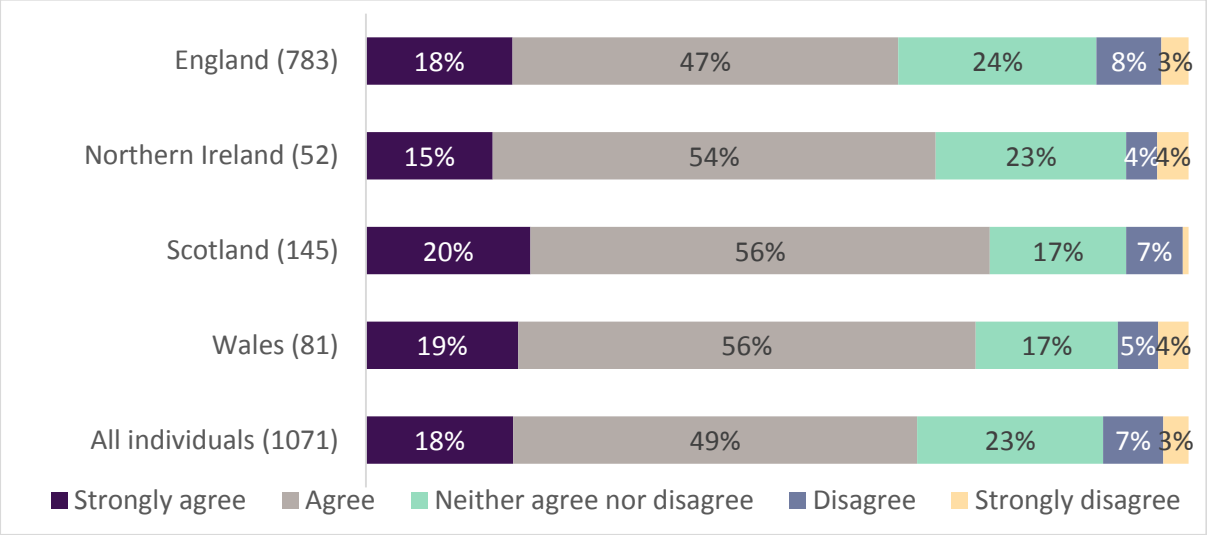
255. The consultation went on to explore respondents' views on the design of the programme standards and asked whether the design enables education providers and their practice partners to be creative and innovative in the way they develop programmes.

5.2.1 Design of programme standards

256. The overall picture is shown in the figure below, with 67% (525) either agreeing or strongly agreeing. Respondents in Scotland 76% (110) and Wales 74% (60) agree slightly more strongly.

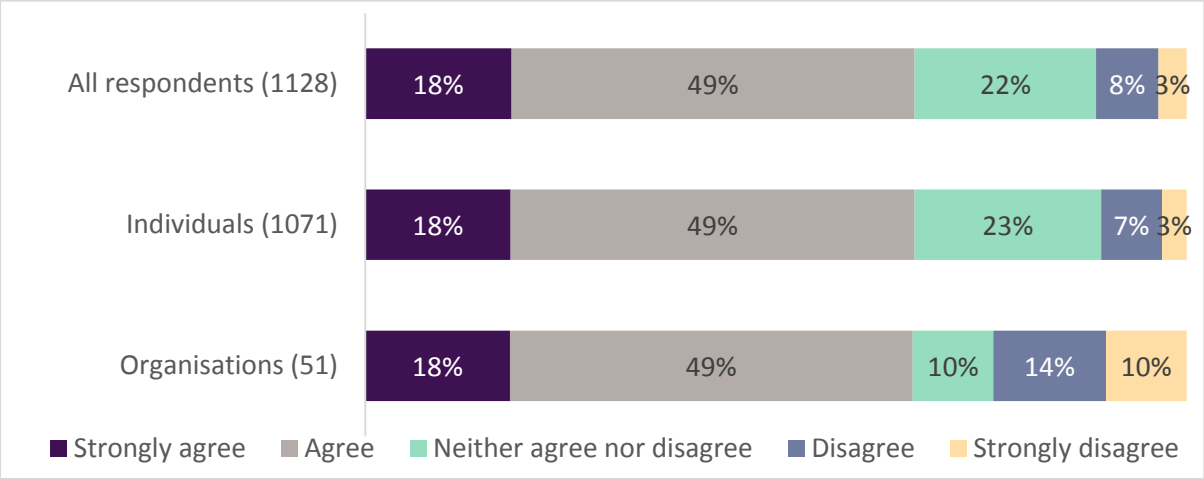
> *The approach for AEIs, together with their learning partners, to plan the design of curriculum presents opportunities for flexibility to decide on [the] ratio of theory to practice.*
>
> Professional organisation or trade union

Figure 41 Whether the design of the programme standards enables education providers and their practice partners to be creative and innovative in developing programmes, by respondents' nation



257. Organisations have a higher level of disagreement than individuals (24% vs 10%), although 82% (18) of education providers agree (n=22).

Figure 42 Whether the design of the programme standards enables education providers and their practice partners to be creative and innovative in the way they develop programmes

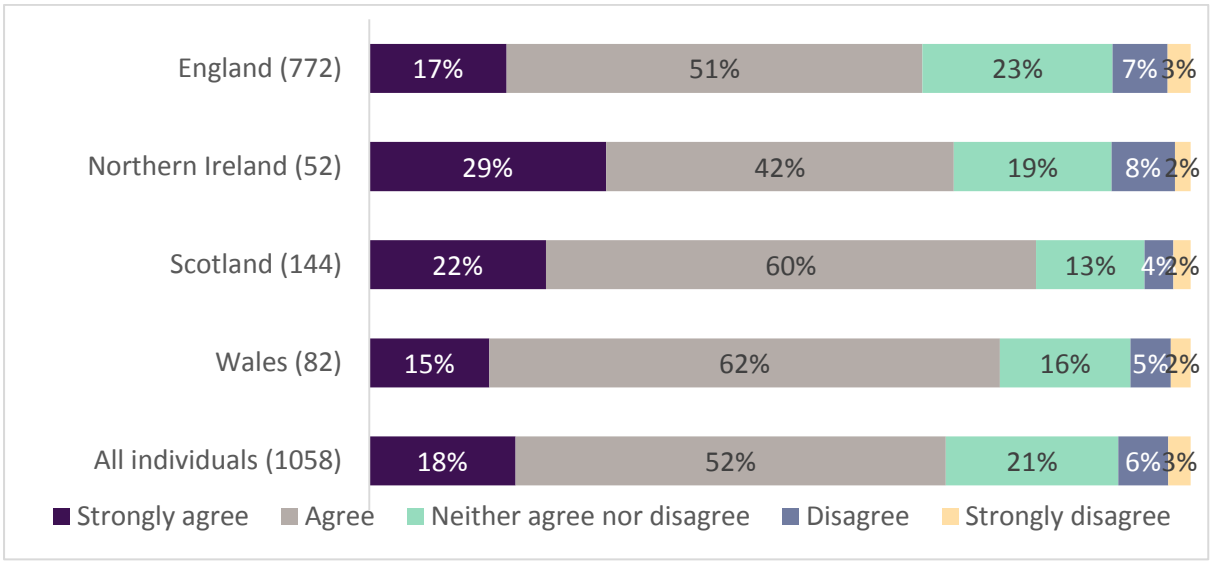


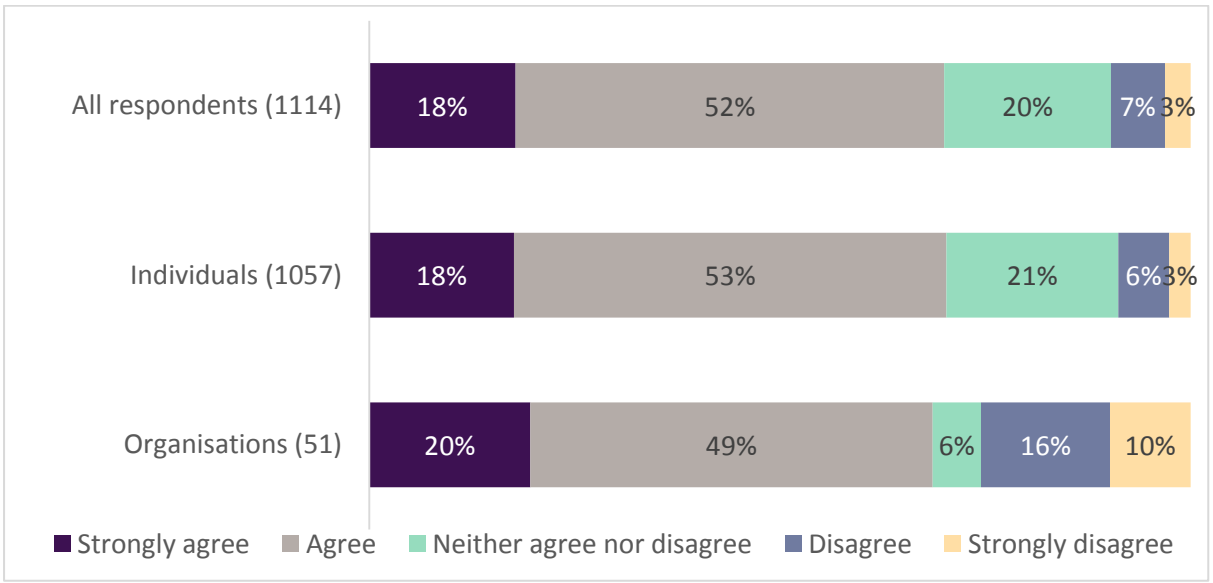
258. The consultation next explored whether the draft standards will enable Approved Education Institutions (AEIs), together with their practice learning partners, to design a curriculum which supports students in meeting programme outcomes for their intended field of SCPHN practice (HV, OHN, and SN).

5.2.2 SCPHN – curriculum design

259. Over two thirds 70% (740) of all respondents agree or strongly agree, while some 10% (106) disagree or strongly disagree. Respondents in Scotland 81% (117) and Wales 77% (63) agree slightly more strongly.

Figure 43 Whether the draft standards will enable AEIs, together with their practice learning partners, to design a curriculum which supports students in meeting programme outcomes for their intended field of SCPHN practice, by respondents' nation (top) and type (bottom)





260. A quarter - 26% (13) - of organisations disagree or strongly disagree with this. Around three quarters 76% (16) of responding education providers agree or strongly agree (n=21).

261. Of the 10% of respondents disagreeing or strongly disagreeing, a total of 82 responses were received to explain their rationale. Their views are explained below.

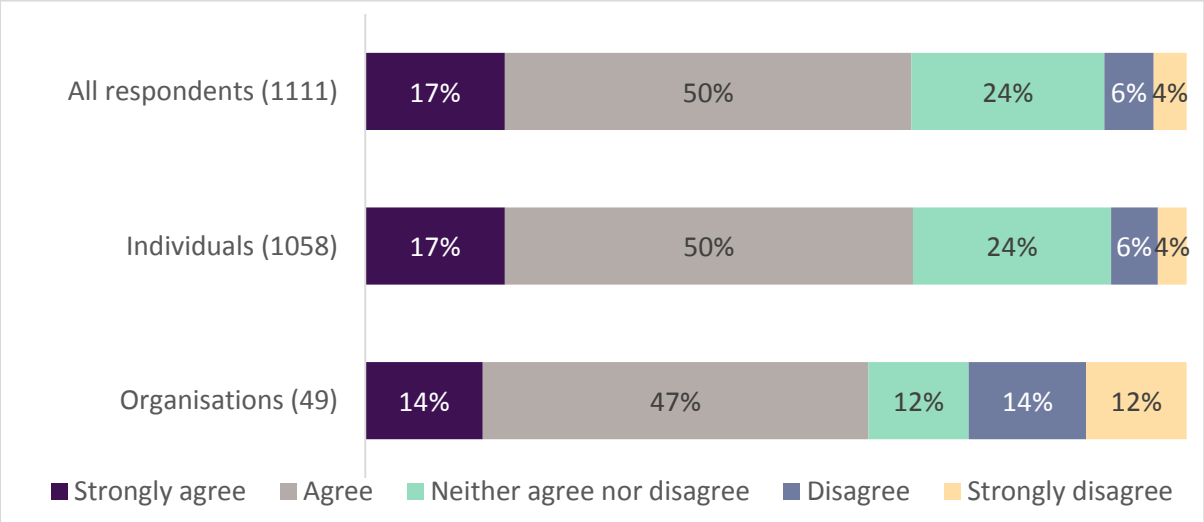
a. The draft standards allow too much variation and allow AEIs too much freedom. This could result in poorer outcomes for some students or AEIs, which in turn could affect patient safety levels. Therefore, respondents argue that there is a need to be more specific (42/82).
b. There needs to be a consistent approach across the UK (5/82).
c. The programme standards are not only too generic, but the standards should be more role specific, particularly for OHN (3/82).
d. It will be challenging to meet the expectations set out in the programme standards, as some standards will not only be difficult to gain experience in due to lack of opportunity, but some may also be challenging to evidence in practice (14/82).

5.2.3 SPQ – curriculum design

262. The consultation also explored whether the draft standards would enable AEIs, together with their practice learning partners, to design a curriculum which supports students in meeting programme outcomes for their intended field of SPQ practice (CCN, CLDN, CMHN, DN, GPN and the proposed new community SPQ).

263. In total, 67% (744) of respondents agree or strongly agree with this, while some 10% (111) disagree or strongly disagree. Around 77% (110) of respondents in Scotland agree to a greater extent, while a quarter of organisations (26%) disagree or strongly disagree with this (n=110). Around three quarters, 73% (16), of responding education providers agree or strongly agree (n=22).

Figure 44 Whether the draft standards will enable AEIs, together with their practice learning partners, to design a curriculum which supports students in meeting programme outcomes for their intended field of SPQ practice



264. In total 79 responses were received from respondents disagreeing or strongly disagreeing with this proposal. There are similar themes to those concerns raised about the same proposal for SCPHN, with the most common concern being the risk of variation and potential of a lack of consistency.

a. Standards bespoke to each field of practice need to be developed, otherwise – respondents argue – there is a risk that learning may be diluted in critical areas for each specialist role. It is therefore important to set out the length of the course and the proportion of time spent in clinical practice, otherwise variation could lead to disparities in patient safety and could also devalue the course for professionals (35/79).
b. There is a need for a standardised UK-wide approach, otherwise there is currently too much room for regional and national variation (4/79).

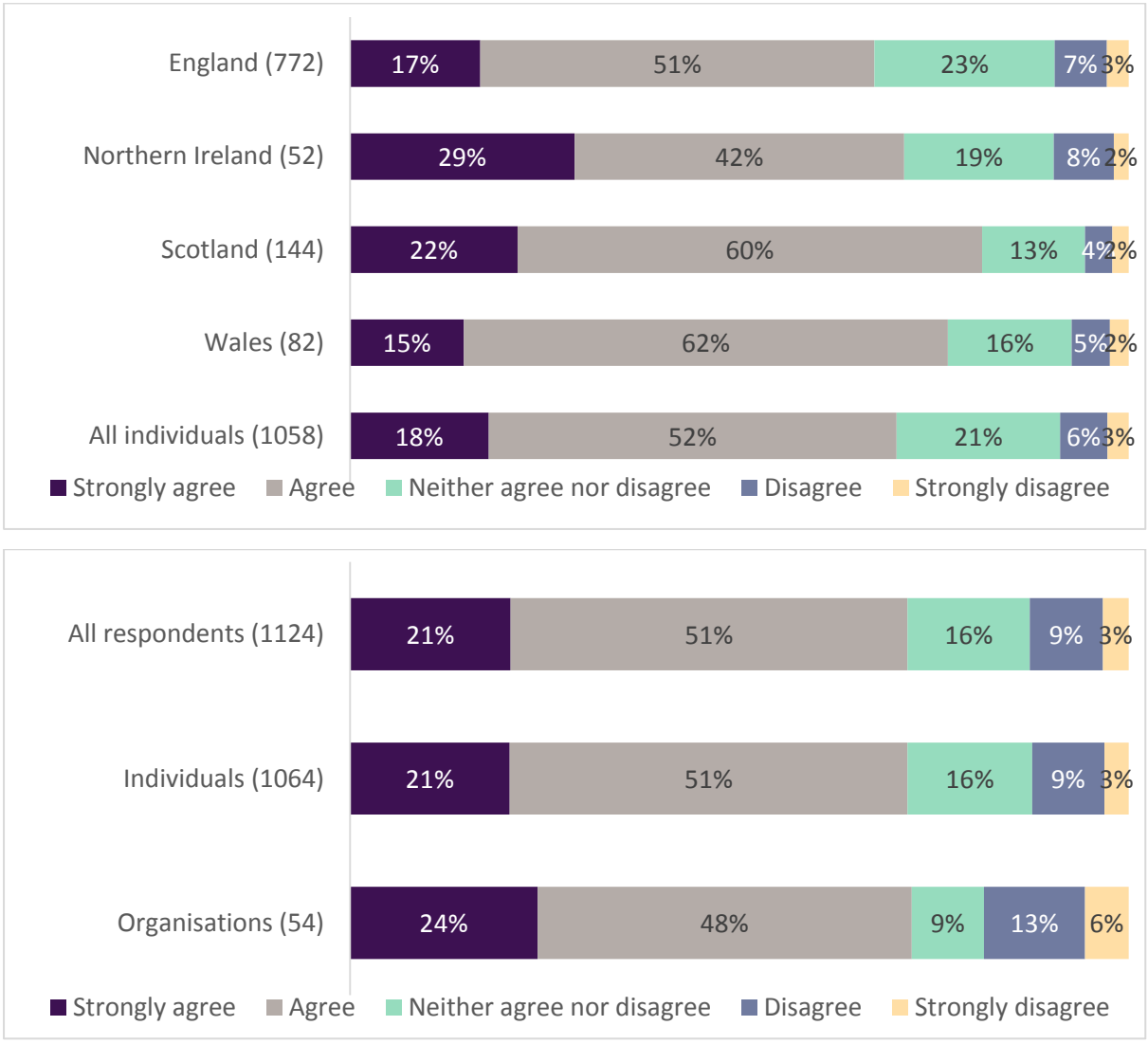
5.2.4 Integrating theory and practice into the curriculum

265. The consultation explored whether AEIs, together with their practice learning partners, should have the flexibility to decide how theory and practice are integrated into the curriculum to support students to meet the programme outcomes.

5.2.5 SCPHN – theory and practice

266. Seventy two percent (761) of all respondents agree or strongly agree that AEIs should have flexibility for SCPHN programme outcomes. Individual respondents in Scotland and Wales agree to a slightly greater extent 78% (112 and 64 in each nation), while 21% (5) of organisations disagree or strongly disagree with this (England n=24). There was no disagreement to the proposal among organisations in Scotland, Northern Ireland, and Wales (total responses, Scotland 10, Northern Ireland 6, and Wales 7).

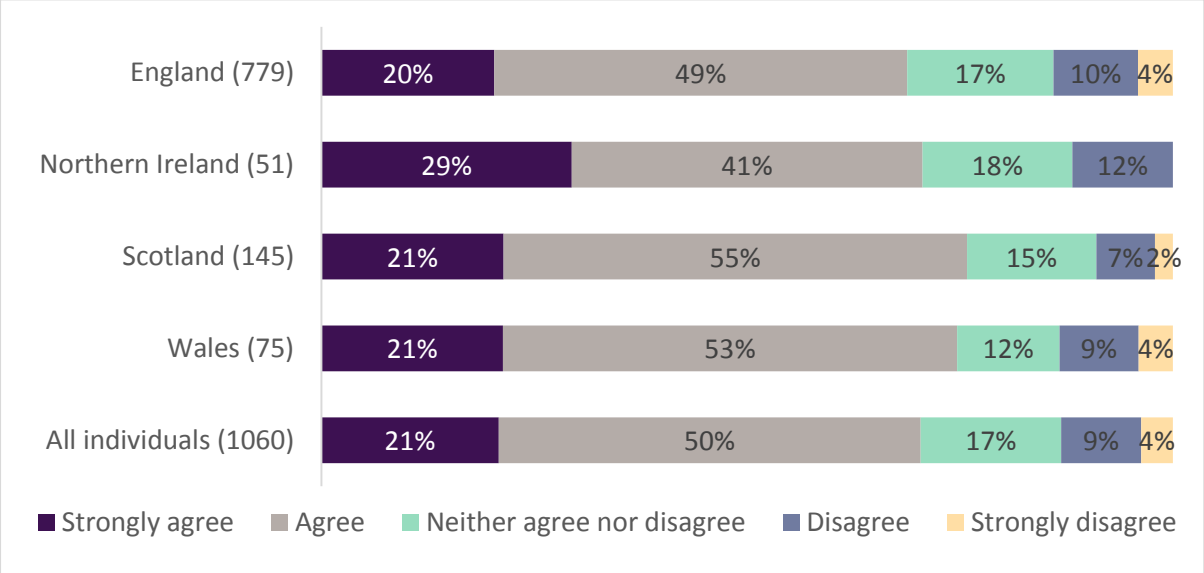
Figure 45 Whether AEIs, together with their practice learning partners, should have the flexibility to decide how theory and practice are integrated into the curriculum to support students to meet the SCPHN programme outcomes, by respondent nation (top) and type (bottom)

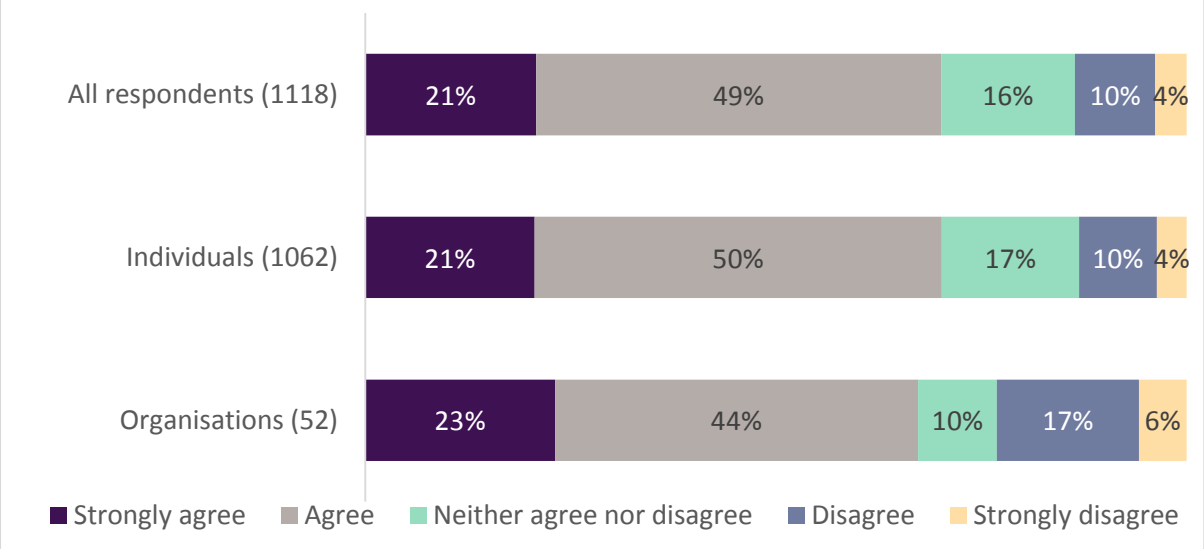


5.2.6 SPQ – theory and practice

267. Seventy percent (742) of respondents agree or strongly agree that AEIs should have the flexibility to decide how theory and practice are integrated into the curriculum to support students to meet the SPQ programme outcomes. Respondents in Scotland and Wales agree to a slightly greater extent (76% and 75% in each respective nation agree or strongly agree). Just under a quarter - 23% (12) - of organisations disagree or strongly disagree with this.

