The Association of Advanced Nursing Practice Educators (AANPE)

The competence and curriculum framework for the medical care practitioner: consultation response on behalf of the Association of Advanced Nursing Practice Educators (AANPE)

Document compiled by:

Dr. T.D. Barton Ph.D. M.Phil. B.Ed. Dip.N. RGN RNT
School of Health Science, Faculty of Health and Human Sciences
University of Wales Swansea
Morriston Hospital Campus
Swansea SA6 6NL

Tel: 01792 703771 (Work Office), 01792 517349 (Home Office)
Email: T.D.Barton@swansea.ac.uk

AANPE Executive Committee:

- Dr. Mike Walsh (Chair) - St Martins College (Lancaster and Carlisle)
- Helen Ward (Senior Lecturer) (Deputy Chair) - South Bank University
- Katrina Maclaine (Senior Lecturer) – South Bank University, London / RCN NP Adviser
- Jenny Kell (Senior Lecturer) – University of Teeside
- Wendy Fairhurst (Senior Lecturer) – University of Manchester
- Professor Caroline Carlisle - University of Manchester
- Heather Griffiths (Senior Lecturer) – Bournemouth University
- Dr. David Barton - University of Swansea
- Douglas Allen (Senior Lecturer) – Glasgow Caledonian University

AANPE Website:

http://www.aanpe.org

AANPE Consultation Response / Structure:

The Association of Advanced Nursing Practice Educators (AANPE) represents a collaborative network of Higher Education Institutions (HEIs) across the United Kingdom (UK) who are providers of advanced clinical programmes of education for nurses (AANPE HEI list appended). The AANPE liaises closely with the Royal College of Nursing (RCN) Nurse Practitioner Association and the Nursing and Midwifery Council (NMC). The development work of the AANPE has played a significant part in the implementation of the national competency standard for Advanced Nurse Practitioner practice being introduced to the nursing register by the NMC.

The AANPE has reviewed the Department of Health (DOH) consultation document "The competence and curriculum framework for the medical care practitioner" – November 2005. This paper reports on that review.

This review is structured in the following way:

- An introduction provides the general observations and concerns of the AANPE regarding the main implication of the proposed Medical Care Practitioner (MCP).
- The general body of the consultation document is broadly reviewed.
- Specific questions within the consultation are addressed.
- A conclusion summarises the main features and recommendations of the AANPE.
- AANPE Membership is listed
- MCP competencies are contrasted with the NMC competencies.

Introduction:

It is important to note from the outset that that AANPE is concerned that the MCP consultation lacks material reference to the well-developed national advanced clinical competency framework (Advanced Nurse Practitioner) developed by the UK nursing profession. The consultation also overlooks other significant government backed initiatives, notably those of the Emergency Care Practitioner (ECP), First Contact practitioner and the recent non-medical prescribing developments. Furthermore, although programmes of advanced clinical education are well established in HEIs throughout the UK, many of these designed to deliver to multi-professional groups, this consultation appears to have overlooked or disregarded these.

From the outset, the consultation document presumes medical control and regulation of the proposed MCP, and that future advanced clinical roles should be subsumed to this regulation. As an identified entry group is that of the existing health professions (assuredly the most significant supply of such candidates), it also presumes that these professions will accept such a drain on their own best clinical practitioners to a medically dominated regulator. This will undermine and devalue the contribution and role of those who have attained high levels of clinical skills within their parent professions and who would not wish alternative professional affiliation. For example,

since 1990 nurse practitioners have developed in practice in the UK, offering the skills of diagnosis, patient management and autonomous professional practice. Indeed, a robust body of research evidence now exisits to demonstrate that nurse practitioners practice safely and effectively, with high levels of patient satisfaction (Horrocks et al, 2002). This MCP proposal would recruit existing nurse practitioners with financial incentives, thereby devaluing nurse practitioner developments in the UK. This clearly is neither resource effective, nor professionally desirable.

In a multi-professional environment and modern health service the AANPE would expect MCP developments to be within a national framework of advanced clinical competence that was negotiated on behalf of all healthcare professions. This would most appropriately reflect the particular and unique contribution to healthcare that each of those professions offered.

