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The Queen's Nursing Institute
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The Queen's Nursing Institute Scotland
Clare Cable, Chief Executive

The Royal College of Nursing
Dame Donna Kinnair, Chief Executive & General Secretary

The Royal College of Nursing
Julie Green, Chair, RCN District and Community Nursing Forum

The Royal College of Nursing
Rachel Hollis, Chair, RCN Professional Nursing Committee

24 March 2021

Dear colleague

NMC review of post registration standards

Thank you for your letter of 12 March 2021, outlining your concerns regarding the draft standards for community specialist practice qualifications. We would like to reiterate that we remain committed to co-producing new standards of proficiency and associated programme standards for new community nursing specialist practice qualifications

(SPQs). We have shared your letter and our response to you with our Council, as we have done with all of your previous correspondence.

We would have happily arranged a meeting to discuss your concerns. As you know, the post registration steering group (PRSSG) had a thorough discussion at its meeting in December 2020 and the majority view was that we should seek the Council's permission to proceed to public consultation. This discussion included the representatives of the four country Chief Nursing Officers who are responsible for roll out and delivery of key priorities for their respective populations and health and care services. As might have been expected, there have been a range of different opinions at PRSSG in relation to a number of areas since the project began, but there has always been consensus in relation to the current standards being out of date and no longer reflecting what contemporary specialist community nurses need to know and be able to do, and that the consultation process will play a key part in shaping the final standards.

We are saddened that you have challenged the credibility of our standards development process when we have taken significant steps to continually inform and update both the PRSSG and other stakeholders on the emerging evidence and themes throughout the pre consultation engagement phase.

We therefore have a number of points we would like to clarify by way of response to your letter, which are outlined below.

The purpose of the Pye Tait report (Pye Tait 2020)

Pye Tait were commissioned to do two things, firstly to provide an ongoing thematic review of each of the engagement events as they occurred, and secondly to provide a final summary report for Council which was a descriptive account of the pre-consultation engagement activity, as was stated in paragraph 44 of the Council paper presented on 27 January 2021. Pye Tait were not commissioned to interpret what was said at the events, or provide recommendations of what should or should not go into the draft standards.

The virtual method of engagement that we employed as a result of the COVID-19 pandemic facilitated this type of review because, unlike the face to face workshop sessions that we normally hold, all of the events were audio recorded, and all of the chat box comments could be saved and analysed. As this was a departure from our normal process, we wanted the report to provide additional assurance to Council about the method and reach of the engagement.

In relation to the ongoing review, Pye Tait provided us with themes 24 hours following each event. The emerging themes were then played back to the attendees of subsequent events. This enabled us to maximise opportunities for the standards discussion groups and other stakeholders to test assumptions, and discuss and comment on what the output of the wider events had been to inform the drafting of standards. Representatives of many of the organisations who were signatories to the letter we received were involved across the range of activities, and standards drafts were shared with many of them for comment.

We were therefore not reliant on the final Pye Tait report to inform the content of the standards. The report is a thematic review of what was said at the events and the date

of the report is merely when the final summary was produced by Pye Tait for Council, and wider dissemination through publication on our website.

The points raised at each of the engagement events, together with the evidence were used to shape the development of draft standards, and we are now at a point where we believe that seeking wider views through a rigorous 16 week public consultation process would be valuable.

We have reviewed your analysis of the Pye Tait report. You are correct in saying that some of the issues raised by individuals at the engagement events were not translated, verbatim, into standards content. The reasons for this are discussed in more detail later, but are summarised below:

- Some of the requirements identified during the events, while important, are not at the level of detail of a regulatory standard. We would expect this level of detail to be reflected in curriculum level learning outcomes for specific community nursing fields of practice. However, we have taken the essence of most of these suggestions and translated them into higher level regulatory standards.

- Some of the knowledge and skills requirements you have identified are already incorporated within the new pre-registration standards. As you know, one of the design principles is that post registration standards must surpass what we require at pre-registration level and so these would not be included.

- Some requirements identified for specific community fields of nursing practice in the engagement events were later felt to be appropriate to all fields of practice, so cannot therefore be identified as bespoke requirements

- We would argue that some of the items you have raised are already incorporated into the draft standards, however in some cases these have been not been expressed or worded in the way that you have done. We can also see, from your comments, where some of the standards need to be made more explicit. We are very open to rewording and strengthening the standards if the consultation process indicates that there are better ways of expressing particular points, as we have done in the case of all of our previous sets of standards.

