IFF Research

Evaluation of the NMC pre-registration standards: Summary report

Prepared for the NMC
By IFF Research

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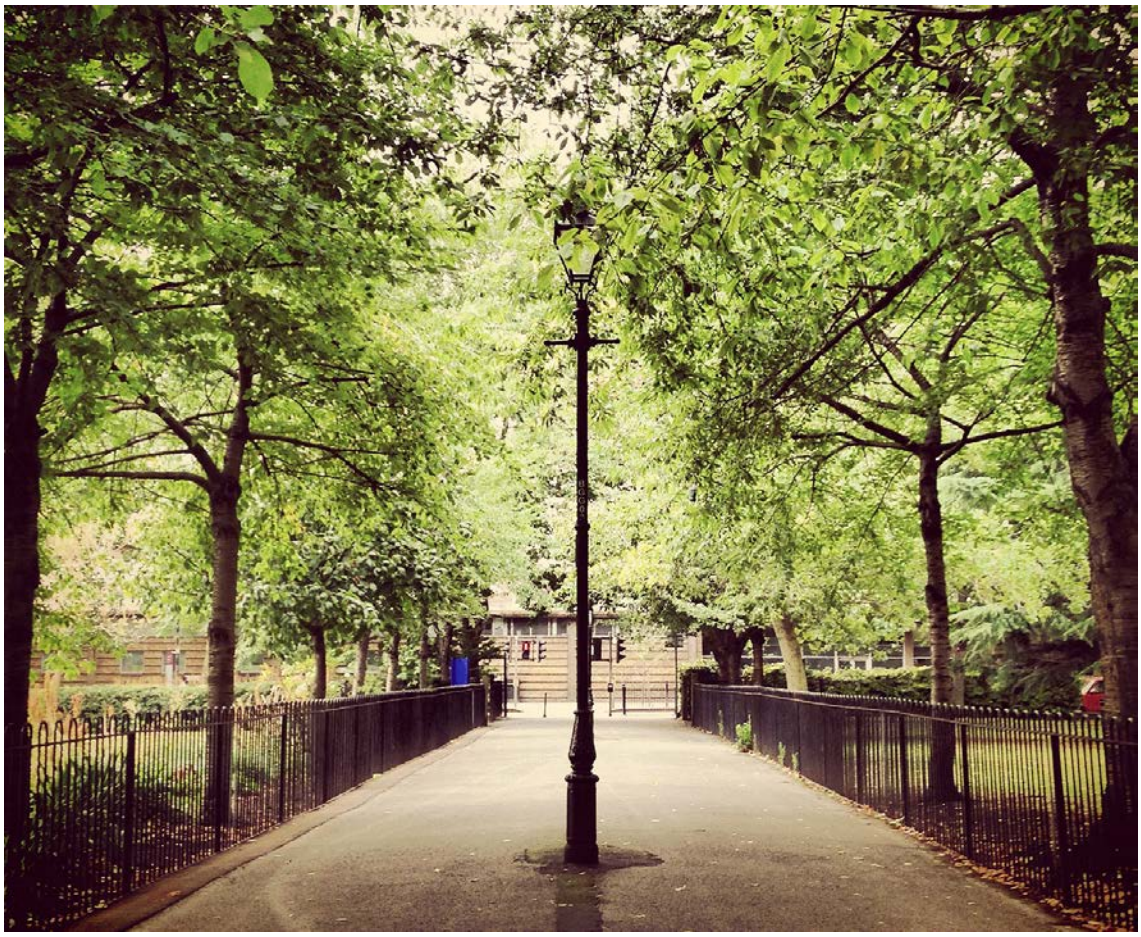

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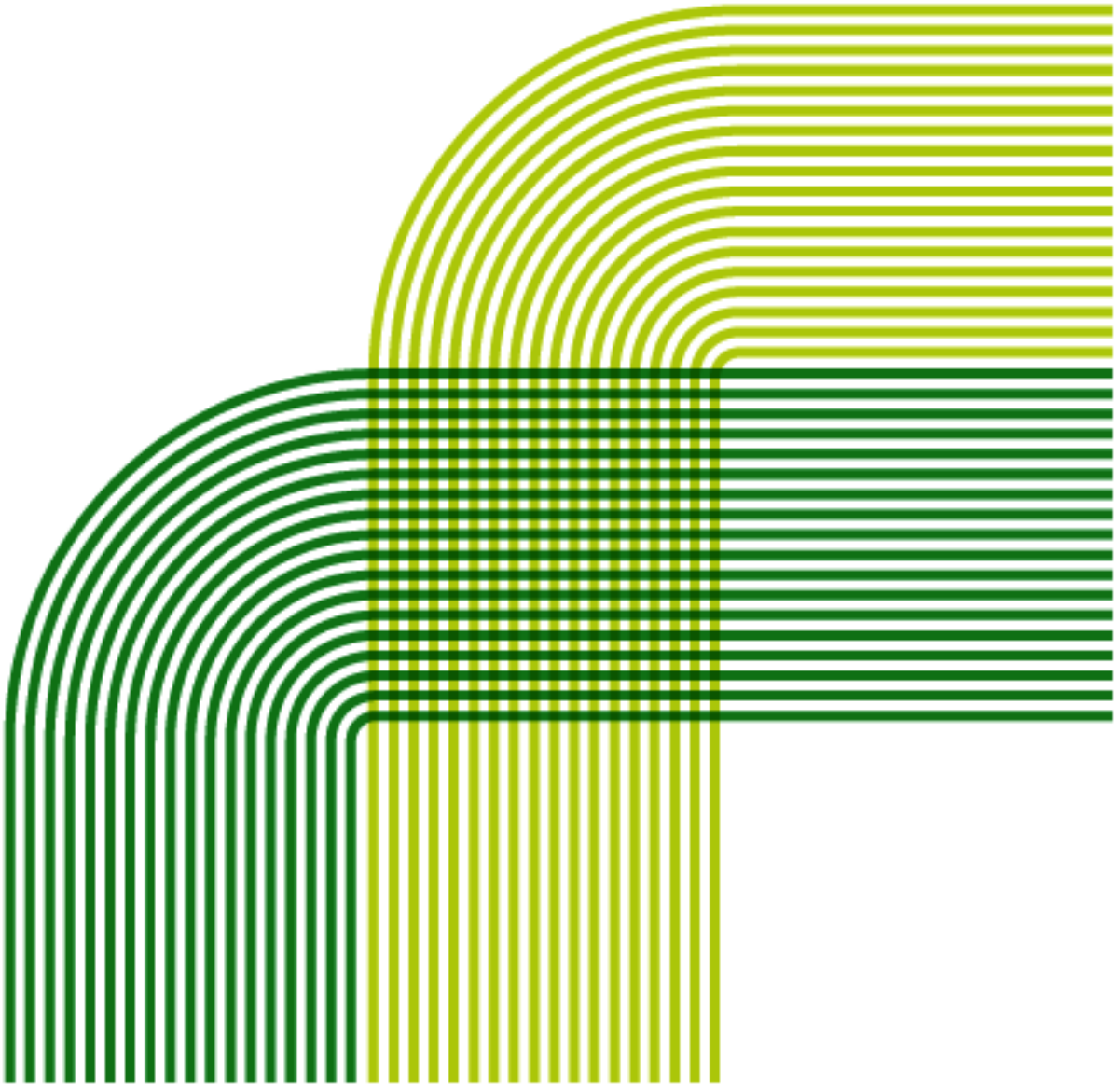

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1 Aims, context and approach

Aims and objectives

1.1 The NMC commissioned IFF Research in July 2014 to carry out an evaluation of the NMC's pre-registration standards and guidance, consisting of:

- Standards for pre-registration nursing education (SPNE) (2010)
- Standards for pre-registration midwifery education (SPME) (2009)
- Standards to support learning and assessment in practice (SLAiP) (2008)

1.2 As a collective, these documents set the standards for student competence (i.e. the knowledge, skills and behaviours a student nurse or student midwife should possess at the end of their education programme) as well as educator and mentor requirements.

1.3 The evaluation examines the effectiveness of the standards in terms of:

- protecting the public;
- preparing nurses and midwives for their professional roles and responsibilities;
- their reach, intelligibility and accessibility to key stakeholders.

1.4 The evaluation investigates whether or not the standards achieve what they set out to achieve. The scoping stage of the evaluation therefore involved working with the NMC to define the 'outcomes' for each set of standards, i.e. to establish what the NMC expects from individuals at the point of entry to the register.

1.5 The evaluation considers:

- whether the outcomes aimed for by the standards are appropriate (and sufficient) for newly registered nurses and midwives;
- to what extent the outcomes are consistently achieved;
- the role the standards play in ensuring outcomes are achieved compared to other factors.

