

Response to the consultation on the regulation of a new profession – nursing associates

October 2018

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Introduction

The Nursing and Midwifery Council (NMC) is the independent healthcare regulator for nurses and midwives in the UK and nursing associates in England.

We exist to protect the public by regulating nurses and midwives in the UK and nursing associates in England. We do this by setting standards of education, training, practice and behaviour so that nurses, midwives and nursing associates can deliver high quality healthcare throughout their careers.

We maintain a register of nurses and midwives who meet these standards, and we have clear and transparent processes to investigate nurses and midwives who fall short of our standards. From 2019, nursing associates will also be able to join our register.

Our role, functions and powers are set out in the Nursing and Midwifery Order 2001 ('the Order').

Background

The Shape of Caring review (Health Education England, 2015) identified a skills gap between the roles of the unregulated healthcare assistant workforce and the registered nursing workforce. In October 2015, the Government announced the creation of a new healthcare profession in England called nursing associates. The aim of introducing this new role was to bridge this gap, to strengthen the capacity and skills of the nursing and caring workforce, and help meet the changing health and care needs of patients and the public.

Following the Government's announcement, Health Education England (HEE) worked with education providers and employers to develop a pilot programme to train an initial 2,000 nursing associates in England. The first nursing associate programmes started in January 2017, and we expect the first nursing associates to qualify in early 2019.

The Government determined that statutory regulation of the nursing associate profession was required to protect the public. In January 2017, our Council agreed to the Department of Health's request to regulate nursing associates in England.

From 16 October 2017 to 26 December 2017 the Department of Health and Social Care consulted on changes to our legislation to give us the legal powers to regulate nursing associates. It published [a response to the consultation](#) in April 2018. Parliament approved the necessary changes to our legislation in July 2018, when we legally became the regulator for nursing associates.

Between 9 April 2018 and 2 July 2018 we consulted on proposed standards and guidance that would allow us to regulate nursing associates. We developed our proposals in the context of the Department of Health and Social Care's consultation, which proposed that the approach to the regulation of nursing associates would be broadly the same as the approach that applies to nurses and midwives. We didn't consult on the need for the role, the nature of the role, whether the role should be

regulated, changes to our legislation or nursing associates fees. These questions were covered in previous consultations.¹

The consultation covered the following.

- *Standards of proficiency for nursing associates.*
- Revisions to our Code.
- Education and training:
 - *Standards framework for nursing and midwifery education.*
 - *Standards for student supervision and assessment.*
- The new *Standards for pre-registration nursing associate programmes.*
- Other regulatory requirements relating to registration, revalidation and fitness to practise.

The consultation was available in two versions. One version was aimed at professionals and stakeholders and the second was aimed at members of the public.

A total of 1,149 respondents answered some or all the questions in the consultation aimed at professionals and stakeholders. We received 16 separate responses from stakeholder organisations. The consultation aimed at members of the public received 120 responses.

Community Research, an independent research company, analysed the responses that we received and gave us the data to produce this report.

Most of the responses that we received to the professional/stakeholder consultation were from individuals (80%). We had 113 responses from people who said they were responding on behalf of organisations. Responses to the 'About you' question in the consultation indicated that the highest proportion of individual responses came from UK-registered nurses (56%), nursing associate students (24%), and nursing and/or nursing associate educators (28%). The majority of organisation responses came from NHS employers of nurses or midwives (51%) and education providers (18%). Most organisations were based in England (78%) although 16% of organisations operated across the UK.

Responses to the 'About you' question indicated that most of the individual respondents were female (83%), and 14% of respondents were male (3% of respondents preferred not to answer). The largest age group to respond was individuals between the ages of 45-54 (35%). 7% of the respondents to this question reported a disability. 87% of the respondents identified as any white ethnicity. Other ethnicities made up 6% of respondents although 6% of respondents preferred not to say. 9% of respondents reported their sexual orientation as gay, lesbian or bisexual. The majority of respondents identified themselves as Christian (53%) or of no religion (37%).

¹ See Department of Health and Social Care's [Consultation on the regulation of nursing associates in England](#), and our [Consultation on the registration fees for nursing associates](#).

The version of the consultation aimed at members of the public didn't include demographic questions. However, of the 120 people who responded, 47 indicated that they were members of the public, and 44 said that they were nurses or midwives. The rest said that they were other professionals and students.

Alongside the consultation we ran a series of engagement events and opportunities. These included:

- two webinars and a Twitter chat to give background to the consultation and answer queries
- three workshops in Manchester, London and Birmingham with a combination of healthcare professionals, educators, employers and nursing associate students
- two events for patients and the public in Manchester and London
- one focus group with parents of young children and one focus group with young people
- ten interviews with people with learning disabilities
- working group discussions on specific elements of the consultation where necessary such as GP practice and children's services.

We're grateful to everyone who responded to the consultation and who participated in our stakeholder events.

This report gives an overview of the responses that we received to the consultation, the main themes raised in comments from respondents and our response to issues raised. We've reviewed all the comments made in response to the consultation and raised in our engagement events. In updating the standards, we've benefited from advice and clinical input from a group of experts. This group was involved in developing the draft standards in advance of the consultation. The standards are aligned to the new standards for nurses, which we published in May 2018 after this consultation began.

Executive summary

The vast majority of respondents supported the proposals we put forward in the consultation.

Around four out of five (82%) respondents to the stakeholder consultation thought that the *Standards of proficiency for nursing associates* set the right levels of knowledge and skills for all nursing associates at the point of registration.

89% of respondents to the stakeholder consultation agreed that the updated Code could apply to nursing associates as well as the other professions that we regulate. 83% of respondents to the public consultation agreed that the Code should apply to nursing associates as well as nurses and midwives.

Around nine out of ten of respondents to the stakeholder consultation agreed that the *Standards framework for nursing and midwifery education* (91% of respondents agreed) and the *Standards for student supervision and assessment* (90% of respondents agreed) should apply to nursing associates.

We asked a number of questions about the *Standards for pre-registration nursing associate programmes* in the stakeholder consultation. In all but one question, respondents supported our proposals by majorities of between 62% and 80%.

The question where we received less support concerned the recognition of prior learning for registered nurses wishing to join nursing associate programmes. Just under half of respondents (46%) agreed with our proposal that there should be no cap. But, as 28% of respondents disagreed and 19% neither agreed nor disagreed, 'agree' was the most popular answer. There were some areas of misunderstanding in relation to how a registered nurse would become a nursing associate. We've addressed these [below](#) and we've updated the standard in response to concerns raised about registered nurses with restrictions on their practice.

We asked a number of questions about our other regulatory requirements. Over 90% of respondents to the stakeholder consultation thought that our English language requirements should apply to nursing associates in the same way that they apply to nurses and midwives. Agreement ranged from 90-95% in relation to applying all five of our revalidation requirements to nursing associates and most respondents (69%) felt that there weren't any specific implications of extending our fitness to practise approach to nursing associates.

In the stakeholder consultation we asked people to consider whether the proposed changes had any impacts on people who share protected characteristics under the Equality Act 2010. Most respondents (76%) thought that there would be a positive impact or no impact on those who share these characteristics.

As our proposals received a high level of support, we feel that the approach that we've taken is the correct one. However, we've reviewed all the comments and suggestions put forward in the consultation, and where appropriate we've updated our standards to incorporate them.

Most significantly, we've included a new option for protecting students' learning in practice for work-placed programmes in the [Standards for pre-registration nursing associate programmes](#). We've done this in recognition of the fact that for the first time we're regulating a profession that most people will join via a work-placed route. We'll keep this approach under review so that we can be sure there are no unintended consequences.

We've given more detail on the changes that we've made in the relevant sections below.

The *Standards of proficiency for nursing associates*

The standards of proficiency set out what all nursing associates should know and be able to do when they join the register. In common with other professions, nursing associates can acquire further knowledge and skills with the right training and clinical governance.

Approved education institutions, and their practice placement partners, will need to ensure that nursing associate education and training programmes enable students to demonstrate these proficiencies and qualify as nursing associates.

The Department of Health and Social Care's intention is that nursing associates support the delivery of nursing care across a wide range of health and care settings and practice fields. Nursing associate is a generic role across the fields of nursing. Their education needs to give them understanding and experience of working with children and adults, and with people with learning disabilities and mental health conditions.

The consultation asked seven questions about our draft standards of proficiency for nursing associates (six in the professional and stakeholder consultation and one aimed at members of the public). We designed these standards to align with the latest [Standards of proficiency for registered nurses](#). They were structured under six headings, describing the key components of the role.

The consultation for professionals and stakeholders also asked four questions about the annexes to the *Standards of proficiency for nursing associates*. These annexes set out the communication, skills and procedures that nursing associates must be able to demonstrate at the point of registration.

Questions about the *Standards of proficiency for nursing associates*

The level of knowledge and skill required

Responses from the stakeholder consultation

The stakeholder consultation asked three questions about the level of knowledge and skill required of all nursing associates at the point of registration.

Question 1:

Do you agree or disagree that the *Standards of proficiency for nursing associates* set an appropriate level of knowledge and skill for all nursing associates at the point of registration?

A large majority of respondents (82%) agreed that the *Standards of proficiency for nursing associates* set an appropriate level of knowledge and skill for nursing associates. Only 12% of respondents disagreed. 6% of respondents neither agreed nor disagreed.

Individuals were significantly more likely to strongly agree (29%) than organisations (16%). Among individuals, nursing associate students were significantly more likely to strongly agree (42%) than registered nurses/midwives (22%) and educators (20%).

Just over a quarter of respondents to this question provided a reason for their answer.

Those who agreed with the question, mainly commented that the standards reflected what the role required. They also said that the standards made the distinction between the role of a nursing associate and a nurse clear. For example:

“The difference in the standards of proficiency between the Nursing Associate and Registered Nurse fulfil the requirement initially set out by the NMC to have clear definition between the two roles. The Nursing Associate role is able to adequately meet the current skills gap between health care assistants and registered nurses identified by Shape of Caring review (HEE, 2015).” (NHS employer)

Those who disagreed, mainly commented that the standards were too close to the standards for registered nurses and that the standards were too high or too ambitious.

There were also a number of common issues raised, regardless of whether respondents agreed or disagreed. The main themes related to:

- Assessments - some respondents felt that nursing associates could undertake assessments and others wanted greater clarification around what's expected of a nursing associate with regard to assessment. For example:

“We broadly agree that the level is appropriate. However, we believe that there is a lack of clarity in Platform 3 on the level of assessment of patients. The way in which the standards are currently written means that it is not always easy to understand what level of patient assessment a nursing associate is expected to undertake. This ambiguity relates to both patient acuity and complexity and the need to escalate to a registered nurse or other registered professional.” (Professional organisation or trade union)

- The level of responsibility and overall accountability of nursing associates - some respondents felt that greater clarity was needed. For example:

“I think the level of skill is appropriate. But something needs to be done to ensure that the workforce, including TNA's, understand the very clear boundaries. In my experience so far, there is a lack of understanding at all levels.” (Registered nurse)

- Clarity around terms like 'demonstrate', 'monitor' and 'understand'.

Less frequently mentioned was the view that the standards were too focused on adult and/or acute care:

“[organisation] believes that as this is a generic role there should be more content on mental health and learning disability skills; particularly in person centred care, personhood and principles of practice in these fields.” (Professional organisation or trade union)

Our response

We welcome the fact that the overwhelming majority of respondents agreed that the standards set the appropriate level of knowledge and skill for nursing associates.

Some respondents who disagreed with the question felt that the standards were too close to the standards for registered nurses. But as the [response to the question on this issue shows](#), this was not the majority view.