The nature of regulatory standards

UK wide regulatory ‘standards of proficiency’ which describe what professionals need to know and be able to do are by their nature high level and outcome focused.

This enables a degree of future proofing which would not be possible if the standards specified a high level of detail, and allows universities and practice partners to take successive new local and national priorities into account when developing their programmes. Detailed content and learning outcomes are therefore seen at the level of the curriculum developed by the educational institutions who deliver programmes leading to regulatory qualifications.

The draft post registration standards build on and surpass the format and content successfully adopted for the Future Nurse standards. These consist of one set of standards that applies to each of the fields of nursing practice. The specific learning outcomes required for students to qualify in a particular field of nursing (adult, child, learning disabilities and mental health) are seen at a curriculum level. This approach

was fully consulted on and has been welcomed. We believe that this would be similarly successful and would improve the accessibility and provision of post registration programmes, but we await and will be guided by the consultation response.

You refer to the QNI voluntary standards in your letter. We have used the QNI standards as a reference document frequently in our standards development. We applaud the way that they have been developed. In our view the QNI standards are a good example of what content could be considered as part of the design and development of curricula, and reflect course level learning outcomes. This means that our regulatory standards and the QNI standards, while serving a different purpose, are potentially complementary in terms of providing the best foundation for post registration community nursing education.

Development of bespoke standards

As part of our post registration pre consultation engagement we sought to understand what was important for each of the fields of community nursing practice. I can confirm that all the sources of evidence we have drawn on, including the engagement themes and the different strategy and policy positions in each of the four UK countries, were used to construct the evidence base from which the draft regulatory standards were formulated.

As part of the pre consultation engagement we sought to explore whether one set of standards could apply to all fields of community nursing practice or whether there was a need for additional bespoke standards. Some potentially bespoke issues were raised, for example, knowledge about diagnostic overshadowing was identified as required specifically for community learning disabilities nursing, but when tested with other groups of community nurses, they thought this requirement was equally important to all fields. Unsurprisingly, a need for all speciality community nurses to be capable of performing an autonomous clinical assessment in a range of situations, was deemed appropriate across all fields.

This does not mean that we expect all nurses with community specialist practice qualifications to be taught exactly the same content across all of the regulatory standards, or undertake their roles and responsibilities in exactly the same way. The context of how these regulatory standards are taught, the experience in practice, and the programme learning outcomes for each field of community nursing practice, is where the field specific knowledge and skills should be seen. We have made this a requirement for those responsible for education and training through the draft post registration education programme standards, which sit alongside the standards of proficiency, and these are also being consulted on.

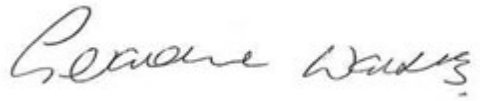
Approach to the consultation and the timing of its launch

In recognition of the pressures facing professionals and the feedback we have heard on the timing of the consultation from the Royal College of Nursing and others, we've delayed the original start date and extended the consultation period to 16 weeks (from the usual 12 weeks) to give people more time to participate. We have had several requests to proceed with the SCPHN consultation without further delay. Given this, if we did not include the SPQ standards in the consultation, we would not have the capacity to revisit this work until 2022. At that point, it would be more sensible to incorporate into the wider piece of work to explore our approach to the regulation of advanced practice

generally. We have recently sought the views of the Chief Nursing Officers or their representatives who would like us to proceed with both elements of the consultation. The public consultation itself will provide further opportunities for all our stakeholders to identify what else needs to be included, or what needs to be strengthened or removed to make these draft standards better. We will use the independent evidence from the consultation and continue to work with PRSSG and other stakeholders to make decisions and finalise these standards.

We hope this clarifies our position in relation to the concerns you have raised. As ever, we would be willing to meet with you to discuss this further, if that would be helpful.