Strategic context for the evaluation

Reviews of failures of care

1.6 The health sector has been profoundly affected by reviews into failures of care in settings such as Mid Staffordshire, Morecambe Bay, Port Talbot and the Vale of Leven[1], with many suggesting that nurses and midwives do not have the necessary knowledge and skills and often fail to demonstrate the core values of caring and compassion in their practice.

1.7 This evaluation into Pre-registration education standards was a public commitment made by the NMC in response to the Francis inquiry report.[2]

The future shape of health and care practice

1.8 Across the four countries of the UK there have been numerous report and policy documents predicting the need for change in both the capabilities of healthcare professionals and in the environment within which care will be delivered. These include:

- In England, the Shape of Caring Review[3], co-sponsored by Health Education England and the NMC and published as the Raising the Bar report in March 2015,
- In Wales, the Health Professional Education Investment Review[4] published in April 2015
- 'Setting the Direction for Nursing and Midwifery Education in Scotland'[5] published in February 2014
- 'Evolving and Transforming to Deliver Excellence in Care: A Workforce Plan for Nursing and Midwifery In Northern Ireland'[6] published in December 2014

[1] The Francis Inquiry was a public inquiry into how poor care at Mid Staffordshire Foundation Trust was allowed to happen in the period between January 2005 and March 2009, published Feb 2013: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf
The Cavendish Review, July 2013. An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf
The Keogh Mortality Review , July 2013, reviewed the quality of care at 14 Trusts which were persistent outliers on mortality indicators: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
Berwick review into patient safety August 2013 : https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
The Vale of Leven Hospital Inquiry Report November 2014: http://www.valeoflevenhospitalinquiry.org/Report/j156505.pdf
The Morecambe Bay Investigation March 2015: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf
Trusted to Care Report, May 2014, reviewed the quality of care at two hospitals in Port Talbot with a particular focus on care of the elderly, medicine management and complaint handling. http://gov.wales/docs/dhss/publications/140512trustedtocareen.pdf

[2] http://www.nmc.org.uk/news/news-and-updates/nmc-formally-responds-to-the-francis-report/

[3] https://www.hee.nhs.uk/our-work/developing-our-workforce/nursing/shape-caring-review

[4] http://gov.wales/topics/health/publications/health/reports/education-investment-review/?skip=1&lang=en

[5] http://www.gov.scot/Publications/2014/02/4112

[6] http://www.nipec.hscni.net/Image/SitePDFS/Final%20Draft%20DHSSPS%20Workforce%20Plan%20for%20Nursing%20%20Midwifery%202015-2025.pdf

The changing face of regulation

Everybody involved in healthcare is focused on learning the lessons of the reports into failures of care and making sure that concerns are received and acted on before they result in patient harm. There is a clear expectation that regulators will improve their collective understanding of what they know about their regulated populations, from their own data or that of others, and ensure that the way they regulate increasingly focuses on identifying risk and preventing harm by pooling information and aligning regulatory activity.

A stronger voice for patients and service users

1.9 One of the key messages from high-profile failings in care is that harm could have been prevented if the views of patients and their families had been heard and acted upon. As a result, it is increasingly common for policy development and public discussions to involve patients' organisations or experts by experience.[7] Greater transparency of healthcare data will cause the public to be better informed and more scrutinising of services. The health care sector, including professional regulators, recognise that better involvement of informed service users in service design and evaluation will improve the quality and safety of care.

Demographic and workforce change

1.10 Registered nurses and midwives deliver care in a wide range of settings, from hospitals, surgeries and care homes, to community-based services and service users' homes. They also work in related fields such as education, management and policy. They may be providing care directly, through others or even remotely, using new technologies. The NMC's challenge is to regulate such a large and diverse workforce, to communicate effectively with all its registrants and to set and uphold standards that are meaningful and appropriate for a wide range of nursing and midwifery roles.

1.11 The UK has an ageing population with more complex health conditions and a higher proportion of the population living with long-term conditions that can often be managed outside the hospital. More healthcare needs to be delivered in the community with closer working between health and social care. Presently, parts of the UK have integrated their health and care services more than others, but in all settings, nurses and midwives increasingly practise as part of teams with members of other professions where respective roles and accountabilities can be complex. The recognition that multi-disciplinary teams have an important role to play in ensuring patient safety means that traditional roles and ways of working are being challenged. This sits alongside the ongoing debate about the necessary numbers and types of healthcare professionals in any given setting in a climate of scarce resources.

1.12 It is intended that this evaluation will stimulate future discussions about how nursing and midwifery education should develop to ensure nurses and midwives emerging from education programmes meet the needs of the patients and families of the future.

Devolution and divergence

1.13 The NMC regulates nurses and midwives in England, Northern Ireland, Scotland and Wales. Health is a devolved matter and divergence is an increasing trend in healthcare policymaking. There are

[7] http://www.cqc.org.uk/content/involving-people-who-use-services
http://www.rcgp.org.uk/policy/rcgp-policy-areas/rcgp-northern-ireland-patients-in-practice-group.aspx

differences in the role of competition in healthcare, of integration between health and social care, and around the development of some roles.

1.14 However, because the regulation of healthcare professionals is a UK-wide matter, the public should be assured that a nurse or midwife in any part of the UK is working to the same standards, irrespective of the setting. The standards for pre-registration nursing and midwifery education, together with the SLAiP standards, contain high level principles that are applicable across the four countries of the UK.

Summary

1.15 A complex UK healthcare system facing a number of changes and pressures requires collaborative working from a number of stakeholders, each of whom must examine their own role in overcoming these challenges. It is in this context that the Nursing and Midwifery Council commissioned this evaluation of its standards for pre-registration education and SLAiP standards.

Research approach

1.16 The evaluation includes both nursing (including all four fields of nursing: adult, children's, learning disabilities and mental health) and midwifery.

1.17 In this report, general findings applicable and relevant to both the nursing and midwifery professions are commented on collectively (the term 'students' refers to both nursing and midwifery students unless otherwise specified). Any differences or findings only relevant to one profession are highlighted and discussed separately.

1.18 The evaluation consisted of extensive qualitative research (40 group discussions and 135 in-depth interviews) with a wide range of stakeholders, including:

- Student nurses and midwives
- Newly registered nurses and midwives
- Mentors and sign-off mentors
- Preceptors and co-ordinators of preceptorship programmes
- Employers
- Lecturers, deans and education commissioners
- Seldom heard groups
- Senior stakeholders, including regulators, Chief Nursing Officers, Trade Unions and professional groups, Practice Education Facilitator (PEF) network representatives, LSAMO and LME chairs and Public Health England

1.19 In addition, online surveys were carried out with:

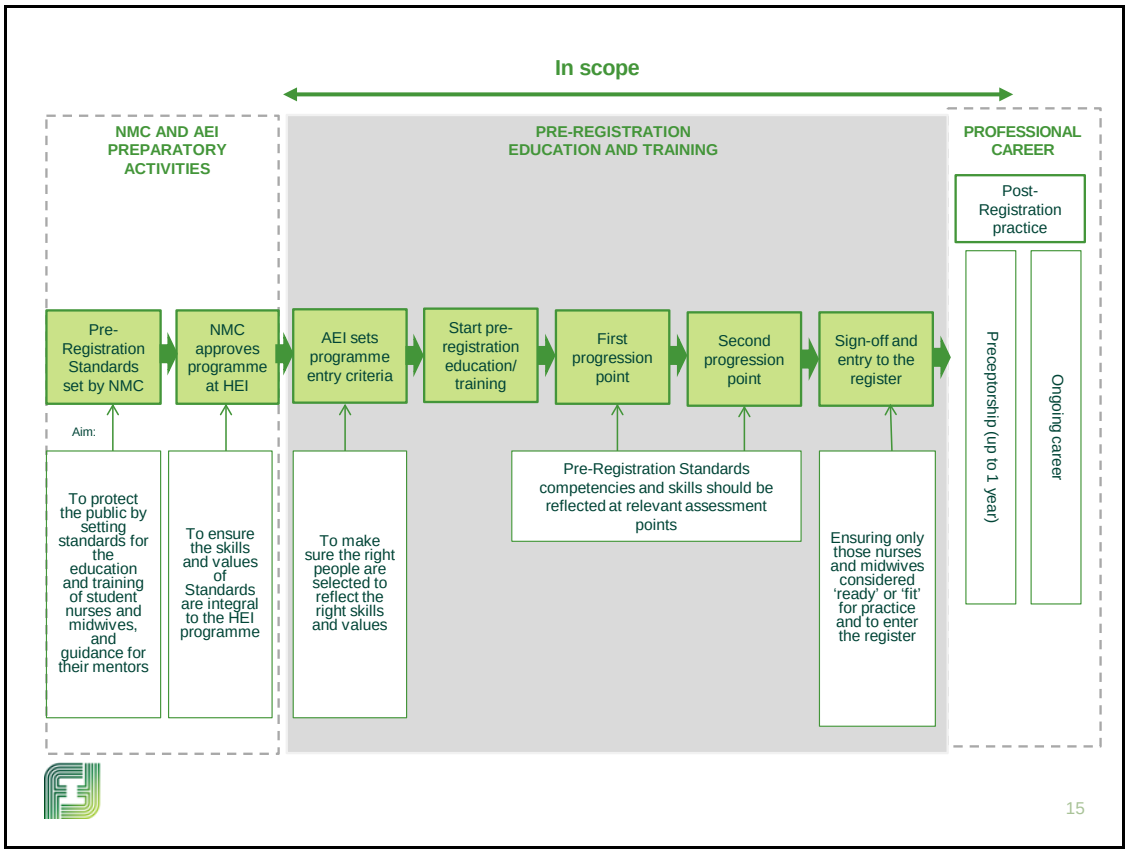
- The general public, consisting of 2,000 UK adults (aged 16+)
- 3,424 student nurses and midwives and newly registered nurses and midwives educated to the current standards for pre-registration education, from throughout the UK