Figure 46 Whether AEIs, together with their practice learning partners, should have the flexibility to decide how theory and practice are integrated into the curriculum to support students to meet the SPQ programme outcomes, by respondents' nation (top) and type (bottom)





5.2.7 Programme length

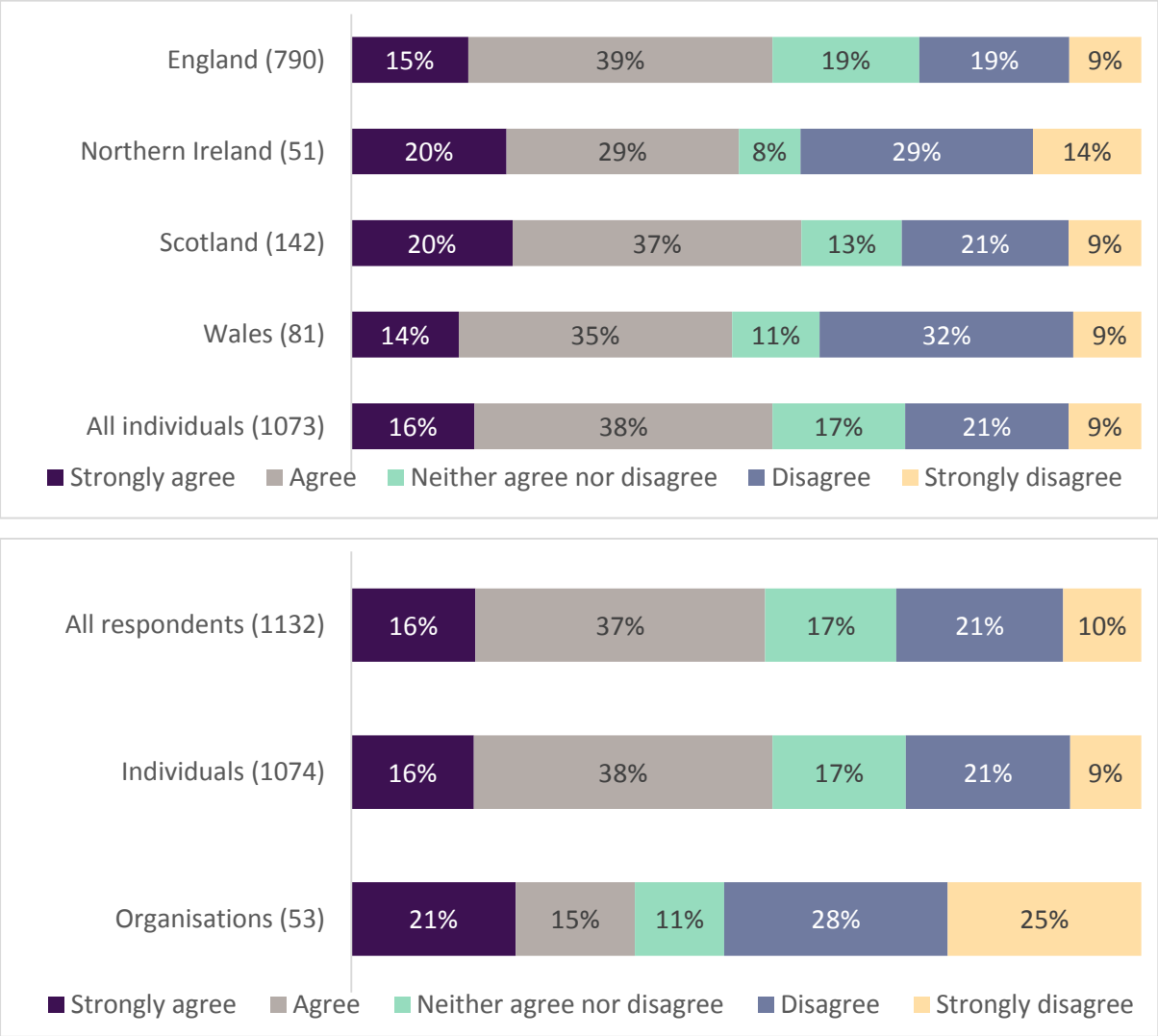
268. The draft outcome focused programme standards do not specify the duration of SCPHN and SPQ programmes, giving AEIs, together with their practice learning partners, flexibility to develop programmes of suitable length that the NMC intends will support student achievement of proficiencies, programme outcomes and the qualification to be awarded. The consultation explored respondents' views on this proposed approach.

5.2.8 SCPHN – programme length

269. Overall, 53% (600) of the 1132 respondents agree or strongly agree with the proposal not to specify the duration of SCPHN programme length, while 31% (351) - disagree or strongly disagree.

There were some differences in views between the four countries of the UK, as shown in the tables below.

Figure 47 Whether the draft standards should not specify the duration of SCPHN programmes, by respondents' nation (top) and type (bottom)



270. Meanwhile, just over one in three - 36% (19) – of organisations agree to some extent with this proposed approach and over half - 53% (28) - disagree or strongly disagree.

271. Respondents disagreeing or strongly disagreeing with this proposal were given opportunity to explain their answer, and 309 responses were received. These responses are detailed below.

a. The length and duration of the course should be standardised, with a stipulated timeframe set by the NMC to alleviate unwarranted variation and inequalities in delivery and outcomes and across nations. The current approach leaves too much room for discrepancies (276/309).
b. A non-standard programme length will result in quality being lowered and the course being devalued with consequences of variation in training will lead to varying quality and calibre of graduating students in terms of their skills,

preparedness and competency in practice. Shorter courses might become the norm in order to attract more students and cut costs (138/309).

c. A minimum timeframe (see below) should be set in order to achieve realistic and meaningful learning and development of skills. While reasonable adjustments are recognised, there should also be a maximum timeframe, with some respondents arguing that some students may take too long – perhaps an indication of their competence (57/309)
d. Suggested minimum timeframes should be set:
    - No less than 12 months (mentioned by 21 respondents)
    - No less than 18 months (4)
    - No less than nine months (2).

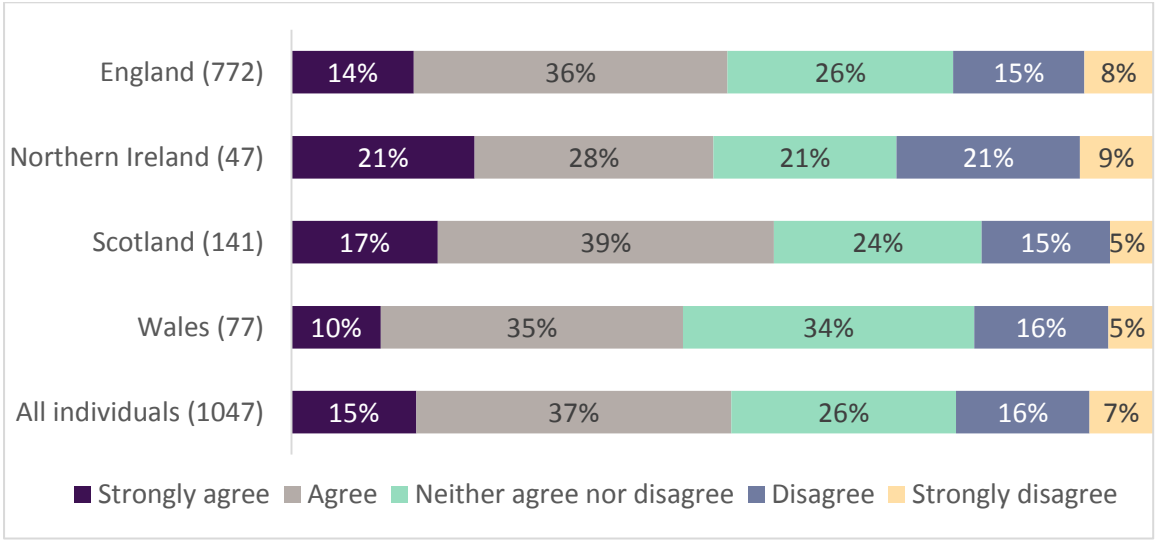
The risk here is that budgetary pressures will lead to the development of the shortest programme. This is likely to lead to inequality in the preparation of SCPHNs with those areas that have more resources having longer programmes…. We already have noticeable variation in the preparation of HVs which causes issues when they move areas and find they are not competent in an aspect that those educated in that area are. This limits movement and poses a risk to practice.

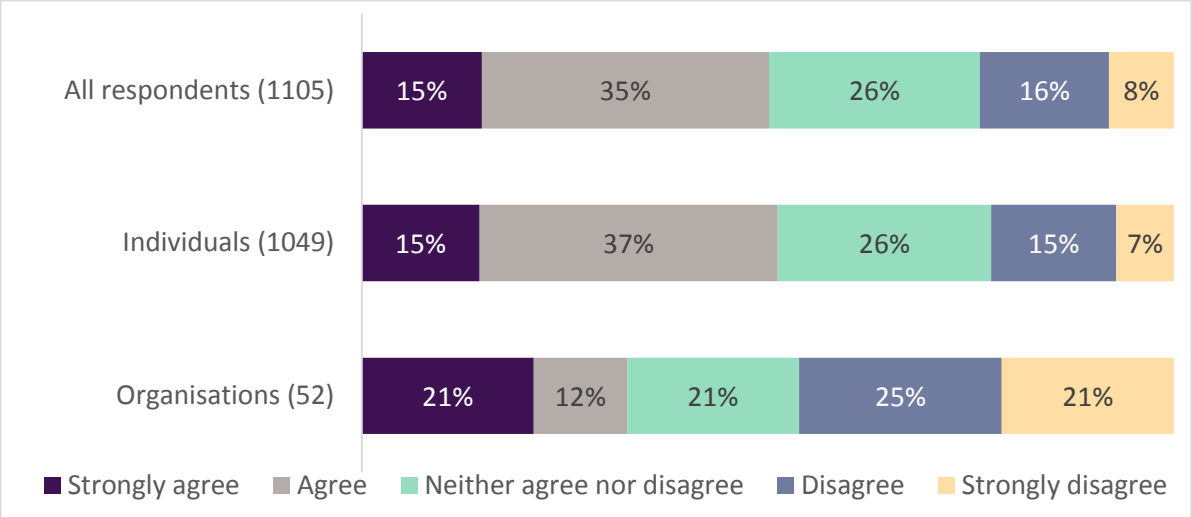
Registered nurse with SCPHN

5.2.9 SPQ – programme length

272. For SPQ programmes 50% (552) of 1,105 respondents agree or strongly agree with the proposal to not specify the duration of SPQ programme length. Meanwhile, 46% (24) of organisations disagree or strongly disagree.

Figure 48 Whether the draft standards should not specify the duration of SPQ programmes, by respondents' nation (top) and type (bottom)





273. Of the 24% (265) disagreeing or strongly disagreeing with this proposal, 210 responses were received in explanation of their answer. As before, there are similar themes emerging for SPQ as for the same proposal for SCPHN and these are summarised below.

a. There should be a stipulated timeframe set by the NMC to ensure the length and duration of the course is standardised. This would alleviate unwarranted variation and concerns about course quality and inequalities across nations in delivery and outcomes, as the proposed approach allows too much freedom which could lead to discrepancies (161/210).
b. Fears that AEIs could be driven by costs in a "race to the bottom" as explained before (30/210).
c. A minimum timeframe, such as 12 months (6) and 9 months (1), needs to be set to achieve realistic and meaningful learning and development of skills (30/210).

5.2.10 Consolidated practice period

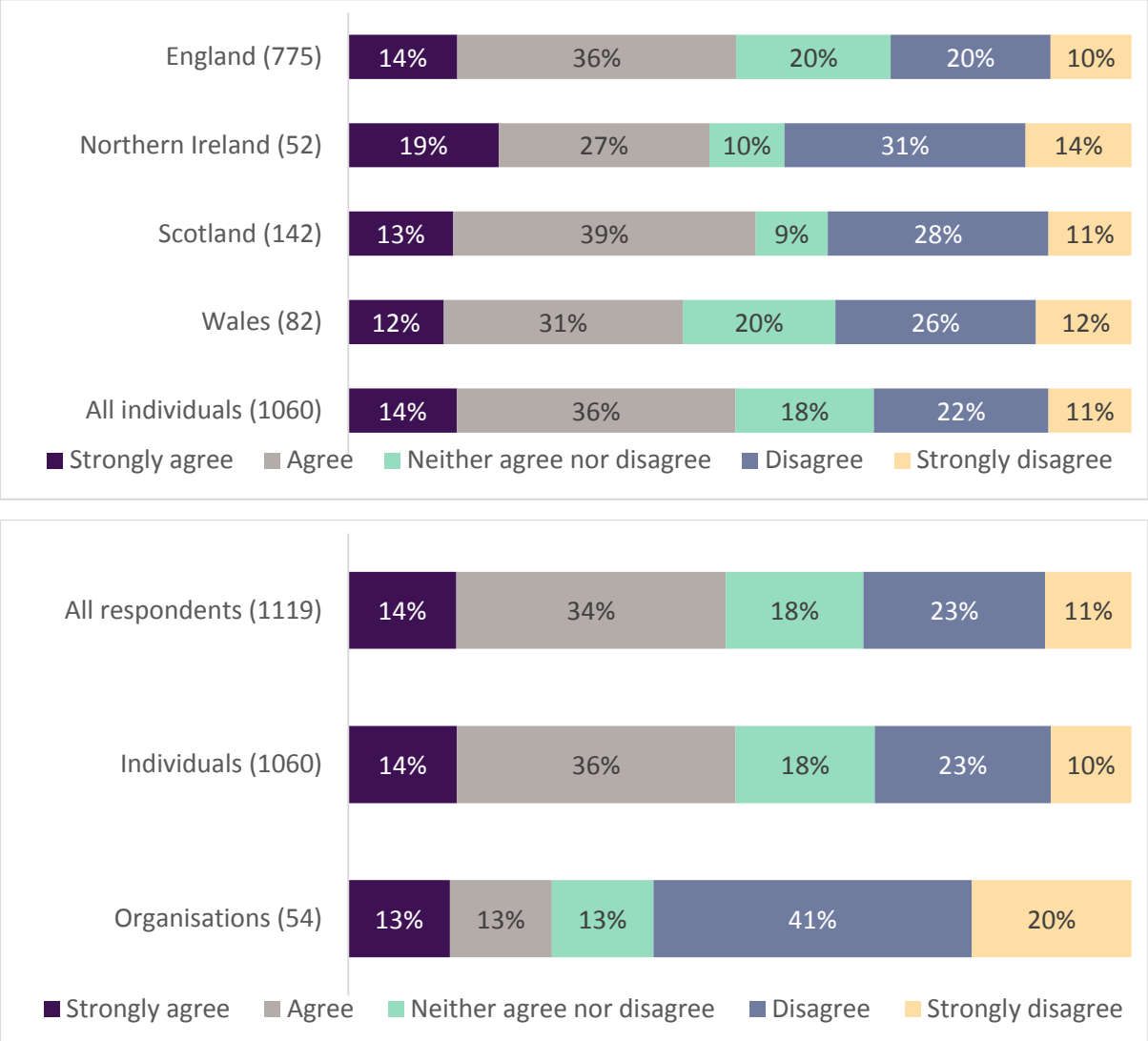
274. The draft outcome focused programme standards do not stipulate the requirement for SCPHN and SPQ programmes to have a specified period of consolidated practice.[11] The NMC noted in its consultation that this gives AEIs and their practice learning partners the flexibility to develop programmes that support continuous student achievement of proficiencies, programme outcomes and the qualification to be awarded.

5.2.11 SCPHN - consolidated practice period

275. As shown in the figure below for SCPHN programmes, 48% (509) agree or strongly agree with the proposed approach to not stipulate the requirement to have a specified period of consolidated practice. While Northern Ireland and Wales show similar levels compared to the overall picture, 43% (Northern Ireland) and 39% (Wales) disagree or strongly disagree.

[11] Previous standards indicated a timeframe for undertaking practice in a defined area of practice.

Figure 49 Whether the draft standards should not stipulate the requirement for SCPHN programmes to have a specified period of consolidated practice, by respondents' nation (top) and type (bottom)



276. Meanwhile 26% (14) of organisations agree to some extent with this proposed approach and over half - 61% (33) - disagree or strongly disagree.

277. Of the 34% (380) respondents disagreeing or strongly disagreeing with this proposal, 310 responses indicate a strong preference for the benefits of consolidated practice.

a. The importance of consolidated practice is a crucial element of learning for students to apply learning and strengthen their practice in a safe and supportive environment, without academic pressures (165/310).
b. The timeframe should be a standardised requirement to achieve parity and equity across all organisations and students with a stipulated time period dictated by the NMC. Several (predominantly respondents in England and Scotland) are particularly concerned about the possibility of regional disparities and advocate for a national standard across the UK (162/310).

c. Benefits (in no particular order) which (23/310) respondents highlight include practising:

- autonomy,
- caseload management,
- time management,
- ability to build rapport with patients/families/clients,
- analysis and critical thinking,
- confidence and competence in practice,
- opportunity to practise leadership,
- safety (for students and public), and
- recognising strengths and weaknesses to work on.

d. Concerns about the detrimental impact of losing consolidated practice altogether. Students who do not have (enough of) this can result in their dropping out (11/310).
e. There could be too much variation leading to inequalities and inconsistency (51/310).
f. Specific recommendations for a minimum timeframe ranging from 6 weeks to 2 years:

- 10 weeks (mentioned by six respondents),
- 3 months (two respondents), and
- 12 months (two respondents).

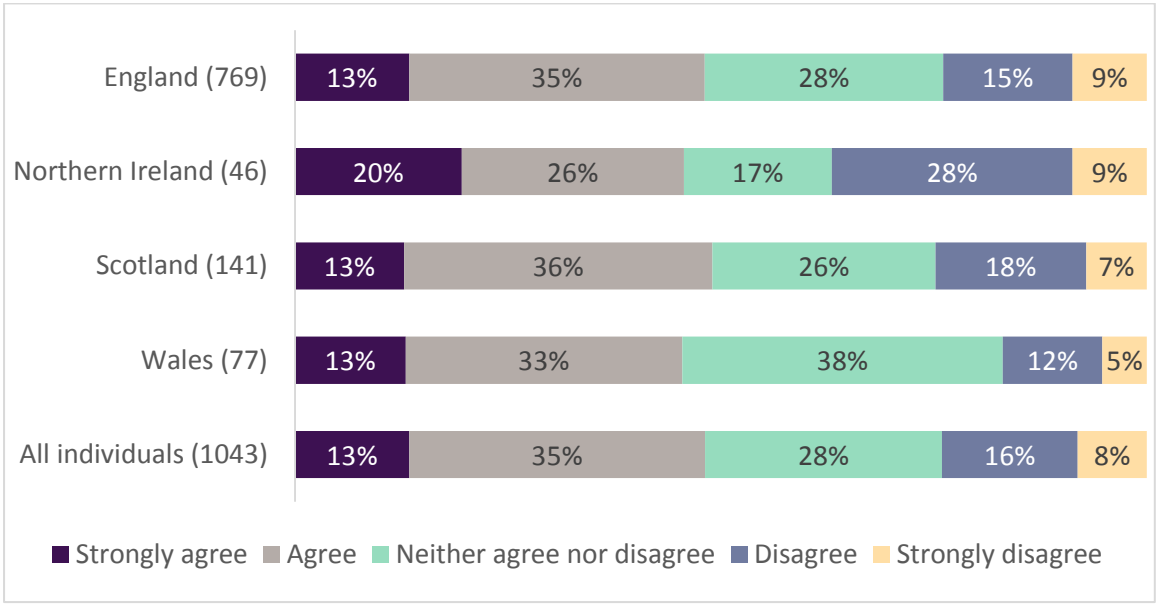
It is always [good for] student SCPHN HV's to take more responsibility but still have a student status should they encounter any issues they need enhanced support with prior to becoming fully qualified.