Unfortunately, this consultation appears to be yet another clinical initiative amongst many that has failed to capture the multi-professional context, in this instance by introducing and imposing a traditional medically regulated role. **In isolation this proposed role will potentially destabilize and undermine the extensive work in progress by other professions in establishing new advanced clinical roles.**

The competency framework matches much of those curriculums already operating in many HEIs. The proposed MCP competencies compare with existing frameworks. An illustration of this is provided in the attached mapping exercise that we have conducted with the Nursing and Midwifery Council (NMC) proposed competency domains for Advanced Nurse Practitioner regulation. This comparison is advantageous in two respects. Firstly it indicates that the general principles of the MCP framework (theoretical and clinical) accord with the existing developed frameworks and curricular. Secondly, this means that programme adaptation to facilitate MCP outcomes would be relatively simple, if the HEI considered that there was merit in their doing so.

General Content Review

Section One - Introduction:

The MCP consultation introduction adequately sets the foundation for the role. However, it is misleading to infer that the expansion of clinical skills by non-medical staff has been directed by medical teams. In reality, medical practitioners have supported multi-professional role expansion, but that expansion has been directed, led and implemented by the respective healthcare professions. It follows that the suggestion of fragmented competency development is also misleading and does not reflect some well-developed competency frameworks and collaborative working between professional groups at a national level. Thus, it cannot be accepted that the MCP represents a 'new way of working'. The role outlined is that of a physician (doctor) assistant, and as such it is a well-documented role that contributes in part to the totality of the multi-disciplinary team.

The suggestion that all healthcare professionals defer to the doctors 'ultimate responsibility' for patient care is authoritarian, and sits uneasily with advanced

clinical roles that already exist and are developing within nursing and allied health professions outside of medical regulation. It would be necessary to explore in more depth the issue of healthcare professional's responsibility and accountability in terms of professional, legal, moral and ethical imperatives. It is also important that the MCP proposal be compared and contrasted with the recent NMC work on a register for Advanced Nurse Practitioners.

Section Two - The MCP Competency Framework:

This is section of the consultation is detailed and outlines a curriculum and MCP competency framework that, given appropriate resource, could enable the required level of practice – although the timescale is extremely tight if candidates have no prior clinical experience. However, Section 2.1. observes that prospective students will be drawn from a variety of settings and that this will require flexible student profiling and possible access programmes. This has significant feasibility and resource implication, and requires exploration with HEIs regarding programme funding, delivery and student numbers.

In addition the AANPE strongly recommends that, although individuals might decide to take this route, all efforts must be made to avoid specific targeting of experienced nurses or paramedics to makeup any required numbers of MCPs.

To date pilot programmes have focused on existing health professionals and there is no evidence base on the MCP role in relation to the suggested major pool of applicants (Life Science graduates) to justify the UK wide implementation of MCPs at this stage. A smaller scale fully-evaluated introduction of the MCP role into general medicine would be more appropriate as a next step, with Life Science graduates as the main target group.

The range of assessment strategies are appropriate although it will be interesting to see how the suggestion that individual HEIs autonomy of assessment design will work with a national knowledge-based examination. The competencies themselves are detailed. As indicated earlier, the AANPE has undertaken a mapping exercise of these competencies with the current NMC competency domains for advanced nurse practitioners. This has demonstrated a close alignment.

The issue raised on prescribing is a difficult one. This should be viewed in the wider professional context of prescribing currently being debated nationally and at regional level. The AANPE stance on prescribing is that all advanced clinical practitioners who wish to prescribe must have undertaken an identified programme of clinical education that enables that skill in accordance with current legislation and professional regulation.

Section Three - The Curriculum Framework

This section of the consultation has quite rightly identified the demand for a national registration framework for MCPs. This is similar to discussions on registration frameworks within other current health care professions. However, no specifics of

that proposed registration or regulation is provided in this section or later sections. As government review of health professions regulation is currently underway it will be necessary to know more on the regulation of this group of practitioners, and their place in the wider arena of developing advanced clinical professionals.

The AANPE question the statement in 3.5.1 that programmes could be less than 3 years in length, particularly for life science graduates. Our experience with NP preparation is that even very experienced nurses need a minimum of 2 years to develop competencies akin to those proposed for MCPs. The suggested 70 hours for Mental Health, Obstetrics and Gynaecology and Paediatrics (acute setting) are all inadequate for developing the knowledge and skills required to demonstrate competence in these areas for life science graduates with no previous health care experience. In addition, it cannot be assumed that acute paediatric experience will be sufficient to prepare MCPs for paediatric practice in other health care settings.