1.20 As a point of clarity, where this report refers to "stakeholder" opinion, we mean the collective views of all audiences listed in paragraph 1.20 (unless otherwise specified). Where the report refers explicitly to "senior stakeholders", we mean the views of key groups of individuals listed in the final bullet point (for example Chief Nursing Officers, Trade Union Representatives.).

1.21 In the main, this report comments on the findings from the qualitative stage of the evaluation (and therefore does not include the views of the general public), but reference is made to the quantitative findings ahead in Chapter 2, which covers public views on the outcomes expected of nurses and midwives, in Chapter 3 on entry criteria, and in Chapter 7, which summarises wider public opinion of the language used within the standards and their accessibility.

1.22 As outlined in Figure 1.1 below, the evaluation focuses on the role of the standards in the student journey, from the point where students enter the programme, through their different progression points, to their point of entry to the NMC register. It also covers preceptorship as some recent graduates who studied under the current Standards were in this stage of initial professional practice when they took part in the evaluation.

Figure 1.1: The student journey



1.23 Evaluation activities took place in all four nations of the UK: Scotland, England, Wales and Northern Ireland so that the evaluation could reflect the country specific implementation of nursing and midwifery pre-registration education and the devolved healthcare systems in each country. For example, in Wales and Northern Ireland, the first cohort of nurses trained to these standards only graduated in September 2015. Therefore, the views of newly registered nurses and nursing preceptors in Northern Ireland and Wales were not included in the evaluation (but Welsh and Northern Irish representatives from all other stakeholder groups were included).

Points to consider

1.24 Based on the findings from the evaluation, this report outlines key points for the NMC to consider in terms of the content of the Standards and in terms of supporting their implementation.

1.25 These key points are highlighted as demonstrated in the boxes below:

Text contained in this format indicates instances where the standards themselves could play a role in better preparing students for professional practice

Text contained in this format relates to where the NMC and wider stakeholders can play a part in ensuring that the Standards are implemented most effectively. Addressing these issues will often require collaborative working and the NMC will need to carefully consider (including through discussion with others) what its role should be.

2 Preparedness for practice

Are the standards aiming for the right outcomes?

2.1 The standards for pre-registration education outline the knowledge, skills and behaviours that student nurses and midwives should possess on completion of their education programme, i.e. at the point of registering for professional practice (referenced throughout the report as 'outcomes')[8], in accordance with the Code.[9]

2.2 The two respective sets of outcomes are outlined below:

Nursing

A newly qualified nurse is expected to:

- Deliver high quality essential care to all
- Deliver complex care to service users in their field of practice
- Act to safeguard the public, and be responsible and accountable for safe, person-centred, evidence-based nursing practice
- Act with professionalism and integrity, and work within agreed professional, ethical and legal frameworks and processes to maintain and improve standards
- Practise in a compassionate, respectful way, maintaining dignity and wellbeing and communicating effectively
- Act on their understanding of how people's lifestyles, environments and the location of care delivery influence their health and wellbeing
- Seek out every opportunity to promote health and prevent illness
- Work in partnership with other health and social care professionals and agencies, service users, carers and families ensuring that decisions about care are shared
- Use leadership skills to supervise and manage others and contribute to planning, designing, delivering and improving future services.

[8] For nursing, the list of respective outcomes has been extracted from Section 1 (page 5) of the SPNE. For midwifery, a single cohesive, equivalent list is not presented in the SPME, so outcomes have been derived from various sections of the document and these were tested with stakeholders as part of the scoping stage of the evaluation.

[9] The Code, Professional standards of practice and behaviour for nurses and midwives (NMC, 2015): http://www.nmc.org.uk/standards/code/

Midwifery

A newly qualified midwife is expected to:

- Use effective communication and interpersonal skills to support women and their families
- Deliver safe and effective care that is responsive to the needs of women and their families in a variety of care-settings
- Act with respect for persons and communities and not discriminate in any way against those in care
- Be prepared for and understand the need to update and enhance their knowledge and skills in response to the changing needs of women and their families
- Work in partnership with women and collaboratively with the wider healthcare team and external agencies to ensure women receive appropriate care
- Deliver sound evidence-based care and support women throughout their pregnancy, labour, birth and postnatal periods
- Deliver care that demands knowledge of psychological, social, emotional and spiritual factors than can positively or adversely influence normal physiology
- Use skills and knowledge to manage and deliver care in obstetric and neonatal emergencies
- Act as autonomous practitioners and lead carers to women experiencing normal childbirth in all settings including midwife-led units, birthing centres and the home
- Use critical decision-making skills to refer the woman or baby to other health professionals or agencies if it is identified that normal processes are being adversely affected and compromised
- Act with professionalism and practise within a professional, ethical and legal framework based on respect for the wellbeing of women and their families

2.3 Stakeholders generally feel that the outcomes outlined in the SPME and SPNE accurately represent the core requirements for newly registered professionals. They are felt to be relevant and reflect the changing nature of both the nursing and midwifery professions.

2.4 The majority of the public also think that nurses (88%) and midwives (89%) are fit for practise if they can meet the outcomes at the point of registration. As a set of high level criteria, the general feeling is that both sets of outcomes appropriately and accurately reflect expectations of new registrants.

Outcomes to clarify / re-consider

2.5 However, there is debate in both professions over to what extent new registrants should be expected to achieve certain outcomes (and what can be developed safely and appropriately post-registration during preceptorship and ongoing learning):

These areas should be re-considered and clarified where necessary (with regards to requirements *at the point of entry to the register)*:

- **Leadership (nursing)**
- **Autonomy (midwifery)**
- **Complex care (nursing)**
- **Managing and delivering care in emergencies (midwifery)**
- **Working with others i.e. what is expected in terms of inter-professional and multi-agency working (both professions)**

Outcomes to add

2.6 Stakeholders also comment that additional outcomes should be added to the current set:

The NMC should consider adding / further emphasising the following outcomes within the standards for pre-registration education:

In both nursing and midwifery:

- The need for registrants to have an awareness of, and adherence to work within, the limitations of their own skill set and knowledge

In nursing:

- There is most demand for a more explicit reference to the attainment of core clinical skills and abilities (e.g. the ability and confidence to administer drugs)

But also call for the addition of outcomes relating to:

- The pursuit of ongoing learning and development
- The development of evaluative skills
- An understanding of ways to mitigate the emotional and personal impact of the stresses of the job
- An ability and willingness to teach and support colleagues

In midwifery:

There is a particular call for the addition of:

- An outcome to do with the promotion of the wider public health agenda (already present in the nursing outcomes)
- A more explicit reference to compassion (also already present in the nursing outcomes)