Yours sincerely



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NMC response to QNI feedback regarding bespoke standards

QNI proposal for bespoke standards	Current wording of the proposed draft SPQ standard of proficiency	Related standards already included in Future Nurse. Standards of proficiency for registered nurses (2018)	Associated draft standards for post registration programmes that make reference to the fields of community nursing practice SPQs
Use behaviour change techniques such as motivational interviewing or positive behaviour support to bring about a change of lifestyle which positively promotes health (All)	2.3 recognise health as a fundamental human right and evaluate the effects of social influences, health literacy, individual circumstances, behaviours and informed lifestyle choices when enabling people to take steps to improve their own mental, physical and behavioural health 2.4 critically assess health needs in partnership with people, families, communities and populations, supporting them to own their actions and the behaviours necessary for behavioural change	See standard 2.7 Platform 2 See Annex A: Communication and relationship management skills section 3	

Develop anticipatory care plans for the management of an exacerbation or crisis of an existing physical, behavioural, or mental health problem (All)	3.9 undertake a person-centred and informed assessment by proactively obtaining and critically evaluating a range of sources of information, seeking additional advice or guidance when indicated 3.10 critically analyse complex assessment data, and distinguish between normal and abnormal findings, recognising when prompt action is required, including requesting additional investigations and, when appropriate, escalating to or involving others 3.14 maximise opportunities for shared decision making when developing care plans and planning future anticipatory care planning through the use of a range of problem solving, influencing and negotiation skills 3.16 pro-actively seek to mitigate risks in relation to a person's changing mental and physical health circumstances, their living environment, social arrangements, or relevant conditions	See 3.3, 3.13, 3.15

Undertake an assessment of the patient's current and past history including physical examination in order to manage exacerbations of a long-term condition (DN) Undertake an assessment of the patient's current and past history including physical examination in order to manage a long-term condition or complex co-morbidities (GPN) Undertake an assessment of the child's current and past history including physical examination in order to manage exacerbations of a long-term condition (CCN) Undertake an assessment of challenging behaviours and the impact of these on family relationships and social functioning (CLDN) Undertake an assessment of mental health status during a period of crisis including suicidal ideation, behaviours, and self-harm (CMHN)	3.1 create and apply a person-centred approach to care, facilitating a partnership approach to assessment, shared decision making and care planning when working with people, their families, communities and populations 3.6 assess and plan the care of people when they are vulnerable, agreeing whether there is a need for support and if so at what level, to ensure maximum levels of independence through the continuum of care 3.9 undertake a person-centred and informed assessment by proactively obtaining and critically evaluating a range of sources of information, seeking additional advice or guidance when indicated 3.10 critically analyse complex assessment data, and distinguish between normal and abnormal findings, recognising when prompt action is required, including requesting additional investigations and, when appropriate, escalating to or involving others	See 3.1, 3.2, 3.3, 3.4, 3.5, 3.10, 3.13	The draft programme standards have specific standards that state what approved education institutions and their practice learning partners must do. This includes: 2.5.2 ensure programme learning outcomes reflect the Standards of proficiency for community nursing that are tailored to the context of community practice. These may be within community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing or in other specified field(s) of community nursing 2.6.2 set out the general and professional content necessary to meet the Standards of proficiency for the community nursing SPQ that is tailored to the specified field of community nursing practice. These may be within community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing or in other specified field(s) of community nursing
Screen for frailty and identify how the patient's functioning and independence may be maximised through re-enablement and rehabilitation – see definition of frailty as a syndrome (DN)	3.6 assess and plan the care of people when they are vulnerable, agreeing whether there is a need for support and if so at what level, to ensure maximum levels of independence through the continuum of care	See 3.9, 7.8 and, Annexe B, Part 2, 3-10	