Section 3.5.2. refers to the expected work role of future MCPs. The AANPE is keen to understand how this role will interface with equivalent existing and emerging clinical roles – notably the nurse practitioner, clinical nurse specialist, emergency care practitioner and paramedic practitioner.

In response to the questions posed on page 24 the AANPE suggests that the life-long philosophy of clinical supervision and continuing professional development CPD be promoted.

The AANPE is clear that 'assimilation' of practitioners into a medically aligned model / framework is an undesirable philosophy that undermines the multi-professional context of advanced and diverse clinical practitioners. It is crucial that the MCP role be negotiated in collaboration with other key professional regulators, notably the NMC, the Health Professions Council (HPC), and the General Medical Council (GMC). As already indicated, failure to initiate such collaboration will undermine, devalue and de-stablilise existing professional developments. **It is important to note that advance clinical nurses and paramedics represent significant clinical resource and service numbers in the UK NHS and it is reprehensible to marginalise them.**

Section Four – Assessment and Accreditation:

The consultation refers to the requirement of national assessment of theoretical knowledge and of clinical competence. This contrasts with the suggestion that HEIs will individually tailor programmes. National assessment is possible, however there are clearly mixed messages in this consultation suggestion, and consequently resource implications which may be significant are unclear.

Page 29 refers to a future MCP professional body. This raises again the demand for multi-professional collaboration if this proposal is not to undermine other clinical healthcare roles.

In response to the questions on page 30, the AANPE suggests that the consultation looks to the model established by the RCN Accreditation Unit in approving HEI

programmes that provide Nurse Practitioner preparation, against established and rigorous quality competency criteria.

In response to the questions on page 31, the AANPE would support the need for periodic re-registration and evidence of CPD and clinical competence.

Section Five – Core Syllabus:

The suggested core syllabus is appropriate although the AANPE would suggest inclusion of:

Consultation and interpersonal skills.
Physical Examination and Health Assessment.
Diagnostic reasoning/investigations.
Haematology.
Professional accountability.

Section Six – Validation and Accreditation:

The AANPE strongly suggests that an accreditation body has representation from Nursing and Allied Health Professions.

Section Seven – Regulation and accountability:

The AANPE believes that the title "Medical Care Practitioner" would be confusing for the public, who would assume that the individual is a qualified Doctor. We suggest that "Doctors Assistant" would explcitly describe the nature and purpose of the role and line-management to the public and other health professionals.

The issue of dual registration is contentious. We have already indicated that the AANPE is concerned that proliferating new professions, without multi-professional consultation and dialogue, is problematic. Whilst undoubtedly the MCP role will have a place in healthcare, it should not be seen as a role that subsumes all other roles, or be viewed in a hierarchical fashion. Dual registration also raises questions of role confusion and public protection. What would for example be the outcome of a nurse was removed from the nursing register – would they be able to continue to practice as an MCP (or visa versa)?

Section Eight – Proposed Timeframe:

The consultation document does not address the wider professional context – it is therefore difficult to gauge or agree a timeframe.

Consultation Questions (Response compiled from AANPE members responses):

Q1 : MCP proposals regarding prescribing powers, must be in line with other non-medical prescribing developments, and any education for MCPs in this area should be alongside what is provided for nurses, pharmacists, AHPs etc. A separate case should not be made for MCPs.

Q2 :

The AANPE members have identified a number of issues from this question:

Regarding the proposed definition:

- The emphasis on the "medical model" is at odds with delivering holistic care. Traditionally the medical model has been criticised by many writers, and modern medicine has moved away from this older construct. Thus, emphasis on working within the general medical team is at odds with current ethos of multi-disciplinary team collaborative working.

- We note that "defined supervision" contrasts with NPs who work autonomously.

- Bullet points under definition (p3) – all these points are undertaken by NPs and therefore if this is what is needed by the health service, commensurate emphasis should be placed on NP education and development!

- "New way of working" – it is not clear in this consultation how this role will differ from what is already provided by NPs. However, we acknowledge the potential of a "Physician Assistant" under the supervision of Doctors to undertake tasks that doctors need assistance with in order to comply with EWTD 48 hours compliance by 2009. We also agree that it is important to have clear lines of accountability for this role.

- The consultation refers to a broad MCP "clinical knowledge base" – but the consultation does not acknowledge that this is the case for Nurse Practitioners.