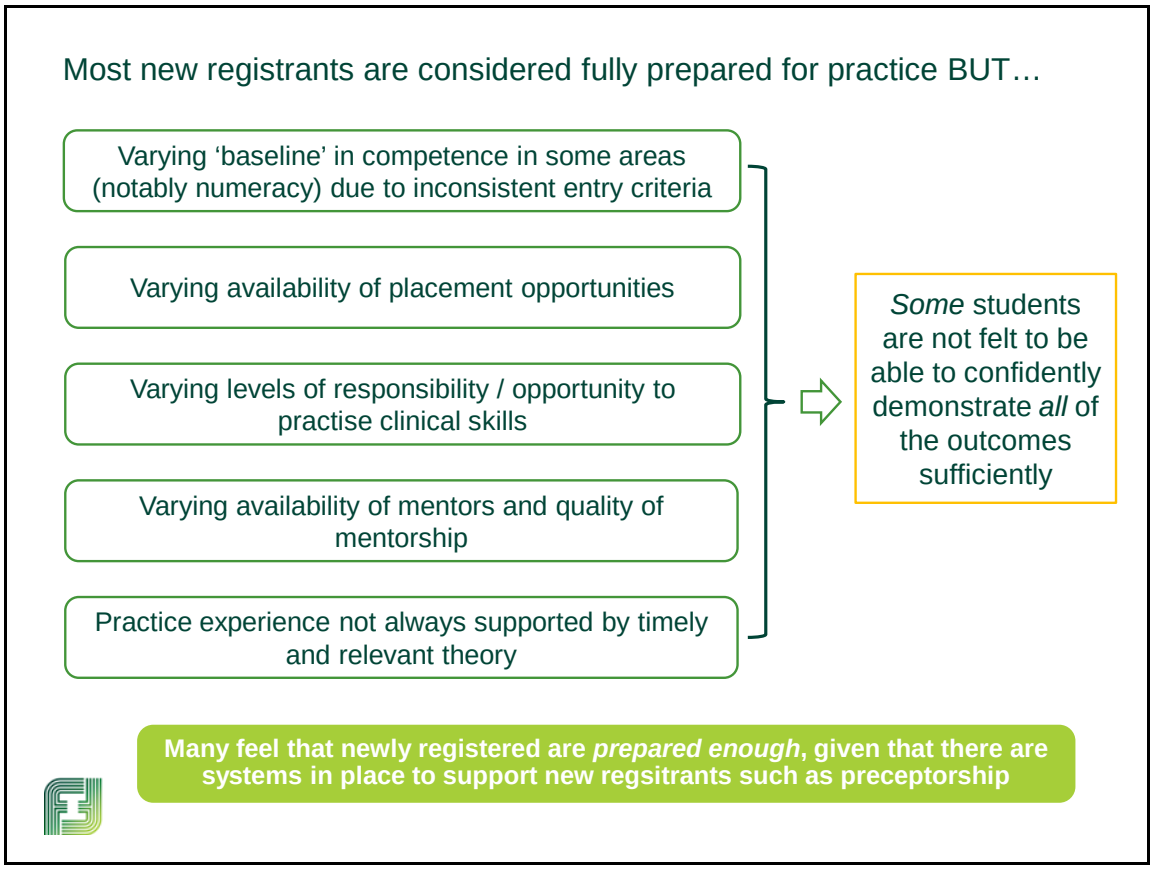
Less commonly, there are calls for outcomes to be added relating to:

- Understanding the importance of consent and ensuring it is always obtained (from women or their families) regarding clinical procedures
- The delivery of effective pre-conceptual care

Are nurses and midwives fit for practice at the point of registration?

2.7 While newly registered nurses and midwives generally demonstrate a high level of preparedness for professional practice, not *all* students can demonstrate *all* of the outcomes outlined in the standards at the point of registration. The reasons for this are summarised in Figure 2.1 below:

Figure 2.1: Reasons why new registrants are not always fully prepared for practice



2.8 Not only is there considerable inconsistency and variation in how students are selected, taught and assessed between different university programmes, but the student learning experience can differ enormously in terms of placements and mentor quality even between those on the same programme, at the same university.

2.9 Although many of these inconsistencies and knowledge / skills gaps are effectively dealt with through a period of preceptorship, this in itself is subject to a great deal of variation.

2.10 Irrespective of the variation in students' experiences, stakeholders consistently comment on the same skills or knowledge 'gaps' and these are discussed further below. Pertinently, in many areas where new registrants are perceived to be less confident or proficient, there is associated debate about the extent to which they *should* be expected to demonstrate these skills or behaviours.

Skills / knowledge gaps

2.11 Some new registrants are perceived to lack certain skills, for example giving injections and setting up IV drips, and as a rule this is attributed to insufficient practical exposure – either due to students not being given the authority to undertake certain procedures or because the settings of their placements could not facilitate the practice of such skills. Practice in managing and administering drugs can be a challenge, it was felt, because students do not always have the right numeracy skills to make safe calculations.

Complex Care (nursing)

2.12 In relation to the other outcomes, slightly lower levels of new nurses report that they highly confident in dealing with complex care[10].

2.13 It is evident that student exposure to complex care varies significantly and it is often determined by the nature of the practice settings they are allocated to during their undergraduate programme.

2.14 Reflecting this finding to a certain extent, stakeholders' opinion is divided about how well prepared newly registered nurses are in delivering complex care. Significantly however, there is an ongoing debate about the level of knowledge and aptitude nurses should be able to demonstrate in this area at the point of registration. To some stakeholders therefore, it is not imperative that newly registered nurses are "fully prepared" to deal with complex care issues immediately following graduation. The minimum expectation from stakeholders is that new registrants should be able to identify complex care issues appropriately and refer such instances to more experienced staff.

Dealing with emergency cases (midwifery)

2.15 Similarly, in comparison to the other midwifery outcomes, lower levels of new registrants report that they are highly confident in dealing with emergency cases., those who have had limited exposure to emergency cases are felt to need additional preparation in dealing with obstetric and neonatal emergencies.

2.16 Again, the minimum expectation from stakeholders is that new midwives should be able to identify and refer such instances to more experienced staff.

Leadership (nursing)

2.17 The extent to which newly registered nurses should be able to demonstrate leadership is also contentious and stakeholders tend to feel new registrants lack confidence in this area – both because they have been supervised throughout their education programme and because they may feel uncomfortable delegating to other professionals and healthcare assistants who may have many more years' experience in a particular practice setting.

Working as autonomous practitioners (midwifery)

2.18 Stakeholders also express concern that midwives struggle to work autonomously at the point of registration. Again, stakeholders feel that student midwives often do not have enough opportunity to

[10] However, the majority of new nurses (83%) still report that they are confident overall in this area (score of 7 or above out of 10).

demonstrate autonomy throughout their course (as they are constantly supervised whilst on placements).

Inter-professional and multi-agency working

2.19 It is often felt that students do not have sufficient opportunity to work within both multi-disciplinary and multi-agency teams during their undergraduate programme (this is particularly felt in relation to working with social care teams who may be working with the same patient or mother). This results in new registrants not always knowing what options there are in terms of referrals and who to ask for help.

Promoting health, preventing illness

2.20 All stakeholders agree that at the point of registration many nurses are not confident in terms of their wider role in promoting health and preventing illness.

2.21 Some stakeholders mentioned this also being true of newly registered midwives (although there is currently no specific outcome for midwives relating to health promotion).

Professionalism, communication and softer skills

2.22 The majority of new registrants are felt to be good communicators overall, especially in their field of practice. However, newly registered nurses can sometimes struggle to communicate with all types of patients outside their chosen field.

Delivering care in a variety of settings

2.23 Where students do not have adequate exposure to different settings, this lack of experience means some question new registrants' preparedness to work in particular settings.

2.24 Some stakeholders call for programmes to place less emphasis on community placements, although others feel newly registered nurses and midwives are least prepared for employment in community settings. This is felt to be exacerbated by a serious shortage of community nurses and midwives in some areas, which means that student placements in the community are not as available as they ideally should be (and where they do exist there is often an absence of qualified mentors). Further, where students do have experience of community placements, by the nature of the work, the range of tasks they are able to undertake can be much narrower than those they are able to conduct within an acute setting (where it is felt that students obtain much greater exposure to essential nursing and midwifery skills).

Delivering care to all (regardless of nursing field)

2.25 It is widely held that it can be difficult to get 'adequate' placements that provide sufficient experience of the four fields and that, as a result, newly registered nurses can feel challenged while delivering the care of some patients.

2.26 Most commonly, it is felt that newly registered adult and children's nurses are not sufficiently prepared to deal with the mental health needs of individuals. There is also some feeling that learning disabilities and mental health nurses do not always benefit from adequate exposure to the physical aspects of care and the opportunity to develop a broad clinical knowledge to deal with both physical and mental needs of their patients.

3 Assessment for entry to programmes

The standards for pre-registration education require that as a baseline, applicants to any nursing or midwifery programme at an approved education institution (AEI) need to be able to demonstrate:

- Aptitude in Numeracy
- Aptitude in Literacy
- IT skills
- Good health and good character
- Appropriate academic and professional entry requirements (SPNE)

Appropriateness and clarity of current entry criteria

3.1 Overall, amongst stakeholders there is broad agreement that the current entry criteria offer an appropriate baseline of requirements. This view is also echoed by the general public.