Recognise and respond to deterioration in a patient's long-term condition amending treatment plans as appropriate and arranging for a different form of care as appropriate in the absence of other clinicians (DN) Recognise and respond to deterioration in a patient's long-term condition amending treatment plans as appropriate (GPN). Recognise and respond to deterioration in a child's long-term condition amending treatment plans as appropriate and arranging for a different form of care as appropriate in the absence of other clinicians (CCN) Recognise and respond to deterioration in a patient's behaviour and / or functioning arranging for assessment or alternative forms of care as appropriate in the absence of other clinicians (CLDN) Recognise and respond to deterioration in a patient's mental health status and during periods of crisis arranging for assessment or alternative forms of care as appropriate in the absence of other clinicians (CMHN)	3.8 select and use appropriate communication strategies and relationship management skills when interacting with people, including families and carers, who have a range of mental, physical, cognitive, behavioural and social health challenges, and those at or near the end of life 3.16 pro-actively seek to mitigate risks in relation to a person's changing mental and physical health circumstances, their living environment, social arrangements, or relevant conditions 3.17 make autonomous decisions in challenging and unpredictable situations, and be able to take appropriate action to assess and manage risk 7.5 understand and recognise the need to respond to the challenges of providing safe, effective and person-centred nursing care for people who have co-morbidities and complex care needs	See 3.13, 4.10	3.3.2 provide practice learning opportunities that allow students to develop, progress and meet the Standards of proficiency for intended SPQ: these may be within the fields of community children's nursing, community learning disabilities nursing, community mental health nursing, district nursing, general practice nursing or in other specified field(s) of community nursing

Provide comprehensive care at home, as the lead professional, at the end of an adult's life, including symptom control and physical and psychological care for the patient and their family (DN) Provide comprehensive care at home, as the lead professional, at the end of a child's life. Including symptom control and physical and psychological care for the child and wider family (CCN)	4.8 work with people and where appropriate their families and carers to agree and provide evidence-based person-centred nursing care for those who are dying or near to the end of life	See 4.9 and, Annex B Part 2, 10
Provide bereavement care to spouses, partners and families recognising where an abnormal bereavement reaction may be experienced and referring to others for psychological support and counselling (DN) Provide bereavement care to parent and other siblings recognising where an abnormal bereavement reaction may be experienced and referring to others for psychological support and counselling (CCN)	4.9 sensitively accommodate the preferences, beliefs, cultural requirements and wishes of the deceased and people who are bereaved *NB: there is implicit reference to the needs of people who are bereaved but we will discuss how this can be strengthened during the post consultation assimilation phase of the project.*	See Annexe B, part 2, 10.6

Teach patients and / or carers or family members about disease self-management including drug administration and self-monitoring (DN) Teach patients and / or family member or carers about the safe performance of clinical procedures for self-care (DN) Teach patients and / or carers or family members about disease self-management including drug administration and self-monitoring (GPN) Teach children and families about disease self-management including drug administration and self-monitoring (CCN) Teach children and families about the safe performance of clinical procedures for self or family led care (CCN) Teach carers or family member about positive behaviour support to maximise independence and safety (CLDN) Teach the client, carers and or family members about actions to be taken in response to a mental health deterioration or crisis (CMHN). Teach the patient, family members and / or carers how to recognise changes in the client's mental health status (CMHN)	1.8 create and maximise opportunities for people to remain independent and be involved in decision making about their care 4.2 agree with the person, their family or carers when a person's ongoing assessment, care planning and treatment *NB: Many of the draft standards suggest specialist community nurses promote participation and self care for people and patients. We agree more explicit language that can be used regarding education and teaching of families, and we can consider this during the post consultation assimilation phase of the project when finalising the standards once the consultation has closed.*	See Annexe B Numerous references to supporting self care and using strength based approaches

Autonomous management of complex wounds of mixed aetiology where there is conflicting evidence and incomplete clinical protocols (DN)	1.4 be accountable for their decisions, actions and omissions, recognising their own personal competence when working with complexity, risk, unpredictability and incomplete information 4.1 autonomously manage complex episodes of care from referral to service and admission to discharge from caseload or referral to other appropriate services or agencies 4.5 initiate a range of evidence-based care and treatment interventions, including therapeutic interventions, social prescribing and care that may be supportive, curative, symptom relieving or palliative *NB: we generally do not make references to any specific diseases or conditions.in our standards, but we expect an appropriate level of detail to be included in curricula*	See 4. And, Annexe B Part 2 4	
Advocate for people with a learning disability and liaise with others to ensure that they have access to physical health services and health assessment (CLDN)	4.4 proactively engage with, and effectively and respectfully advocate for, people using services provided by other professionals or agencies to identify and address any inconsistency, disagreement or conflict	See 7.9	
Ensure people have access to talking therapies either providing these directly or liaising with others to ensure access to appropriate therapeutic interventions (CMHN)	4.5 initiate a range of evidence-based care and treatment interventions, including therapeutic interventions, social prescribing and care that may be supportive, curative, symptom relieving or palliative	See Annexe A. 3	