Some respondents asked for clarity on the nursing associate's role in assessment. To clarify the standards of proficiency include the skills that nursing associates will need to be able to input and contribute to assessment, such as monitoring, evaluation and specific assessment skills. The *Standards of proficiency for registered nurses* go further and are consonant with nurses needing the knowledge and skills for primary assessment. Our proficiencies don't set out roles and tasks that nursing associates will or will not fulfil because that is not their purpose. However, there will be guidance on safe deployment of nursing associates from other organisations.

Some respondents felt that the standards were too acute or adult focused. Although this isn't the intention, and we feel that the standards are appropriate for a generic role, we've added some wording to clarify. In some instances, we've incorporated suggestions on how to make the standards more generic. For example:

- We've added some wording to the introduction to the standards. This confirms that nursing associates provide care for people of all ages, from different backgrounds, cultures and beliefs and who have different mental, physical, cognitive and behavioural care needs.
- We've also made it clear that the outcome statements for each platform have been designed to apply across all health and care settings and that nursing associates should be able to demonstrate an awareness of how requirements vary across different health and care settings.
- We've updated some areas of Annexe A (communication and relationship management skills) to include age appropriate communication techniques and to clarify that reasonable adjustments should be made where appropriate to support understanding during communications.

Following careful consideration of all the consultation comments, we've updated some areas of the Standards of proficiency. We've improved the wording to provide further clarity throughout and to align, where appropriate, to the final *Standards of proficiency for registered nurses* (published during the nursing associate consultation period).

Question 2:

Are there any further areas of knowledge or skill that you would expect all nursing associates to be able to demonstrate at the point of registration?

Most respondents (55%) didn't think that there were further areas of knowledge and skill expected of nursing associates at the point of registration. 16% of respondents said that

they didn't know. Around a third of respondents (30%) made suggestions about further areas to be covered.

Organisations (48%) were more likely to answer 'yes' to this question than individuals (28%).

The minority of respondents who answered 'yes' and provided comments made a number of suggestions. The most commonly mentioned areas were:

- intramuscular injections
- basic assessment skills, including observation skills
- non-clinical skills, for example, assertiveness, resilience, communication, leadership, and conflict resolution
- skills relating to specific areas of practice, for example working with children and young people, people with learning disabilities and those with mental health conditions.

Respondents also mentioned a number of other skills, the majority of which are in fact covered in the annexes to the standards of proficiency. These are addressed in questions [below](#). The specific skills mentioned included:

- catheterisation
- IVs/cannulation
- medicines administration
- leadership/mentoring/team leader skills
- care plans
- venepuncture
- medication/feeds via naso-gastric tube.

Our response

As there was a considerable amount of overlap in the responses to this question and question 3, we have considered these two questions together below.

Question 3:

Are there any areas of knowledge or skill included within the *Standards of proficiency for nursing associates* that do not need to be included or that go beyond what you think should be expected of all nursing associates at the point of registration?

Most respondents (71%) didn't think that there were any areas of knowledge or skill in the standards that should not be included or that went beyond what should be expected

of all nursing associates at the point of registration. 12% of respondents answered 'don't know'. Some respondents (17%) felt that there were areas which shouldn't be included.

Registered nurses or midwives (18%) were more likely to say that there were areas of knowledge and skills in the standards that shouldn't be included than nursing associate students (9%).

Of the minority of respondents who felt that some areas shouldn't be included, specific areas mentioned in the comments included:

- medicine management/drug administration
- specific skills, such as cannulation, venepuncture and to a lesser extent, naso-gastric tubes, catheterisation, bed-making and end of life care.

Our response (to questions 3 and 4)

The majority of respondents were content with the areas of knowledge or skill included in the standards of proficiency and didn't feel that any further skills should be included or removed.

A minority of respondents suggested that further skills or areas of knowledge be included (30% of respondents to question 3) or that some areas be removed (17% of respondents to question 4). Opinion was divided about the areas of knowledge that should be included or removed, with skills such as cannulation, medicines administration and venepuncture appearing in response to both questions. As noted above, many of the skills mentioned are relevant to the annexes to the standards of proficiency.

In considering whether to include or remove areas of knowledge or skill, we've discussed the issues raised in the consultation with a group of clinical and educational experts and asked for their advice and input.

Some of the comments mentioned communication and relationship management skills such as skills relating to assertiveness and conflict resolution. We've considered these comments and where appropriate updated Annexe A. For example, we've added in reference to being assertive when required and removed the reference to confrontation strategies.

Some respondents thought that venepuncture should be removed from the standards of proficiency as it was too advanced or because nursing associates wouldn't need it. We discussed this with the expert group and the majority of that group felt that it should remain in the standards of proficiency. As only a small number of respondents raised this in the consultation and in our external engagement, we've continued to include it in our updated standards.

Following the consultation, we've decided to remove cannulation from the standards. A greater number of respondents highlighted this as an issue in various places in the consultation. After discussion with the expert group we agreed that this should be removed. Cannulation is a more complex skill to learn than venepuncture and involves longer training. There was also the view that this skill wouldn't be required by all nursing

associates and some might not have the opportunity to maintain competence post-registration. However, this doesn't mean that nursing associates can't be trained to cannulate if they need this skill in their particular setting.

The administering medicines section of the standards received some comments, specifically in relation to the routes of administering injections, where some stakeholders felt that the intramuscular route should be included and the intradermal route removed. We discussed this with the same group of experts and as a result have updated the standards to include intramuscular injections and to remove intradermal. We hope that including intramuscular injections also helps to address concerns that some raised on the focus of the standards, as these skills are particularly valued in community settings, including mental health.

Responses from the consultation aimed at the public

We also asked an open-ended question about the skills and knowledge nursing associates needed in the version of the consultation aimed at the public:

Nursing associates will be expected to provide compassionate, safe and effective care and support to people in a range of care settings. What skills and knowledge do you think nursing associates need to deliver high quality care?

We received 110 responses to this question. 43 people responded as members of the public, and 58 as professionals or students.

Respondents highlighted compassion and empathy and medical or clinical knowledge as key to delivering high quality care. Comments focused on the need for nursing associates to:

- have an understanding of anatomy and physiology
- be expert, professional and capable, with strong communication skills (including English language), social skills and organisational skills
- be able to administer medication
- recognise their own limitations and know when to ask for help.

Our response

We welcome the comments made in response to this question. We're pleased that the areas of knowledge and skill highlighted by members of the public, students and professionals are included in the *Standards of proficiency for nursing associates*.

Are the standards appropriate for a generic role?

The stakeholder consultation asked:

Question 4:

Do you agree or disagree that the *Standards of proficiency for nursing associates* are appropriate for a generic nursing associate role?

Three quarters of respondents (75%) agreed that the *Standards of proficiency for nursing associates* were appropriate for a generic nursing associate role. 12% of respondents disagreed, and 13% neither agreed nor disagreed. Nursing associate students were more likely to agree or strongly agree (89%) than registered nurses or midwives (68%) or educators (75%)

Many respondents gave no reason for their answer. A minority of respondents made comments along the following lines:

- Some of the skills were not relevant to all areas and so it would be difficult for some nursing associates to gain exposure to maintain proficiency post-registration.
- The skills were too focused on adult and/or acute care and didn't give enough attention to community healthcare, mental health or children and young people.
- Not all the skills are relevant to every area. So there should be the opportunity for some skills/training to be determined locally rather than to try to cover everything in a generic role. For example:

*"There is recognition that generic standards are appropriate to train Nursing Associates, but once qualified NAs may need additional support or training when they are employed in a more specialised or independent setting."
(Government or public body)*

Our response

We welcome the positive response to this question (75% agreed) and are content that our current approach is appropriate for a generic role. We've acknowledged that some respondents felt that the standards were too focused on adult care. We've addressed these concerns in our responses above.

To clarify, the standards of proficiency set out the skills that we will require of all nursing associates at the point of registration. We highlight this principle in various sections in the standards. Nursing associates will be able to develop further skills in specific settings. Approved education institutions and their practice placement partners may decide to include additional elements in their programme, if they would like their nursing associates to gain additional skills in certain areas. Finally, our approach to revalidation can accommodate the fact that as they progress in their careers, people on our register may move away from their initial scope of practice.

Do the standards make the differences between nurses and nursing associates clear?

We asked one question about this in the consultation for stakeholders and professionals.

Question 5:

Do you agree or disagree that the *Standards of proficiency for nursing associates* distinguish the knowledge and skill expected of the nursing associate in comparison with what is expected of a nurse at the point of registration?

The majority of respondents (70%) agreed that the *Standards of proficiency for nursing associates* distinguish the knowledge and skill expected of a nursing associate in comparison with a nurse. 17% of respondents disagreed and 14% neither agreed nor disagreed. Nursing associate students were more likely to agree (80%) than registered nurses/midwives (66%).

Respondents who agreed and provided views said that they were able to see identifiable differences between the two sets of standards. For example:

“This clearly differentiates between the level of requirement of a nursing associate and a registered nurse, the skills annex within this, particularly makes noticeable differentiation” (NHS employer).

Of the minority of respondents who disagreed with the question and then provided comments the themes in the comments included:

- Some general concern around what they felt was a lack of distinction between the two roles.
- The need to make a clearer distinction in the role that registered nurses and nursing associates have in assessment. Some of these respondents felt that assessment should always rest with the registered nurse. Others suggested that in practice, nursing associates would need to carry out some level of assessment to perform their role. For example:

“There needs to be greater reference to the role of the NA in assessment. NA's need to be able to operate as intended when the plans for the role were introduced; if the role in assessment is not clarified, the risk is they will only be allowed to function as [healthcare support workers] and the full benefit of the training and education will not be realised.” (Anonymous organisation)

“The clear blue water between what the registered nurse is expected to do, compared to the nursing associate, is supposed to be that the nurse assesses the patient, makes a nursing diagnosis and develops a plan of care, but within the nursing associate skills annex there is still reference to NAs assessing.” (Registered nurse)

Our response

We welcome the fact that the majority of respondents (70%) felt that the distinction between the roles was clear within the Standards of proficiency. We have always been clear that there will be a degree of overlap just as there is between nurses and other members of multi-disciplinary teams.

Some respondents asked for clarity around assessment. As we've said [above](#) our standards require nursing associates to have the skills and knowledge to contribute to assessment at the point of registration, whereas our nursing standards carry an expectation that at the point of registration, nurses can assume overall responsibility for assessment and resulting care plans. We hope that the changes that we've made to the standards will also provide further clarity on the distinction between nurses and nursing associates.

Progression to nursing

Question 6:

We have been asked to ensure nursing associate programmes can provide a progression route to nursing degrees. Do you agree or disagree that the *Standards of proficiency for nursing associates* taken together with the new *Standards of proficiency for registered nurses*, help educators define the additional requirements for programmes that will enable progression to degree-level nursing?

74% of all respondents agreed that the standards would help educators define the additional requirements for programmes to enable progression to degree-level nursing. 11% of respondents disagreed and 15% neither agreed nor disagreed. Agreement was higher among educators (84%) and nursing associate students (88%) than registered nurses/midwives (69%).

Those that agreed with the question and provided comments mainly expressed general support. They said they saw a difference between the standards for nursing associates and registered nurses and that the pathway to becoming a registered nurse was clear.

The minority of respondents who disagreed with the question mainly referred to the need for a clearer distinction between the roles of a nursing associate and a registered nurse.

Additional themes raised in comments from both those who agreed and disagreed included:

- Questions about the ability and time needed to progress from a nursing associate to a registered nurse in a specialist field
- The need to ensure consistency across educational standards
- Questions about whether and how nursing associates could use their existing skills during further studies to become a registered nurse.