3.2 There is most debate amongst stakeholders about the inclusion of IT skills in AEI's entry requirements; while some stakeholders believe these skills could easily be taught to the required level post-admission, others argue that IT literacy is becoming increasingly important as computer systems become more integral to the way healthcare is delivered.

3.3 There is also a general agreement that the entry criteria are too vague and should be tightened up to promote consistency between AEIs.

> *"Whilst in general terms it's difficult to see why we wouldn't apply such criteria, the devil is in the detail … in principle, yes, but how those might be articulated, how those might be measured, and what impact it might have are open to much wider discussion."*
>
> **Senior Stakeholder, Midwifery and Nursing, Scotland**

3.4 Most stakeholders feel that there is a lack of clarity around the terms *"good health"* and "*good character"*. There is particular comment that the term *"good character"* is misleading and suggests representation of broader qualities than the NMC currently intends / specifies.

There is a call for the standards to further define how "good health" and "good character" should be interpreted and measured:

- **For "good health", sufficient clarification may be achieved if the NMC were to raise awareness of the current guidance for AEIs[9]**
- **NMC could consider seeking replacement of the term 'good character' with an alternative which would more effectively communicate a narrower meaning (e.g. *'a requirement to be honest and trustworthy'* – this is based on an individual's conduct, behaviour and attitude and takes into account convictions, cautions and pending charges)**

[11]Health and character guidance for AEIs: http://www.nmc.org.uk/education/what-we-expect-of-educational-institutions/good-health-and-good-character-for-aeis/

3.5 There is also some feeling that the requirement in the SPNE that AEIs must specify *"appropriate academic and professional entry requirements*" is not prescriptive enough, and equally, that the SPME should provide greater clarify about how "*evidence of literacy and numeracy may be determined from academic or vocational qualifications"*. As discussed earlier, it is felt that it is imperative that students have a basic level of numeracy to enable them to accurately make safe drug calculations.

The standards could provide more measurable benchmark criteria in terms of literacy and numeracy (whether this in terms of the level 2 grades[12] that need to be achieved or in the form of setting standardised tests)

Additional entry criteria

3.6 Although the current entry criteria are felt to be broadly appropriate, most stakeholders suggest one or two additional criteria they would like to see included or made more explicit within the current requirements. Most frequently, there is suggestion that *compassion* should be added (as there is a widespread feeling that this cannot be easily taught) and/or *motivation* (as there is concern that some students apply to education programmes for the wrong reasons).

The NMC should consider adding to the standards, a requirement that AEIs conduct values-based recruitment (in particular, ensuring that motivation and compassion are considered). This would help to ensure that candidates hold the values and principles set out in the Code[13].

Related to this, guidance on how values-based recruitment should be conducted would be welcomed by AEIs.

Student and service user involvement

3.7 There is considerable variation in terms of how students and service users participate in AEI recruitment processes. Their contribution ranges from direct involvement (sitting on interviewing panels or taking part in role plays with applicants) to indirect involvement (e.g. devising questions, meeting with or showing around potential students) to no involvement at all.

Although not considered a major issue by most stakeholders, the NMC should consider whether it wishes to reduce the level of variation in how service users are included in the recruitment process or whether the current level of flexibility for AEIs is permissible or even desirable.

[12] Most commonly, level 2 qualifications refer to GCSEs in England and Wales, the Junior Certificate in Northern Ireland and SVQs in Scotland. However Level 2 may also include BTEC First Diplomas and Certificates; Cambridge or OCR Nationals at Level 2

[13] The Code, Professional standards of practice and behaviour for nurses and midwives (NMC, 2015): http://www.nmc.org.uk/standards/code/

3.8 Where service users are involved, they are felt to be able to play a valuable role in assessing important 'softer skills' such as communication and compassion and this is considered particularly relevant to learning disability and mental health nursing, where it is felt that effective interaction with service users can be more challenging. Additionally, stakeholders argue that early exposure to service users is beneficial as it can help applicants get a better feel for what is involved in working within the profession before enrolling.

3.9 Stakeholders are generally in favour of including service users (directly or indirectly) in selection processes, but they also cite some practical challenges in doing so such as ensuring their objectivity and facilitating the appropriate and sensitive use of (among others) children, busy mothers and those with mental health issues or learning disabilities.

> *"I don't think we're clear enough on what the role of the service user is and what training and support we give them to be part of a selection process."*
>
> **Senior Stakeholder, Midwifery and Nursing, Scotland**

> *"The challenge is how do you get access to them, how do you pick the right person who perhaps has the knowledge of the standards and the wider picture of what's required?"*
>
> **Seldom Heard Group, Nursing, UK**

The NMC could consider providing AEIs with guidance on the appropriate selection and training of service users in the standards for pre-registration education.

3.10 Overall, it is also felt that the involvement of students in the recruitment process can be useful. There is a widespread feeling that many applicants to nursing and midwifery programmes do not have a realistic perception of the demands of the university programme and/or working in the profession. There is therefore a call for a greater focus on communicating the reality to applicants early on, with some feeling that involving existing students in the recruitment process can help to this to happen.

Some stakeholders suggest that the standards could include a reference to the need to make applicants to nursing and midwifery programmes aware of the realities of the profession during the recruitment process.

4 Theory-practice balance and integration

The standards for pre-registration education require an approximate 50/50 split between the academic and practice-based components of AEI's programmes. Specifically:

- **In nursing, "***Overall the programme requires 50 percent theory (2300 hours) and 50 percent practice (2300 hours)"*
- **Midwifery programmes must reflect "***no less than 50 per cent practice and no less than 40 per cent theory"*

As mentioned in the SPNE, the requirements for nursing are derived from the European Union Directive Recognition of Professional Qualifications 2005/36/EC.[11]

4.1 Most stakeholders feel the current split between academic and practice-based elements of undergraduate programmes is appropriate so long as the quality of placements (and mentorship) is high and effectively facilitates the attainment of essential skills. [14]

4.2 However, some would like to see an increase in the emphasis on practice (particularly nursing teachers and mentors) pushing it up closer to 60-70% of the time split. In reality, this is unlikely to be feasible in a context of limited placement opportunities as well as limited mentor numbers.

4.3 Reflecting this wish to further recognise the importance of practice within the overall programme however, some stakeholders also call for nursing students' performance in practice to count towards their final degree grade (this is already the case in midwifery).

The NMC should consider whether to mandate nursing students' performance in practice counting towards their degree grade through the SPNE

4.4 In terms of the integration of theory and practice, there is a comment that exam revision and university assignments are frequently scheduled during practice placements, which are always demanding and which can be particularly stressful (for instance, where students have been placed in settings far from home or are working night shifts).

The NMC should consider working with AEIs on how they can best pace their programmes to ensure that students are not over-burdened with essays and coursework whilst they are on placement.

[14] The EU directive (article 31) specifies that nursing programmes must consist of at least one third of theoretical training and one half of clinical training so the NMC Standards are slightly more prescriptive. On midwifery, the EU directive (article 42) simply states that *"The theoretical and technical training shall be balanced and coordinated with the clinical training in such a way that the knowledge and experience [required] may be acquired in an adequate manner"*.

4.5 On a separate note, stakeholders raise concerns that whilst on placement, students are not always given the opportunity to demonstrate certain clinical skills (even under the supervision of a mentor) as some NHS Trusts and Health Boards prohibit students from undertaking particular procedures.

The NMC should consider providing guidance to NHS Trusts and Health Boards to discourage rules which limit students' opportunities to practise essential skills.

Communication between universities and practice placements

4.6 In many instances, it is felt that university and practice environments operate fairly independently from one another.

4.7 Many mentors report a lack of clarity about what students are learning throughout the academic elements of their programme which makes it more difficult for them to link academic theory to practice.

> *"Sometimes I don't know what they have done at university. I would love to hear a bit more about what it is they are covering."*
>
> **Mentor, Midwifery, England**

4.8 One of the main channels of contact between AEIs and mentors is the Practice Assessment Booklets which mentors and students use. These are founded in the standards but often interpreted and compiled solely by those based at AEIs. The Essential Skills Clusters and competencies are interpreted differently by universities and mentors alike; consequently many mentors would like a better steer on how the content of these booklets (and of the standards) should be interpreted.

> *"Sometimes the competencies are so convoluted I have to ask the students what they think they mean."*
>
> **Mentor, Nursing, Wales**

4.9 Where regional assessment documentation has been produced (e.g. the Pan-London Practice Assessment Document or the All Wales National Practice Assessment Tool) stakeholders, particularly mentors, respond positively to the standardisation. The compilation of this documentation involved input from practice as well as from AEIs, and the end result is felt to minimise the risk of differing interpretations of what it means to have achieved particular competencies.