- The consultation does not clearly articulate the level of complexity that MCPs would be expected to deal with.

- Point 1.3. states that a degree level education programme required, but this is at odds with current view of advanced practice level in future being at Masters level. It also states that HEIs can determine length and academic level of programmes. It is suggested that there is a need for central determination to standardise this and prevent "quick fix" approaches which might jeopardise patient safety. The eleven RCN approved Nurse Practitioner preparation programmes all employ rigorous assessment of their graduates, including all of the aspects listed here (with the exception of a national exam).

- There is a need to look at other competency frameworks to demonstrate synergy and link to national standards. Having mapped the core competencies

listed 01 – 17 against the NMC standard for Advanced Nurse Practitioners we have identified that these correlate with the MCP role.

- In regard of core procedural skills, these can all can be undertaken by nurse practitioners, this dependent on the setting in which they are working. For example, a nurse practitioner in an Accident & Emergency department (A&E) would be able to relocate a dislocated shoulder, but a nurse practitioner in general practice would very rarely require this skill and consequently they would not be able to maintain a safe and proficient level of competence in this area by working in this setting. The same would be true for splinting for common musculoskeletal injuries or obtaining an arterial blood gas sample. This has implication for the extent and breadth of the skill of an MCP working across general medicine, A&E and general practice.

- In regard of specific core clinical conditions, the MCPs ability to develop and maintain competence in the full breadth of conditions listed in this section is questioned. For example in 1A it says that the MCP will normally be able to manage the condition without regular or routine referral. However many of the conditions are very context dependent. A GP in primary care would not automatically have the knowledge or skill to be readily able to manage all of these conditions in general practice e.g. hypovolaemic shock, near drowning, acute poisoning, orbital cellulites, ureteric trauma, renal trauma.

In conclusion, there seems to be a mix of skill (general medicine, A&E and primary care) without any suitable rational for the separate groupings or level of input expected for the MCP.

Q3 : Yes – particularly with what is expected for the MCP in this document

Q4 : Responses to this varied between 6 months to 24 months minimum with sign off all clinical competencies across a breadth of patient problems and age groups

Q5 : Yes but closely, but closely supervised and monitored

Q6 : Yes

Q7 : Yes as long as robust process employed

Q8 : The regulatory body for MCPs should make this decision as the holders of the register.

Q9 : We agree with the comments made in section 3.6.4 and the requirement to undertake a specified number of hours within the role. Normally an HEI will not allow an individual to AP(E)L more than 50% of a programme and we assume that this would be the case for MCP preparation. An HEI's quality assurance processes and a robust matrix of assessment of competence for each graduate should ensure public protection.

Q 10 : The section on assessment is particularly strong and demonstrates awareness of the need for rigorous processes. A single national assessment is not currently in

favour in the UK for health professionals but works effectively in the USA and for other skills based professions, and we therefore agree with this proposal to ensure standards are achieved across all MCP graduates.

However section 4.3 also talks about having the exam on a 6 yearly basis. This does not tie in with current discussions in other health professions regarding what processes are needed for periodic re-registration and therefore the MCP proposals needs to be reviewed in the light of this.

Q 11 : Yes - to ensure a single standard is established and implemented and thereby counter any variations across HEI provision.

Q12 : Agreed - as long as multi-professional clinical perspective is ensured in validation panels.

Q13 : We question the 6 yearly cycle as discussed in Q.10 but support idea of this proposal.

Q14: We agree (see answer to Q10)

Q15: We assume it will fall to the registrant, but hope employers will be asked to contribute to this fee.

Q16: Yes - nurse practitioners have all of these areas in their curriculum, except histology (as not used explicitly within the role). We recommend that other core areas should also include:

Paediatrics (including growth and development)
Quality Assurance / Clinical governance
Evidence based Practice
Non-pharmacological management of all pertinent conditions
Holistic health assessment
Clinical Decision making
Political and economic influences on health
Health promotion (different to health education)

Q17 : Obviously the development of a knowledge base to underpin clinical practice is paramount, but MCPs do need to understand the wider context and develop an individualised patient centred approach. MCPs must not solely focus on "cure" but also on preventative aspects of care / support of patients with long-term conditions alongside their acute presentations.

Q18 : Yes, but regulatory issues need to be addressed quickly to ensure public protection through an explicit professional regulatory framework.