Our response

We're satisfied that the positive response to this question shows that the *Standards of proficiency for nursing associates*, taken with the *Standards of proficiency for registered nurses*, help educators to define the additional requirements for programmes that will enable progression to degree-level nursing.

In response to this question, some respondents asked for more information about progression to nursing, the time it would take and whether they would be able to use their nursing associate skills. We cover these issues in more detail in the section relating to the [Standards for pre-registration nursing associate programmes](#).

When a nursing associate wishes to join a pre-registration nursing programme, the requirements for recognition of prior learning would apply. This means that approved education institutions will need to consider how much of the applicant's prior learning as a nursing associate can count towards the pre-registration nursing programme, up to a maximum of 50% of the programme.

Questions about the annexes of the *Standards of proficiency for nursing associates*

The annexes of the *Standards of proficiency for nursing associates* set out the communication skills and procedures that nursing associates must be able to demonstrate at the point of registration. As the nursing associate role is generic, we've drafted the annexes to enable nursing associates to demonstrate skills that can be applied in a range of health and care settings and to care for people with different needs. These skills don't need to be demonstrated in every setting or across all stages of the life-span.

Annexe A outlines the communication and relationship management skills required of nursing associates. Annexe B outlines the procedural skills required. The stakeholder consultation asked for views on these two annexes.

Overview of responses

Annexe A: Core communication and relationship management skills

We asked two questions about communication and relationship management skills in the stakeholder consultation. There were some areas of overlap, so our response below addresses both of these questions.

Question 1:

Are there any further core communication and relationship management skills which you would expect of all nursing associates at the point of registration?

Most respondents (74%) felt that there weren't any further core communication or relationship management skills that should be included in Annexe A. 18% of respondents felt that there were other skills that could be included and 8% answered 'don't know'.

Organisations were more likely to feel that further skills were needed than individuals (38% compared to 14% respectively). Nursing associate students were less likely to feel that more skills should be included than registered nurses or midwives (5% and 19% respectively).

In the main, comments from the minority of respondents who felt that further skills should be included related to:

- Communicating with patients with additional or different needs. For example, communicating with people with a cognitive, hearing or speech impairment and with people of all ages and diverse backgrounds.
- Working and communicating within teams and with colleagues. For example, working effectively with registered nurses, including escalating issues, leadership, supervision and mentoring and working within a multi-disciplinary team.
- More advanced skills, including handling difficult conversations or situations.
- The use of IT and digital media, for example including electronic care records and the use of social media.

Question 2:

Are there any communication or relationship management skills included in Annexe A that do not need to be included or that go beyond what you think should be expected of all nursing associates at the point of registration?

The vast majority (83%) of respondents didn't feel that there were any communication or relationship management skills that should be removed from Annexe A. Only 6% of respondents felt there were. 11% answered 'don't know'.

Only a small proportion of respondents went on to make comments. Some of these reflected views on the nursing associate role in general which were outside the scope of the consultation. The main theme from the comments related to supervision and delegation, with some respondents expressing confusion about who nursing associates might be supervising or delegating to.

Our response (to questions 1 and 2)

We welcome the fact that most respondents felt that the communication or relationship management skills included in Annexe A were the right ones (with 74% of respondents to question 1 saying that there weren't any further skills they would include and 83% of respondents to question 2 saying they didn't feel that we should remove any skills).

Respondents raised some issues relating to Annexe A in response to earlier questions. We've considered these comments [above](#). Where appropriate, we've incorporated them into the updated standards. These include changes made to incorporate references to age appropriate communication techniques, and to remove reference to confrontation strategies.

A minority of stakeholders continued to raise questions about supervision and delegation. This was one area of the consultation where such matters were raised. We can confirm that nursing associates will be able to delegate and to supervise other staff. The Standards of proficiency provide examples of people that nursing associates should be able to supervise at the point of registration (Platform 4: Working in teams, 4.7). These are nursing associate students, health care support workers and those new to care roles. This platform also provides information on delegation, stating that nursing associates must be able to “recognise where elements of care can safely be delegated to other colleagues, carers and family members”.

The Code also provides information on accountability and delegation and we’ve produced some additional material on this which is available on our [website](#).

Annexe B: Core procedural skills

Question 3:

Are there any further core procedural skills which you would expect of all nursing associates at the point of registration?

Two thirds (67%) of respondents said that there weren’t any further core procedural skills that we should include in Annexe B. 23% of respondents thought that there were further skills that we should include and 10% answered ‘don’t know’.

Organisations were more likely than individuals to expect further procedural skills to be included (42% compared to 20% respectively). Educators were more likely than nursing associate students to say that no further skills were expected (80% and 63% respectively).

The most commonly mentioned skills that respondents thought we should include were:

- Intramuscular (IM) injections. Some respondents commented that this was particularly important in mental health and GP practice settings. Others said that without these skills, nursing associates wouldn’t be able to carry out some important functions. For example,

“The absence of the requirement for the NA to learn how to administer medication via the intramuscular route means that they will be unable to meet the requirements elsewhere in the standards relating to health protection. For example, they will be unable to play an active role in national immunisation programmes, including those for flu and pneumococcal vaccinations. Annexe B section 1.i, states that NAs will recognise and take “immediate action” in medical emergencies including anaphylaxis. As immediate action in anaphylaxis is an intramuscular injection of adrenaline.” (Government or public body)

- Catheterisation. Although Annexe B makes specific reference to catheterisation, this was mentioned in a number of responses. Few of these respondents gave detail as to what further information they expected.

- Intravenous (IV) therapy. There were some concerns that the nursing associate role would be limited if they were not able to perform IV therapy.

A smaller number of respondents recommended that we include other skills. These were:

- skills relating to naso-gastric (NG) tubes;
- the administration of medicines
- venepuncture/bloods/phlebotomy
- cannulation (although a significantly larger number of respondents said that we shouldn't include this in response to question 4 below).
- ongoing evaluation or assessment
- health promotion
- skills appropriate to the nursing associate's area of practice.

Question 4:

Are there any of the core procedural skills included in Annexe B that do not need to be included or that go beyond what you think should be expected of all nursing associates at the point of registration?

70% of respondents felt that there weren't any core procedural skills that should be removed from Annexe B. 20% of respondents thought that there were some skills that should be removed and 10% of respondents answered 'don't know'.

Organisations (30%) were more likely than individuals (19%) to say that some of the procedural skills shouldn't be included. Registered nurses/midwives (24%) and educators (25%) were more likely than nursing associate students (7%) to say that some of the skills shouldn't be included.

A number of respondents provided comments and suggestions as to what we might remove from the Annexe. Most of these suggestions were about clinical skills. Others were about the scope of practice, the focus of the guidance or the clarity of the terms.

The main specific clinical skills that respondents thought we should remove were:

- cannulation
- venepuncture
- the administration of medication
- bed making
- blood sampling
- injections

- ECG
- stoma care
- neurological observations
- catheterisation/self-catheterisation
- external feeding.

Other respondents made comments about the broader skillset in Annexe B. These concerned:

- the level of skill required at registration (with some feeling that some of the skills were not required of nurses at registration, or could be developed post-registration).
- overlap with the role of registered nurses
- maintaining competence in skills which nursing associates may be exposed to only infrequently
- views that the skills listed were too adult-oriented or too focused on acute settings
- the view that the list of skills was overly prescriptive
- requests for clarity in relation to specific procedures.

Our response (to questions 3 and 4)

The majority of respondents felt that there weren't any further core procedural skills that should be included (67% of respondents) or removed (70% of respondents) from Annexe B of the standards.

Again, a number of skills, such as cannulation, venepuncture and catheterisation appeared as skills some respondents thought should be included in the standards and others thought shouldn't be included.

Following consideration of the comments made in the consultation and input from the clinical and educational expert group, we have:

- updated the standards to include intramuscular (IM) injections and to remove intradermal.
- kept venepuncture in Annexe B as only a small number of respondents specifically expressed concerns about it.
- removed cannulation, as a greater number of respondents highlighted this as an issue and due to the complexity and length of time involved in training someone to cannulate. There was also the view that this skill would not be required by all nursing associates.

- removed stoma care as this was an issue raised by a reasonable number of respondents as being too specific and not appropriate for a generic role.

We've provided more information on our reasoning behind some of these decisions [above](#).

The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates

Our Code outlines the professional standards that people on our register must uphold to practise in the UK. It was published in 2015, and is well known and positively regarded by nurses and midwives.

In the consultation, we proposed updating the Code to include nursing associates, but didn't propose fundamental changes to the standards set out in the Code. We provided an updated version in the consultation. This included a new introduction and a small number of amendments to make sure the wording was fit for the purpose of regulating all three professions that we now regulate.

We asked two questions about the Code in the consultation for stakeholders and professionals and one question in the consultation for the public. We've provided an overview of the responses to each of these questions below and then our response on the Code.

Stakeholder consultation

Question 1:

Do you agree or disagree that the revised introduction explains how the Code can apply to nursing associates as well as the other professions we regulate?

An overwhelming majority of respondents (89%) agreed that the revised introduction explained how the Code can apply to nursing associates. Only 5% of respondents disagreed and 6% neither agreed nor disagreed.

Organisations (98%) were more likely to agree than individuals (87%) although the levels of agreement were very high. Individual nursing associate students (97%) were more likely to agree than registered nurses and midwives (85%).

A relatively small number of respondents (39 out of 505) provided comments. Of those who agreed with the question, one of the main themes was that the Code should apply equally to all professions on the register:

"We agree that only one Code should regulate the three professions. Nursing associates and registered nurses should be regulated by the same legislation, even though the professions' titles are different"
(Charity/voluntary sector organisation)

From those who disagreed, there were calls for greater clarity between the roles of nursing associates and registered nurses. This theme was also echoed in some of responses from those who agreed with the question.

There were also comments relating to accountability and delegation from both those who agreed or disagreed with the proposals. A number of respondents felt that there was not enough clarity and understanding about what this meant and how it should be applied:

“I still don’t think that accountability is really understood by Registered nurses let alone this new role.” (Anonymous respondent).

“Without explicit lines of accountability, there is a risk of patient and staff confusion, and a negative impact on patient safety.” (Professional organisation or trade union)

Question 2:

Are there any standards within the Code that you think should not apply to nursing associates?

90% of respondents said that there were no standards in the Code that were inappropriate for nursing associates. Only 5% of respondents expressed the view that there were standards in the Code which shouldn’t apply to nursing associates. 6%² of respondents said that they didn’t know.

A small proportion of respondents provided comments to explain their answer. The most common theme in the comments was general support for applying the Code to nursing associates. As with responses to the question above, there was a call for greater clarity in roles and accountability.

Some comments suggested more specific changes or clarifications in language. Some made comments relating to specific relationship management and procedural skills that they felt weren’t appropriate for nursing associates.

Consultation for members of the public

The consultation aimed at members of the public included the following question about the Code:

Do you think that the Code that currently applies to registered nurses and midwives should also apply to nursing associates when they join our register?

83% of respondents believed that the Code should apply to nursing associates and 14% said the Code should not apply. 3% of respondents answered ‘don’t know’. Students or professionals were more likely to agree with the question than members of the public, although the levels of agreement were high (84% and 81% respectively).

A number of respondents gave reasons for their answer. Those that agreed with the question highlighted that nursing associates were part of the nursing team and applying the same Code recognised this.

The minority of respondents who disagreed with the question and provided comments thought that there should be a difference in the professional status of registered nurses and nursing associates. This would reflect the different training requirements and different levels of pay.