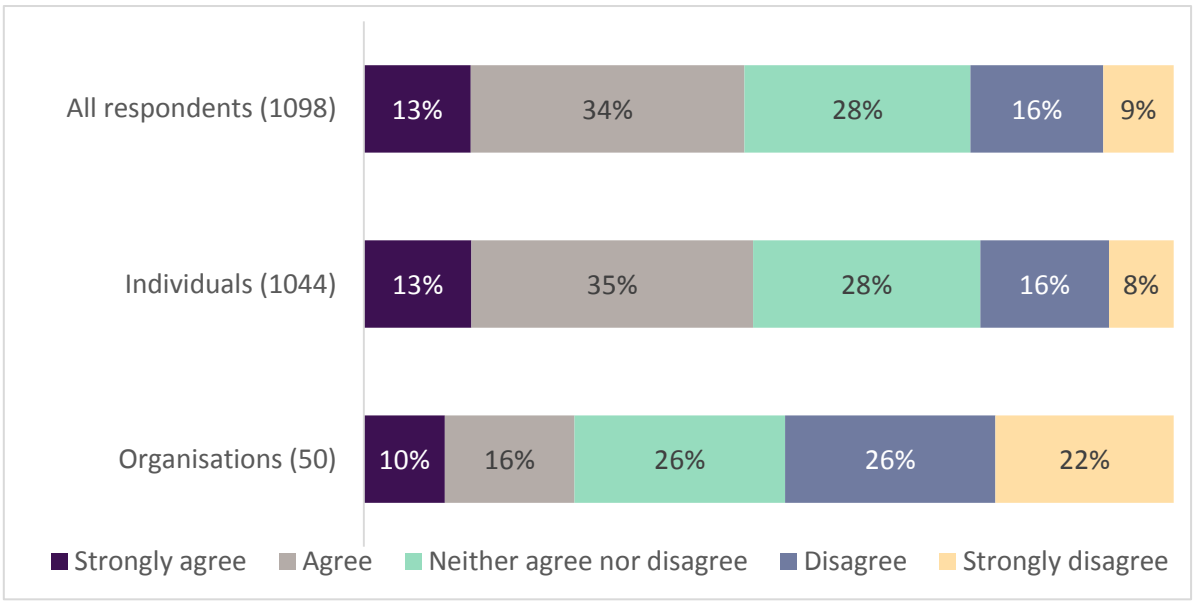
Registered nurse with SCPHN

5.2.12 SPQ -consolidated practice period

278. As shown in the figure below, for SPQ programmes, just under half - 47% (516) – of all respondents agree or strongly agree with the same proposed approach to not stipulate the requirement to have a specified period of consolidated practice. Some 37% of respondents in Northern Ireland disagree or strongly disagree. Meanwhile, nearly half of organisations - 48% (24) - disagree or strongly disagree with this proposed approach.

Figure 50 Whether the draft standards should not stipulate the requirement for SPQ programmes to have a specified period of consolidated practice, by respondents' nation (top) and by type (bottom)





279. Twenty five percent (275) disagree or strongly disagree with this proposal, of which 200 responses were received and summarised below, but again with very similar themes as before including the positive benefits of consolidated practice (74/200).

a. There could be too much variation that may lead to inequalities and inconsistency and leading on from concerns about the quality of the course and overall impact on public protection (53/200).
b. There is a fear that otherwise students may be signed off too early without sufficient preparation in order to meet staffing demands (10/200).

c. The timeframe should be standardised to achieve parity and equity across all organisations and students. A stipulated time period has many benefits that can be incorporated into student learning (15/200).
d. Three respondents give more specific timeframe suggestions, ranging from six to 15 weeks.
e. Two respondents mention that the credits should also be specified, with one organisation stating that the programme standards should specify that this qualification is a full Masters programme of 180 credits.
f. One organisation responding offline via the NMC mailbox highlights wider issues of practice learning including digital learning and development availability, and the digital capabilities of lecturers.

Consolidated practice is an essential period that allows the student to develop their skills in a supportive environment. We currently have variation and the programmes with consolidation result in a more confident, prepared and empowered professional from feedback from practice partners.

Education provider

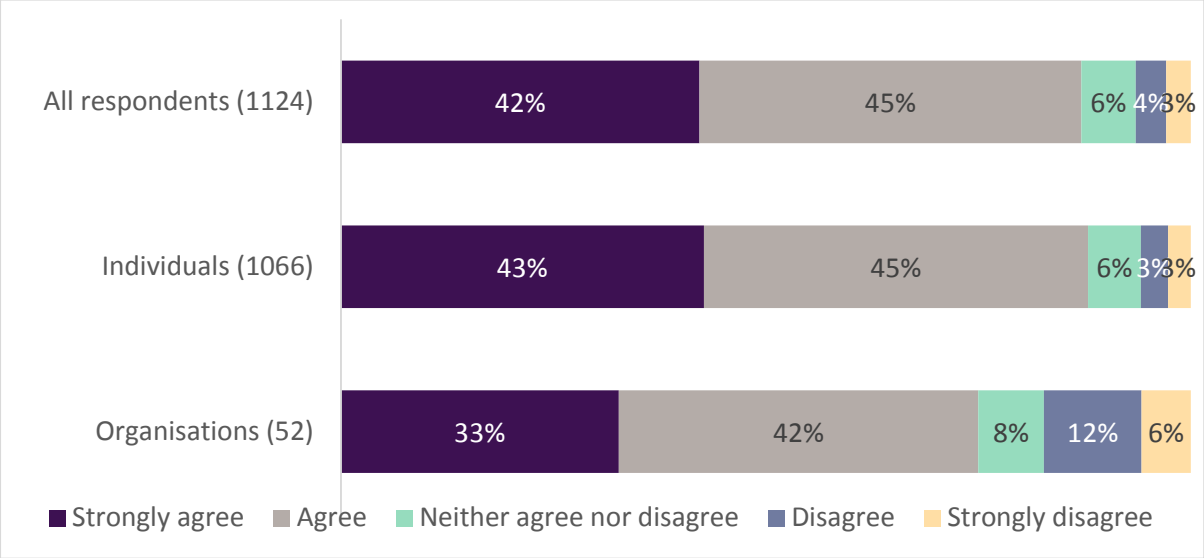
5.3 Complying with NMC standards for student supervision and assessment

280. The NMC is proposing that the supervision and assessment of post-registration SCPHN and SPQ students must comply with the NMC standards for student supervision and assessment. These state that practice supervisors and practice and academic assessors should be suitably prepared, and should receive ongoing support to fulfil their roles when supervising and assessing these post-registration students.

5.3.1 SCPHN student supervision and assessment

281. As shown in the figure below, 87% (978) agree or strongly agree with the proposal on supervision and assessment of SCPHN post-registration students. Responding organisations have a higher level of disagreement than individuals (18% vs 6%).

Figure 51 Whether the supervision and assessment of post-registration SCPHN students must comply with the NMC standards for student supervision and assessment



282. Of the 7% (79) disagreeing or strongly disagreeing with this proposal 59 provided a rationale for their selection. These are summarised below.

a. There is still a role for the practice teacher or a specialist role for teaching and assessing, possibly through the use of an additional qualification to ensure student SCPHNs receive specialist knowledge, leadership and teaching. Assessors need to understand the complexity of these roles (27/59).
b. Colleagues can be asked to be practice supervisors despite not wanting to teach or having the skills and ability to do so, which can result in poor outcomes for students and patients. High caseloads can impact the time and resources staff have available to support students, so ensuring that there is adequate support available for supervisors and assessors is equally important for some. Some mention a belief there is a lack of practice supervisors and practice assessors available, particularly in the areas of HV and OHN (10/59).
c. The term "suitably qualified and prepared" is open to interpretation and may potentially mean that organisations could decide these criteria for themselves (5/59).

Students should have practice assessors that are very well prepared to supervise and assess the students, however the SSSA guidance has removed the 'practice teacher' role and already in practice we are seeing a decline in the supervision and assessment of post-reg students as a consequence of this….

Education provider

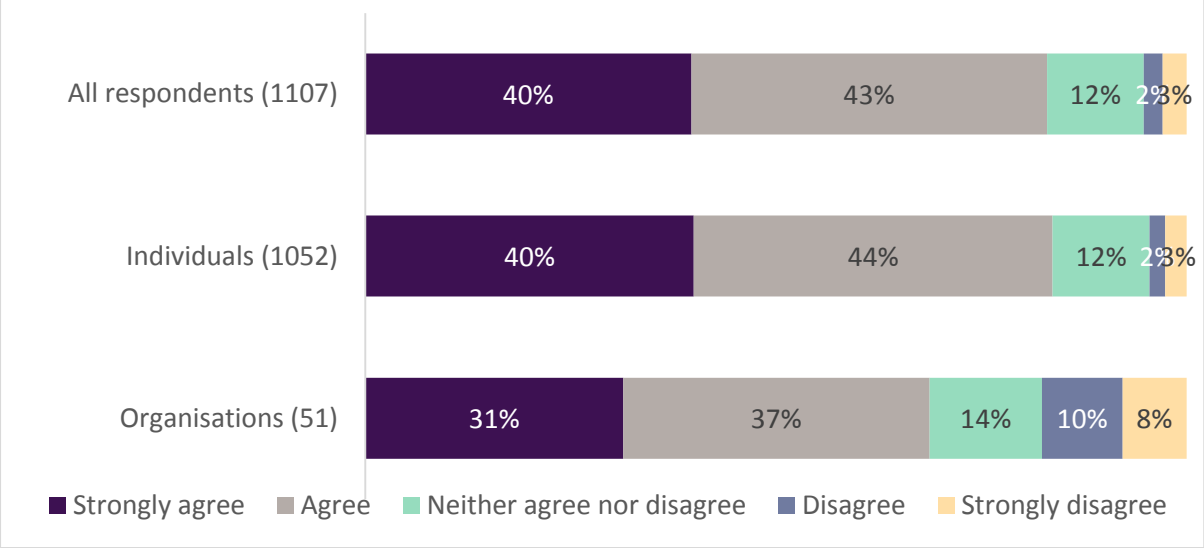
The preparation of the PA/PS [Practice Assessors/Practice Supervisors] in accordance with the SSSA [Standards for Student Supervision & Assessment] is not adequate to prepare the PA/PS in relation to the assessment and supervision of the SCPHN student.

Registered nurse with SCPHN

5.3.2 SPQ – student supervision and assessment

283. As shown in the figure below, for SPQ post-registration students 83% (919) agree or strongly agree. Responding organisations have a higher level of disagreement than individuals (18% vs 5%).

Figure 52 Whether the supervision and assessment of post-registration SPQ students must comply with the NMC standards for student supervision and assessment



284. Of the 5% (55) disagreeing or strongly disagreeing, 40 responses were received, again with similar themes emerging to those concerns raised about the same proposal for SCPHN.

a. There needs to be better guidelines set for assessor and supervisor roles to avoid inconsistent outputs (31/40).
b. Assessors should also be of a higher standard than the student and may need additional preparation to enable sign off at this specialist level (6/40).

There are reportedly misconceptions of the differences in Practice supervisor and Practice Assessors particularly in General Practice Nursing as most often there is only one other qualified nurse in a position to support any trainee GPNs.

Registered nurse with a community SPQ annotation

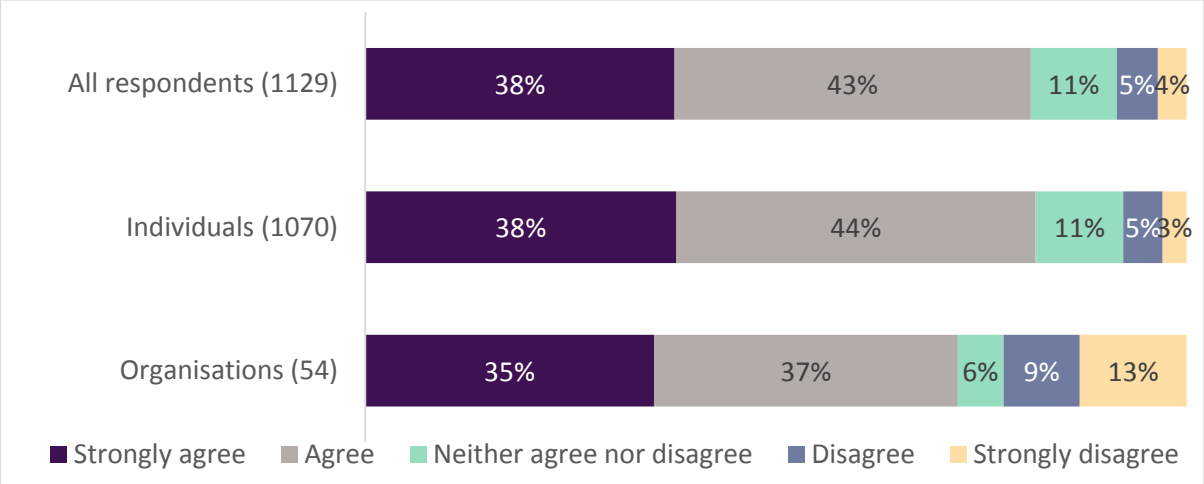
5.3.2 Evidencing relevant prior learning and experience necessary

285. To facilitate effective supervision and assessment for SCPHN and SPQ post-registration students, the NMC is proposing that practice supervisors and practice assessors for SCPHN and SPQ programmes must be able to evidence relevant prior learning and experience necessary for the practice supervisor and assessor roles. For example, this might include undertaking a period of preceptorship in line with the NMC principles for preceptorship and/or in line with local and national preceptorship policies for SCPHNs or SPQs, prior to assuming a practice supervisor and/or assessor role of post-registration SCPHN and SPQ students.

5.3.3 SCPHN – evidencing prior learning and experience

286. As shown in the figure below for SCPHN post-registration students, 81% (915) agree or strongly agree. Responding organisations have a higher level of disagreement than individuals (22% vs 8%).

Figure 53 Whether practice supervisors and practice assessors for SCPHN programmes must be able to evidence relevant prior learning and experience necessary for the practice supervisor and assessor roles



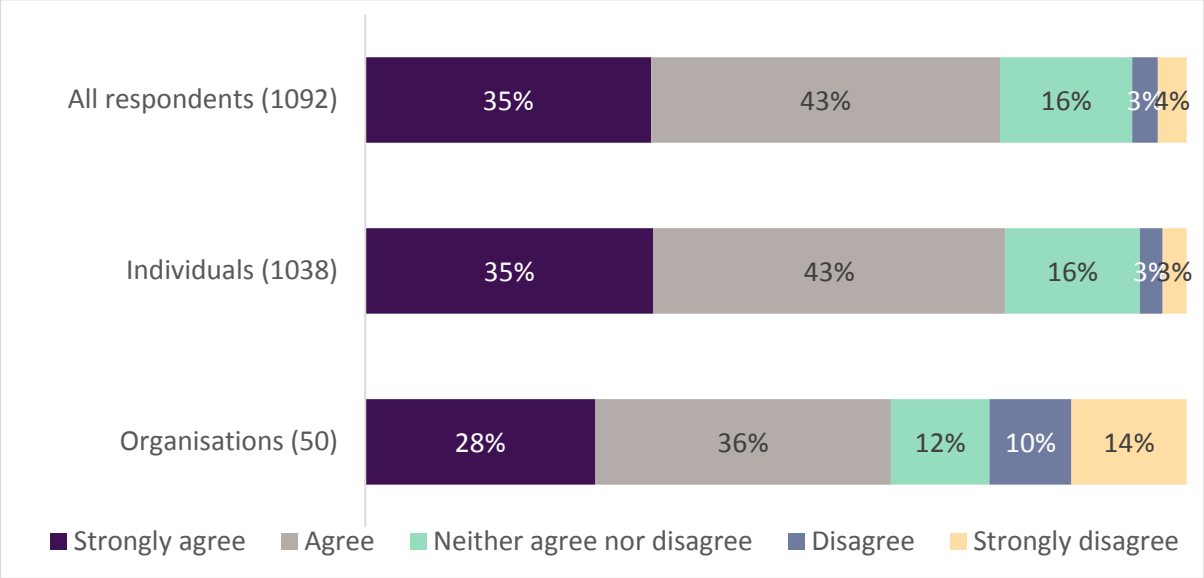
287. Of the 9% (102) respondents disagreeing or strongly disagreeing 78 responses were received. These are summarised below.

a. The complex nature of these roles means students should be supervised and assessed by senior staff, ideally someone with a formal teaching qualification or a fellow. The 'Practice Teacher' role is still of some value and is better able to support students for this qualification. It is especially important when the learner is not achieving the requirements for safe and effective practice and may need further support (60/78).
b. OHNs further note that, as their work is usually in the private sector, it may not be in their employers' interest to allow time for training students, they would have to undertake supervisor work on their own time (6/78).
c. As an alternative view, some suggest the NMC's proposed approach for the supervision and assessment of SCPHN post-registration students is unnecessary: completing a SCPHN programme requires an element of leading so these individuals should already be prepared to teach, and nurses with years of experience should not have to do extra work to prove their competence and may find it difficult to evidence their skills (19/78).

5.3.4 SPQ – evidencing prior learning and experience

288. As shown in the figure below for SPQ post-registration students, over three quarters - 78% (851) - of respondents agree or strongly agree with this proposal. Responding organisations have a higher level of disagreement than individuals (24% vs 6%).

Figure 54 Whether practice supervisors and practice assessors for SPQ programmes must be able to evidence relevant prior learning and experience necessary for the practice supervisor and assessor roles



289. Of the 7% (76) disagreeing or strongly disagreeing, 52 comments were received, again with similar themes emerging as for the same proposal for SCPHN.

a. More specialist preparation for both supervisor and assessor roles is needed. Supervisors should hold the same SPQ qualification as the student to be able to fully appreciate the complexities of the role, and therefore to be able to assess if someone is truly competent in the skills/knowledge required (41/52).
b. The return of the 'Practice Teacher' role and qualification would help as this is seen as important for SPQ programmes, and for future progression (5/52).

5.4 Other considerations

290. Respondents were given a chance to add final comments about any part of the proposed post-registration programme standards, and 240 responses were received. An analysis of those shows a number that have not been mentioned in earlier sections. These are summarised below.

a. The positives of the standards, such as an appreciation of the academic level of the qualification or being grateful for the recognition of these roles (30/240).
b. A lack of availability or access to practice assessors, particularly for OHN (16/240).
c. Organisations, in particular, value flexibility being factored into the standards so that there is room for local adaptation (12/240).
d. Other issues, each raised by a handful of respondents, are in relation to the administration of the courses, including that:
    - there should be options to convert between courses from one specialism to another, or an ability to more easily transition between roles with dual registration (11/240),

- they are too academic which, in their opinion, does not necessarily lead to a "good" SCPHN/SPQ nurse (11/240),
- students should have post-registration experience before studying towards a post registration qualification (11/240),
- student wellbeing should be supported as part of the course (9/240), and
- 'Advanced Practice', or ACP, should be included as part of the course as this requires many of the same skills (9/240).

6. Summary of findings from research with the public

291. This chapter presents the feedback received from members of the public on the draft standards. It is split into two sections – the first section covers the feedback received from the online consultation for the public and the easy read version, while the second outlines views received from the focus groups and depth interviews with the public.

Key findings for Chapter 6 – the views of the public (n=473)

- High levels of agreement with the intentions of the draft standards for each SCPHN area (90%+), with slightly lower levels (but still high) for the prescribing element (75%+).
- There is lukewarm support to retain the RPHN qualification (55% agree) but high levels of uncertainty as the public feel uninformed on this topic. Similar levels of support are seen for the RPHN prescribing element (65% agree).
- A warm reception (71% agree) to the proposed new specialist practice qualification for nurses in other community fields, although many feel insufficiently informed to comment.
- High levels of agreement (90%+) with the intentions of draft specialist community nursing standards
- Good levels of agreement that the draft standards for specialist community nursing could be extended to other roles (83% agree).
- The structure, format and layout are well-received, although the language is noted to be "heavy going" in places.
- The majority feel that their current and future needs will be met by the draft standards. Concerns are raised as to how they will be regulated in practice and how nurses will be monitored.
- The majority feel that the draft standards reflect what specialist nurses need to know and do, but a large minority would like more detail about expectations for specific roles.
- The public feel more emphasis is required on specialist nurses' all-round knowledge/experience, and on mental health training/awareness

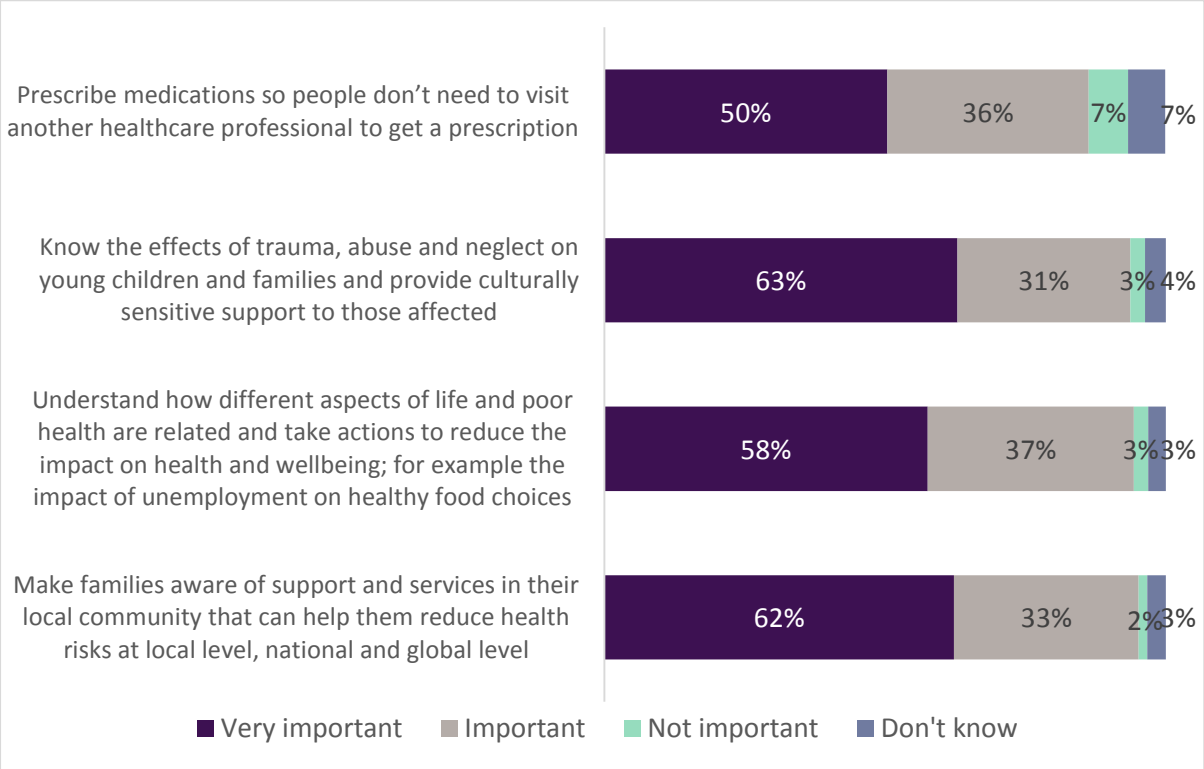
6.1 Survey findings from members of the public

6.1.1 Health visitors

292. Members of the public responding to the online consultation were presented with a series of statements about health visitors and asked to rate their perceived importance. These statements were partly linked to the six spheres of influence in the draft standards of proficiency for SCPHN.