The NMC may have a role to play in terms of:

- **Supporting mentors being given the opportunity to feed into Practice Assessment Booklets**
- **Facilitating the development of standardised Practice Assessment Booklets across AEIs, with a need to consider a National Assessment Framework as a natural extension of this**
- **Generally encouraging closer relationships and information sharing between practice and AEIs**

The role of Practice Education Facilitators (PEFs) and Link Lecturers

4.10 Link lecturers and Practice Education Facilitators (PEFs) are both felt to have important roles to play in the integration of theory and practice.

4.11 While link lecturers are present at most AEIs to assist practice-based learning through advice to mentors on educational matters, there are clear variations in how they deliver this in practice. Where link lecturers are regularly seen at practice placements, they are highly valued by both mentors and students. However, some link lecturers only turn up to clinical settings if there is an issue with a student and in these cases mentors can feel unsupported. Many therefore suggest that details / requirements of the link lecturer role should be clarified.

4.12 PEFs can also bridge the gap between universities and practice placements, and there is often a close relationship between PEFs and universities. Many also feel that the introduction of PEFs has been very beneficial in coordinating mentors and mentorship training. However, currently the role of the PEFs has not been formally implemented or standardised across all employers in the UK. There is therefore a call for this role to be recognised in some way by the NMC.

The standards could:

- **more clearly define the role of the link lecturer (in terms of setting out requirements for the role)**
- **recognise the important role of Practice Education Facilitators**

The NMC may have a role to play in terms of promoting and support the role of link lecturers and PEFs more broadly, as these relationships are critical in ensuring a joined-up approach between lecturers and mentors and can help ensure that:

- **Students receive a more consistent message on how to interpret the Standards;**
- **Any struggling students are identified earlier;**
- **Students are assessed consistently.**

Practice Placements

4.13 The availability of practice placements was stated as a concern by **all** stakeholder groups. Ward closures, budget restraints and increasing student numbers have exacerbated a lack of availability meaning some students struggle to obtain enough experience in acute settings. Some AEIs are becoming more reliant on special schools and residential care homes to provide placements for first year nursing students (which in turn, often struggle to supply NMC registered mentors, limiting sign-off opportunities). There is also the issue of students returning to the same placement setting limiting their experience of different settings.

4.14 A shortage of placements means that multiple students are often undertaking placements in the same place at the same time which limits the amount of time mentors can spend with them and reduces the opportunity for students to learn and demonstrate essential skills.

"The wards are often completely overrun with students, and you're fighting to get jobs. You can't get much done."

Student, Nursing, Wales

4.15 A lack of availability of placements can lead to students being allocated particular placements at times which are not ideal (e.g. gaining no experience in acute settings until their second year or being exposed to types of cases about which they have not yet been taught any theory).

4.16 As already mentioned, a lack of availability of placements also means that students' exposure to other nursing fields can be limited.

4.17 A lack of placements is generally considered less of an issue in midwifery, with the most common concern reported being a lack of experience of specialist perinatal mental health services. There were also some comments that a lack of birth centre placements means that midwives do not always gain sufficient exposure to normal births and that a lack of community placements means that some are not sufficiently exposed to home births.

4.18 In spite of these practical issues many stakeholders would welcome further guidance about how long students should spend in each placement setting to ensure students are exposed to an adequate range. This could be in terms of broad setting type (community / acute) or be more specific (for example, labour ward and birth centre could be further split out in terms of acute settings within midwifery). Some would also like the SPNE to specify which of the four fields of nursing students should get exposure to and how long placements in other fields need to be.

The NMC could consider suggestions that it recommend the minimum number of hours students should spend in each placement setting. However, these suggestions must be considered for feasibility in terms of the lack of availability of placements in some localities.

5 Mentorship

5.1 Mentors are fundamental to the success (or not) of a student's placement and can be a major factor in boosting a student's confidence and overall performance.

> *"[My mentor] really, really grew me and I left that particular placement a completely different student midwife; confident, empowered, strong, which I can only assume you will continue to pass on to women."*
>
> **Student, Midwifery, Scotland**

5.2 There is frequent comment that individual mentors can "make or break" a student's placement experience alongside a widespread acknowledgement that the quality and consistency of mentorship varies from excellent to very poor.

> *"The quality of the mentor has more influence over usefulness of the placement rather than the setting of the placement itself."*
>
> **Student, Nursing, Scotland**

5.3 Overall, stakeholders (including students and new registrants) maintain that *most* mentors perform well but a high proportion also report that a significant minority of mentors do not sufficiently satisfy expectations of the role (often, but not exclusively, attributed to low staffing levels and time pressures . Many students and new registrants are able to refer to at least one negative mentor experience (albeit some cite the encounters of their peers that they learned of second-hand).

Are fair and appropriate judgements being made?

5.4 Stakeholders *generally* feel that mentors make appropriate judgements of students' abilities, but also report that students are not *always* assessed fairly or appropriately. In most cases where it is felt that judgements are not appropriate, it is felt that students are being assessed too leniently.

5.5 As well as factors discussed in more detail below (inconsistency in training and in how mentorship systems work in practice), this inconsistency in approach is the result of varying interpretation of the standards, the influence of mentors' dispositions and characters (e.g. finding it difficult to fail students), the time they have available to work with students and to consider their performance and whether mentors are able to access wider support when making their assessments (which is widely felt to be beneficial where it happens).

Sign-off mentor and mentor roles

Since 2008 the NMC statutory midwifery committee have required that all midwife mentors must also meet the additional criteria to be sign-off mentors.

In nursing however, there is still a distinction made between a mentor and a sign-off mentor, whereby students '*must be supported and assessed by mentors'* but the '*sign-off mentor must make the final assessment of practice and confirm that the required proficiencies for recording a specialist practice qualification have been achieved'*[1].

NMC circular 05/2010, to be read in conjunction with the SLAiP standards, outlines the distinction between the points of 'sign-off' between nursing and midwifery; '*this must be at the end of a programme for nursing, and at progression points as well as at the end of a programme for midwifery'*.

5.6 Although the NMC requires that all midwifery mentors should also undertake a sign-off role, in reality, most experienced midwifery mentors have not undertaken the additional sign-off training and so there is often a two-tier system still operating in midwifery.

5.7 Across both professions, there is some inconsistency in the understanding and delivery of the mentor / sign-off mentor roles.

> *"The title 'sign-off mentor' can lead to confusion - mentors do not know if they can sign-off students for anything throughout the year."*
>
> **Senior Stakeholder, Nursing, Wales**

5.8 There is variation both in terms of when sign-off mentors play a role (at the end of each placement / at each progression point / on sign-off to the register) and in how they do so (i.e. how directly they get involved in assessing students and to what extent they work with mentors and other colleagues to do so).

5.9 In terms of whether the mentor and sign-off mentor roles should be distinct, opinion is evenly divided. Those in favour of keeping the roles distinct argue that, as the student works predominantly with the mentor, the sign-off mentor can have a greater degree of objectivity and can therefore act as a 'safety net'. However, others worry that this system can lead to the mentor feeling less accountable for their decisions.

> *"I am a big fan of having two mentors. To my mind it makes it a bit more objective…judgement can depend on your expectations of people and your expectations of yourself."*
>
> **Mentor, Nursing, England**

> *"I think it was bonkers to make a distinction between mentors and sign-off mentors. You shouldn't sign anything off unless you absolutely sure that someone can do it. By creating two roles, you have disempowered the mentor and encouraged ultimate judgements to be made by the sign-off mentor."*
>
> **Senior Stakeholder, Midwifery and Nursing, England**

As opinion is roughly equally divided on whether the mentor and sign-off mentor roles should be distinct or combined, the debate on which structure best ensures objectivity and accountability (and avoids 'failing to fail') is clearly ongoing and the NMC should consider its view.

Mentorship recruitment

5.10 Whilst being a mentor is not compulsory, mentors state that it is an expectation of their employer that everyone becomes one (often due to resourcing issues). Opinion is divided among stakeholders on the issue of whether everyone should be a mentor. A slight majority feel that a reluctant mentor is unlikely to be a good mentor and so mentorship should not be made compulsory. A significant proportion of stakeholders, however, argue that the development of others is a core component of the professional role and can be beneficial in the ongoing development of the mentor too.

"I don't think the blanket approach to mentorship is good. Not everybody is good and not everybody wants to do it."

Mentor, Nursing, Northern Ireland

"It probably should be obligatory once you qualify because even if they don't want to do it, it ends up developing your confidence. It's only when you become a mentor you realise how much you know and it helps keep it in your mind so it helps both of you to go over things all the time."

Employer, Nursing, Scotland

The NMC may wish to take a stance on whether everyone should be a mentor or not. This feeds into the debate on the sustainability of a one-to-one mentorship model more generally.