² Here the percentages add up to 101%. This is due to rounding.

Our response

There was strong support across both the stakeholder (89% of respondents agreed) and public consultations (83% of respondents agreed) for the proposal that the Code should apply to all the professions that we regulate.

We've the same expectations of professional behaviour for nurses and midwives and this is why we currently have one Code. We believe that having one Code helps patients and the public to be confident that the same high standards of behaviour apply to everyone on our register. It is common practice for regulators to apply the same Code across the professions they regulate. Given the significant support for this proposal we intend to continue with this approach.

We made it clear in the consultation that nurses, midwives and nursing associates will uphold the Code within their limits of competence. In common with nurses and midwives, nursing associates will have their own distinct standards of proficiency, setting out the specific knowledge and skills required to join the register.

Some respondents asked for clarity in relation to roles, accountability and delegation. We have produced some additional material on this which is available on our [website](#). In updating the Code following the consultation, we've considered the more specific suggestions put forward by respondents and provided further clarity in a number of areas. For example, we've given more explanation about the importance of professionals working within the limits of their competence.

Education and training

Questions about the *Standards framework for nursing and midwifery education*

The *Standards framework for nursing and midwifery education* includes standards that apply to all education institutions that are delivering NMC approved programmes and their practice learning partners. It covers:

- Learning culture
- Educational governance and quality
- Student empowerment
- Educators and assessors
- Curricula and assessment

In the consultation aimed at stakeholders and professionals we proposed applying the standards framework to the providers of nursing associate programmes.

Question 1:

Do you agree or disagree that the *Standards framework for nursing and midwifery education* should also apply to providers of nursing associate programmes?

91% of respondents agreed with the proposal to apply the standards framework to nursing associate programmes. 5% disagreed, and 4% neither agreed nor disagreed. Nursing associate students were more likely to agree than registered nurses/ midwives (95% and 89% respectively).

Those who agreed with the proposal and provided comments thought that it was appropriate to apply common standards across nursing, midwifery and nursing associate programmes and to have consistency across professions. They said that it was important to enable the career progression of nursing associates. Some said that the providers of nursing associate programmes should also be able to offer nursing degree programmes.

A number of respondents mentioned supernumerary or protected learning time. We cover this [below](#).

Of the minority of individuals who disagreed with the proposals, some said that they disagreed with nursing associates being mentors, assessors and/or supervisors. They questioned whether nursing associates would be sufficiently trained to carry out these roles. Some respondents said that the nursing associate role is (or should be) a completely different role to that of nurse or midwife, and so a different set of standards should apply.

A very small number of respondents voiced concerns over what they saw as an overlap of roles between nursing associates and registered nurses. The application of the same education standards contributed to this concern.

Some respondents asked for further clarity on a number of points:

- The relationship between our standards and apprenticeship requirements
- The sorts of institutions that are eligible to become approved education institutions for the purpose of delivering nursing associate programmes.

Our response

We welcome the fact that over 90% of respondents agreed with applying the standards framework to nursing associate programmes. We've updated the standards framework so that it can apply to nursing associate programmes.

A minority of respondents were concerned about applying the same standards to nurses and nursing associates. However, the standards framework is designed to apply to all approved education institutions. So it already applies across different professions (registered nurses and midwives), different types of programmes (pre-registration as well as post-registration) and to different learning models, including apprenticeships.

The standards framework covers issues such as the learning culture and educational governance of programmes while the [Standards for pre-registration nursing associate programmes](#) set out the specific requirements for nursing associate programmes. The same approach applies to pre-registration nursing programmes, where the specific requirements are set out in the *Standards for pre-registration nursing programmes*.

Some respondents asked about the type of institutions that could train nursing associates. We address this question [below](#).

A minority of respondents raised concerns about nursing associates acting as mentors, assessors or supervisors. We believe that in the future nursing associates that are suitably trained and supported in line with the *Standards for student supervision and assessment*, should be able to act as supervisors and assessors, just as nurses and midwives do. However, we recognise that it may be some time until there is an available pool of sufficiently experienced nursing associates to act in these roles, and so we've said that nurses can also undertake these roles.

Questions about the *Standards for student supervision and assessment*

The *Standards for student supervision and assessment* set out what we require for student learning and supervision in the practice environment. They also set out how educators will assess students across theory and practice. We've designed these standards to apply to all NMC approved education programmes. In the consultation we proposed applying them to nursing associate programmes.

In the consultation aimed at stakeholders and professionals we asked two questions about these standards.

Question 1:

Do you agree or disagree that the *Standards for student supervision and assessment* should also apply to nursing associate education programmes?

90% of respondents agreed that these standards should also apply to nursing associate education programmes. 5% disagreed, 3% neither agreed nor disagreed and 1% answered 'don't know'. Nursing associate students were more likely to agree than registered nurses/midwives (98% compared with 88% respectively).

Those who agreed with the proposal said that there was a need for consistent, high standards for all registered nursing professions to ensure equal treatment for all students and to maintain the rigour of the register.

"Training needs to be consistent and it is important that the educational standards and competencies are nationally recognised to maintain a recognised standard for the training of Nursing Associates across all training sites." (NHS employer)

Among this group there were opposing views on whether nursing associates should act as supervisors or assessors. Some felt that it should only be registered nurses, while some supported the idea of nursing associates acting as supervisors but not assessors. Others wanted to see the role broadened to other healthcare professionals too. We covered the subject of assessors in question 2.

Of the small minority of respondents who disagreed some said that they didn't support the idea of nursing associates supervising or assessing students, and especially not student nurses. For example:

"Only RN should be assessing a student nurse. Supervision, sharing of knowledge and experience from an associate is essential though." (Registered mental health nurse)

Respondents with varied opinions also made some comments in relation to whether nursing associates should have supernumerary status. We cover supernumerary [below](#).

There were some calls for clarification on whether nursing associates would be assessing student nurses and whether supervision and mentoring would be covered in pre-registration programmes.

Among some stakeholder organisations, there was some support for a more flexible approach to practice-based learning. Some suggested that more attention should be paid to ensuring mentors and supervisors had the time and support for this role in practice.

Question 2

Do you agree or disagree that registered nurses and nursing associates should be able to fulfil the role of academic or practice assessor?

The majority of respondents (65%) agreed that registered nurses and nursing associates should be able to fulfil the role of academic or practice assessor. 22% of respondents disagreed and 13% neither agreed nor disagreed.

Individuals were more likely to disagree than organisations (26% of individuals and 11% of organisations). Among individuals, registered nurses/midwives and educators were more likely to disagree than nursing associate students.

In the main, those that disagreed and gave us comments thought that registered nurses should retain responsibility for assessing students. Some of these respondents thought that nursing associates should never become assessors. They thought it would place an unfair burden on nursing associates given their role and pay grade or that it should be graduate-level nursing professionals performing assessment. Respondents often expressed an inaccurate view that nurses would be accountable for the practice of nursing associates, whereas the clear implication of professional regulation is that nursing associates will have their own individual professional accountability.

*“The RN is ultimately accountable for any failing in practice so all practice should be viewed and assessed by an RN to ensure correct practice is achieved.”
(Anonymous respondent)*

Some respondents thought that nursing associates could have a role in assessing students but only following additional training or preparation, or if they had developed an acceptable level of experience and within their own area of expertise.

“There was strong agreement amongst respondents that nursing associates should be able to fulfil the roles of practice assessors for nursing associates, subject to appropriate education, experience and achieving the required level of clinical competence... However, given the recent reductions in CPD funding, this may be challenging to achieve.” (Professional organisation and trade union)

Others thought that nursing associates should only be able to assess or supervise nursing associate students.

Our response

We welcome the fact that the majority of respondents agreed with our proposals to apply the *Standards for student supervision and assessment* to nursing associate programmes (90% of respondents) and to allow registered nurses and nursing associates to fulfil the role of academic or practice assessor (65% of respondents).

As noted [above](#) our position is that, in time, nursing associates should be able to act as supervisors and assessors, just as nurses and midwives do. We recognise that it may be some time before nursing associates can take on these roles and acknowledge the comments made by some respondents around the importance of training. We already set requirements around the training and experience needed for all supervisors and assessors in the [Standards for student supervision and assessment](#).

The *Standards for student supervision and assessment* also make it clear that student nurses are assessed by registered nurses and that student nursing associates are assessed by a registered nursing associate or a registered nurse.

We'll update the *Standards for student supervision and assessment* to apply them to nursing associate programmes. We've also developed some [supporting information](#) which includes further information about the practice supervisor role. There will also be supporting information on academic assessor and practice assessor roles.

Standards for pre-registration nursing associate programmes

The *Standards for pre-registration nursing associate programmes* set out the legal and entry requirements, availability of recognition of prior learning, length of programme, methods of assessment and information on the award that all approved education institutions and their practice placement partners must meet to run approved pre-registration nursing associate programmes. They must also meet the requirements set in the *Standards framework for nursing and midwifery education* and the *Standards for student supervision and assessment*.

Our education standards relate to entry to the new profession of nursing associate; they are not standards exclusively for use in the apprenticeship context. We know that the government intends apprenticeship to be used to fund nursing associate programmes, but we also know that conventional, non-apprenticeship routes are planned. In any case our role is to set the standards for a profession, not a route. Regardless of the approach adopted, education providers must meet our standards to run nursing associate programmes.

The *Standards for pre-registration nursing associate programmes* are entirely new.

The consultation aimed at stakeholders asked eleven questions about these standards. The consultation aimed at the public asked two questions relating to the values and personal qualities that nursing associates need, and the split between theoretical and practical learning.

In the following sections, we provide a brief overview of the responses received in each area and give our response.

Values and personal qualities of nursing associates

The consultation aimed at members of the public asked the following question:

We think that when accepting student nursing associates on to courses, educators should take into account their values and personal qualities. What values and personal qualities do you think nursing associates need to deliver compassionate, safe and high quality care?

There were 96 responses to this question, 39 from members of the public and 49 from professionals or students.

Compassion and empathy were the most commonly mentioned qualities. Other personal qualities that were frequently raised included:

- being trustworthy, reliable and honest. This was particularly important to members of the public.
- dedication and commitment. This was particularly important to students and professionals.

- expertise and professionalism. Members of the public mentioned this in relation to education and general demeanour.

Respondents also highlighted:

- communication and social skills
- organisational skills
- medical/clinical knowledge
- being willing to listen or a good listener.

Our response

Our *Standards for pre-registration nursing associate programmes* require approved education institutions and their practice learning partners to confirm on entry to the programme that students demonstrate the values and can the learn behaviours that are set out in our Code.

The qualities and values mentioned in response to this question are reflected throughout our Code and our standards. It is clear that these are important to the public and professionals alike, and we are reassured by the responses that we are taking the right approach in applying these to nursing associates.

Recognition of prior learning

The Standards permit approved education institutions to recognise the prior learning of applicants wishing to join nursing associate programmes up to a cap of 50% of the programme.

This means that an approved education institution cannot offset prior learning against more than 50% of a nursing associate programme.

In the consultation aimed at stakeholders we asked two questions about the recognition of prior learning.

Question 1:

Do you agree or disagree that a 50 per cent cap on the recognition of prior learning is also appropriate for applicants wanting to join a nursing associate programme?

Most respondents (65%) agreed that a 50% cap was appropriate. 18% disagreed, 14% neither agreed nor disagreed and 3% of respondents answered “don’t know”. Organisations were more likely to agree than individuals (79% compared to 63%).