Q19 : "Medical Care Practitioner" would be confusing for the public, who would assume that the individual is a qualified Doctor. It is suggested that "Doctors Assistant" would explcitly describe the nature and purpose of the role and line-management to the public and other health professionals.

Q20: The timescale maybe appropriate, although this is difficult to gauge. However, it is very important that employers be encouraged by the MCP steering group to critically appraise the benefits of the introduction of this role to service delivery and most importantly patient care, and not just adopt this role without adequate consideration of similar roles (nurse practitioners) that are already in place.

Q 21:
The evaluation of the role seems positive but is based on experienced American Physicians Assistants not UK novices.

Conclusion and Recommendation:

The AANPE represents a current HEI resource that has capacity to produce advanced Nurse Practitioners and other advanced clinical practitioners on a significant scale – if appropriate resource is made available as part of workforce development funding streams across the UK.

However, we have made it clear that this consultation document has revealed a lack consultation with the multi-professional development of Advanced Nurse Practitioners and other advanced clinical practitioners. There are sweeping and incorrect generalisations on the current status of national frameworks of competence and this leads to an worryingly unbalanced proposal that sits in isolation of other government strategic proposals for healthcare delivery.

The need for multiple professional roles that meet diverse demographic needs is not disputed by the AANPE. We support the introduction of MCPs (doctors assistants) to meet the challenges of the EWTD 48 hour compliance by 2009. This will also prevent nurses being used inappropriately for tasks such as clerking or procedures that would not utilise a nurse's knowledge and skills to maximum advantage. However, the established benefits of nurse practitioners must not be overlooked in the process of focusing resources on MCP development.

The AANPE recommends the consultation be revisited in collaboration with the NMC, HPC, GMC and AANPE. The development of a national curriculum for diverse healthcare professionals undertaking advanced clinical skills would be an outcome that was more appropriate and flexible.

References:

Horrocks, S., E. Anderson, and C. Salisbury. 2002. "Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors."*British Medical Journal* **324 (7341)**: 819–23.

AANPE Members:

- Birmingham and Black Country STTA For Programme Details Contact:
    - Linda Dunn **Linda.Dunn@bbcha.nhs.uk**

- Bournemouth University, Institute of Health & Community Studies Royal London House, Christchurch Road, Bournemouth, Dorset BH1 3LH BSc (Hons) Nurse Practitioner / MSc Nurse Practitioner (RCN APPROVED) For Programme Details Contact:
    - Heather Griffith **Hgriffit@bournemouth.ac.uk**
    - Jean Smalley **Jsmalley@bournemouth.ac.uk**
    - Dawn Dann **ddann@bournemouth.ac.uk**

- Buckinghamshire Chilterns University College Chalfont Campus, Newlands Park, Gorelands Lane, Chalfont St Peter, Bucks HP8 4AD MSc Advance Nurse Practitioner / BSc (Hons) Nurse Practitioner (RCN APPROVED) For Programme Details Contact:
    - Lesley Bridges **Lbridge01@bcuc.ac.uk**
    - Audrey Cullum **acallu01@bcuc.ac.uk**
    - Julie Welch **jwelch01@bcuc.ac.uk**.

- Cardiff University For Programme Details Contact:
    - Rhian Barnes **Barnesrc1@cf.ac.uk**

- City University, London. St Bartholomew's School of Nursing & Midwifery, 20 Bartholomew Close, West Smithfield, London, EC1A 7QD. MSc Nursing (RCN approved.) For programme details contact Victoria Lack on :
    - Victoria Lack **v.lack-1@city.ac.uk**

- Clinmed University For Programme Details Contact:
    - McDowell Joan **J.R.McDowell@clinmed.gl.ac.uk**

- College of St Martin Lancaster, LA1 3JD BSc (Hons) Nurse Practitioner / BSc (Hons) Emergency Practitioner / BSc (Hons) Nurse Practitioner (Distance Learning) / MSc Nurse Practitioner / BSc (Hons) Neonatal Nurse Practitioner (RCN APPROVED) For Programme Details Contact:
    - Mike Walsh **m.walsh@ucsm.ac.uk**
    - Fiona Smart **f.smart@ucsm.ac.uk**

- Coventry University For Programme Details Contact:
    - Dawn Court **d.court@coventry.ac.uk**

- Glasgow Caledonian University For Programme Details Contact:
    - Allan Douglas **D.Allan2@gcal.ac.uk**