293. Generally, there is broad agreement among the public with the intentions of the draft standards. Over 85% agree that it is 'important' or 'very important' for HVs' work and practice to align to the practices outlined in the four statements. The statement achieving the lowest level of support relates to prescribing, although 86% do still agree this is (very) important.

Figure 55 Perceived importance of aspects for HV (public views)



Base: variable from 454 to 456 respondents.

294. The public were asked if, in addition to these knowledge and skills, there is anything else they believe that HVs need to know and be able to do, and 77 responses were received.

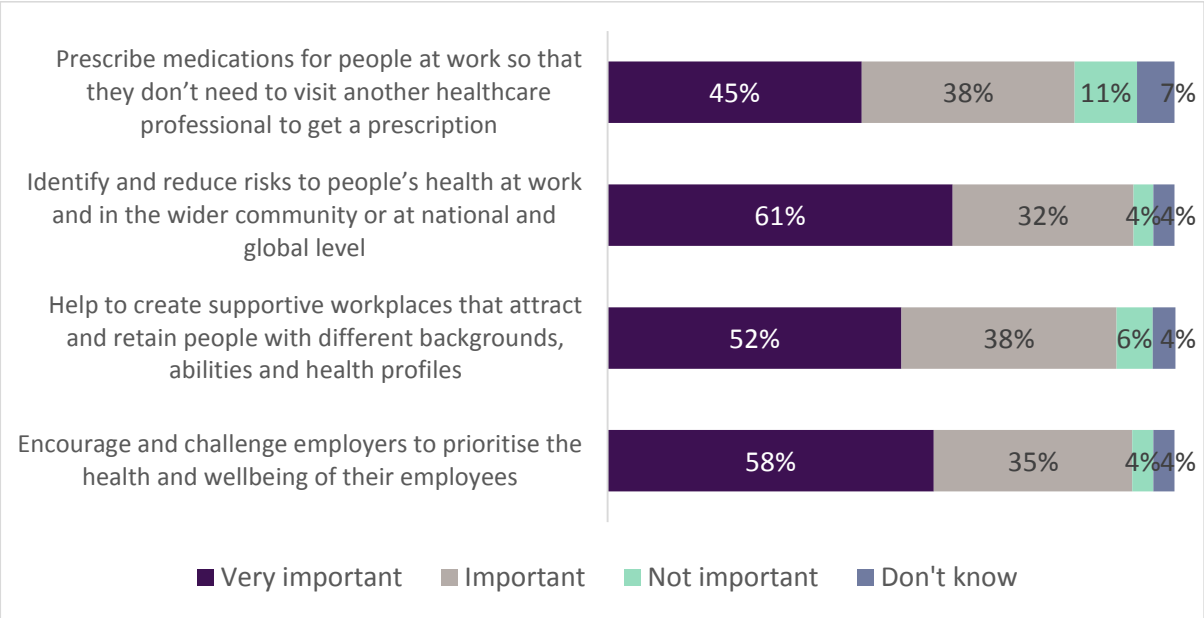
a. It is vital for nurses in general to be fully aware of the warning signs for serious genetic conditions. Specifically, these respondents refer to Neurofibromatosis type 1, which is a condition that can show early symptoms of marks on the skin of young babies (5/77).[12]
b. HVs are not perceived to treat or care for mothers who show signs of deteriorated mental health (e.g. postpartum depression) and they suggest that mental health training should be incorporated (8/77).
c. HVs should be able to assist parents without being judgemental (e.g. due to cultural differences) and they should be empathetic and reassuring towards new parents (6/77).

[12] Note: Neurofibromatosis is mentioned by a dozen respondents in many of the open-ended questions on the public survey and appears to have been the topic of a campaign-type response from these individuals.

6.1.2 Occupational health nurses

295. Members of the public were next presented with a series of statements about occupational health nurses and asked to rate their perceived importance. These statements were partly linked to the six spheres of influence in the draft standards of proficiency for SCPHN.

Figure 56 Perceived importance of aspects for OHN (public views)



Base: variable from 453 to 454 respondents.

296. Generally, there is broad agreement among the public with the intentions of the draft standards. Over 80% agree that it is 'important' or 'very important' for OHNs' work and practice to align to the practices outlined in the four statements. The statement achieving the lowest level of support relates to prescribing, although 83% do still agree this is (very) important.

297. The public were asked if, in addition to these knowledge and skills, there was anything else they believe that OHNs need to know and be able to do, and 57 responses were received.

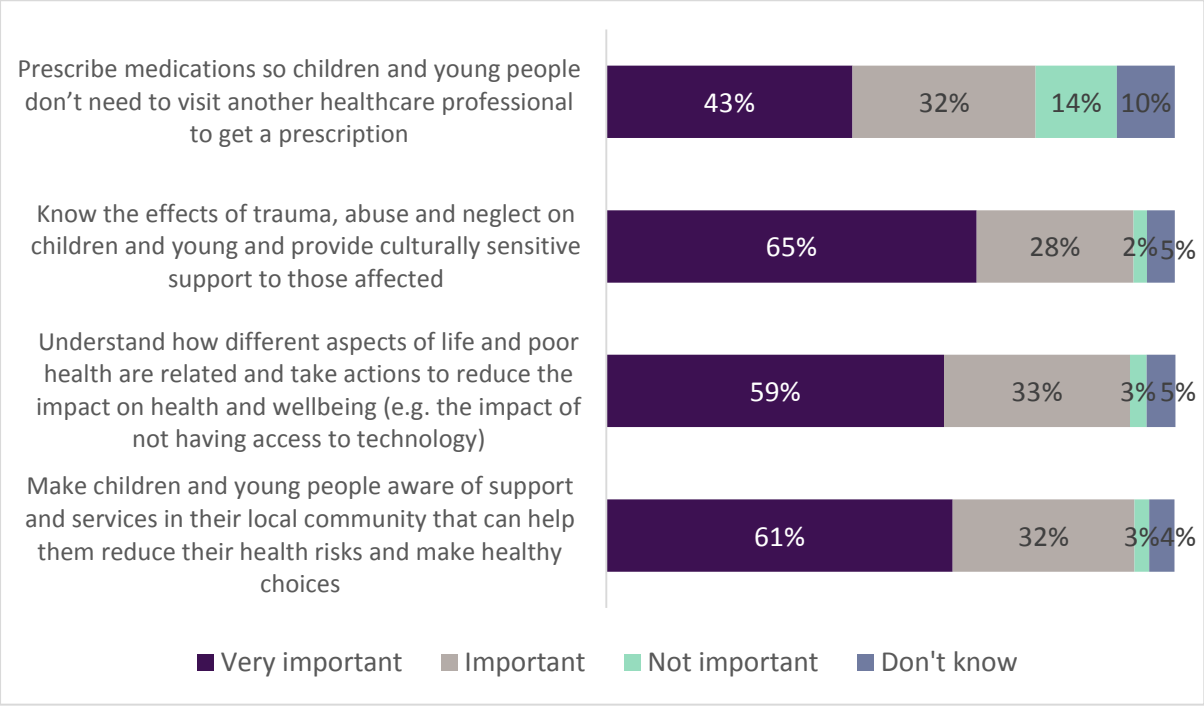
a. One in eight respondents add that OHNs should be required to have extensive knowledge of the health and safety requirements of the company they are employed by, in order to understand when safety standards are not being met 7/57).
b. There is a need for mental health to be encompassed more clearly in the training for OHN (3/57).

6.1.3 School nurses

298. Members of the public were also presented with a series of statements about school nurses and asked to rate their perceived importance. These statements were partly linked to the six spheres of influence in the draft standards of proficiency for SCPHN.

299. Generally, there is broad agreement among the public with the intentions of the draft standards. Over 90% agree that it is 'important' or 'very important' for SNs' work and practice to align to the practices outlined in three of the four statements. The statement achieving the lowest level of support relates to prescribing, although three in four (75%) do still agree this is (very) important, while 14% believe it is not important.

Figure 57 Perceived importance of aspects for SN (public views)



Base: 453 respondents.

300. The public were asked if, in addition to these knowledge and skills, there is anything else they believe that SNs need to know and be able to do, and 54 responses were received.

a. SNs should support both the child and their family in and out of the school environment, especially regarding bereavement support, safeguarding, and protection from abuse (9/54).
b. SNs additionally should be highly competent regarding psychological issues and issues relating to mental health, such as sexuality or LGBT, body dysmorphia, anxiety and depression (8/54).
c. SNs should be familiar with, and knowledgeable about, a large range of genetic disorders and their low-level symptoms, so that they can enable a swift diagnosis (8/54).
d. There could be higher awareness that SNs could facilitate mental health support (1/54).

6.1.4 Registered public health nurse

301. The NMC currently has a broader registered public health nurse (RPHN) qualification along with the three SCPHN qualifications. As part of the online consultation, the public were asked whether the NMC should retain this RPHN qualification for other types of public health nursing roles, along with the SCPHN HV, OHN, and SN qualifications.

302. Over half of respondents agree that the RPHN qualification should be retained (55%) while one in six disagree with this (15%) and the remaining respondents are unsure (30%). Respondents were asked to provide reasoning for their response, and over 400 substantive comments were received and explained below:

a. These nurses would benefit from an increased level of skill, understanding, and knowledge in a wider range of fields, were they to obtain this accreditation. It would greatly help the public in the future, as they would be better equipped to deal with specific problems (35/400).
b. This would provide the public with reassurance that the care provided is of a high standard as the nurse in question would have multiple accreditations (23/400).
c. The inclusion of more qualified nurses could help take any external pressure off doctors, staff and other nurses when providing healthcare to patients (8/400).
d. The RPHN qualification should not be retained as these nurses are already qualified and already hold the required skills and training without needing an additional qualification. Practical training and experience are far more important, and acquiring another accreditation can create additional pressure for individuals (7/400).

It can never be a bad thing to have more qualifications available. It can only support and improve the knowledge and understanding.

Member of the public, White British

Nurses need to spend more time nursing and less time studying for more qualifications they don't need.

Member of the public, White British

303. Respondents who are unsure typically explain that they do not feel sufficiently informed to be able to comment on this matter.

304. The public consultation also asked whether RPHN should be able to prescribe medications so that people do not need to visit another healthcare professional to get a prescription. 451 respondents agree with this (293, 65%), while 17% (76) disagree. The remainder are unsure (82, 18%). A notably high proportion of respondents in Northern Ireland disagree (45% agree and 45% disagree).[13]

305. Respondents disagreeing and those unsure were asked to provide reasoning for their response, and 41 substantive responses were received and explained below.

[13] NB small sample size – 11 responses to this question were from Northern Ireland.

a. There may be too great a risk to public safety if these nurses do not have access to relevant medical records. Prescriptions should be received from doctors in order to alleviate any potential risk that arises from lack of training. Nurses should provide recommendations regarding treatment, as long as a doctor or GP makes the final decision.

It depends on the individual nurse's level of expertise…junior and new nurses shouldn't, [but] more experienced nurses should have the ability to prescribe.

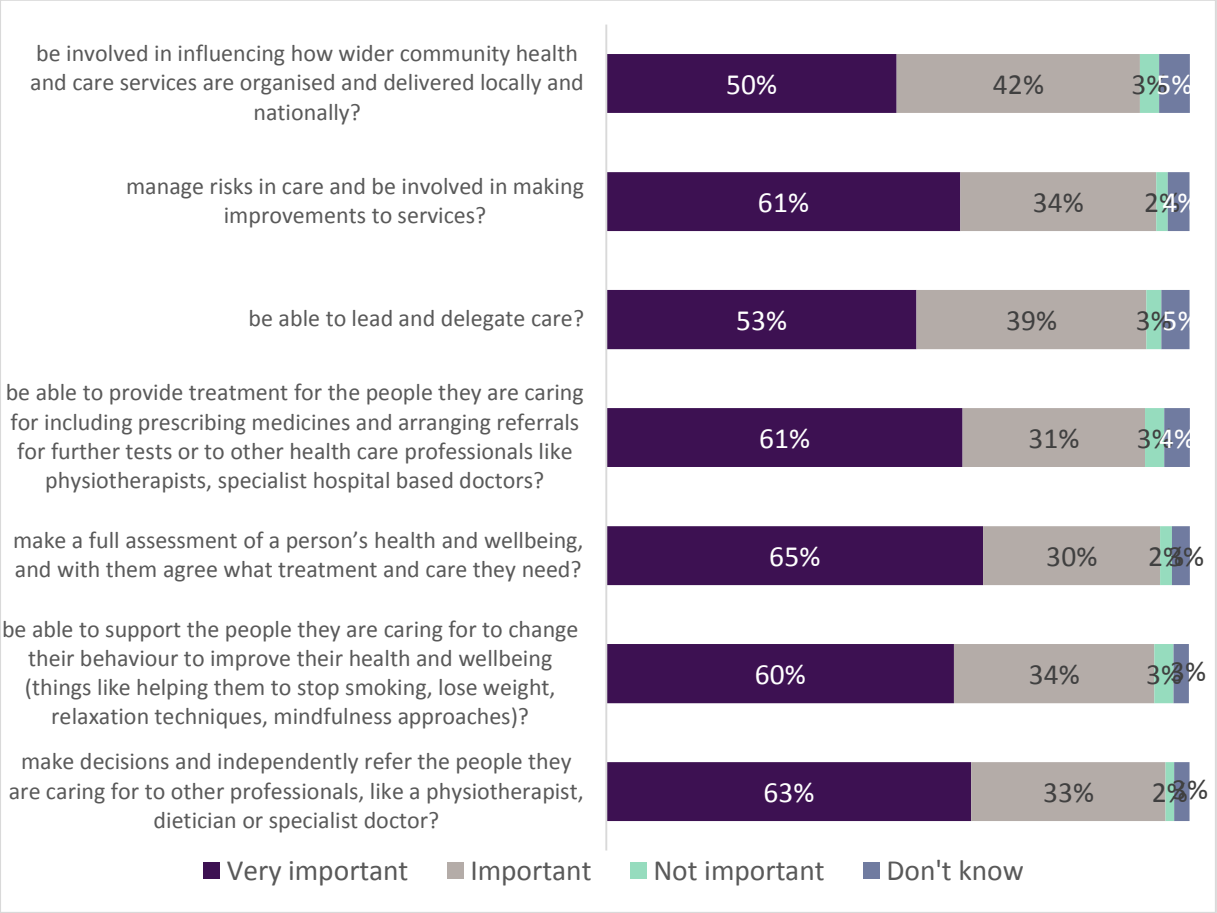
Member of the public, (ethnicity not provided)

6.1.5 Specialist community nursing

306. Members of the public responding to the online consultation were presented with a series of statements about specialist community nurses and asked to rate their perceived importance. These statements closely related to the seven Platforms in the draft standards for community nursing SPQs.

307. Generally, there is broad agreement among the public with the intentions of the draft standards and Platforms. Over 90% agree that it is 'important' or 'very important' for specialist community nurses to adhere in their practice and ways of working to each Platform (base varies from 455 to 457). Similar levels of agreement are seen across the main public survey and the easy read survey.

Figure 58 Perceived importance of each Platform for specialist community nurses (public views)



Base: variable from 455 to 457 respondents.

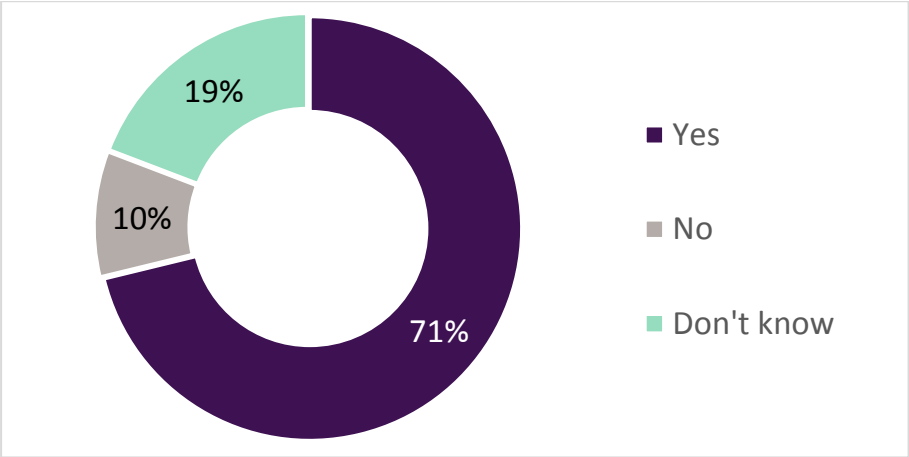
308. The public were asked if, in addition to these knowledge and skills, there was anything else they believe that specialist community nurses need to know and be able to do. Approximately 40% of respondents answered in the affirmative in relation to each SPQ area (CCN, CLDN, CMHN, DN, and GPN), and of these, an average of 109 substantive comments were received as summarised below.

a. All nurses need to have good all-round knowledge and suitable experience, and they should have in-depth background information on their patients prior to treatment to ensure the highest quality care. This includes the skills associated with caring for autistic people and people with learning disabilities and also those struggling or needing home visits (17/109).
b. As part of their general knowledge, all specialist community nurses should be required to have mental health training to understand how to alter treatment methods or make reasonable adjustments to handling patients, as well as having the capability to understand alternative treatments such as counselling (13/109).
c. A core knowledge base is required for all nurses in general. Additionally, there should be individual specific skills that apply to each nursing specialisms to ensure their roles are performed to a suitable standard (10/109)
d. CLDNs should be able to raise concerns on a patient's behalf, particularly where the patient's parent or guardian is incapable of raising such concerns (5/109).

6.1.6 Proposal for a new specialist practice qualification

309. The online survey with the public outlined how the NMC is proposing a new 'specialist practice qualification' for nurses working in other fields of community nursing practice, for example care homes, hospices, residential and educational settings, in prisons and health and justice settings. Respondents were asked whether they believe it is necessary for nurses working in these other community settings to have an NMC-approved specialist qualification.

Figure 59 Should nurses working in specialist community settings have an NMC-approved specialist qualification (public views)?



Base: 458 respondents.

310. Over two thirds, 71% (325) of the public agree with this proposal while 10% disagree (46). A similar response proportion was seen in the easy read survey. Three respondents argue that this is important for continuity and quality of care in these settings which can, otherwise, be easily overlooked.

311. Those disagreeing or unsure (133) were asked to explain their reasoning, and 130 substantive responses were received.

312. Around 80 of these simply note that they lack sufficient expertise about NMC-approved specialist qualifications, or do not fully understand the implications of the question posed, to be able to form a valid opinion. Others suggested:

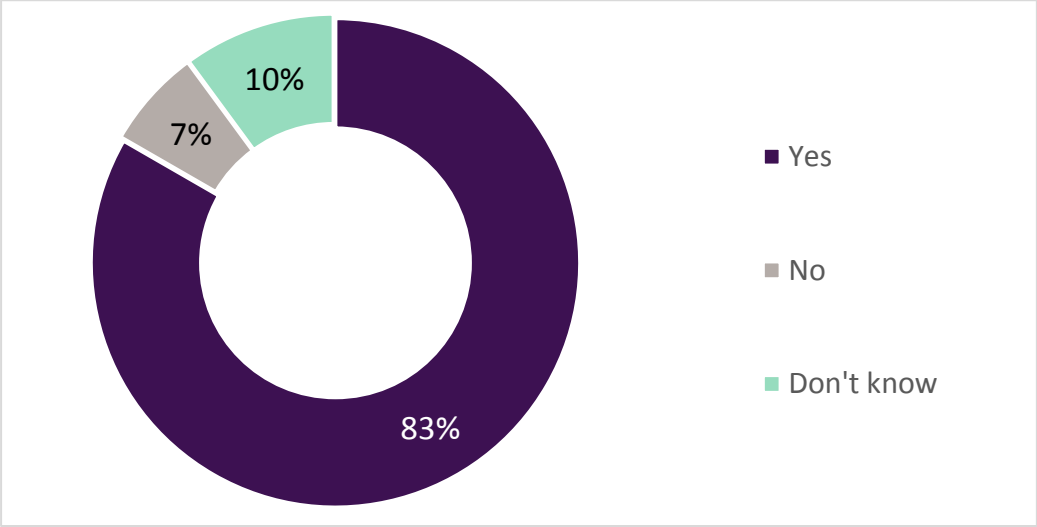
a. confusion over the notion that these nurses should need such qualifications, as they believe that these community nurses already have the required skills and experience required to do their job effectively to a high standard (10/50),
b. uncertainty if these qualifications are necessary, as these nursing roles are underpaid and understaffed and likely already under high pressure. Again in the belief that a qualification is to be mandated, there is a view that nurses will be discouraged from taking certain career paths as it will create more paperwork and financial barriers (10/50), and
c. experience is more important than further qualifications or at least an optional path (8/50).