Among those who provided comments, some respondents felt that the cap was too low and others argued that it was too high. For example:

“I don't know how you would ensure that there was sufficient breadth of knowledge from prior learning to validate a 50 per cent credit. I believe all students should have to complete the whole programme in order to join the register.” (Registered nurse)

“Foundation degree or part of a registered nurse programme where the course content and learning objectives could be mapped to more than 50%. More flexibility around this is required. Placement and practice hours would need to be achieved.” (NHS employer)

A few respondents raised concerns that learners may get credits for unrelated learning:

“Surely it depends on what the subjects studied were and how recent - should be individualised” (Registered nurse)

Some respondents felt that the cap should be higher where a portfolio of previous learning and experience was shown to be equivalent to nursing associate training. One specific example given was the case of assistant practitioners:

“For those who have completed a Foundation degree to work as an Assistant Practitioner; they should be assessed individually, with a bespoke placement programme to enable transfer. For some this may be a year, for others only 1 placement.” (NHS employer)

Among the minority of respondents who disagreed and provided comments, the main concern was that recognition of prior learning would result in a reduction in learning specific to the nursing associate role.

Our response

The recognition of prior learning is a well-established principle across education providers. It allows a student's previous relevant experience to be taken into account by the education provider when they join a programme. It's up to the education provider to decide exactly how much previous experience can count towards a student's current programme. This is decided on a case by case basis by the education provider.

In the consultation we proposed that this previous experience could count up to a maximum of 50% towards a nursing associate programme (unless that individual was a registered nurse – see question 2 below).

The standards presented in the consultation make it clear that recognition of prior learning is only allowed for learning which is capable of being mapped to the *Standards of proficiency for nursing associates*. This means that courses which covered unrelated learning would not count.

Some respondents suggested that the cap should be higher for assistant practitioners with a foundation degree. After careful review we've decided that we shouldn't apply a higher cap for assistant practitioners. This is because there is no group approach that we could safely apply, as the content of assistant practitioner programmes can vary significantly.

We believe that applying 50% cap is the correct approach to take and the majority of respondents to the consultation supported this. This is a discretionary matter for education providers.

Question 2:

Do you agree or disagree that for registered nurses there should be no recognition of prior learning cap on to nursing associate programmes?

Just under half (46%) of respondents agreed with the proposal. 28% disagreed and around a fifth (19%) neither agreed nor disagreed.

Individuals were more likely to disagree than organisations (30% compared with 20% respectively). Registered nurses or midwives were more likely to agree than nursing associate students (48% compared to 35% respectively).

The main comment raised in responses (from those who agreed or disagreed) related to the implications for the quality of care. Some expressed concern about the time that had lapsed between training or previous practice or about this route being used by people subject to fitness to practise sanctions:

"I think this needs to be clearer in relation to fitness to practise issues which may have been raised. No cap is OK as long as there is guidance on what may preclude a registered nurse from joining the register for nursing associates." (Nursing educator)

Another reason given by those who disagreed was the need to recognise the differences between the nurse and nursing associate syllabus.

A small number of those who agreed with the proposal stated that registered nurses should be assessed before becoming nursing associates. For example:

"Registered nurses should not automatically be able to join the nursing associate register or practise as a nursing associate. Registered nurses who are employed in nursing associate posts should be required to pass a separate nursing associate assessment which would enable them to join the nursing associate register." (Professional organisation or trade union)

Our response

It's clear from the comments made that there was some level of misunderstanding in relation to this question. The split of opinion across the various options reflects this.

We proposed not applying a cap to the recognition of prior learning of registered nurses who wish to join a nursing associate programme. However, as stated above, the education provider retains discretion to decide on a case by case basis how much prior learning they choose to recognise.

We require all approved education institutions to *"demonstrate a robust process for the recognition of prior learning and how it has been mapped to the programme learning outcomes and proficiencies."* (Standards framework for nursing and midwifery)

education, requirement 2.8). This should take into account the differences between the nurse and nursing associate syllabuses, as noted in the comments. The length of time that has lapsed between someone's training or previous practice and them applying to join a nursing associate programme should also be considered.

We acknowledge the concerns raised about individuals who may be subject to fitness to practise sanctions. This issue isn't specific to nursing associate programmes and is something that education providers should be equipped to deal with.

In response to the concerns raised we've updated the *Standards for pre-registration nursing associate programmes* to include references to restrictions on practice. The cap will not apply to registered nurses without restrictions on their practice.

Some respondents suggested that a return to practice programme could mitigate the risks of individuals subject to fitness to practise sanctions. However return to practice programmes are designed to return someone to the part of the register that they were previously on. To clarify, registered nurses won't be able to automatically join the nursing associate part of our register. They'll need to be awarded an NMC approved nursing associate qualification.³

Although this question received less support than others, more respondents agreed than disagreed. We remain of the view that this is the right approach to take. We hope that the comments above and the updated wording in the standards have addressed some of the concerns of the minority of respondents who disagreed with the proposal.

The split between theory and practice

The *Standards for pre-registration nursing associate programmes* proposed an equal balance of theory and practice in the curriculum. This mirrors the requirement for nursing programmes. We proposed that the same approach should apply to nursing associate programmes, to facilitate progression to nursing degrees.

We asked three questions about this in the consultation – two questions in the consultation aimed at stakeholders and one in the consultation aimed at members of the public. Our response [below](#) covers all three questions.

Question 3:

Do you agree or disagree that nursing associate programmes should provide an equal balance of theory and practice learning?

Over three quarters (77%) of respondents agreed that there should be an equal balance of theory and practice learning. Fewer than one in five (16%) disagreed. 6% of respondents neither agreed nor disagreed, and 1% answered 'don't know'.

The respondents who agreed with the proposal and provided comments thought that it was important to maintain a good balance between theory and practice. They felt this

³ If they are applying from outside England, where we do not have the powers to approve nursing associate education providers, we will need to evaluate their qualification to see if it meets our standards. These applicants may be required to sit a test of competence.

would enable progression to the registered nurse role and would mirror the requirements set out in EU legislation. It would also help nursing associates understand 'why' as well as 'how'. Examples of comments include:

"This is an important principle in RN preparation, and we see no reason to deviate from this in the case of associates. This is also important if associates are to seek accelerated entry into RN programmes." (Other organisation)

"They should learn the theory to understand their practice whatever that equates to. Nursing is a practically based role but requires a thorough understanding of the theory to keep patients safe and promote their wellbeing to a high standard." (Retired Registered Nurse)

Several mentioned the value of work-place learning. Other respondents said that more supernumerary time was required to support practice learning and one stakeholder organisation commented that nursing associate training and education should be the joint responsibility of employers and educators.

The minority of respondents who disagreed with the proposal and provided comments mainly thought that there should be more practice than theory. They highlighted the emphasis on technical skills and the generic nature of the role in support of their arguments. For example:

"I think it should be weighted more strongly towards practice. Two years isn't a lot of time to gain competence and confidence in clinical settings." (Registered nurse)

Other comments made comparisons with apprenticeships (which often have an 80:20 split), noted that the current practice of having one day a week at university worked well, or suggested that theory could also be taught in a practice setting. A few respondents mentioned the role of simulation.

A small number of respondents said that a 50:50 balance would be too costly for employers. For example:

"This will be difficult to facilitate in practice, particularly as most NHS Trusts will be using the apprenticeship levy to fund and will be paying a salary to the TNAs. This maybe be possible for a non-apprenticeship route, however the answer maybe to make the apprenticeship route longer in order to facilitate less time away from productive working hours." (Registered nurse)

"The imposition of an equal balance of theory and practice learning is not realistic for work-based learning routes." (Professional organisation or trade union)

Question 4:

If you answered disagree or strongly disagree to Q3, which of the following do you consider would be an appropriate balance of theory and practice learning?

- **More theory and less practice learning**
- **More practice learning and less theory**
- **No requirement set by the NMC**

The majority of respondents answering this question thought that there should be more practice and less theory (60%). 26% thought there should be more theory and less practice and 15% said NMC shouldn't set the requirement.

Those who supported a more practice-based approach felt that the success of the role depended on practical skills and that it was best to spend more time learning in a work-based setting.

Those who thought more theory was required felt that it was important nursing associates understand the theory that underpins their practice. For example:

“Nursing needs to be a more problem solving profession. Less focus on skills and tick boxes.” (Nursing educator).

In the comments respondents were divided over whether or not practice learning should be supernumerary, and whether or not changes were needed to the model used in the HEE pilot.

Some stakeholder organisations had differing views on whether the NMC should specify the split between theory and practice. For example:

“If the NMC do not set specific requirements, the impact of this could be high levels of variation between training programmes. This would undermine the development of a standardised education programme.” (Professional organisation or trade union)

“A definitive split should not be set by the NMC.” (Professional organisation or trade union)

Consultation for members of the public

In the consultation aimed at the public, we asked the following question on the split between theory and practice:

One of our main responsibilities is to make sure nursing associates are trained safely and effectively. As nursing associates will be involved in delivering hands on care, we think they should spend half of their training time in settings such as hospitals, care homes and GP surgeries learning practical skills and the other half learning the theory that will underpin their practice. Do you agree with this approach?

The vast majority of respondents (85%) agreed with this approach. Only 12% disagreed and 3% answered 'don't know'.

Those who supported the approach welcomed the practical element of the training and the inclusion of different health care settings. For example:

"We need nurses/nursing associates who can recognise signs/symptoms and treat/manage accordingly. Not just those taught to write an essay about it." (Member of the public)

Several individuals suggested that there was scope to include even more hands-on care experience.

The respondents who disagreed with the proposed approach often did so because they felt that more practical training was needed. For example:

"There is not enough hands on care. It should be 70/30 clinical/school room" (Member of the public).

Among both those who agreed and disagreed, there were several respondents who raised concerns about nursing associates being used as "cheap labour". As we have noted elsewhere, we do not play a role in setting the pay for nurses or nursing associates or their deployment and so these comments are out of the scope of this consultation.

Our response

The majority of respondents to both the stakeholder and the public consultations supported an equal balance between theory and practice in the training of nursing associates and we're satisfied that our approach is the correct one. In comments, respondents noted that this would be consistent with the requirements for nurses and would therefore help progression from nursing associate to registered nurse.

It is clear from the comments that respondents value practice-based learning, and those that disagreed with the proposed 50:50 split were more likely to support a greater focus on practice. As a result of the majority support for the proposed approach for an equal balance of theory and practice in the nursing associate programme, this position has remained in the final standards. This doesn't mean that students must spend half of their programme hours in an educational institution and half in a practice learning environment. It is about the content of the learning, not the location.

Learning experiences

The *Standards for pre-registration nursing associate programmes* specify that students should be provided with learning experiences involving patients with diverse needs across the lifespan, and in a variety of settings.

We didn't specify how time should be spent, to give approved providers the flexibility to develop broad training programmes. When we approve programmes we'll be able to consider whether the learning experiences are sufficiently broad. This is consistent with the approach that we take to nursing programmes.

We asked two questions about learning experiences in the consultation aimed at stakeholders:

Question 5:

Do you agree or disagree that this is the right approach to secure appropriate breadth in the learning experiences of student nursing associates?

Most respondents (69%) agreed that the approach set out in the consultation was the right one. 19% of respondents disagreed, and 10% neither agreed nor disagreed. 2% of respondents answered 'don't know'.

Nursing associate students (34%) were more likely than registered nurses/midwives (18%) and educators (16%) to agree with the approach.