There is certainly demand for allowing a second mentor to count towards the 40% of supervised time which each student must have. In addition, getting wider healthcare teams more involved in assessments is felt by many to be a more flexible model. Having university staff and mentors collaborating on assessments is felt to have the added benefit of promoting consistency in how students are assessed.

5.11 All stakeholders agree that attention should be paid to how mentors are motivated. There is a strong feeling among many stakeholders that there is a need to raise the profile of the mentorship role to give it broader appeal. There is a particular call for allowing enough time for the effective delivery of the role.

There are opportunities for the NMC to work with others to raise the profile of the mentorship role and to make it appeal more to nurses and midwives.

Financial recognition aside, this could include encouraging employers to:

- **recognise the importance of mentorship in annual reviews**
- **allow time off in lieu for any time spent out of hours on mentorship delivery or training**
    - **or, preferably, protecting time for the mentor to perform the role within working hours (for example, ensuring it is possible for sign-off mentors to spend 1 hour a week with each student alongside their other roles and responsibilities).**

Protecting time or allowing time off in lieu is certainly a challenging area to address given pressures on staffing throughout the health sector. However, it does feel that enabling mentors to spend sufficient time on the role is critical if the overall quality of mentorship is to increase.

The NMC should work with others to establish ways to raise the profile of mentorship (thereby encouraging greater willingness to undertake the role).

Mentor training

5.12 It is felt that mentorship training has improved in recent years and is more thorough for a range of reasons including the publication of the SLAiP standards and the introduction of the PEF role (which, as already mentioned, there is call to standardise and implement further).

5.13 However, the fact also remains that mentorship training lacks consistency and resourcing pressures and budget constraints often mean that only limited time is spent training mentors. Particular concerns with the current training (or lack of it) include:

- Insufficient guidance for mentors on how to teach students
  - Some feel that a focus on the mentor's role in assessment can mean that the support and education role is not always emphasised enough
- Insufficient guidance on how to deal with failing students and provide constructive feedback
- A lack of up-to-date knowledge of modern clinical practice for those mentors who initially trained years ago

The NMC should consider taking more of a role in overseeing the education and training of mentors, including training updates, to ensure greater consistency in how the Standards are interpreted.

There is some call for the NMC to re-introduce a standardised mentor qualification which could be issued following successful completion of an approved education programme.

The NMC may also be able to play a role in encouraging student feedback to be given to mentors to help them to improve.

The NMC should consider further emphasising the mentor's role in teaching students within the SLAiP standards (to balance the perceived existing focus within training programmes on the mentor's role in student assessment)

The standards could recommend (or possibly even mandate) a greater focus in undergraduate programmes on preparing students for future mentorship roles.

- **It is felt that an early introduction to mentorship would not only help to better prepare future mentors but also serve to reinforce the notion that mentorship is an important and valued responsibility within the nursing and midwifery professions.**

6 Preceptorship

Preceptorship is currently not mandatory but the NMC *'strongly recommend(s) that all 'new registrants' have a period of preceptorship on commencing employment'*[15].

Preceptorship is defined as '*the support and guidance that enables qualified nurses to make the transition from being a student to becoming a more confident practitioner to practise in line with NMC standards'*[16].

The importance of preceptorship

6.1 The importance of preceptorship is recognised by all stakeholders, especially in terms of enabling new registrants to develop their confidence, refine their leadership skills and develop any further clinical skills they may need.

> *"The preceptorship year is really important. If we didn't have it we wouldn't have a standardised level of midwives, we wouldn't be able to check and support their competence properly."*
>
> **Practice Education Facilitator, Midwifery, Wales**

6.2 Indeed, both students and new registrants reported that the offer (and known quality) of a preceptorship can be a major influence on employment choice.

Availability of, and variance in, preceptorship

6.3 While most employers offer a preceptorship programme to both newly registered nurses and midwives, there is significant variation in employers' approaches to preceptorship. Best practice schemes are felt to:

- Last at least 6 months duration, although ideally 9-12 months
- Allocate a dedicated preceptor to new registrants
- Offer a structured assessment programme
- Allow time for registrants to reflect on their own practice and learnings
- Foster a supportive atmosphere

6.4 Poor preceptorships, on the other hand, may last only a few weeks with little guidance; while in worst case scenarios there is no offer of a preceptorship at all.

6.5 There is a general consensus that while efforts are being made to develop a more systematic approach to preceptorship in all four nations, there is still some way to go.

> *"I think preceptorship can make or break a new registrant … I really do think it needs to be a bit more robust in that it is actually being carried out. It's talked about but I don't think it holds the same weight with the likes of the*

[15] Preceptorship guidelines (NMC)(2006)
[16] The Standards for pre-registration nursing education (2010)

standards and they are quite rigorous … preceptorship needs to be equally tight."

Lecturer, Nursing, Northern Ireland

Should preceptorship be regulated?

6.6 In line with its perceived importance, most stakeholders feel that it should be mandatory for all UK employers to offer a preceptorship programme. Whilst regulation of preceptorship is more contentious, a slight majority of stakeholders are in favour of this as long as it does not impose excessive burdens on employers.

The NMC should consider its role in terms of ensuring high quality approaches to preceptorship are offered more consistently. There are a range of options possible here:

- **At the 'light touch' end of the spectrum, this could mean the NMC providing more guidance on what a 'best practice' preceptorship looks like in terms of length and other desirable features.**
- **Going further would be to regulate preceptorship**
  - **While this may be beyond the NMC's current remit, it is worth serious consideration as the current frameworks for preceptorship, which have been developed at a strategic level but which are not backed up by enforcement, are not always implemented by employers.**
- **A further alternative (also frequently cited by stakeholders) is for the NMC to support a system in which students undertake a four year programme, with the last year based solely in practice, effectively acting in place of a preceptorship.**

7 Familiarity with, and understanding of, the standards

7.1 The standards are broadly fit for purpose in terms of their *reach, intelligibility and accessibility;* with stakeholders tending to refer to them according to their (perceived) needs and to appreciate their flexibility.

Familiarity with the standards

7.2 Familiarity with the standards varies considerably between groups of stakeholders and, as would be anticipated, levels of engagement are heavily linked to job role.

7.3 Lecturers tend to be most familiar with the standards, especially those involved in designing curricula and responsible for the compilation of Practice Assessment Booklets. PEFs also tend to refer to the standards regularly to assist them in their role.

7.4 While students have an awareness, detailed knowledge is low for the standards for pre-registration education, and this is, understandably, even more the case for the SLAiP standards. However, it is widely held that students' lack of knowledge is not concerning as long as the standards are firmly embedded in their undergraduate programme (both in terms of theory and practice).

7.5 Familiarity with the standards documents amongst mentors is surprisingly low and their lack of knowledge is perceived to be a greater problem than that of students. Any interaction with the pre-registration education and SLAiP documents is often indirect, with mentors tending to rely on mentor updates and their training to inform their assessment of students and how to undertake their role. While it could be argued that detailed knowledge of the standards is not necessary as long as Practice Assessment Booklets and mentor updates interpret them consistently and successfully, clearly a greater familiarity with the source documents limits the opportunity for differing interpretations (e.g. of skills, competencies, the role of the mentor) to flourish.

7.6 Employers are generally aware of the standards for pre-registration education and SLAiP standards; however engagement with the documents is often infrequent and most do not have a detailed knowledge of the content. This means that employers do not always know what a nurse or midwife should be capable of on entry to the NMC register, which could potentially have implications for devising and implementing appropriate preceptorship programmes.

The NMC should consider working with other stakeholders to raise the profile of, and increase the use of, the standards; particularly among mentors (and to a slightly lesser extent, employers).

Understanding of the standards

Language

Key user groups

7.7 The flexibility of the standards is seen as a positive by many.

> *"The joy of them is that they are written in such a way that you can flex and that's vital when it comes to placement issues and capacity and creativity in the programme."*
>
> **Senior stakeholder, Nursing and Midwifery, Wales**

7.8 However, across all stakeholder groups there is consensus that particular elements of the standards for pre-registration education are too ambiguous in their meaning. Crucially, the language of the competencies and Essential Skills Clusters is often described as 'woolly' or vague. AEIs therefore interpret the standards differently when compiling Practice Assessment Booklets. The skills presented in these booklets are then also interpreted differently by the mentors using them. As a result, mentors are not always clear how they should be assessing students.

> *"I have things in front of me that you have to read about 10 times … why would we write anything that's open to that level of interpretation and make it difficult for very busy nursing staff? It should be very clear, simple, straightforward, plain English."*
>
> **Employer, Nursing and Midwifery, Northern Ireland**

7.9 Stakeholders felt there should be clearer definitions of:

- The difference between '*contributes to*' and '*participates in*' in terms of students' attainment of particular competencies (nursing)
- The term 'complex care' (nursing)
- What 'self-administration' means in relation to the administration of medicine (nursing and midwifery)
- What *'demonstrates an understanding'* of entails (nursing and midwifery)

7.10 To further aid clarification, some stakeholders feel that the skills and competencies would be clearer if they were written in an active rather than a passive voice.