I think nurses have to jump through enough hoops and do enough paperwork at the expense of actually helping people without introducing extra hurdles.

Member of the public, Mixed or multiple ethnic groups: White and Asian

313. Public respondents were also asked whether the knowledge and skills previously described (relating to specialist community nursing roles) would also apply to specialist nurses working in any role in the community.

Figure 60 Do the knowledge and skills also apply to specialist nurses working in any role in the community (public views)?



Base: 457 respondents.

314. Five in six or 83% (379) members of the public agree with this proposal while one in ten or 10% (48) disagree and the remaining group, 7% (32), are unsure.

315. Of those 17% disagreeing or unsure, 72 substantive responses were received. As before, the majority (52) note that they lack sufficient knowledge of these specialist nursing roles to be able to comment. Other responses are:

a. certain roles are too different and separate from each other to justify having a generic standardised approach, and that there is a large difference in providing treatment in (for example) a care home or a prison (5/20),
b. a "one size fits all" approach would potentially be detrimental as each role has specific needs (2/20), and
c. qualifications are not important for nursing and instead they suggest that nurses learn most of what they need to know from their peers and through experience, whereas a qualification may be time consuming rather than beneficial (2/20).

316. In total 144 substantive responses on any other final commentary were received. Around 28 of these note support for the proposed qualification in the belief it will be good to implement. Others suggest:

a. the training of these nurses is highly important and that improving the knowledge and skills of these nurses via this route will overall lead to a higher standard of care and an increase in patient confidence (18/144),
b. the qualification should include training in mental health, specifically relating to identifying and treating such issues, and also soft skills such as communication (6/144),
c. concerns that there will be little or no funding or support for these nurses if this qualification is mandated (5/144),
d. the qualification itself is unnecessary, the practical skills gained from what these nurses are already doing is more important (4/144), and
e. the qualification should not be mandatory but should remain optional (2/144).

6.2 Qualitative research findings

317. Prior to participating in an in-depth interview or focus group, participant members of the public were sent a short document to read in advance. This provided individuals with a brief background to the NMC and outlined the purpose of the consultation. It summarised the draft standards of proficiency for SCPHN and outlined the six spheres of influence, and also summarised the draft standards of proficiency for SPQ and the seven Platforms. Links were included to the full draft standards, should individuals be interested in reading further.

318. Due to time constraints, the focus groups and in-depth interviews did not go into the same level of granularity as the online survey, but high-level discussions about the draft standards and the nursing roles involved were held. This section outlines the findings arising.

6.2.1 Accessibility and clarity

319. The majority of participants in the focus groups and interviews believe that the standards are fairly clear and easy to understand, although some have suggestions for improvement.

320. They also state that the structure, format, and layout is fairly clear and easy to follow.

> *I read it and felt it was very concise and was easy to follow, well-structured and the language used was simple. I felt I fully understood it. No changes need to be made, it was very clear and concise.*
>
> Carer, White British

321. The glossary to help explain some of the more complex terminology is noted as beneficial, although it might be better placed at the start of the document, or to explain terms on the same page they appear.

322. Whilst the document is not something many would usually read, a few participants state that it is positive to have the standards available to them. These individuals note that it is important to know what level of care to expect and to have something to refer back to in instances where this falls short.

It's important for accountability – having these standards publicly available gives the public a rough idea of what to expect from their care.

Person with long-term illness, and physical disability, White British

323. Participants in the focus groups/interviews suggest that the document could be clearer or feel the language could be improved. These individuals typically note the language can be "*heavy going*" or "*jargon-esque*" in places and that it could be simplified. Some perceive that the meaning of some words (e.g. "*autonomous*" or "*evidence-based care*") are unclear in the context of these nursing roles.

They put big words in but it's not always easy for everyone to understand what they mean, as well as being able to read them.

Traveller, parent of child under 4, and person using HV services

324. Some specific comments about the wording are noted by participants.

*"*Autonomy*" surprised me, [is that like] entrepreneurship? I don't really get what that means in the context of a nurse, or in a free at the point of service healthcare system. I just think of* The Apprentice *when I hear that word.*

Parent with child under 4, and person with long-term illness, Mixed Black British

People don't like the word 'needs' all the time because it feels like you're being dismissed as special needs, and not seen as 'rights holders'. Disabled people generally don't like being referred to as vulnerable either. Its context that makes them vulnerable.

Person using social care, and person with physical disability, White Irish

325. When asked about the clarity of the standards, some participants recognise that the document will need to be adapted and made accessible for certain audiences. This issue is noted by individuals from different backgrounds and not necessarily only by people within such target audience categories. Suggestions for improvements include, for:

- people with learning difficulties: will require an easy read format, "*pictorial for people with learning difficulties*", or support available to help read the document through with someone.
- young people: simpler sentence structure, shorter, and written in a way that is accessible to "younger people",
- non-native English speakers: it should be available in other languages, and
- blind, dyslexic, deaf, or illiterate: the standards should be available in an audio format, or the document needs to be accessible using a screen reader or a text-to-speech service, or support available to help read it through with someone.

Most travellers are illiterate, so they can't read or write. So, they might need help. It would be good if there was a setting in which it could be read to them, like they have for deaf people [text to speech].

Gypsy/Traveller

It was easy to read for me, but for someone else with a bit more severe Down's Syndrome or learning disabilities, I think they would probably need help from

someone to help them read it because there's quite a lot of long words that they might not understand.

Person with learning disabilities and/or autism, White British

326. Others suggest the use of a video, pictures or a poster could make the information more appealing to a wider audience, and individuals participating in a focus group of young people suggest publicising through the use of social media to make the information more accessible.

327. A small number suggest that the document is too long or has too much information.

328. Around one in six participants suggest that the standards are too general and/or that the different roles needed to be more clearly defined. Some suggest they would like to see more examples, in order to clarify meanings about how these principles might be implemented and what they mean in practice. However, it is possible that these individuals only read the shortened pre-read document that they were supplied with, rather than reading the draft standards in full.

6.2.2 Priority topics

329. Focus group and interview participants were asked to identify what they believe are the key attributes and abilities required by specialist nurses. From this exercise across all qualitative participants, three themes arise: communication and soft skills, high quality of care and delivery, and a deeper knowledge of important and/or sensitive subjects.

330. **Communication and soft skills**: Participants believe that is it important for specialist nurses to communicate effectively with patients and demonstrate that they listen to their problems. A few participants noted that they had experienced issues in which they felt they were not being listened to by a nurse, which they feel ultimately led to a lower level of care.

It would help if the school nurse listened instead of making excuses for me such as blaming school related stress; I wished the nurse heard that I was actually struggling with mental health not just with exam stress.

Young person (16-20yrs) using mental health services, White British

If people do not describe things in a way I will understand, I will be anxious about the treatment I receive. It will make me feel as though I don't have some control about my treatment. It is important that the treatment described accounts for the fact I am blind.

Person using social care, White British

The nurses must be very adept at communicating with the children at the right level, this is crucial as it puts the children at ease with the nurse.

Parent with children aged 4-16, White British

331. Related to soft skills, several respondents comment on the attributes that they believe specialist nurses should have. These include (from most to least commonly mentioned) being:

- empathetic/compassionate,
- friendly and approachable,

- trustworthy and honest,
- non-judgemental,
- non-patronising, and
- patient.

> *They need to be approachable and friendly, so I can open up to them. They need to have a good bedside manner. They all affect me; I have long term health conditions and an invisible disability. It is important nurses have empathy.*

Person using social care, White British

332. **High quality of care and delivery**: Participants state that it is vital to have access to specialist nurses and associated healthcare both inside and outside of the hospital environment. A small number note that they have had particular difficulty during the Covid-19 pandemic in being able to access specialist nurses.

> *They [the specialist nurses] need to be accessible; the fact occupational health and community nurses can come to you is really important. Accessibility is important as at times I have not been able to leave the house due to mental and physical disabilities.*

Person using social care, White British

333. Regarding limited access to healthcare, one participant states that members of the Traveller community do not receive an adequate level of contact with certain specialist nurses.

334. Respondents also feel strongly about the quality of their care, and a number observe that Sphere B (improving and changing practice in line with evidence) and Platform 4 (providing evidence-based care) are the most important points for specialist nurses to uphold. Participants perceive that evidence-based care is vital for individual assessment and treatment.

> *[Sphere B] stood out to me. I think it is quite important to see that included because the evidence is constantly evolving…it's good [for the nurses] to constantly question themselves about what they are doing and asking themselves: 'where's the evidence that say this will most likely improve the situation for the patient?' It should be at the forefront of any medical professional role to follow the latest evidence…because it evolves over time.*

Parent using HV services, White British

335. Other points that participants make regarding the delivery of their care are that nurses should:

- improve and promote health,
- be able to lead and work in teams,
- maintain confidentiality,
- have accountability and take responsibility for mistakes, and
- be coordinated and organised (medical records, appointment times etc).

336. **Deeper knowledge of important and/or sensitive subjects**: focus group and interview participants believe that specialist community nurses' knowledge is a priority. These individuals typically note that professionals' knowledge may impact on the level of care or approach that the

patient receives. Examples of the issues and topics that the focus group and interview participants believe specialist community nurses should be trained about include:

- mental health, including anxiety and depression in children and young people, and conditions such as Asperger's, autism, and dementia,
- learning disabilities and how they differ to mental disorders,
- LGBT issues, including sexual health, gender transitions, and medication options,
- niche issues in children when working with toddlers and babies,
- cultural sensitivity, including being aware of differences in treatment for different cultures, and
- "invisible" illnesses and their signs, including endometriosis, heart conditions, and sickle cell anaemia.

337. It is commonly mentioned that school nurses should be more aware and sensitive about mental health issues within school children.

> *When I was at school, I would have benefited from a better understanding of mental health on the nurse's part. I am going to college in September, and I will be anxious leaving home and hope there will be support for students who suffer from anxiety.*
>
> School child (aged 12-16), White British

338. Respondents also suggest that specialist community nurses should be actively aware of inequalities and should strive to promote human rights for all their patients, especially for ethnic minorities.

> *I come across people from ethnic minorities not being cared for properly…being from ethnic minority, sometimes it's overwhelming experience to go to a doctor and talk about your problems. Some people I come across in my work feel undermined by the healthcare professionals.*
>
> Parent of children under 4, and person of working age, White (ethnic minority)

339. One member of the traveller community believes health visitors have not treated them fairly or non-judgementally in the past.

340. Qualitative participants additionally note that specialist nurses should have an in-depth background knowledge of their patients before treating them. Participants note that patients can then avoid having to explain their condition multiple times which would then put them at ease, while the nurse would also have a deeper understanding of individuals' histories.

> *It is important they have researched the patient's illness before visiting them. This will give the patient confidence that they are being treated as an individual and not just something that needs to be done during the day.*
>
> Carer, White British

6.2.3 Knowledge and skills requirements

341. Focus group and interview participants were asked about the knowledge and skills requirements of specialist nurses. Participants provided their thoughts on the extent to which the draft standards reflect what they feel specialist nurses should know and do, the extent to which the standards reflect their own personal needs, and any aspect they felt to be missing or could be improved. This section is split into three parts: general comments, SCPHN, and SPQ.

342. **General comments**: The majority of participants feel that the draft standards do reflect what specialist nurses need to know and do, with many stating it is clear on what should be expected from a specialist nurse.

> *As a potential service user, I have a good idea of what the nurses need to know and be able to do. They reflect what I need or would expect to need from each specialist nurse.*
>
> Person using social care, White British

343. However, a number of participants believe the draft standards are too vague or broad, and that the document does not go into enough detail about what each specialist community nurse role is and what they do. However, it is possible that these individuals only read the shortened pre-read document they were supplied with, rather than reading the draft standards in full.

> *They give a general overview of what nurses need to know and be able to do, they do lack detail about the actual work the nurses are supposed to do.*
>
> Person using social care, Mixed race

> *It is a general overview; it gives a good basic description. This makes it easy to read, though I feel as though I do not know much detail about the actual roles they do. The draft standards do not really tell me the type of service I can expect from them.*
>
> Traveller, Parent with children under 4, Gypsy/Traveller

> *The standards are all too generic. They are too broad. It's like they have been written to please the employer. The job of a school nurse is very different to a health visitor, and their roles are very different so what they need to know is very different. The standards should all be separated out into individual roles because what they each need to know is very different.*
>
> Person of working age, Black African

344. A small number of participants, while supportive of the draft standards, raise concern over their regulation and implementation in practice. These individuals believe that the draft standards reflect what they need from the specialist community nurses but perceive that this does not happen in reality.

345. Some participants agree that they would feel comfortable receiving care if these were the standards the nurses were conforming to. A small number note that healthcare should be tailored to the individual to ensure everyone is treated equally.

> *It should also include that each person gets individual care based on their own unique experiences.*
>
> Refugee/asylum seeker, African

346. With regard to missing aspects within the draft standards, many respondents note that "soft" skills are not as present in the draft as they would have liked. These missing skills include:

- communication skills,
- empathy and compassion, and
- building a relationship with patients.

347. It should be noted that these aspects are incorporated in the NMC's pre-registration standards of proficiency for registered nurses.

348. Other areas which participants believe require additional emphasis within the standards include mental health and its associated symptoms. These participants feel there is too much focus on the physical aspects of conditions and treatments and the standards give too little thought to mental health. Children (aged 12-16) and young people (aged 16-20) who use mental health services brought this issue up the most frequently.

> *Specialist nurses should be able to read and action on early warning signs [of mental health issues].*
>
> Young person (aged 16-20) using mental health services, White British

349. Knowledge of specific mental health and minority group issues are noted to be generally lacking throughout the standards by a minority of participants. This is particularly in relation to LGBT+ and minority ethnic individuals and their healthcare treatment. These concerns are raised almost exclusively from people who are a part of minority groups themselves.

> *Nurses need to be aware that the UK is multicultural, it's diverse. Certain treatments are not acceptable for some cultures/religions, so nurses need to be aware of patients' needs. This should definitely be included in the standards.*
>
> Refugee/asylum seeker, Black African

350. **SCPHN**: For **health visitors**, a small number note that "Autonomous Practice" is very important to them when receiving care for their child, noting that Sphere A effectively shows what they would expect.

351. A few participants are concerned that HVs may judge a mother's parenting methods, living arrangements, and decision to breastfeed or not. Two participants from the Traveller community are specifically concerned about HVs in their homes, believing – from past experience – that they are judged unfairly on their lifestyle rather than their parenting skills. This group of individuals feels that the draft standards need to emphasise more the need for HVs to be non-judgemental.

> *Being a traveller, you feel labelled or looked down upon, by a lot of people. So, a lot of the time traveller families don't like having health visitors or anyone coming to investigate…because they don't want that judgment. A lot of travellers' fears are around social services.*
>
> Traveller, Gypsy/Traveller

352. Participants also flag that there should be more support for the mental health of mothers, and that compassion is required by HVs to deal with issues such as postpartum depression.

> *More about support after birth is important really… I'd say not having the compassion was the one thing I felt was missing, it always seemed like they couldn't wait to get out of there.*

Parent with child under 4, and person of working age, Black, African, Caribbean or black British: African

353. For **occupational health nurses**, two participants raise concerns that OHNs can sometimes be less focused on employee health, and also note that training for OHN can vary between companies. Participants feel that the standards should provide an outline that OHNs will provide the same level of healthcare in all workplaces.

> *I don't feel Occupational Health Nurses are focused on employee health…[by] working for the organisation [they] had a primary objective to satisfy my employer…I didn't feel treated as a patient.*

Person with long term illness, and person with physical disability, White British

354. The few participants specifically commenting on OHN believe they should also focus on mental health problems, specifically to tackle work-related stress and other miscellaneous mental health issues that may affect a person's ability to work.

> *It would be good to have more information about mental health training. Because they deal with people going back to work and…it would be good to know they [occupational health nurses] have training and understanding of those mental health issues.*

Parent with children aged 4-16, and person using HV services, White British

355. For **school nurses**, the most common point from participants is that the draft standards are lacking sufficient focus on mental health. Younger participants aged 12-20 are concerned that SNs are poorly equipped to deal with such problems, with several claiming their issues and early warning signs were ignored or went unnoticed.

> *Having an understanding of different mental health issues and being able to recognise if something isn't working and needs changing [is important to have].*

Young person (aged 16-20) using mental health services, White British

> *Mental health issues in sport are becoming increasingly common with people having training more than 7 times a week will definitely cause them to go to a nurse and I think they should be shown how to help with them...At the moment I am struggling to squeeze in revision for my GCSEs between cricket practise myself. School nurses or GP nurses could help manage that. Instead of just saying go to a school counsellor or talk to your friends. It would be good to see more support.*

School Child (aged 12-16), White British

356. There is a notable overlap between participants who raise concern about SN mental health training and those who feel that there is a lack of confidentiality regarding medical and mental health records within the school environment. These participants believe the standards should include a guarantee that such information remains private, or that patients are at least notified if members of staff need to be informed for safety reasons.

> *Confidentiality should be more emphasised in the draft standards.*
>
> Young person (aged 16-20) using mental health services, White British

> *In a school, there needs to be some sort of agreement about privacy. Some reassurance about things they've already discussed, or who they are going to share it with. It should be strictly emphasised about confidentiality. If they do have to tell some, tell the person beforehand so they aren't surprised.*
>
> Young person (aged 16-20), Black, African, Caribbean or black British: African

357. A small number of participants also believe that safeguarding is under-emphasised for SN in the draft standards. These individuals would like to see the standards stress the importance of this training and awareness to be able to recognise issues so that children can be protected.

> *[The draft standards] didn't include safeguarding; people and teachers sometimes do need to know to see warning signs but it needs to be clear to the patient. Standards should have confidentiality and safe-guarding points.*
>
> Young person (aged 16-20) using mental health services, White British

358. **SPQ**: Though all had the opportunity to do so, only one participant commented on **Community Children's Nursing** to note that all the information is presented well and is clear what CCNs need to be able to do.

359. For **Community Learning Disability Nurses**, the draft standards are generally well-received by participants. Two specifically comment that assessing people's needs is especially important and that they had experienced the benefit of this during their experience. One young person aged 16-20 using mental health services comments that LGBT identity needs to be better acknowledged with regard to CLDN. One carer participant notes that greater distinction is required in the standards between learning disabilities and autism.

360. Participants who have had involvement with **Community Mental Health Nurses** have had mixed experiences. Positive encounters were based on person-centred care planning and understanding individual needs, holistic support such as helping with other appointments or healthy eating, being non-judgmental, being knowledgeable, and having regular follow up contact which all led to building a trusting relationship. However, for experiences that were less positive, participants share issues around access to services where there has been poor communication and their needs have not been listened to or taken into account when planning their care. The importance of reaching out and building trust through understanding individual needs is seen as especially important for this role.

> *My experience is that the mental health nurses don't get back to you. It happened with me and my daughter. If they offered more help, it would have been taken. You spill your guts out to this person, and they say ok I'll help you, and then they don't even get back to you. It's hard to open up to anyone else.*

Person using social care, White British

361. Platforms 6 and 7 are seen as especially important for this role with a small number of participants indicating that the mental health system needs to improve so that these standards lead to CMHN playing a part in those wider system improvements.

362. When it comes to **District Nurses**, participants who had received care from DNs generally feel that the SPQ standards are reflective of what these nurses are already doing. Positive experiences stem from good communication with other professionals and services such as GPs and consultants, alongside their ability to work independently within wider Trust constraints. Training and evidence-based care is valued by participants as long as it accompanied by instinctive person led care.

> *The standards are very high for a district nurse. If all these are incorporated in their training, it is one more feather in their cap. These standards are already being applied in my experience; I couldn't find any fault in them.*

Person aged 75+, Asian/ Asian British Indian

363. Specific areas for improvement are noted by two participants, based on their past experiences.

- Better avenues for family involvement to help identify changes in patients which nurses may not spot.
- Better recognition or assessment of individual needs, particularly in relation to understanding Traveller needs, for example understanding that trust needs to be built.

364. The aims of the draft standards for **GP nurses** are generally well received. Platform 2 (Promoting health and preventing ill health) is recognised as a firm expectation of what a GPN should be doing, with a third of those specifically commenting on GPNs noting this point.

365. Understanding and assessing individual needs is valued by participants, coupled with an empathic approach and involving family in communication where required.

366. Participants with experience of GPN care agree with the use of evidence-based care as a way of maintaining continuous professional development. The benefits of having up to date training and maintaining a good knowledge base is valued in addition to being able to clearly communicate this information to patients. One person suggests the need for better mental health training and counselling skills for GPN, in particular.

367. It is noted by another participant that GPs, and in turn GPNs, are often the first port of call for patients so covering good communication in Platforms 1, 6 and 7 is key to ensuring collaborative working with other services. Two participants note that GPNs should have more independence in terms of prescribing or being able to make decisions without having to refer back to a doctor.

6.2.4 Vision, ambition, and inclusivity

368. **Vision and ambition**: Approximately two thirds of focus group and interview participants feel that their current and future needs will be met by the draft standards. Some qualify this by referring to positive experiences of care they have already received, while others refer to specific

elements of the draft standards which help to meet their needs. SPQ Platforms 1 to 3 and SCPHN Sphere B are specifically noted in this regard.