Around a fifth (21%) of respondents made further comments. Those who agreed said that they thought it was important to ensure students had breadth in their learning experiences and flexibility in how this is achieved. Those who disagreed had similar views and asked for more guidance, placing emphasis on the need for rigorous monitoring. For example:

“Need to have stringent competencies to ensure that they are met by utilising a variety of placements. This will provide evidence that more than a single placement/clinical environment has been utilised to fulfil the requirements of the programme.” (NHS employer)

Other main themes raised across respondents who agreed or disagreed included:

- A request for more clarity around terms such as 'experience' and 'exposure', and on whether exposure must be through placements. And requests for guidance to ensure that nursing associates had sufficient exposure to the types of people they're likely to be working with when they qualify. For example:

“There a risk that a student nursing associate might only experience predominantly adult placements but on qualification and registration will go on a register whereby they could work in any nursing field setting. We are concerned therefore, that a lack of guidance from the NMC will lead to unacceptable variation in learning experiences for nursing associate students.” (Professional organisation or trade union)

- Some respondents felt that it was important not to be too prescriptive. Some suggested there should be an agreed minimum amount of time in all fields to ensure depth of knowledge.
- Some respondents mentioned the HEE's current requirements for experience close to home, at home and in hospital and across lifespan as a helpful way to ensure students are exposed to different environments.

Some respondents felt that experience was spread too thin and that it was not realistic to cover everything in a two-year training course. Others felt the requirement for breadth restricts the time students can spend in their chosen areas and the ability of employers to develop a specialised workforce where required.

Question 6:

If you answered strongly disagree or disagree to Q5, which of the following do you think would be a better alternative to make sure approved education institutions provide students with a wide exposure to nursing practice?

- **Setting a specific requirement for hours per field/setting in the standards**
- **Provide guidance on what would be appropriate**
- **Monitor this through quality assurance of nursing associate programmes**
- **Other- please specify**

A total of 91 respondents answered this question, 64 individuals and 21 organisations (6 didn't state how they were responding). Not all the responses came from those individuals who disagreed with Q5. Some respondents came from those who agreed, neither agreed nor disagreed or who answered 'don't know'.

Respondents were able to select more than one response for this question. The most popular response was that we should provide guidance on what should be appropriate (56%). The other options (in order of popularity) were:

- Setting a specific requirement for hours per field/setting in the standards (47% of respondents)
- Monitor this through quality assurance of nursing associate programmes (37% of respondents)
- Other (14% of respondents)

Only a small number of respondents made suggestions for alternative models. These included:

- A balance of time spent between the main fields of nursing (including learning disabilities and children's nursing)
- Some support for setting a specific hours requirement
- More field-specific programmes rather than generic training.

One response expressed concern based on anecdotal evidence that too much leeway could result in variation for some nursing associate students:

"Respondents highlighted significant variation and inconsistencies in the current trainee nursing associate test sites and expressed concerns about the implications of an even looser framework... Respondents felt

that the NMC should provide greater clarity regarding requirements for, and quality assurance of, a standardised training curriculum, placement length and exposure to different care settings." (Professional organisation or trade union)

Our response

Most respondents (69%) agreed with the approach set out in the consultation. They felt that it was important that the *Standards for pre-registration nursing associate programmes* ensure that students had breadth in their learning experiences and approved programmes have flexibility in how this was achieved. We therefore feel that our approach is justified and that we don't need to be more prescriptive about how time should be spent.

A number of respondents, some who agreed and some who disagreed, asked for more clarity and guidance. We will therefore provide some additional supporting information on this.

We note the comments about the importance of robust monitoring. As stated in the consultation, when we approve programmes we will be able to consider what AEs and their practice placement partners have put in place to meet this standard and whether the proposed learning experiences are sufficiently broad. As for all programmes, monitoring will assess continued compliance with the standards.

Protected learning time in practice

Making students supernumerary means that they must not be counted in the staffing numbers, which are required for safe and effective care delivery in a setting. This doesn't mean that students can't deliver care. The amount of supervision they require will change as they gain proficiency and confidence.

The consultation aimed at professionals and stakeholders asked for views about applying supernumerary status to practice placements for pre-registration nursing associate programmes. Some stakeholders had suggested that we should consider other approaches to supporting student learning in practice, now that professional education is provided through different models. We therefore asked for views on whether respondents thought that this was appropriate.

Question 7:

In principle, do you agree or disagree that supernumerary status on practice placements should be a requirement for pre-registration nursing associate programmes?

66% of respondents agreed that supernumerary status on practice placements should be a requirement for pre-registration nursing associate programmes. 21% of respondents disagreed and 12% neither agreed nor disagreed. 1% of respondents answered 'don't know'.

Individuals were more likely to agree (71% compared with 45% of organisations). For individuals agreement was highest among nursing associate students (94%). 65% of registered nurses or midwives and 66% of educators agreed.

Those respondents who agreed and provided comments said that it was important to have protected learning time on placements:

*"Supernumerary status, while often not fully realised in practice, is essential to protect the student's learning opportunities. It says to other staff "this person is here to learn" as a clear statement of intent."
(Nursing educator)*

Student nursing associates were particularly likely to mention the importance of having some supernumerary time to support their learning and to signal this to other staff. They also thought it was important to ensure that they didn't miss out on opportunities.

A number of responses expressed support for supernumerary status on the basis of patient safety and effective learning:

"Protected learning or protected time is not sufficient. We believe that any compromise to supernumerary status compromises patient safety as well as undermining trainee nursing associate students' learning and ability to practise safely on registration." (Professional organisation or trade union)

"[Organisation] agrees that practice based learning is essential for nursing associates who will join the register. CQC also agrees that this must be managed in a way that is safe for people in their care, and which ensures that nursing associate students have time and support to learn when they are on placement. Where students are additional to staffing levels this must be clear and this position should not be compromised due to capacity and staffing levels." (Regulator)

However, many respondents didn't believe that all placement time should be supernumerary. They expressed concerns about the financial sustainability of the training and how it would fit the apprenticeship model.

"We know from employers in the social care sector and from our discussions with other employer representatives (i.e. NHS employers) that this poses a critical threat to the success of Nursing Associate development. As most students are intended to be employed, often as apprentices - employers are paying them to undertake a role whilst training in the workplace." (Government or public body)

*"The feedback from employers is that if all placements were supernumerary they would not train any future nursing associates."
(Government or public body)*

Those respondents who disagreed and provided comments raised similar points. They were particularly concerned that employers wouldn't be able to find the budget or staff to backfill, resulting in few nursing associate training places.

A number of respondents suggested possible alternatives. We cover this in the following question.

Question 8:

Do you agree or disagree that the NMC should permit a different interpretation of the supernumerary requirement in the light of work based learning models (such as apprenticeships) provided that patient safety and student learning can still be safeguarded?

62% of respondents agreed that the NMC should permit a different interpretation of the supernumerary requirement. 24% disagreed, 12% neither agreed nor disagreed and 2% answered 'don't know'.

Individuals were more likely to disagree than organisations (25% compared with 15%). Nursing associate students were more likely to neither agree nor disagree (25% compared with 9% of registered nurses/midwives and 12% of educators).

Some of the themes raised in comments were common to respondents who agreed or disagreed. These included the importance of having protected learning time within the training and the need for safeguards to ensure patient safety.

Many of those who agreed repeated the points made above. For example some thought that training nursing associates would be unaffordable unless there was an alternative to the supernumerary model. Others said that placements external to the home setting should be supernumerary, but that work based learning could be undertaken in the home setting where they could be included in the numbers.

A number of respondents gave examples of alternative interpretations. For example:

- Work-based learning could work without supernumerary time
- The language of 'supernumerary' could change
- Not all supported workplace learning needed to be supernumerary, and not all supernumerary learning was necessarily of high quality.

Some professional stakeholders submitted detailed proposals for alternative models.

Our response (to questions 7 and 8)

Both of our proposals received majority support. 66% of respondents agreed that supernumerary should be a requirement for pre-registration nursing associate programmes. However, 62% also agreed that the NMC should permit a different approach.

As part of our consultation engagement, we set up a task and finish group to explore our approach to protecting learning in practice. This group included representatives from employers, education providers, HEE, NHS Employers and the Department of Health and Social Care.

Following discussions with this group, we developed an alternative for approved education institutions and their practice partners. This is included in the updated

Standards for pre-registration nursing associate programmes (Standard 3.5, option B). This option is available for work-placed learning routes and asks providers to demonstrate how they will protect a defined amount of time to be spent learning in practice. Of time spent in practice settings, only protected learning time can count towards programme hours.

Working with the task and finish group we've developed [supporting information on protected learning time in practice](#) which covers releasing students for academic learning and external placements. It also gives examples of activities that could contribute to protected learning time and what we will look for when approving programmes via Option B.

We'll evaluate the impact of this option so that we can be sure that there aren't any unintended consequences for patient safety, student learning or equality of opportunity.

Supernumerary status remains a requirement for other pre-registration programmes. We'll review the learning from our evaluation in due course to see whether the protected learning time approach could be adopted more widely without compromising patient safety or student learning.

Qualification level

In the consultation we proposed that nursing associate programmes should be a foundation degree based on the Regulated Qualifications Framework (England). This is typically two years in length.

HEE's nursing associate test sites were able to award any English Level 5 qualification, although very few chose to award anything other than a foundation degree.

In the consultation for professionals and stakeholders we asked whether respondents agreed with our approach.

Question 9:

Do you agree or disagree that the academic award associated with nursing associate programmes should be a foundation degree?

Four out of five respondents (80%) agreed with the proposal. Only 9% disagreed, 9% neither agreed nor disagreed, and 1% answered 'don't know'. Individuals were more likely to disagree than organisations (11% compared to 4% respectively).

Those that agreed with the proposal thought that a foundation degree was the appropriate standard and would be familiar to the public. For example:

"This should be at the level of Foundation Degree to show the academic requirement for nursing associates, this allows for them to have a clear standard of education and theory to underpin their clinical practice." (NHS employer)

Of the small minority who disagreed, some said that they had concerns about the word 'degree' being associated with this qualification and thought it should only apply to

registered nurse qualifications. Others said we should allow any level 5 qualification, and some suggested a Diploma.

Our response

The high level of support for nursing associates to be awarded a foundation degree reflects the preferred approach taken in the HEE's nursing associate test sites. As such the final *Standards for pre-registration nursing associate programmes* require the award of a foundation degree.

Institutions applying for approval to run nursing associate programmes will therefore need foundation degree awarding powers, or to have access to those powers through another foundation degree awarding institution.

Programme Hours

The *Standards for pre-registration nursing associate programmes* specified that programmes include at least 2,300 programme hours – that is the hours protected for learning, whether in education institutions or practice settings.

In the consultation we asked for views on this proposal.

Question 10:

Do you agree or disagree that nursing associate pre-registration programmes should include at least 2,300 protected theory and practice learning hours in total?

Over three quarters of respondents (77%) agreed with the proposal. Only 9% disagreed, 11% neither agreed nor disagreed and 3% answered 'don't know'.

Individuals were more likely to agree than organisations (80% compared with 69% respectively). Nursing associate students were more likely to strongly agree than registered nurses or midwives and educators (37% compared with 24% and 21% respectively).

Those who agreed and provided comments recognised the importance of having protected hours. They also said that the requirement must be applied consistently across providers and be consistent with standards for registered nurses. Some mentioned that work-based learning should count towards these hours and raised concerns about the compatibility with apprenticeships.

Those who disagreed and provided comments thought that work-based learning should count towards the hours and linked this to interpretations of supernumerary. Others thought the requirement should be higher or more flexible. For example:

"I would like to see more hours included. What will the trainee be doing for the other 1000 hours (or thereabouts) during their programme if it lasts for 2 years?" (Nursing Associate Educator)

A small number thought that 2,300 hours was too high. A few felt the requirement was too rigid and that training providers should be able to count previous learning and experience.

