Nurse education in the UK moving beyond the EU regulations

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In 2018 the Nursing and Midwifery Council (NMC) launched its Future Nurse and Realising Professionalism standards (NMC, 2018a; 2018b; 2018c). Collectively, these three-part standards specify the knowledge and skills that NMC registrants must demonstrate when caring for people of all ages and across all care settings and they incorporate an EU directive (NMC, 2018d:13). These NMC standards reflect what the public can expect nurses and midwives to know and be able to do to ensure the delivery of safe, compassionate and effective care.

Now that the UK has left the EU, the NMC is no longer required to continue to include the EU minimum requirements within its education standards. Through a recent online consultation, which closed in May (NMC, 2021a), it sought the views and input of public groups, professionals and partners across the UK about current education programme standards around areas such as:

■ Entry requirements

■ Knowledge and skills for nursing

■ Use and types of simulation

■ Programme length and ratio of theory/ practice hours

■ Overall impact (positive and negative) of any potential move away from alignment with the EU directive such as with people who share a protected characteristic as set out in the Equality Act 2010.

The NMC consultation fielded questions about the current EU 4600 hours programme requirement (of which at least a third is theoretical study and at least half is clinical study). One of the questions asked whether this is the minimum number of hours necessary for someone to practise safely and effectively as a registered nurse (RN) at the point of registration and asked participants to consider the appropriate length of time to achieve proficiency for safe and effective nursing practice. Another question considered the time required to achieve the standards of proficiency and whether this should be based on competency and outcomes rather than on number of hours.

Taking the above two questions into consideration, the results of the consultation could potentially reduce the length of the programme, and the time that students spend in the practice learning environment because this could be dependent on individual competency. A further set of questions focused on simulation and whether simulation should count towards practice learning and theory.

Types of simulation were identified and participants were asked which could help someone to practise safely and effectively as an RN. Types included:

■ Simulated situations involving real people using nursing services

■ Manikins or models

■ Role-play using real people, who could include colleagues, students or actors

■ Using digital programmes to educate and assess knowledge and decision-making

■ Using virtual or augmented reality systems to replicate real-life situations.

This was an interesting set of questions because, potentially, simulation could be used much more widely and effectively within future education standards and, indeed, within its current recovery standards the NMC enables students to practise and learn through simulated practice learning where conventional clinical practice is not available or is not possible. It can be used for up to a maximum of 300 hours (8weeks) of the overall 2300 practice learning hours (NMC, 2021b). However, in the recovery standards, the final practice learning assessment necessary for award and eligibility to register should take place in an audited practice placement setting and meet the standards for student supervision and assessment (NMC, 2021b). The questions around the use of simulation have provided the opportunity to rethink student nurse competency, supervision, and assessment and how this could be achieved through balancing the use of simulated learning with providing students with practice learning experiences from within the range of learning environments.

This competency, supervision and assessment balancing act, combined with a reduced programme length, particularly the time that students spend learning in practice that is dependent on competency, could be appealing to the wide range of audiences. These include providers of nurse education, Health Education England (HEE) and the Department of Health and Social Care (DHSC), as more students could be educated at any one time, thus addressing the focus on the 50 000-nurse recruitment target (DHSC, 2020). This could also address student placement capacity issues. Although the consultation did not focus on factors that promote an effective learning environment, the outcomes of the consultation may impact on these. If students potentially spend less time learning from within the practice learning environment, this could impact on developing relationships with, for example, practice supervisors, practice assessors, users and carers. Indeed, evidence from the Reducing Pre-registration Attrition and Improving Retention project (RePAIR) (HEE, 2018:4) has consistently captured evidence of how important the clinical component of the programme is to students. The student experience, their desire to stay on the programme or,

indeed, to consider applying to work in a service upon registration, is heavily influenced by the clinical supervisor and the culture in that clinical setting. On the other hand, students spending less time in a poor practice learning environment carefully replacing this type of learning with simulation, could in fact reduce attrition in pre-registration programmes.

A different question asked whether the knowledge and skills specified within the EU directive are necessary for safe and effective nursing. Current theoretical instruction in the EU directive includes the following key areas (NMC, 2018d:13):

■ Nursing

■ Basic sciences

■ Social sciences.

Clinical instruction is related to:

■ General and specialist medicine and surgery

■ Childcare and paediatrics

■ Maternity care ■ Mental health and psychiatry

■ Care of the old and geriatrics

■ Home nursing.

This terminology to depict knowledge and skills is dated and, indeed, the clinical instruction identified in the EU directive is no longer fit for purpose or representative of the practice learning experiences required by the future nurse. Furthermore, the EU knowledge and skills align to the traditional pathogenic model, with a missed opportunity to identify knowledge and skills that support personalised care through engaging with models of social prescribing (Howarth and Leigh, 2020) enabling students to support communities to become resilient, a key part of preventing illness, protecting health and promoting wellbeing, and supporting a wider community resilience. Introducing models of social prescribing would require changes to clinical instruction, providing students with learning experiences that take place within the voluntary, community and social enterprise sectors, mirroring experiences through applying the different types of simulated practice. What will not change, nor has this been considered within the consultation, is the NMC's expectation that universities, together with their practice learning partners, continuously work in partnership to implement the nursing education standards, co-creating and delivering pre-registration programmes. Indeed, this collaboration is essential to take forward the opportunities

and challenges born out of the consultation and to future-proof nurse education at the point when some, all or none of the current EU requirements remain in place.

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