- SPQ Platform 1: Being an accountable and autonomous professional
- SPQ Platform 2: Promoting health and preventing ill health
- SPQ Platform 3: Assessing peoples' abilities and needs, and planning care
- SCPHN Sphere B: Transforming specialist community public health nursing practice: evidence, research, evaluation and translation

> *They meet my current needs and I believe they will meet my future needs. Platform 3 is very re-assuring to me, the idea of planning my care with family is vitally important.*
>
> Carer, Asian or Asian British: Pakistani

> *Yes, they seem to be able to meet my future needs. If they are able to provide individual care…. if they are able to be sympathetic to different people's individual needs from whatever background, then that is what they should be doing.*
>
> Parent with child aged 4-16, and person of working age, Asian or Asian British: Indian

> *No, I do not think they discriminate in any way. I think the standards do a good job, but are they really going to translate to reality? There should be some way of measuring and recording progress in terms of improving people's health and addressing health inequalities*
>
> Parent with children aged 4-16, White British

369. Others state that the standards will meet their needs but that their positive response is dependent on whether the standards are followed and question how the standards would be met in practice, and how this will be monitored. Participants anticipate that the standards will ensure that everyone's needs will be met, but some are concerned whether there will be sufficient regulation and monitoring to ensure the standards continue to be achieved. In the same vein, some participants note that the standards will need to be updated regularly to ensure they meet future needs as healthcare evolves.

> *The priority seems to be on getting these right, but it doesn't matter if nobody is enforcing them, nobody is checking quality care is happening or making sure they follow them….if there's nothing in place to back it up then there's not much point to it.*
>
> Person with learning disabilities and/or autism, White British

> *There isn't anything that leads onto the future – it's only in the moment, there is nothing that looks at how it'll progress, so there needs to be something in the standards to show that it will adapt for the future.*
>
> Child 12-16 using mental health services, Asian/Asian British: Indian

370. Where people feel that the draft standards do not meet their needs, this often relates to poor treatment they have received previously, or poor access, rather than specifically to the standards themselves. Examples of these experiences include poor mental health support; poor awareness of disability needs; and poor awareness of LGBT needs.

371. **Inclusivity:** Three quarters of participants explicitly state that the draft standards are inclusive and non-discriminatory, and these individuals place a high value on inclusive approaches to care. Some point to the standards which specifically mention this intention such as (SCPHN Sphere C) "Promoting human rights and tackling inequalities" and (SPQ Platform 3) "Assessing peoples' abilities and needs, and planning care". A small number of participants note that all health professionals should be abiding by the principles of inclusivity regardless of these standards.

372. However, approximately a third of focus group and interview participants believe that the draft standards could go further to emphasise the specific intention to reduce health inequalities and discrimination. These participants believe that this does not stand out sufficiently and raise concern that this is a 'tick-box' approach as it currently stands. In terms of inclusivity, these individuals suggest more information is needed about 'how' this may be achieved and 'how' to tackle health inequalities. The important nuance of treating people on an equal basis while recognising inequalities is also highlighted. There is an expectation among these participants that care should be free from discrimination.

373. The regulation and implementation of these standards came into question with a small number of participants stating that the standards are only inclusive if they are followed.

374. A few participants raise concerns that access to services and staffing levels may affect the ability for the standards to be met, in terms of inclusivity. These participants acknowledge that it will be overly ambitious for an individual nurse to change wider health inequalities in society beyond their immediate role.

375. With regard to the four nations of the UK, most participants agree that the draft standards are applicable in their respective nations and across the UK. Again a few point out that there are other systems that could potentially reduce the ability of individual professionals to practice consistently. These include regional factors relating to local policies and procedures in different Trusts or Clinical Commissioning Groups (CCGs), differing levels of poverty or socio-economic make up, influence from political systems, limitation in domestic laws, and differing demographics and populations between the nations.

7. Conclusions

376. The respondents to the consultation represent a wide variety of stakeholders, from registered nurses to the general public, and from employers and educators to professional bodies.

377. The overarching conclusion from all audiences is that the draft standards of proficiency are welcomed and largely fit-for-purpose. There are issues of detail and areas which some respondents would like to see improved or enhanced. However, the majority view – broadly speaking – is positive and supportive of the three sets of drafts standards.

378. Views are also presented in the comments received that are not applicable to the remit of the NMC or appear to be misunderstandings about the role of the NMC in the next phase of activity, or expectations that the NMC can influence certain areas or aspects of nurses' working conditions. Additionally, some respondents suggest that, in order to achieve/meet these standards, dedicated time and resource is required for individuals and state that sufficient support should be in place from the NMC, educators and employers such that this can be achieved.

379. The following conclusions can be summarised across the three sets of standards as follows, along with a summary of views from the public.

7.1 Conclusions on Specialist Community Public Health Nursing (SCPHN)

380. **Draft standards of proficiency for SCPHN: 60% (1,137) of all respondents chose to answer some or all questions on SCPHN.**

- ✓ High levels of agreement that the core and field specific standards reflect knowledge skills and attributes required for all SCPHN registrants (75%).
- ✓ There are also high levels of agreement that the draft core and field specific standards for HV, OHN and SN meet each of six spheres of influence (15% or fewer disagree on each point). Taking these two points together suggests that the drafts standards for SCPHN are positively received on the whole.
- ✓ Prescribing element: a slight lean towards this being optional (41% to 48%) over mandatory (33% to 47%), and there is an even split as to whether the V100 or V300 is most appropriate. HV and SN lean towards V100 (54% and 59%) and 55% for V300 for the OHN route.
- ✓ While individuals feel that the Registered Public Health Nursing (RPHN) qualification should be retained, organisations are evenly split, and there is generally a high degree of ambivalence around this topic (41% of all respondents are unsure). Concern is raised that retaining this qualification may result in confusion among professionals and the public.
- ✓ There is broad support that these draft core standards can be applied to other public health nursing roles (63%) but a reasonable degree of uncertainty (27%). Concern is raised that these might need to be more role specific.

7.2 Conclusions on Specialist Practice Qualifications (SPQ)

381. **Draft standards of proficiency for SPQ: 62% (1,177) of all respondents chose to answer some or all questions on SPQ.**

- ✓ There are good to high levels of support that each of the seven Platforms is applicable to each community field of practice (support levels range from 72% to 88% across the Platforms for the five SPQ fields of practice). This suggests that the draft standards are well-received by the majority.
- ✓ Between 64 and 94 comments were received for each of Platforms 1 to 7 from individuals and organisations detailing concerns on why they disagree with the applicability of the standards.
- ✓ Within the above, between 20 to 30 comments were received per Platform on the perceived need for, and expectations of, field specific standards.
- ✓ While there is lukewarm support, there is no overwhelming appetite for a skills annex (48%).
- ✓ Prescribing element: there is stronger feeling that this should be mandated rather than optional, especially for DN and GPN – by more than two thirds – and by just over half for CMHN and CCN. For CLDN this was just over 4 in 10 (42%) – but over half (52%) selected optional. Of the two levels, V300 level is preferred for all routes. Justification for this is largely that V300 is more suitable as it caters for more complex care required at this level as opposed to V100 which some perceive as being either outdated or offering insufficient scope.
- ✓ Two thirds support the proposed additional community SPQ. There is also support that the draft standards are appropriate for nurses in other community settings (64% agree, 13% disagree). Concern is raised that these might need to be more role specific.
- ✓ There are high levels of agreement with the proposed SPQ annotation (71%), to referring to these qualifications as SPQs (73%), and for NMC to regulate these (88%). This suggests these proposals are well-received.

7.3 Conclusions on post-registration programme standards: SCPHN and SPQ programmes

382. **Draft standards for post-registration education programmes: 62% (1,178) of all respondents chose to answer some or all questions, including 69% (56) of all responding organisations.**

- ✓ There are good to high levels of agreement with the proposals around student selection and admission (83% for SCPHN, 77% for SPQ).
- ✓ There is also agreement that the draft standards will allow providers to be creative and innovative, and to design a curriculum that supports students (67%+).

- ✓ Good levels of support for the proposals around supervision and assessment totalling around 87% for SCPHN and 83% for SPQ. Taken together, these aspects of the draft standards have been well-received.

- ✓ There is stronger feeling that course duration should be specified, and that there should be a specified period of consolidated practice within the draft standards. Concerns were raised that this might otherwise impact adversely on quality and outcomes.

7.4 Conclusions on the views from the public on the draft standards for SCPHN and SPQ (n=473)

- ✓ High levels of agreement with the intentions of the draft standards for each SCPHN area (90%+), with slightly lower levels (but still high) for the prescribing element (75%+).

- ✓ There is support to retain the RPHN qualification (55% agree) but high levels of uncertainty as the public feel uninformed on this topic. Similar levels of support are seen for the RPHN prescribing element (65% agree).

- ✓ A warm reception (71% agree) to the proposed new specialist practice qualification for nurses in other community fields, although many feel insufficiently informed to comment.

- ✓ High levels of agreement (90%+) with intentions of draft specialist community nursing standards.

- ✓ Good levels of agreement that the draft standards for specialist community nursing could be extended to other roles (83% agree).

- ✓ The majority of focus group participants and interviewees feel the structure, format and layout are well-received of both sets of standards, although the language is noted to be “heavy going” in places.

- ✓ The majority of these same participants feel their current and future needs will be met by the draft standards. Concerns are raised how they will be regulated in practice and how nurses will be monitored.

- ✓ Again, these participants feel that the draft standards reflect what specialist community nurses need to know and do, but a few would like more detail about expectations for specific roles (see section 6.2.3 for details).

- ✓ The public feel more emphasis is required on specialist community nurses’ all-round knowledge/experience, and mental health training/awareness was mentioned many times in various settings. A small minority, particularly seldom heard sections of the population, note they have had experience of being treated “unfairly”, or being judged, by specialist community nurses.

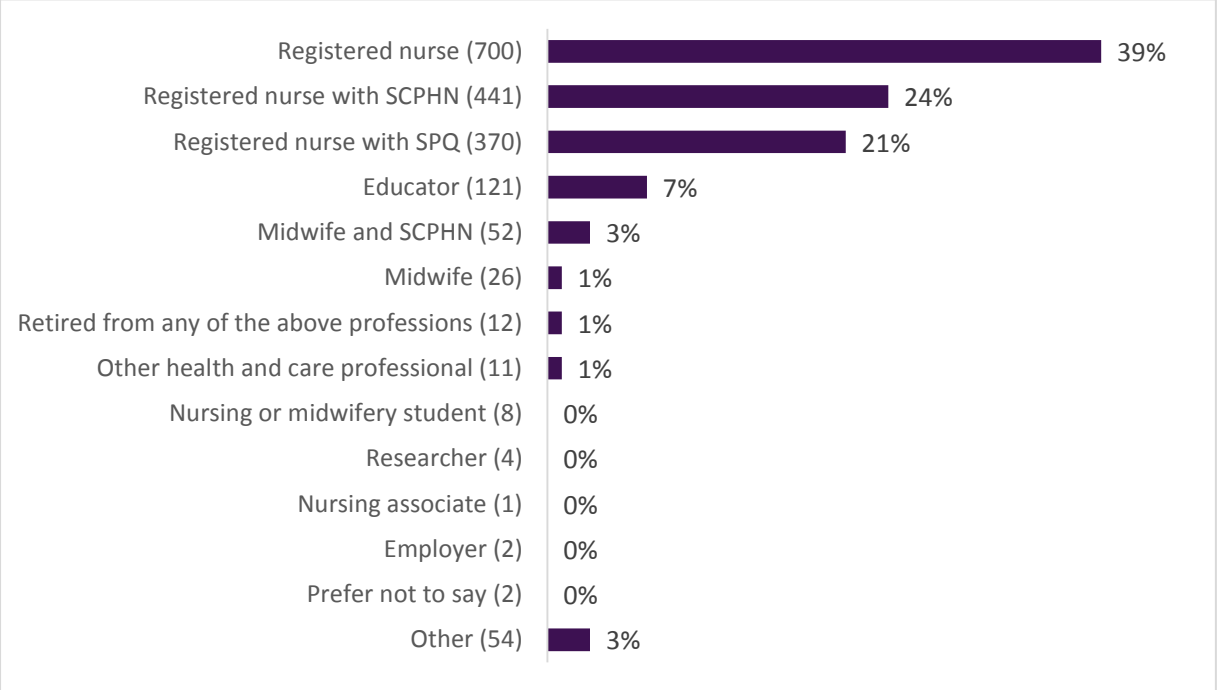
Appendix A: Respondent profile

A.1 Online survey

A.1.1 Respondent background (professional survey)

383. Individuals responding to the professional survey online work in a range of roles. Two in five respondents - 39% - are registered nurses (700), while 24% (441) are registered nurses with SCPHN and one in five - 21% (370) - are registered nurses with a community SPQ annotation. Some 50 'other' responses were received, these are registered nurses who are studying towards a SCPHN or SPQ or are students. A small number (4) are advanced clinical or nurse practitioners.

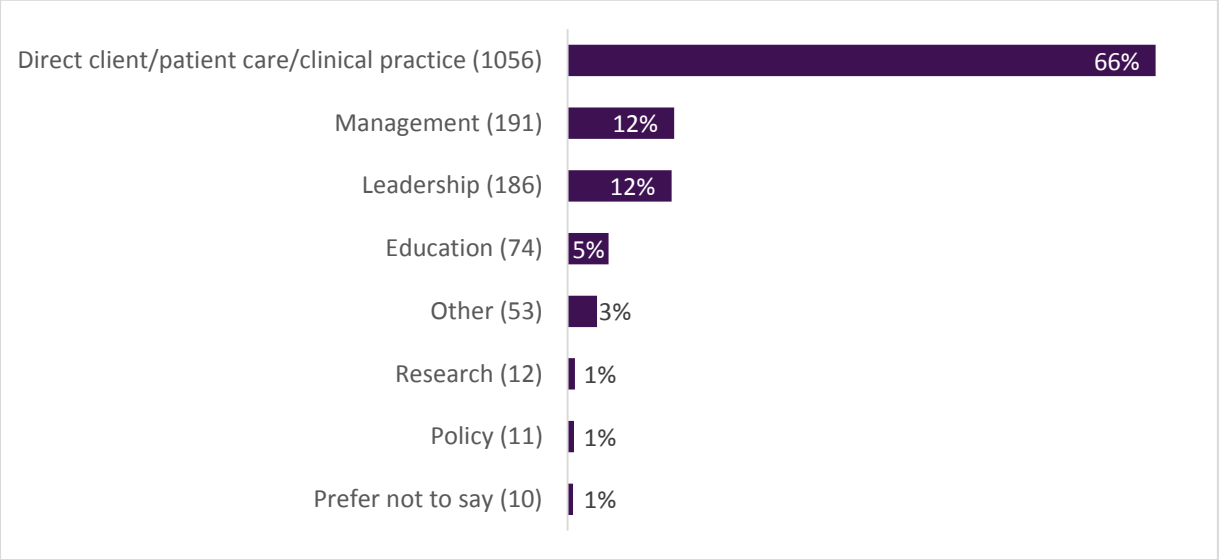
Figure A61 Individual respondents by type of health and social care professional



Base: 1,804 respondents.

384. Registered nurses and midwives were asked about their current practice and 66% (1,056) work directly with patients in clinical practice, while a quarter - 24% (377) - work in management or leadership (n=1,593). 'Other' practices mentioned by 53 respondents most commonly describe their role as safety and safeguarding, while a small number work as advisors on a commission basis, and others are students.

Figure A62 Individual respondents' current practice

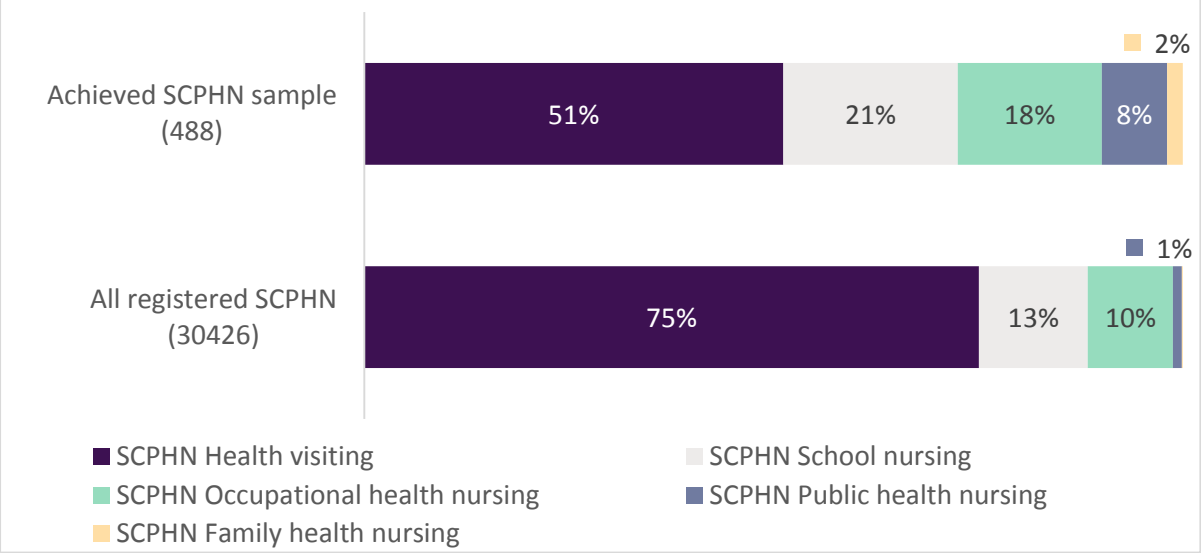


Base: 1,593 respondents.

385. This same group were also asked about their current work setting (a multi-choice question). Over half (53%) of these respondents work in the community setting while one in five (20%) work in an NHS hospital or other secondary or tertiary care and one in ten (11%) in a GP practice or other primary care. Other individuals work across a range of fields from public health (6%), occupational health (5%), in care homes (5%), school/education sector (3%) and a minority (fewer than 3%) work in settings such as prisons, social care, voluntary sector, and government, among others.

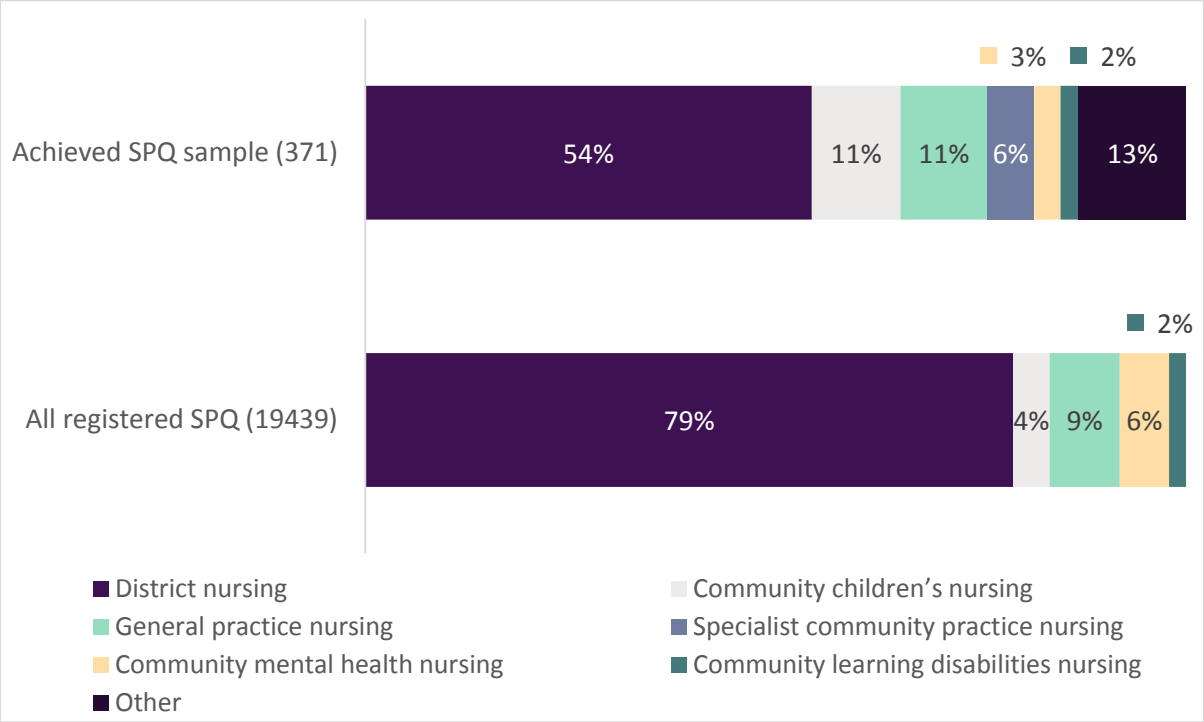
386. Professionals with SCPHN, or studying towards this, were asked which area of practice they work or study in. This was a multi-choice question and has been analysed by responses which shows 51% (249) work/study in HV, whilst most of the others work in SN 21% (102) or OHN 18% (88).

Figure A63 Individual respondents by SCPHN area



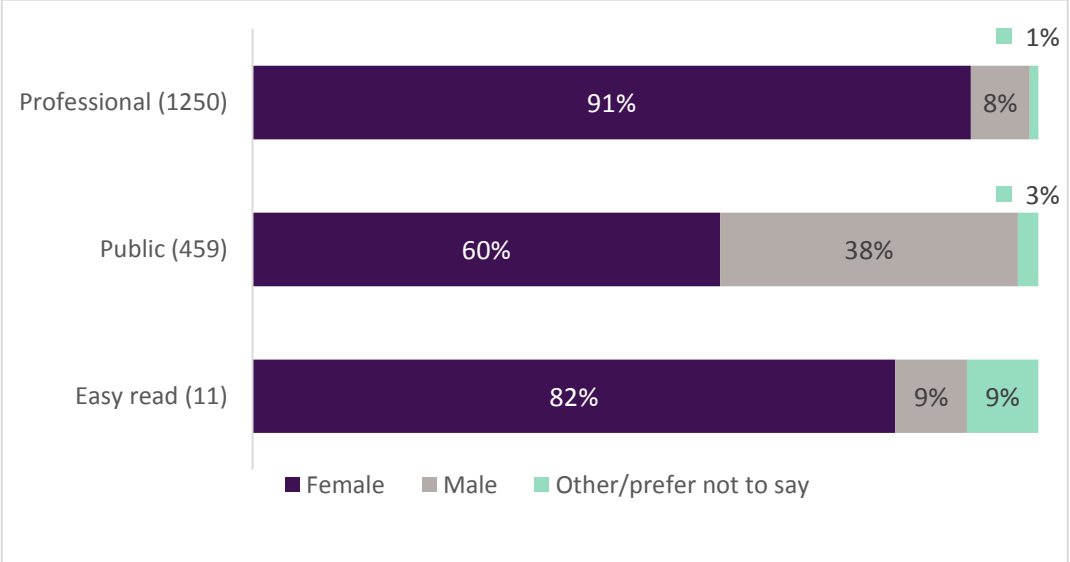
387. Professionals with a community SPQ annotation, or studying towards this, were asked which area of practice they work or study in. Again, this was a multi-choice question and has been analysed by responses which shows the majority are working in or studying for DN - 54% (200) - with a spread across other SPQ areas. “Other” SPQ areas mentioned by respondents focused on their role or workplace setting, with typical responses including clinical education, or palliative care.