A few respondents questioned how the requirement would work with the apprenticeship model:

“2300 hours would equate to 30 weeks per year of protected learning time would equal to around 68% of the apprentice’s time being protected hours which would not be in line with current apprenticeship practice.” (NHS Employer)

Some respondents, particularly those who didn’t agree or disagree asked for more clarity.

Our response

Most respondents (77%) agreed that pre-registration programmes should include at least 2,300 hours of protected theory and practice learning. We are content that this is the correct approach, given the responses received and to facilitate progression to nursing.

In light of the comments received requesting further clarity, we’ve provided definitions in the updated standards of ‘programme hours’ and ‘protected learning time’. We’ve noted that programme hours are protected for learning, in theory and practice. Hours which are not protected for learning, in which students are in effect working in their substantive place of work won’t count towards programme hours.

Protected learning time is defined as designated time in which students are supported to learn. Supernumerary status is one approach to protected learning time. As noted [above](#) the updated *Standards for pre-registration nursing associate programmes* now contain an alternative option for protected learning time. This is available to students training via work-placed learning routes, including apprenticeships.

General comments

Finally, we asked respondents to the stakeholder consultation for any other views on the *Standards for pre-registration nursing associate programmes*:

Question 11:

Do you have any other comments about the *Standards for pre-registration nursing associate programmes*?

This question had 57 responses. 34 were from individuals and 22 from organisations (1 respondent did not tell us how they were responding).

The majority of respondents who commented on this question used the opportunity to repeat points made earlier in the consultation. We’ve covered these in more detail in the relevant sections above. Themes included further suggestions about how to improve the training course, requests for clarity about the relationship between the role of nursing associates and registered nurses and questions about terminology.

Some comments expressed wider views on the regulation of nursing associates. They highlighted the importance of our monitoring of training, communication about the role, and preceptorship. They also suggested some prior qualifications and experience for nursing associate training courses. Some also expressed concerns about the introduction of nursing associates.

Our response

We welcome the input from respondents and have considered their suggestions. As noted above, many of the themes raised repeated points made earlier in the consultation. We've addressed these in the relevant sections.

Comments about the wider role of nursing associates and the introduction of the role are out of the scope of this consultation and so we haven't addressed them here.

Joining our register

We maintain a register of the people qualified and eligible to practise as a nurse or midwife in the UK. We will open a new part of our register for nursing associates on 28 January 2019.

Our registration powers are set out in our legislation. This includes the majority of our requirements relating to:

- Initial registration and routes to registration (from the UK, EU/EEA and non-EU/EEA countries);
- Readmission to the register following a lapsed period;
- Readmission to the register following a fitness to practise sanction;
- Returning to practice
- Leaving the register
- Renewal of registration, including [revalidation](#)

The Department of Health and Social Care's consultation covered the changes needed to our legislation to apply these powers and processes to nursing associates. The Department published its response to the consultation in April 2018 and the changes were made to our legislation in July 2018 (although most will not apply until January 2019).

In this consultation we asked for views about our English language requirements, as this didn't form part of the Department of Health and Social Care's consultation. We proposed that the requirements for nursing associates should be the same as they are for nurses and midwives.

Our legislation requires applicants to demonstrate the necessary knowledge of the English language. They can do this by:

- Studying a recent pre-registration nursing or midwifery programme that has been taught and examined in English
- Achieving the required minimum score of 7.0 in IELTS (International English Language Testing System) or a minimum score of B in the Occupational English Test (OET)
- Registration and one year's practice with a nursing or midwifery regulator in a country where English is the first and native language and where a language assessment was required for registration.

We asked one question about this in the consultation for stakeholders and professionals.

Stakeholder consultation

Question 1:

Do you agree or disagree that our English language requirements for nursing associates should be the same as they are for nurses and midwives?

93% of respondents agreed that the English language requirements should be the same for nursing associates, nurses and midwives. Only 5% of respondents disagreed, 1% neither agreed nor disagreed.⁴

Levels of overall agreement between individuals and organisations were the same. Individuals were more likely to agree strongly (67% compared to 55% respectively). Registered nurses/midwives were more likely to disagree or strongly disagree than nursing associate students (7% compared with 1% respectively).

Of those respondents who agreed and provided a reason for their answer, the strongest theme in their comments was that standards should be consistent across all nursing professions for the following reasons:

- The standards should apply to all professionals on the NMC's register
- Consistency in requirements will facilitate career progression for nursing associates wishing to become registered nurses
- Patients have the same expectations of all staff involved in their care
- Communication is one of the fundamental skills in nursing and inextricably linked to patient safety
- Poor English features prominently in patient complaints.

Examples of comments included

"Communication skills are vital in the profession, as highlighted by the standards. Accepting sub-par competence of the English language will affect communication, and as such, care standards and patient wellbeing."
(Nursing associate student)

"This is a requirement for registration with the NMC and should therefore be the requirement for all people seeking registration with the NMC irrespective of the course they are completing. This is an assurance that the NMC is giving to the public that measures have been put in place to maintain their safety." (Government or public body)

Only 5% of respondents disagreed. Those who gave a reason for their answer were mainly concerned about the approach to assessment and the levels required.

⁴ Note: this does not add up to 100% due to the rounding of figures.

Some respondents (including some of those who agreed) questioned the level of English language required, stating that they felt that 7.0 IELTS was too high. Some thought that it didn't reflect the levels of English language in the current workforce (including native English speakers). Others felt it didn't fit with the role expected of nursing associates (particularly with regard to written English).

Some of the comments highlighted areas of misunderstanding:

- Some respondents felt that IELTS wasn't appropriate and that the OET would be a better alternative (although they acknowledged that it was more expensive). For example:

"IELTS has been failed by many who have undertaken it when English is their first language. The marking criteria needs to be revisited or go to [the] Occupational English Test for the healthcare sector." (Registered nurse)

As noted above, we proposed accepting both the IELTS and the OET tests for nursing associates, as we currently do for nurses and midwives. We believe that it should be up to the applicant to decide which test is the most appropriate for them.

- Some of those respondents who disagreed felt that completion of the nursing associate programme should be sufficient to demonstrate the required level of English language. As noted above, studying a pre-registration programme in English counts as sufficient evidence to demonstrate the necessary knowledge of English.

There were conflicting views on the point at which English language proficiency should be demonstrated. Some argued that it should be an entry requirement to pre-registration nursing associate programmes. Others stated that nursing associates should be allowed to achieve level 7 by the end of the programme.

Our response

We welcome the positive response to this question. Given that over 90% of respondents agreed that the English language requirements should be the same, we intend to proceed with our proposal to apply the same requirements to nursing associates.

We recognise that a minority of respondents felt that the level of English required was too high. Building on the English language policy changes made in November 2017, we are continuing to review our English language requirements. This includes exploring further options for applicants to provide evidence of their English capability and reviewing our information and support for candidates. In response to concerns raised that the IELTS testing arrangements remain too stringent, we reported in July 2017 that we had undertaken an initial 'stocktake' of the current arrangements. We found no compelling evidence that the IELTS wasn't fit for purpose or that the level of competency required was set too high. We'll keep this under review and we'll feed in the comments raised in this consultation.

We note that some respondents commented on the point at which English language proficiency should be demonstrated. For our purposes, we require knowledge of English

at the point of registration. We also ask that approved education institutions confirm on entry that students can demonstrate proficiency in the English language. We allow approved education institutions the flexibility to determine what actions are required to ensure that, once qualified, students will meet our English language registration requirement. Those education providers using the apprenticeship standard need to be mindful of its requirements regarding literacy and numeracy.

Revalidation

Revalidation is the process by which people on our register demonstrate that they continue to be capable of safe and effective practice. Nurses and midwives revalidate every three years to renew their registration.

Many of the revalidation requirements are set out in our legislation. These include the requirement to practise for at least 450 hours for each registration that a person holds, to provide declarations of health and character and to update their professional indemnity arrangement declaration. Following the Department of Health and Social Care's consultation, changes to our legislation applied these requirements to nursing associates.

In our consultation, we asked for views on the elements of revalidation which aren't set out in legislation. We proposed that these revalidation requirements for nursing associates be the same as the requirements for nurses and midwives.

We asked one question about revalidation in the consultation for stakeholders and professionals and one in the consultation for members of the public.

Stakeholder consultation

Question 1:

Do you agree or disagree that the following revalidation requirements for nurses and midwives should apply to nursing associates?

- **Complete at least 35 hours of continuing professional development (CPD), 20 hours of which must be participatory**
- **Collect five pieces of practice related feedback**
- **Write five reflective learning accounts**
- **Hold a reflective discussion with another registrant about their reflective accounts**
- **Provide the details of someone who has confirmed their revalidation declarations.**

The question asked whether respondents agreed or disagreed with applying each of the five requirements to nursing associates. There were high levels of agreement ranging from 90-95% across the five requirements. The greatest support was for 'providing the details of the person who has confirmed their revalidation declarations' and the least support for 'writing five reflective learning accounts', although 91% of respondents still agreed with this. Overall disagreement to this question ranged from 2-3%.

Across all the requirements, there was stronger agreement from organisations than individuals and stronger agreement from registered nurses/midwives than nursing associate students.

Of those respondents who provided comments, the strongest theme to emerge was that revalidation requirements should be the same for all professionals on the register.

Some respondents felt that registered nurses/midwives should act as the confirmer and/or the other registrant in the reflective discussion. However a smaller number of respondents took the opposing view. Some felt that registered nurses should perform these roles until nursing associates were established. A number of respondents asked us to provide clarity on this in guidance.

A small number of respondents disagreed with the principle of revalidation for nursing associates. They gave the following reasons:

- They didn't support our approach to revalidation and therefore didn't think it should apply to nursing associates or nurses and midwives
- They raised capacity issues for fulfilling revalidation requirements particularly around staffing numbers and budgets
- They disagreed with the idea of introducing revalidation requirements straightaway and suggested that it be introduced over time or in the future.

Some agreed with the revalidation components but disagreed with the detail of what was required. For example, some respondents suggest fewer CPD hours, fewer reflective learning accounts and/or fewer pieces of practice related feedback.

The consultation aimed at the public

In the consultation aimed at the public, we asked the following question on revalidation:

We think that it is important for nurses and midwives to keep their practice up to date. One of the ways we check this is by asking them to reflect on their practice, collect feedback and discuss their reflections with a colleague. Do you think that nursing associates should also do the same?

90% of respondents agreed that nursing associates should also be asked to reflect on their practice in the same way as nurses and midwives. 8% of respondents disagreed and 2% answered 'don't know'.

Those that supported reflective practice felt that it was a valuable component of the learning process which would help nursing associates better fulfil their individual role and their role within the wider nursing team. Several highlighted that it would need to be proportional to the role of a nursing associate.

The minority who disagreed with the question felt that the system could be burdensome and ultimately off-putting for potential nursing associates.

Our response

It is clear from both the stakeholder and public consultations that there is strong support for applying the existing revalidation requirements to nursing associates (90-95% agreement and 90% agreement respectively).

We introduced revalidation for nurses and midwives in April 2016. The positive comments in the consultation reflect the positive feedback that we've received from nurses and midwives about their revalidation experience so far. We therefore feel that this will be a beneficial experience for nursing associates and will help them keep their practice up to date.

A small number of respondents suggested that nursing associates shouldn't be able to act as a confirmer or reflective discussion partner, at least until nursing associates were more established as a profession.