7.11 In terms of the SLAiP standards, there is also some confusion around certain terms, notably the phrase '*at least 40% of a student's time must be spent being supervised (directly or indirectly) by a mentor'*[17]*.* Some stakeholders are unsure whether or not contact with a second mentor 'counts' toward the requirement that students are mentored for at least 40% of their time on placement. Equally, there is also some call for the NMC to provide a clearer definition of what *'indirect supervision*' means.

The wider public

7.12 Although stakeholders maintain that the standards are not intended principally for public use, it is felt to be important that the language and content should be accessible to the general public if they wish to refer to them.

7.13 Overall, the public reported that the outcome statements were clear. However, it was also evident that as a general rule, the public favour shorter outcome statements and understand them more easily. Additionally, as a specific point, the term *'safeguard'* was found to require further explanation for a lay audience.

The NMC should consider revising the use of language in the standards, taking into account the specific areas of confusion outlined above.

[17] Section 3.2.3, 'Allocated learning time for mentor activity', Standards to support learning and assessment in practice

Structure

7.14 For many, it is felt that the standards would be more accessible and user-friendly if they were shorter overall and contained shorter sentences. There is also a call for there to be less repetition in terms of Essential Skills Clusters (ESCs) and competencies, which would help aid understanding as well as reduce length.

> *"The competency about maintaining care and dignity of the patient is duplicated 3-4 times. It's unclear whether students only need to demonstrate it once or if it needs to be signed-off on a different occasion each time."*
>
> **Mentor, Midwifery, Wales**

7.15 Stakeholders also comment that the structure of the four domains is not always helpful and that they can be too vague to help assessments.

7.16 It is felt the standards for pre-registration nursing and midwifery education should remain as two separate documents for the two professions but there is some thought that certain components could be designed to mirror each other more closely in terms of layout (and for some, in terms of content). This would make it easier to see where the professions are similar and where they differ. It is most commonly suggested that the layout of the entry criteria in the two documents should reflect each other more.

7.17 It is suggested by some senior stakeholders that the standards for pre-registration education should make more direct and explicit reference to the NMC's Code for Nurses and Midwives[18] to facilitate a more seamless transition from student to registrant.

The structure of the standards for pre-registration education should be considered in terms of:

- **Their length, with a view to being concise and lessening repetition**
- **The role of the domains and how they link to the ESCs and competencies**
- **Where appropriate, how the SPNE and SPME could mirror each other**
- **Links with the NMC Code**

[18] The Code, Professional standards of practice and behaviour for nurses and midwives (NMC, 2015): http://www.nmc.org.uk/standards/code/

8 Summary of actions to consider

8.1 The standards for pre-registration nursing and midwifery education are broadly effective in their key role of preparing new registrants for professional practice. However, not *all* students can demonstrate *all* of the outcomes outlined in the standards at the point of registration.

8.2 It is clear that nurses' and midwives' pre-registration education and training varies considerably, which can lead to knowledge and skill gaps. Such variation occurs not just by geographic area, or even between university programmes, but also from student to student depending on the mentors assigned to them and the practice placements they are allocated.

8.3 The findings of this evaluation highlight key areas for the NMC to consider to help reduce this inconsistency and ensure that all nurses and midwives have the best possible opportunity to gain the skills, knowledge and confidence necessary by the time they enter onto the register.

8.4 **The evaluation has identified clear points of consideration for any future development or revision of the standards.** To recap some of the key themes:

- There is a widespread feeling that the NMC should consider **revising its use of language** in order to reduce ambiguity and, by extension, the variation in how students are supported and assessed. There are a number of specific examples of language perceived to be vague provided throughout this report.
- Many also feel that the **structure of the standards could be improved**. There is most commonly a call for the NMC to reduce the length of the documents and to reduce repetition throughout. More specifically, there is a feeling that the relationship between the domains and the ESCs and competencies should be made clearer. It is also felt that the NMC should consider how the SPNE and SPME could more closely reflect each other.
- Such suggestions are made alongside a generally-held perception that the standards **need to be promoted more to raise awareness of their content** among key audiences (notably mentors, but also employers).

8.5 In terms of the content of the standards for pre-registration education, there is debate over to what extent new registrants should be expected to achieve **certain outcomes** and so these **need to be re-considered and clarified** (with regards in particular to requirements *at the point of entry to the register*):

- Leadership (nursing)
- Autonomy (midwifery)
- Complex care (nursing)
- Managing and delivering care in emergencies (midwifery)
- Working with others i.e. what is expected in terms of inter-professional and multi-agency working (both professions)

8.6 There are also calls for **some outcomes to be added to the standards**. In nursing, there is most commonly a demand for a more explicit reference to be made to clinical skills and ability e.g. the ability and confidence to administer drugs. In midwifery, there is a particular call for the addition of an outcome to do with promoting the wider public health agenda and for the outcomes to make more explicit reference to compassion. In both professions, it is felt there is a need for new registrants to

have an awareness of, and adherence to work within, the limitations of their own skill set and knowledge.

8.7 **The findings of the evaluation also raise questions about the wider role of the NMC and how it can influence systemic issues which impact the training, development and education of nurses and midwives pre-registration.** There is call for the NMC to both collaborate with others to address such wider issues and to clarify (or revise) the content of the standards accordingly.

8.8 **In terms of entry criteria**, there is a particular call for the standards for pre-registration education to:

- Set a benchmark for numeracy and literacy requirements
- Further define how 'good health' and 'good character' should be interpreted and measured
- Provide greater guidance on how values-based recruitment should be conducted in order to better judge candidates' compassion and motivation

8.9 It is also felt that the standards could:

- Refer to the need to make applicants to nursing and midwifery programmes aware of the realities of the professions during the recruitment process
- Provide guidance on how to best select and train service users for involvement in the assessment process

8.10 To **better support the integration of theory and practice** in nursing and midwifery programmes, the standards could more clearly define the role of the link lecturer and also recognise the important role of Practice Education Facilitators.

8.11 Within nursing, there is some call for students' performance in practice to count towards their final degree grade (in order to further recognise the importance of practice within the overall programme) so the NMC should consider whether to mandate this through the standards.

8.12 The NMC may also have a role to play in terms of:

- Working with AEIs on how they can best pace their programmes to ensure students are not over-burdened with essays whilst on placements
- Providing guidance to NHS Trusts and Health Boards to discourage rules which limit students' opportunities to practise essential skills
- Supporting mentors being given the opportunity to feed into the Practice Assessment Booklets currently used to assess students
- Facilitating the development of standardised Practice Assessment Booklets across AEIs, with a need to consider a National Assessment Framework as a natural extension of this

8.13 **In terms of practice placements**, many teachers and mentors would like a minimum number of hours that should be spent in each placement setting to be specified to ensure students are exposed to an adequate range. This could be in terms of broad setting type (community / acute) or be more specific. Some would also like the SPNE to specify which of the four fields of nursing students should get exposure to. However, these suggestions must be considered for feasibility in terms of the lack of availability of placements in some areas.

8.14 **In terms of mentorship**, the NMC should consider its role in three main areas:

- Mentorship recruitment and motivation
  - This could include encouraging employers to protect time for mentorship and to recognise the importance of mentorship in annual reviews
- Mentorship training
  - This could consist of taking more of a role in overseeing the training of mentors, re-introducing a standardised mentor qualification and/or encouraging student feedback to be given to mentors
- Mentorship structure
  - The NMC should consider its view on whether the mentor and sign-off mentor roles should be distinct or combined and whether everyone should be a mentor or not

8.15 The standards could recommend a greater focus in undergraduate programmes on preparing students for future mentorship roles. It is also felt that the standards should place more emphasis on the mentor's role in teaching students (to balance the perceived existing focus in the standards on the mentor's role in student assessment).

8.16 **In terms of preceptorship**, the NMC should consider its role in ensuring that high quality approaches to preceptorship are offered consistently. This could mean the NMC providing more guidance on what a 'best practice' preceptorship looks like, regulating preceptorship or supporting a system in which students undertake a four year programme, with the last year based solely in practice, effectively acting in place of a preceptorship.

9 Next Steps

9.1 The early findings from this evaluation were shared with NMC's Education Advisory Group which includes stakeholders from across the four countries and student representatives. The group was invited to feed back their comments before the final report was prepared. Council will receive this report in January 2016 to provide further steer on delivering the strategic plan for education for the next few years.