Figure A64 Individual respondents by SPQ area



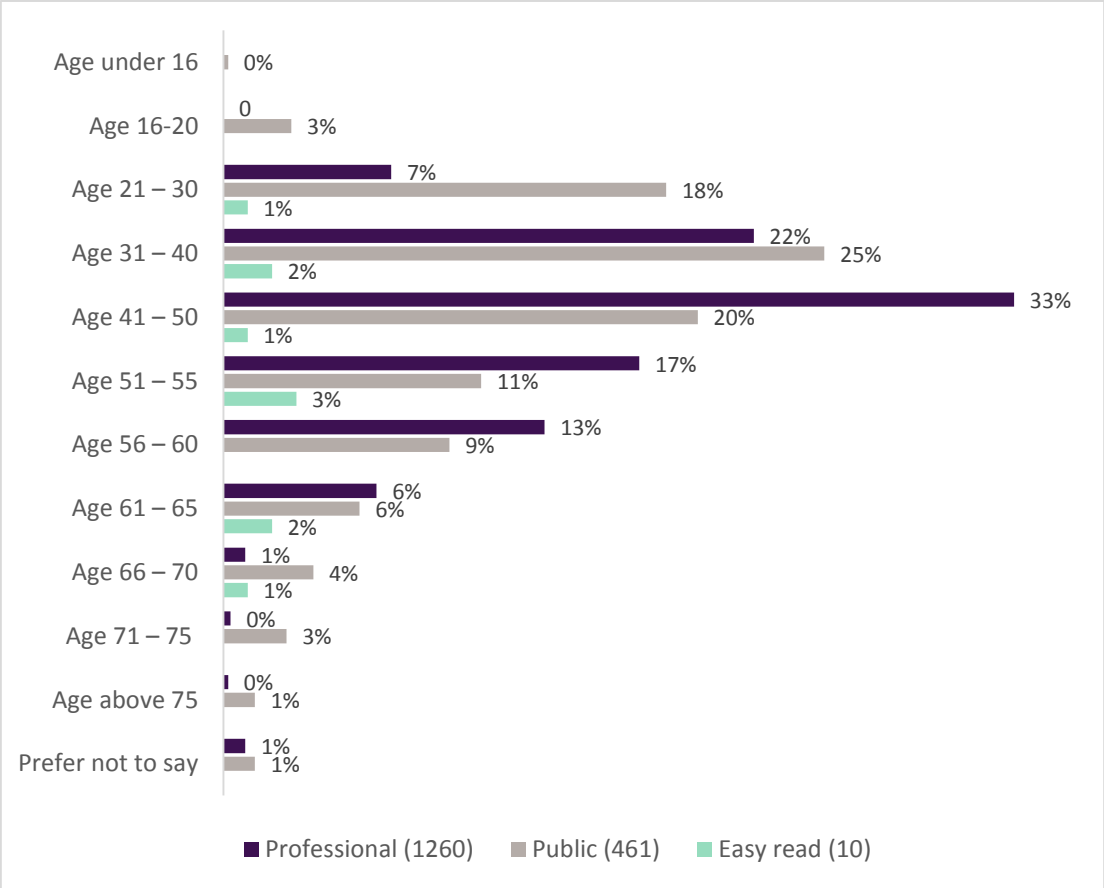
A.1.2 Demographic profile (professional, public and easy read surveys)

Figure A65 Respondent profile by gender



388. Note that, at the end of March 2021, some 89% of the NMC register is female, and 11% male.[14]

Figure A66 Respondent profile by age



389. Note that, relative to the age spread of the register population, this survey achieved a higher proportion of responses from older registrants, and fewer from young registrants. Notably, the proportion of the register aged 21-30 and 41-50 is 16% and 25%, respectively, while the achieved professional sample includes 7% aged 21-30 and 33% aged 41-50.

[14] NMC, March 2021, Annual registration report

Figure A67 Respondent profile by nation[15]

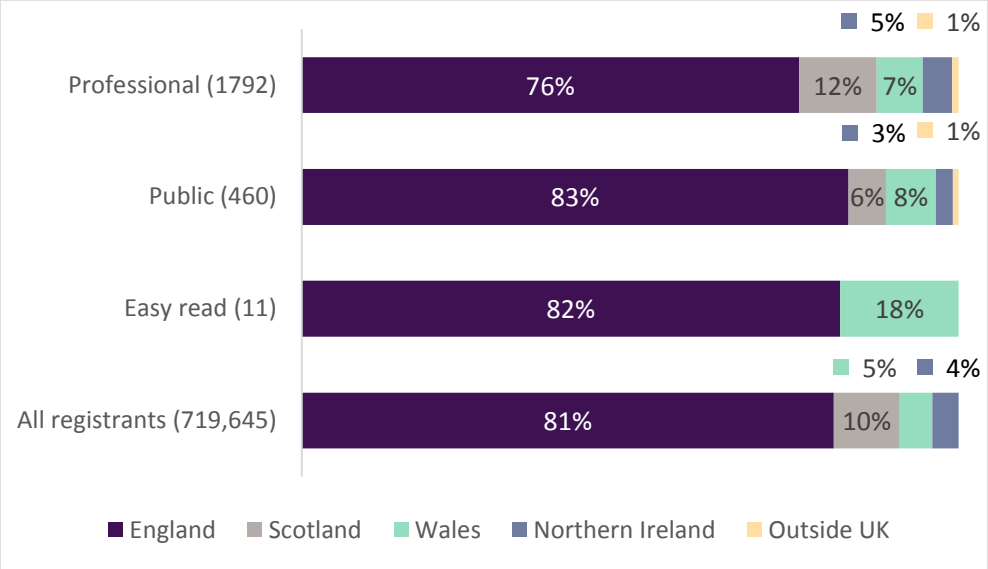
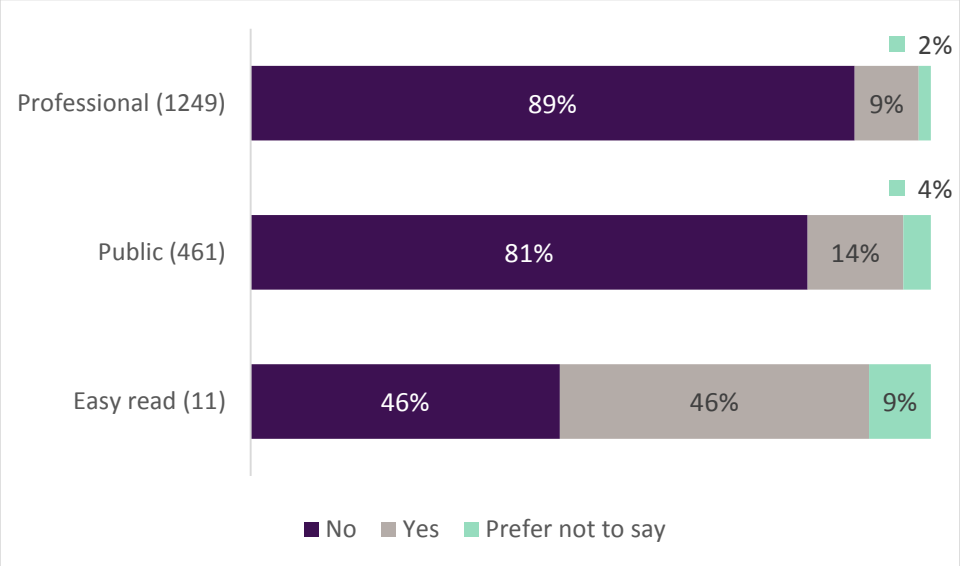


Figure A68 Respondent profile by disability



[15] All registrant data source: NMC mid-year registration report, September 2021. Excludes overseas.

Figure A69 Respondent profile by type of disability

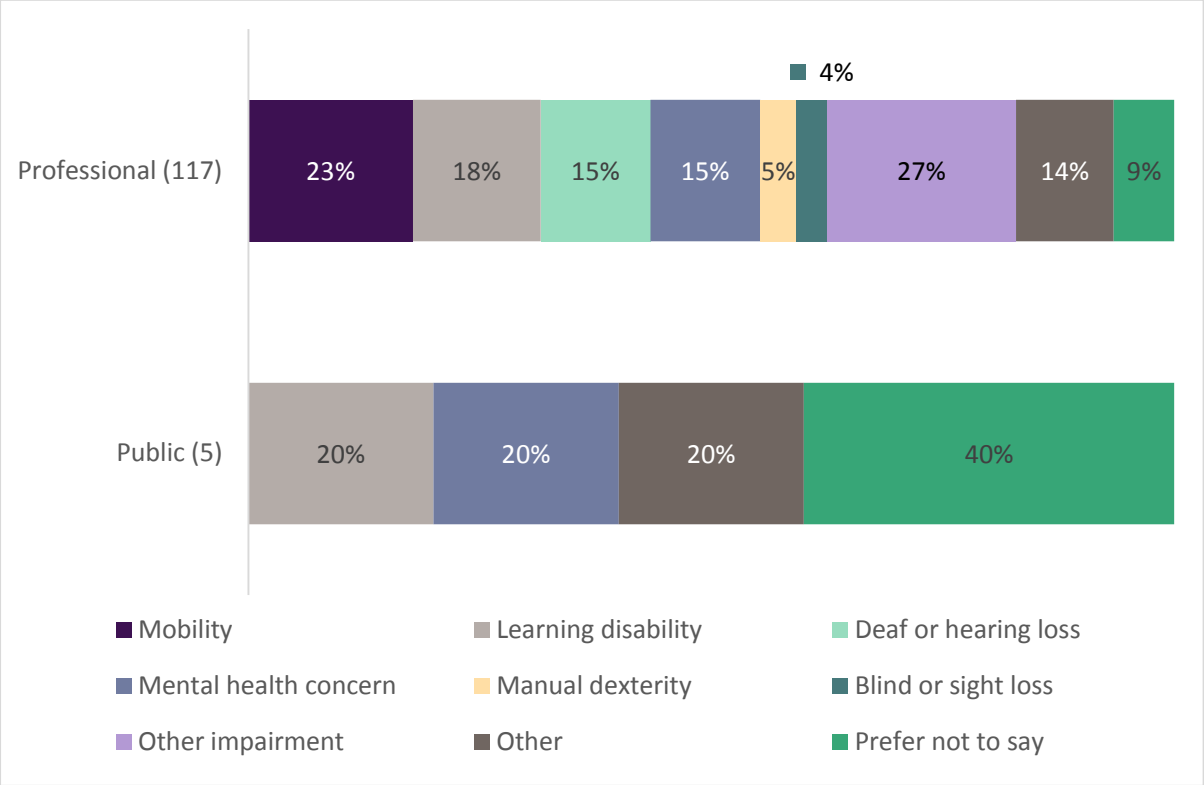
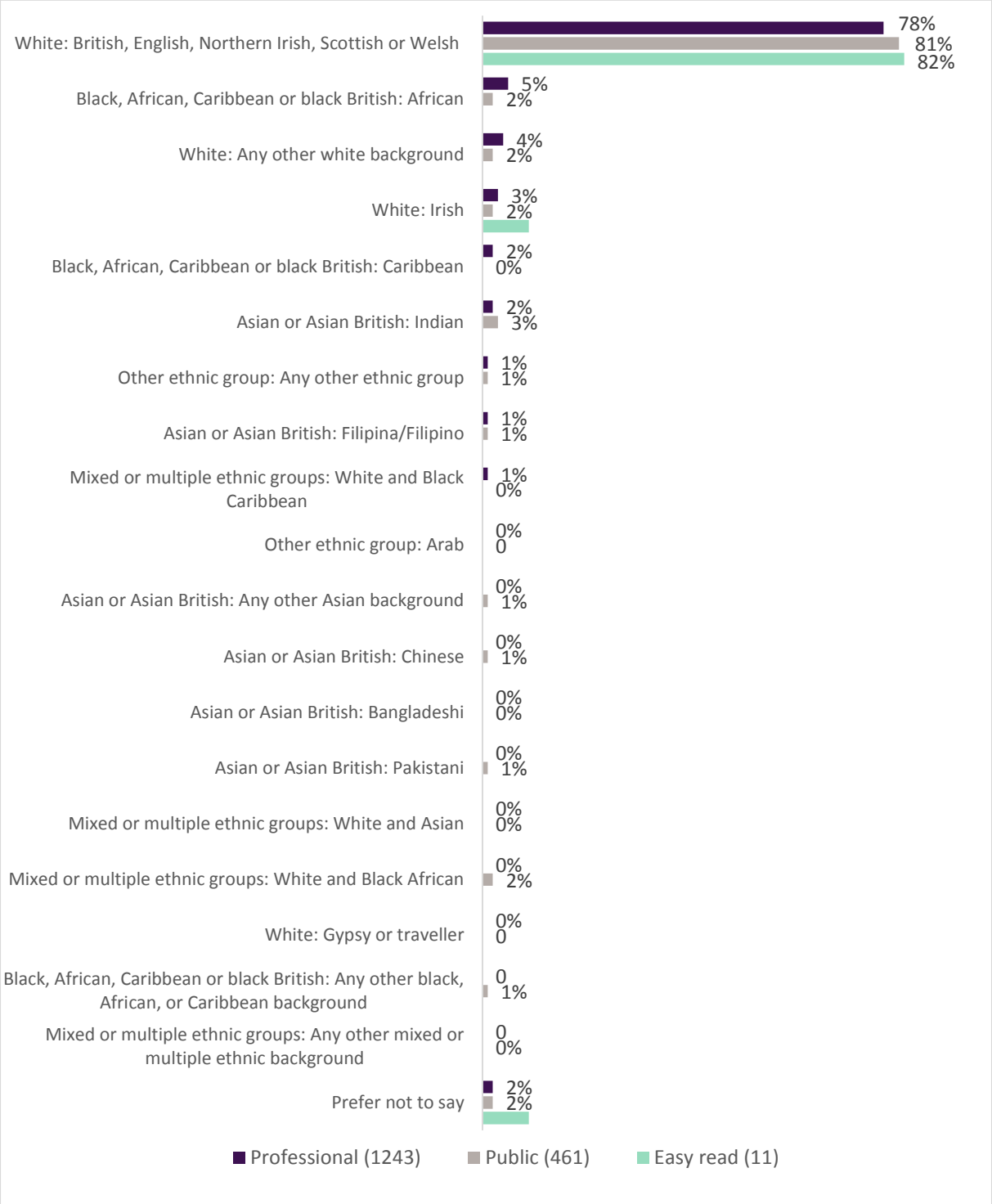


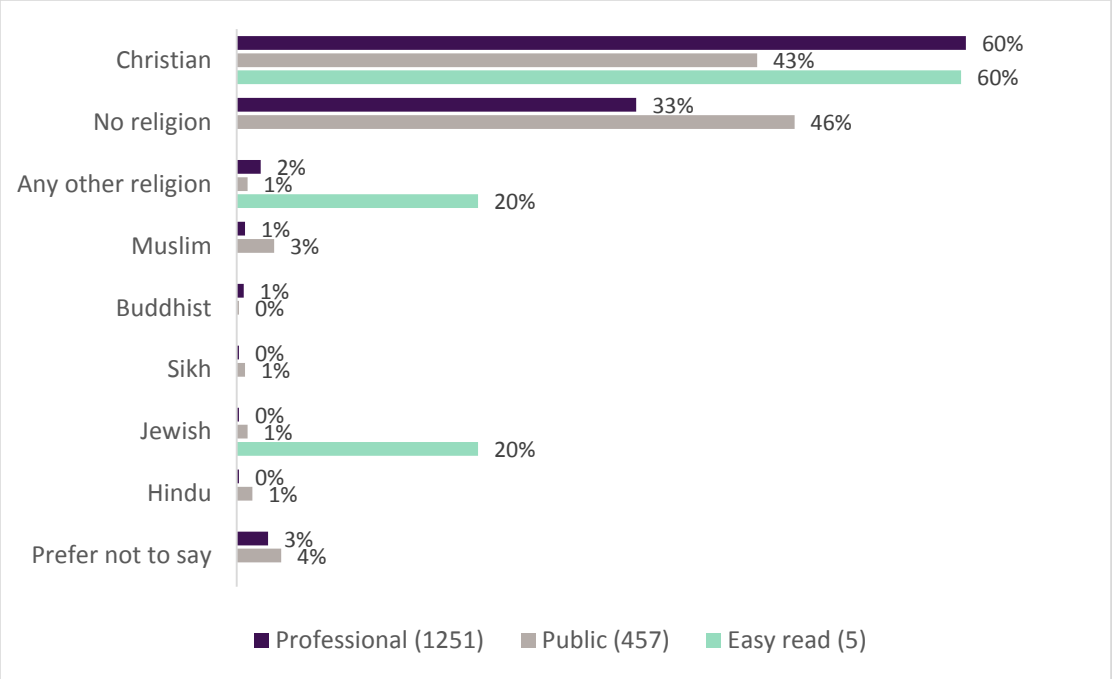
Figure A70 Respondent profile by ethnicity



390. 'Other' ethnic profile listed include Polish, European, Australian, Swedish, and Latin American.

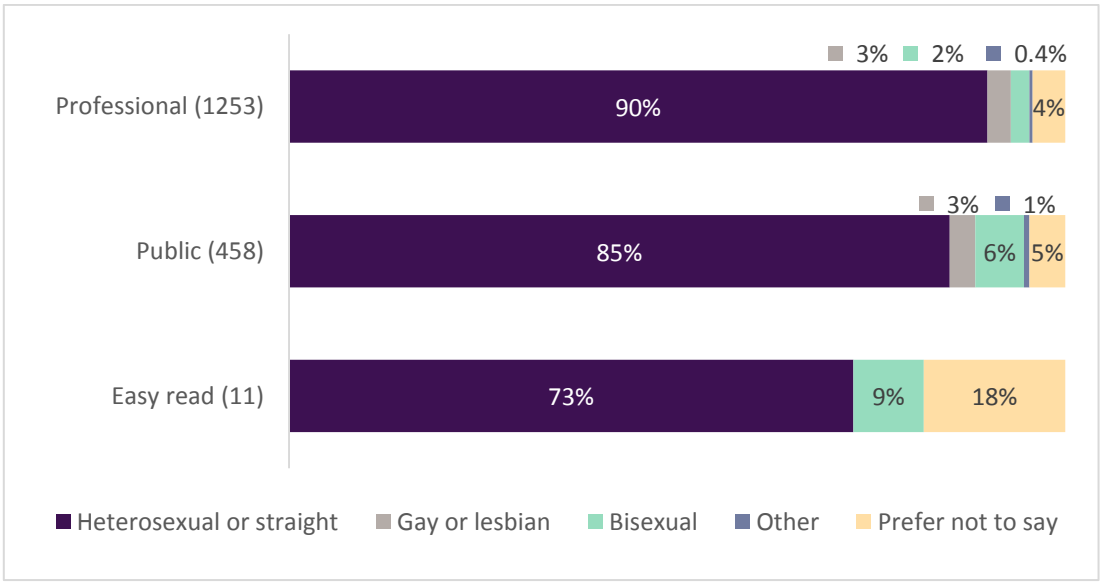
391. For context, of the 731,918 professionals on the NMC register in March 2021, 74% are White, 10% are Asian, 9% are Black, 1.5% are mixed race, 0.9% are other, 2.4% preferred not to say, and 1.6% percent didn't declare.

Figure A71 Respondent profile by religion



392. 'Other' religions listed include agnostic, atheism, Pagan, Catholic, and Spiritualist.

Figure A72 Respondent profile by sexual orientation



393. 'Other' sexualities include pansexual and asexual.

A.2 Qualitative fieldwork

394. Some 77 individuals participated in the 11 focus groups, with an average of 7 participants in each group. In addition to the groups, 49 individual depth interviews were conducted. The demographic profile of participants is detailed below.

Gender	Focus groups	Depth interviews
Female	54%	57%
Male	46%	37%
Other/prefer not to say	0%	6%

Ethnicity	Focus groups	Depth interviews
White: British, English, Northern Irish, Scottish or Welsh	57%	63%
White: Irish	1%	4%
White: Gypsy or traveller	0%	13%
White: Any other white background	8%	4%
Mixed or multiple ethnic groups: White and Black Caribbean	0%	0%
Mixed or multiple ethnic groups: White and Black African	0%	2%
Mixed or multiple ethnic groups: White and Asian	1%	0%
Mixed or multiple ethnic groups: Any other mixed or multiple ethnic background	1%	0%
Asian or Asian British: Indian	4%	8%
Asian or Asian British: Pakistani	7%	2%
Asian or Asian British: Bangladeshi	0%	0%
Asian or Asian British: Chinese	0%	0%
Asian or Asian British: Filipina/Filipino	0%	0%
Asian or Asian British: Any other Asian background	3%	0%
Black, African, Caribbean or black British: Caribbean	1%	0%
Black, African, Caribbean or black British: African	12%	2%
Black, African, Caribbean or black British: Any other black, African, or Caribbean background	4%	2%
Other ethnic group: Arab	1%	0%
Other ethnic group: Any other ethnic group	0%	0%
Prefer not to say	0%	0%

Sexual orientation	Focus groups	Depth interviews
Bisexual	5%	0%
Gay or lesbian	6%	12%
Heterosexual or straight	77%	84%
Other/prefer not to say	12%	4%

Location	Focus groups	Depth interviews
Rural	25%	35%
Urban	75%	65%

Nation	Focus groups	Depth interviews
England	65%	61%
Northern Ireland	9%	8%
Scotland	8%	23%
Wales	18%	8%

Appendix B: List of responding organisations

395. Some 105 consultation responses were received from organisations in total, with 81 via the online survey. In the separate list that follows, 24 offline responses were received through the NMC's mailbox.