Currently, we ask nurses and midwives to hold a reflective discussion with another registered nurse or midwife. We don't set any requirements relating to seniority or the level of experience of that reflective discussion partner and don't believe that there is a need to do so in relation to nursing associates. This is supported by the majority of the respondents to the consultation who felt that the requirements should be the same.

For nurses and midwives we don't specify who the confirmer must be, but we strongly recommend that an individual's line manager act as a confirmer. This person doesn't have to be registered with us. If an individual doesn't have a line manager we recommend that the confirmer be a person registered with us. Failing that we recommend another healthcare professional who is regulated in the UK (for example a doctor). These recommendations would also apply to nursing associates, and we haven't received any evidence which suggests that we should change this approach. However, while numbers of nursing associates are relatively low we envisage that many will turn to others to be confirmers.

A small number of respondents also suggested amendments for nursing associates. These included fewer CPD hours, fewer reflective learning accounts and/or fewer pieces of practice related feedback. We note these comments but haven't received any supporting evidence which would suggest changing our approach for nursing associates.

There was a high level of support for the proposals relating to revalidation. We therefore remain of the view that this is the right approach. Revalidation is a relatively new process and we'll monitor its implementation across all the professions that we regulate, including nursing associates.

Fitness to practise

Our legislation gives us the powers to look into concerns about the conduct or practice of a nurse or midwife. If we find that a nurse or midwife's fitness to practise is impaired we can impose a sanction to protect the public or maintain public confidence in the professions. In the most serious cases, a nurse or midwife can be removed from our register.

The Department of Health and Social Care consulted on extending these powers to nursing associates, and our legislation was changed in July 2018 to allow this to happen (although these changes won't take effect until 28 January 2019 when the nursing associate part of our register will open).

In the consultation we noted that all of our fitness to practise policies and procedures for nurses and midwives would be extended to apply to nursing associates. We asked for views on the impact of this approach.

Overview of responses

Question 1:

Are there any implications of extending our fitness to practise approach to nursing associates that you think the NMC should consider?

Most respondents (69%) felt that there weren't any notable implications of extending the fitness to practise approach to nursing associates. 18% of respondents felt that there were implications, and 13% answered 'don't know'. Registered nurses/midwives (20%) and nurse educators (23%) were more likely than nursing associate students (6%) to believe that there were implications.

Those respondents who felt that there weren't any implications, said that the standards should be consistent for all professionals and that this was essential for public protection.

Among the minority who felt that there were implications, the most common themes raised in comments were:

- concern about the increase of the caseload for NMC fitness to practise panels
- concern about the impact on resources, waiting times for hearings and referrals
- questions about the inclusion of nursing associates on fitness to practise panels.

A small number of respondents (7) asked for greater clarity around accountability and delegation. These respondents noted that nursing associates may be subject to fitness to practise proceedings in spite of carrying out delegated activity. They also said that registered nurses and midwives needed to know what their accountability is in relation to delegating to nursing associates, and any issues around liability when nursing associates are subject to fitness to practise proceedings.

Two stakeholders expressed concerns about applying the fitness to practise process to nursing associates. They worried it could have a disproportionate effect on nursing associates, especially those from ethnic minority groups:

“The main concern we have about mirroring the same processes as nurses in fitness to practise (FtP) proceedings is that the approach could be disproportionate.” (Professional organisation or trade union)

“There are already major issues relating to the disproportionate number of Black nurses and midwives reported to the NMC. UNISON is extremely concerned that our NA members will face the same experience.” (Professional organisation or trade union)

Our response

The majority of applicants (69%) didn't foresee any particular implications of applying our fitness to practise approach to nursing associates. We are satisfied that this is the right approach to take.

A number of respondents made comments about our preparations for managing fitness to practise concerns about nursing associates and the impact that would have on our resources and waiting times. We've been working to prepare staff in our Fitness to Practise directorate so that they're ready to deal with any concerns about nursing associates.

We've also recently launched a [new strategic direction for fitness to practise](#), which we consulted on between April and June 2018. This will help us protect the public in a more effective, proportionate and consistent way. The principles in this strategy will also apply to nursing associates.

Our Code requires all the people on our register to be accountable for their decisions to delegate tasks and duties to other people. It also sets out how to achieve this. Specifically, the Code requires individuals to only delegate tasks and duties that are within the other person's scope of competence. As such, registered nurses would be accountable for their decisions to delegate tasks and duties to nursing associates in the same way as they are already liable for their decisions to delegate to other individuals.

Some respondents raised concerns about the effect on ethnic minority groups. As we acknowledge in our new strategic direction, research has shown that people on our register from outside the EU and from ethnic minority backgrounds are over-represented in fitness to practise proceedings. This is driven by disproportionate referrals from employers. This is a concern in other parts of the regulatory sector. We're aware of these problems and we want the way we regulate to help solve them. This is why we've identified a *'professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety'* as one of our principal desired regulatory outcomes from fitness to practise. As shown [below](#), most respondents thought that the consultation proposals would have a positive impact or no impact on the protected characteristics.

Other views on the regulation of nursing associates

The consultation aimed at members of the public made the following final statement:

If there is anything else you'd like to tell us about the regulation of nursing associates, please let us know.

55 people responded, 23 as members of the public and 27 as professional or students (5 people didn't state in what capacity they were responding).

Respondents shared their general views about the nursing associate role, rather than the regulation of nursing associates. These general thoughts included:

- comments about similarities between nursing associates and the old SEN role
- concerns that nursing associates will replace registered nurses
- calls for more funding to pay for registered nurses
- queries relating to the NMC fee for nursing associates

Those respondents who made more specific comments highlighted concerns about the accountability of the role and the distinction between registered nurse and nursing associate. They also said there was a need for a clear progression route.

Our response

A number of the general comments concerned issues that were out of our remit and therefore not matters on which we consulted. These included the funding and the deployment of registered nurses and nursing associates.

Some respondents asked questions about the fee for nursing associates. We consulted on the proposed fees between 4 December 2017 and 26 February 2018. Council agreed the fees at their meeting in September 2018. You can read our response to the consultation [here](#).

The other comments made in response to this section reflected themes such as accountability and progression. We've addressed these in more detail in the relevant sections above.

Equality, diversity and inclusion

In the consultation we asked respondents to consider whether the proposed changes had any impacts on people who share characteristics protected under the Equality Act 2010. We also asked for views on how proposals might be amended to advance equality of opportunity and foster good relations between groups.

Question 1: Will any of these proposals have a particular impact on people who share these protected characteristics (including nursing associates, nurses, midwives, patients and the public)?

The majority of respondents (76%) felt that the proposals would have a positive impact or no impact on those who share the protected characteristics. Only 5% of respondents anticipated a negative impact and 19% answered 'don't know'.

Organisations were more likely than individuals to say there would be no impact (53% compared to 37%). Registered nurses/midwives and educators were more likely than nursing associate students to say there would be no impact (44%, 44% and 23% respectively). Nursing associate students were more likely than registered nurses/midwives and educators to say there would be a positive impact (52%, 33% and 39% respectively).

Those respondents who felt that there would be positive or no impacts and who provided a view, stated that the nursing associate role would widen participation to a broader group of people. Some respondents expressed support for a focus on equality and diversity. There were also calls for robust monitoring of the protected characteristics to understand the impact of the role on equality and diversity.

Only 13 respondents felt that there were negative impacts. Those that commented were concerned about reinforcing a trend of women occupying lower-paid roles, and about limiting access to people from ethnic minority backgrounds (through English requirements and the recognition of overseas registration). There were also some comments about the impact on those with disabilities, in particular in relation to the requirement in the standards for personal fitness and wellbeing.

Our response

We welcome the fact that the majority of respondents felt that the proposals would have a positive impact or no impact on those who share the protected characteristics.

We don't set the pay for nursing associates or for the other professions that we regulate. The salaries awarded to nursing associates and other healthcare professionals are a matter for their employers and the NHS. Although the comments about women in lower-paid roles are therefore outside the scope of this consultation, once the nursing associate profession is established we'll be able to provide data on the gender balance as part of our annual equality and diversity reporting.

We note the comments made about our English language requirements and the impact that these may have on people from ethnic minorities. We're currently reviewing our English language requirements to evaluate other potential types of evidence, develop

additional support for applicants and explore the evidence base for the IELTS test. This review includes nursing associates.

The recognition of overseas registration is a process that is set out in our legislation and formed part of the Department of Health and Social Care's consultation on the regulation of nursing associates. We're reviewing our approach to the overseas application process to ensure that it is streamlined and cost effective for our overseas applicants, while maintaining robust controls to ensure public protection. Nursing associates are part of this review.

We acknowledge the comments made about our requirement in the standards for nursing associates to "understand the professional responsibility to adopt a healthy lifestyle to maintain the level of personal fitness and wellbeing required to meet people's needs for mental and physical care" (Platform 1: Being an accountable professional). This standard also appears in the *Standards of proficiency for registered nurses*.

Our legislation requires us to be satisfied that people are of sufficiently good health to be capable of safe and effective practice. This is part of our duty to protect the public. In our [guidance](#) we've defined 'good health' to mean that the applicant is capable of safe and effective practice either with or without reasonable adjustments. It doesn't mean that they don't have a health condition or disability. We're currently reviewing our Health and Character guidance and the changes will apply to all applicants and people on our register.

Since the consultation we've developed an alternative approach to protecting learning time in practice (see [above](#)). One of the things that we'll include in our evaluation is whether it leads to any adverse impact on people with protected characteristics.

Question 2:

How might we amend the proposals to advance equality of opportunity and foster good relations between groups?

There were 103 responses to this question, 64 from individuals and 38 from organisations. The following main themes emerged from the comments:

- Ensuring there is good understanding of the distinction between nursing roles, and that the role of nursing associate is valued in its own right (see response [above](#))
- Review pre-learning requirements such as academic preparation and English language requirements to increase accessibility to those in under-represented groups
- Suggestions relating to ensuring recruitment processes are fair and equitable and don't disadvantage people who share protected characteristics
- Consider removing the fitness and wellbeing requirement in the Standards of Proficiency (see our response to question 1 above)

- Consider changing fitness to practise procedures to make them more accessible and fairer to nursing associates who may be less likely to have professional representation (see our response [above](#))
- Enable alternative models of training and working to suit a broader range of applicants and trainees.
- Broaden consultation approach to involve more stakeholders and people who share protected characteristics
- Encourage and enable a diverse culture by ensuring there is a good mix of people trained and employed as nursing associates, supported by strong leadership.

Our response

A number of these themes reflect comments which we've addressed elsewhere in the consultation. We've provided links above to the relevant sections.

Some of the comments were about enabling a diverse culture within the nursing associate profession. For example by ensuring there was a good mix of people trained and employed, that alternative models of training were available and recruitment didn't disadvantage people who share protected characteristics.

We're not able to influence employers, but our *Standards framework for nursing and midwifery education* require approved education providers to:

- ensure learning culture is fair, fosters good relations between individuals and diverse groups and complies with equalities and human rights legislation (R1.10)
- ensure that all students have their diverse needs respected and taken into account, with support and adjustments provided (R3.11)
- ensure students are protected from discrimination (R3.12)

As noted [above](#) our education and training standards have been developed to apply across a range of training models. Following this consultation, we've also amended our supernumerary requirements (see [above](#)) to specifically provide for alternative training models.

Finally, some respondents commented about the consultation process. As part of the consultation, we engaged with parents of young children, with young people and people with learning disabilities to assess the impact of our proposals on these groups of people.

Next steps

We've used the consultation findings to update the nursing associate standards. A final version of these standards was submitted to the NMC Council for approval on 26 September 2018. Following Council, the updated standards and this report will be published on the NMC website.