396. The following 79 organisations responded via the online survey (two did not provide their name):

- All Wales District Nursing Forum
- Belfast Health and Social Care Trust
- Birmingham Community Healthcare NHS Foundation Trust
- Bournemouth University
- Buckinghamshire Healthcare NHST
- Cambridgeshire & Peterborough Training Hub
- Cambridgeshire Community Services NHS Trust
- Cardiff University
- Central London Community Healthcare NHS Trust
- Cheshire and Merseyside Directors of Nursing and Quality Group - Health Care Partnership
- Clinical Education Centre
- Council of Deans of Health
- Cumbria Northumberland Tyne and Wear NHS Trust
- Dementia UK
- Derbyshire Community Health Services NHS Foundation Trust
- District Nursing Salford Care Organisation
- Dorset HealthCare
- East London NHS Foundation Trust
- Faculty of Occupational Health Nursing
- First community health and care
- Health and Safety Executive
- Hertfordshire and Worcestershire Health and Care NHS Trust
- Hertfordshire Community NHS Trust
- Homerton University Hospital NHS Foundation Trust
- Independent Healthcare Providers Network
- Institute of Health Visiting
- Keele University
- King's College London
- Lancashire South Cumbria NHS Foundation Trust
- Liverpool John Moores University
- Local Community Partnerships
- Marie Curie UK
- Mental Health Nurse Academics UK
- NHS Education for Scotland
- NHS England South West Nursing Directorate
- NHS LANARKSHIRE
- NHS Lanarkshire
- Nigerian Nurses Charitable Association UK
- Northamptonshire Healthcare FT
- North West Non-Medical Prescribing Education Group
- Northumbria University
- Northumbria University
- Occupational Health 1st
- Occupational Health Nurses for the Police Service
- PHE
- Practio UK
- Queen's Nursing Institute Scotland
- Queen's University Belfast
- Robert Gordon University
- Royal College of Nursing
- School and Public Health Nurses Association
- Scottish Executive Nurse Directors
- Scottish Network of Post Registration Community Nurse Educators
- Scottish Nursing Guild / Thornbury Nursing Services
- Sheffield Teaching Hospitals NHS Foundation Trust
- Skills for Care
- Society of Occupational Medicine
- Southern Healthcare (Wessex) Ltd
- St Catherine's Hospice, West Sussex

- Sussex Partnership NHS Foundation Trust
- The Queen's Nursing Institute
- The Royal College of Midwives
- The Society if Local Council Clerks
- University of Central Lancashire
- UNICEF UK Baby Friendly Initiative
- UNISON
- Unite CPHVA
- University Hospitals of Morecambe Bay
- University of Chester and Associated Practice Partners
- University of Derby
- University of Hertfordshire
- University of Hull
- University of Salford
- University of Salford
- University of South Wales
- University of South Wales
- University of Stirling
- University Of Sunderland
- University of Surrey

397. The following 24 organisations responded offline via the NMC's mailbox:

- Birmingham and Solihull Mental Health NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Central and North West London NHS Foundation Trust
- Cheshire and Merseyside Directors of Nursing and Quality Group
- Council of Deans of Health
- Five Country Digital Leadership Group for Nursing and Midwifery (DLG)
- Florence Nightingale Foundation
- Health Education England & NHS England and Improvement
- Hertfordshire Community NHS Trust
- Hywel Dda University Health Board
- Institute of Health Visiting
- Joint Adult Social Care (National Care Forum, Care England, Registered Nursing Home Association, National Care Association, My Home Life, Eden Alternative UK, NICHE-Leeds and Providers and Academics Transforming Care Homes together (PATCH))
- National Institute for Health Research
- National Mental Health Nurse Consultant Forum
- Newcastle upon Tyne Hospitals NHS Trust
- Royal College of General Practitioners
- School and Public Health Nurses Association
- The Mental Health Network
- The Queen's Nursing Institute
- UK online Children's Community Nursing forum
- Ulster University
- UNISON
- Unite the Union (in Health)
- WeLDNurses

Appendix C: Topic guides

398. Note: Where appropriate, questions and prompts were tailored and simplified for each audience (e.g. young people, those with learning disabilities, etc.) to ensure understanding.

C.1 Focus group discussion guide

Total length: 90 minutes
Note: in the topic guides we refer to the material that will be sent to the research participants prior to focus group and interview discussions as the consultation documents.

1. Background & introductions	• Welcome • Outline the purpose and structure of focus group, clarify aim of discussion and focus group etiquette. • Refer to the consultation documents & thank participants for completing pre-read.	5 mins
2. Short presentation	• Short overview with slides explaining the role of NMC and consultation aims	5 mins
3. Icebreaker (to put people at ease / build rapport)	• Does anyone know of or have connection/experience with any of the specialist nurses mentioned in the consultation documents and in our slides? (facilitator to remind of roles if unsure) • Have you had experience of care of any of the specialist nurses recently or during COVID-19 pandemic? Has anything surprised or pleased you in terms of that care experience?	5 mins
4. Priority topics for the consultation documents	• Ask participants to send (via chat tool) up to 3 things that they feel strongly about with regard to the role of the specialist nurses; this could be something they have identified from reading through the consultation documents, something that they have personal experience of, or something that may have been overlooked or omitted from the consultation documents that is important to them. • Identify key topics/themes for discussion: why are they so important?	15 mins
5. Review of consultation documents	**Accessibility and clarity** • Thinking about the summary of draft standards, to what extent do you feel it is written in a way that's clear and easy for you to understand? Prompts: - *Do any changes need to be made to language? Or to the format, structure, layout? If so, what?* **Knowledge and skill requirements for each specialist nurse** • Based on the consultation documents that you read beforehand, to what extent do the draft standards reflect what specialist nurses need to know and be able to do? (facilitator to discuss each role in turn) • Do you think the draft standards reflect what you need from each specialist nurse in the home, close to home, in the community, at school or in the workplace in terms of service? Can you explain why you think that? • What (if any) additional standards are needed? Is there anything obvious missing? Note for facilitator: *- SCPHN roles include: health visitors, occupational health nurses, school nurses. SPQ include: community children's nurses, community learning disabilities nurses, community mental health nurses, district nurses, general practice nurses.* *- Facilitator to adjust question to the relevant group of participants, e.g. ask children/young people about school nurses and community children's nurses, and people in employment about occupational health nurses etc.*	50 mins

	-Facilitator can clarify that NMC is proposing an additional SPQ where the field is not specified – this can be a flexible one to fit all kinds of specialist community roles such as specialist nurses in social care or those working in prisons. **Vision, ambition, and inclusivity** • Based on the consultation documents you read beforehand, to what extent do the draft standards meet your current needs? Do you think your future needs are likely to be met? • Do you feel that there are any aspects of the draft standards that could discriminate or disadvantage on the basis of age, gender, sexual orientation, marital status, race, disability or religion? What concerns, if any, do you have? Prompts: *- How ambitious do you think the draft standards are in improving people's health and addressing health inequalities? To what extent do you think they support innovation and creativity?* *-Do you think that the draft standards are applicable to your country, i.e. England/Wales/Scotland/Northern Ireland?*	
6. Final comments / wrap up	• Do you have any final comments you would like to make? • Encourage respondents to complete the online consultation survey. • Thank them for time and contributions. Reassure about confidentiality	10 mins

C.2 Depth interview topic guide

Total length: 40 minutes

1. Background & introduction	• Welcome • Clarify aims, purpose and structure of discussion • Refer to the consultation documents & thank participant for completing pre-read. • Introduction to explain the role of the NMC and the consultation aims	10 mins
2. Icebreaker (to put interviewees at ease)	• Do you know of or have connection/experience with any of the specialist nurses mentioned in the consultation documents and in our slides? • Have you had experience of care of any of the specialist nurses recently or during COVID-19 pandemic? Has anything surprised or pleased you in terms of that care experience?	2 mins
3. Individual responses to the consultation documents	• Ask them about up to 3 things that they feel strongly about with regard to the role of the specialist nurses; this could be something they have identified from reading through the consultation documents, something that they have personal experience of, or something that may have been overlooked or omitted from the consultation documents that is important to them. • Why are these 3 things so important?	5 mins
4. Review of the draft Standards	**Accessibility and clarity** • Thinking about the summary of draft standards, to what extent do you feel it is written in a way that's clear and easy for you to understand? Prompts: *- Do any changes need to be made to language? Or to the format, structure, layout? If so, what?* **Knowledge and skill requirements for each specialist nurse**	20 mins

	• Based on the consultation documents that you read beforehand, to what extent do the draft standards reflect what specialist nurses need to know and be able to do? (facilitator to discuss each role in turn) • Do you think the draft standards reflect what you need – in terms of service or 'my care' and the services you need/expect – from each specialist nurse? Can you explain why you think that? • What (if any) additional standards are needed? Is there anything obvious missing? Notes for facilitator: *- SCPHN roles include: health visitors, occupational health nurses, school nurses. SPQ include: community children's nurses, community learning disabilities nurses, community mental health nurses, district nurses, general practice nurses.* *- Facilitator to adjust question to each participant, e.g. ask children/young people about school nurses and community children's nurses, and people in employment about occupational health nurses etc.* *-Facilitator can clarify that NMC is proposing an additional SPQ where the field is not specified – this can be a flexible one to fit all kinds of specialist community roles such as specialist nurses in social care or those working in prisons.* **Vision, ambition, and inclusivity** • Based on the consultation documents you read beforehand, to what extent do the draft standards meet your current needs? Do you think your future needs are likely to be met? • Do you feel that there are any aspects of the draft standards that could discriminate or disadvantage on the basis of age, gender, sexual orientation, marital status, race, disability or religion? What concerns, if any, do you have? Prompts: *- How ambitious do you think the draft standards are in improving people's health and addressing health inequalities? To what extent do you think they support innovation and creativity?* *-Do you think that the draft standards are applicable to your country, i.e. England/Wales/Scotland/Northern Ireland?*	
5. Final comments / wrap up	• Do you have any final comments you would like to make? • Encourage respondents to complete the online consultation survey • Thank them for time and contributions. Reassure about confidentiality	3 mins

Appendix D: Suggestions of additional or supplementary standards

399. Respondents were given a chance to add final comments about any part of the proposed SCPHN or SPQ draft standards of proficiency, or the programme standards, that they feel are additional, supplementary or could augment the draft standards. They also mentioned aspects, some of which are outwith the remit of the regulatory body. Such concerns are detailed below in separate subsections.

D.1 SCPHN - Potential additional or supplementary content

400. Respondents suggest the draft SCPHN standards could be improved through stronger emphasis of certain aspects. The following are some of the suggestions from those responding to the SCPHN section of the survey:

- bereavement care,
- breastfeeding and infant feeding,
- children and young people rights,
- communicating and working with other services,
- environmental factors,
- families and carers,
- leading and teaching skills,
- learning disabilities and SEND,
- mental health and trauma informed care,
- public health and prevention,
- safeguarding (adults and children),
- sexual health,
- the workplace environment, and
- working with the most vulnerable people.

401. In addition, some respondents perceive certain topics to be absent, or near-absent, within the draft SCPHN standards, however, in several cases, such comments are not fully accurate and some material is indeed already present.

- Advanced assessment
- Child development
- Communication and interpersonal skills
- End of life
- GIRFEC and the Named Person role
- Health surveillance
- Infant feeding
- Infection control
- Lone working
- Mental Health
- Older people
- Prescribing
- Prevention
- Safeguarding

- Understanding 0-19 ages
- Whole population health
- Workplace and regulations

D.2 SPQ - Potential additional or supplementary content

402. Respondents suggest the draft SPQ standards could be improved through stronger emphasis of certain aspects. It should be noted that some suggestions made under specific Platform headings may actually be already included within the standards but under different Platform headings. The following are some of the suggestions from those responding to the SPQ section of the survey.

SPQ Platform 1: - respondent suggestions

403. To help highlight exactly what is required of CCNs in terms of how they should be autonomous in practice:

> 1) Making professional judgements and decisions and work in complex, unfamiliar environments, proactively identifying actions and solutions to problems that may have many interacting factors.
>
> 2) Use safe and effective independent and supplementary prescribing (V300) and medicines administration, optimisation and medicines reconciliation.
>
> 3) Deep awareness of safeguarding and understand the implications a complex health diagnosis can have on a CYP, their family dynamics and relationships, to ensure adequate assessment and action is taken to safeguard the CYP at all times.

404. To help highlight exactly what is required of DNs in terms of how they should be autonomous in practice:

> 1) Supervise the delivery of person-centred care by the DN team ensuring regular evaluation of care.
>
> 2) Promote and model effective team working within the DN team and the wider Multidisciplinary Team - this is a crucial aspect of the role.
>
> 3) Use creative problem solving to develop a positive learning environment and workplace for disciplines and professions learning about caring for people in the community.
>
> 4) For the DN role it is imperative DNs are trained in interdisciplinary and integrated working rather than profession-based silos.
>
> 5) The need to demonstrate resilience and autonomy in the context of changing demand and managing change to meet the evolving shape of services through flexibility, innovation and strategic leadership.

SPQ Platform 2: - respondent suggestions

405. With DN in mind, some additions to the Platforms that respondents believe will be more tailored to the requirements that DNs have when working in communities are:

1) Apply the principles of risk stratification and case management to enable and support those most at risk in communities.

2) Work in partnership to promote the concept of self-care and where possible patient led care.

3) Support the team to facilitate behaviour change and health coaching approaches.

4) Lead and foster a culture of openness and recognition of duty of candour.

5) The standards need to reflect that the DN is a team leader, a role model and is responsible for ensuring safe and effective patient care to a large and diverse caseload of patients - a specialist generalist rather than a nurse focusing on one speciality.

406. Closer alignment with the needs and requirements of a CCN when promoting health and preventing ill health.

1) Use expert knowledge and skills to support CYP and their families with additional needs due to mental health, learning disabilities, physical disabilities and/or with multiple complex long-term conditions.

2) Work with CYP and families to symptom manage their (complex long term) condition; teaching, educating, and assessing them to empower independent management of their condition in the community, knowing when and how to access support to escalate care if and when this is required.

3) Provide expert evidenced-based support to CYP and families in the diagnosis and during management of life-limiting condition, including bereavement support.

4) Apply parallel planning in clinical uncertainty and with fluctuating care needs, including where there may be no formal medical diagnosis.

5) Assess the impact of key transition periods of CYP within their health care journey, supporting the CYP and family with evidence-based intervention support.

SPQ Platform 3: – respondent suggestions

407. To counter a perception of overly adult-centric and generic standards, one respondent suggests five alternatives relating to the assessment of CYP's care, and the direct support that should be provided for families of patients when planning care.

1) Assess and evaluate risk using a variety of tools across a broad spectrum of often unpredictable situations that incorporates safeguarding, including staff, children and young people and families within their home environments.

2) Assess the health-related needs of CYP and their families, developing therapeutic relationships and working in partnership to co-produce care plans identifying roles and responsibilities that include anticipatory and proactive care, delivery of care packages aiming to improve health, well-being and the promotion of self-care in addressing short- or long-term health conditions.

3) Develop care plans and support CYP and their families, through family-centred care model, to ensure inclusion within all community activities, including accessing education settings; working with education and social care providers to teach and assess non-registered professionals' clinical skills required. This includes assessing risk management and delegation care processes.

4) Listen and support CYP and their families to access additional resources to support them in managing their CYP complex health needs within the community setting, including continuing care.

5) Understand and respond appropriately to support the family around the "loss" of the normal child, when their CYP is diagnosed with a complex health condition, including the impact this can have on family relationships, professional relationships and increasing risk of safeguarding.

408. Further suggestions of alternative bespoke standards are provided for DN, to accurately demonstrate their role in relation to assessing peoples' abilities and needs, and planning care. Additional clarity is perceived to be required to:

1) Reflect the key role that the DN plays at the interfaces between care, particularly focusing on their role in admissions avoidance and supporting early patient discharge from hospital - this requires collaborative MDT working across boundaries.

2) Recognise the DN role in maximising the use of a patients personal and local assets to be able to manage complex conditions in the absence of 24 hr nursing care.

3) Use physical and clinical examination skills to undertake assessment of individuals with complex health needs and those presenting with 'acute on chronic' conditions. Use diagnostic decision making.

4) Where appropriate undertake the case management of people with complex needs, co-ordinating responses across providers to ensure person centred care.

5) Ensure all staff are able to recognise vulnerability and understand their responsibilities in terms of safeguarding and risk management.

SPQ Platform 5: – respondent suggestions

409. It is noted that the CCN workforce is a relatively new discipline, and thus requires leadership skills to incorporate the voice of the CYP in leading and developing services, and four additional alternative standards are suggested to more accurately indicate the level of leadership and management skills required of a CCN. These are:

1) Advocate for CYP complex health services, ensuring their voice is heard, supporting co-production, co-design and development at all levels within Community Children's nursing.

2) Use specialist knowledge, expertise, skills, and evidence when influencing and advocating for high quality care and education (health and social) of CYP with complex health needs, at multiagency collaborations, meetings and panels.

3) Promote visibility of CCN services and ensure accessibility through engagement with CYP and their families. Use skills and knowledge to influence service development that reflects the changing complexity of needs within Children's Community nursing.

4) Use knowledge and understanding of social, political, and economic policies and drivers to analyse the strategic imperatives that may impact on community children's nursing services and the wider health care community. Where appropriate, participate in organisational responses and use this knowledge when advocating for children and young people and resources.

410. Bespoke standard suggestions are made regarding leading and managing teams as a DN in the community. Five points are outlined that will reflect more accurately what the requirements are for a DN:

1) The DN is required to lead and manage a team that works remotely through indirect supervision.
2) Use of technology to support team working in remote conditions.
3) Standards needed around team wellbeing, ensuring staff feel valued and appraised.
4) Lead, support, clinically supervise and appraise a mixed skill team to provide community interventions in a range of settings, retaining accountability for the work for a large and complex caseload alongside the work of the team.
5) Lead teams to ensure safe staffing levels in care delivery using effective resource analysis. Have an innovative and responsive leadership style, involving service improvement strategies to ensure efficient and safe use of resources in the community.

411. One respondent notes that the CCN workforce is a relatively new discipline, and thus requires leadership skills to incorporate the voice of the CYP in leading and developing services. This respondent suggests four additional alternative standards that they believe will more accurately indicate the level of leadership and management skills required of a CCN – these are the same four standards outlined at the start of this sub-section Platform 5.

SPQ Platform 6 – respondent suggestions

412. Alternative standards for Platform 6 focus more on patient safety and risk assessment for CCN:

1) Undertake complex clinical risk assessment for children and young people in the community including accessing school; college and social activities and with care needs and equipment ranging from supplemental oxygen through to long term ventilation, from nasogastric tube feeding to total parenteral nutrition.

2) Capture the lived experience and lived existence of CYP and evaluate how these influence and inform current and future specialist CCN practice, policy decisions and design of services.

3) Develop strategies to teach, assess and support the maintenance of competencies for unregulated staff caring for CYP with additional needs, in various community settings. Including developing networks to benchmark practice across different geographical areas.

4) Advocate for CYP complex health services, ensuring their voice is heard, supporting co-production, co-design and development at all levels within Community Children's nursing.

Skills Annex: – respondent suggestions

413. Examples of potential inclusions in a Skills Annex:

1) One organisation lists skills that CMHNs should require including bio-psychosocial assessment, skills in psychosocial formulation, skills for psychosocial therapeutic interventions and skills for working co-productively with service users and their families, social circles and multi-disciplinary teams.

2) For GPN, some respondents state that the skills involved in the annex should specifically include cervical screening, immunisation in both adults and children, sexual health, managing long term conditions, planning effective and complex healthcare etc.

General comments:

414. Some specialities are perceived to be missing (in whole or in part) from the standards, with palliative care, chronic illness care, social justice (prison) nursing, hospice care, private care and social care relating to adults all mentioned, with care home nursing being most commonly mentioned. However, in several cases, such comments are not fully accurate and some material is indeed already present in the draft standards.

D.3 Programme standards - Potential additional or supplementary content

415. Respondents who note additional comments that focus on the programme standards suggest the following additions:

1) Timings to gain the level of skill and experience required. Whilst some respondents give specific timeframes (some state three to five years) the main concern was centred around making sure the standards recognise the importance of time to gain the necessary experience.

2) Teaching style and delivery of the course: some mention, for example, that the current SCPHN course is too academic and does not take practical job experience into account sufficiently.

3) The quality of the teaching staff and practice assessors is a concern for some respondents, who believe that more qualified and more experienced teachers or assessors would result in better end-results for students and patients.

D.4 Potential additional or supplementary content outside of NMC's remit

416. Some respondents mention aspects which are outwith the remit of the regulatory body. These comments are detailed below:

1) About staff resources, budgets, and capacity and how these fit in with the standards as those commenting believe this will make it difficult to achieve the standards, or for students to gain adequate experience, due to current short-staffed capacity. Others are worried about any staff accessing SCPHN courses at all during this pressured time. Respondents acknowledge that resources are necessarily constrained by the set-up of their workplace or Trust/Heath board. The need for funding and investment in these roles due to declining staff numbers is highlighted several times.

2) About the pay band relating to SCPHN roles and making a point that taking on more responsibility should result in a higher pay grade. A similar point was made for SPQ. It was

pointed out that there exists a disparity between similar roles across different Trusts/Health boards or UK nations.

3) About the political and commissioning set up of Health Visiting services, and the perceived lack of influence that health visitors have in the current environment (this comment is from a registered nurse in England).