- Homerton College, Cambridge For Programme Details Contact:
    - Quilligan Sally **quilligan@health-homerton.ac.uk**

- Kings College London For Programme Details Contact:
    - Shelly Peacock **Shelly.peacock@kcl.ac.uk**

- London South Bank University RCN Development Centre, Faculty of Health, 103 Borough Road, London SE1 OAA BSc (Hons) Nurse Practitioner (Primary Health Care) / PG Dip/MSc Nurse Practitioner (Strategic Leadership & Expert Practice) / PGDip/MSc/Clinical Doctorate Children's Advanced Nurse Practitioner (Strategic Leadership and Expert Practice) programme of preparation for Nurse Practitioners (RCN APPROVED) For Programme Details Contact:
    - Katrina Maclaine **Maclaik@lsbu.ac.uk**
    - Helen Ward **wardhn@lsbu.ac.uk**
    - Annaliese Willis **willisaa@lsbu.ac.uk**
    - Sally Patrick **patricsa@lsbu.ac.uk**
    - Claire Anderson **andersco@lsbu.ac.uk**

- Oxford Brooks University For Programme Details Contact:
    - Helen Walthall **hewalthall@brookes.ac.uk**

- University College Northampton For Programme Details Contact:
    - Moria Ingham **Moria.ingham@northampton.ac.uk**

- University of Birmingham For Programme Details Contact:
    - Claire Whittle **C.L.Whittle@bham.ac.uk**

- University of Brighton - MSc Advanced Nurse Practitioner - For Programme Details Contact:
    - Dr Kay Aranda **K.F.Aranda@bton.ac.uk**
    - Chrissie Spiers **C.M.Spiers@brighton.ac.uk**

- University of Central England For Programme Details Contact:
    - Chris Ingram **chris.inman@uce.ac.uk**

- University of Derby Mickleover Campus, Chevin Avenue, Mickleover, Derby DE3 9GX MSc Primary Care Studies (Nurse Practitioner Route) (RCN APPROVED) For Programme Details Contact:
    - Yvonne Cappa **y.cappa@derby.ac.uk**

- University of East Anglia, BSc Nurse Practitioner Pathway and MSc In Advanced Practice, For Programme Details Contact:
    - Shaune Richardson **shaune.richardson@uea.ac.uk**

- University of Manchester For Programme Details Contact:
    - Alison Lynch **Alison.lynch@manchester.ac.uk**

- University of Plymouth Drake Circus, Plymouth, PL4 8AA MSc/PG Dip/PG Cert in Advanced Health Care Practice (RCN APPROVED) For Programme Details Contact:
    - Simon Cooper **simon.cooper@plymouth.ac.uk**

- University of Sheffield For Programme Details Contact:
    - Janet Nolan **j.Nolan@sheffield.ac.uk**

- University of Southampton For Programme Details Contact:
    - Helen Rushforth **her@soton.ac.uk**

- University of Surrey For Programme Details Contact:
    - Macartney Deborah

- University of Teeside For Programme Details Contact:
    - Jenny Kell **j.kell@tees.ac.uk**

- University of Wales Swansea School of Health Science, Morriston Hospital Campus, Morriston, Swansea SA4 6NL - BSc (Hons) Nursing (Nurse Practitioner and Clinical Nurse Specialist) / MSc/PG Diploma Advanced Clinical Practice (RCN APPROVED) For Programme Details Contact:
    - David Barton **t.d.barton@swan.ac.uk**

- University of West England For Programme Details Contact:
    - Stephanie Scott **Stephanie.scott@uwe.ac.uk**

- Robert Gordon University, Aberdeen For Programme Details Contact:
    - Maggie Grundy **M.grundy@rgu.ac.uk**

- Sheffield Hallam University School of Health and Social Care, Southbourne, Sheffield, S10 2BP MSc Advancing Health and Social Care Practice PT (RCN APPROVED) For Programme Details Contact:
    - Jan Denton **j.v.denton@shu.ac.uk**

- Staffordshire University For Programme Details Contact:
    - Pam Campbell **P.K.Campbell@staffs.ac.uk**

- Suffolk College University of East Anglia, Suffolk College, Ipswich, IP4 1LT BSc (Hons) Nurse Practitioner (RCN APPROVED) For Programme Details Contact:
    - Wendi Braithwaite **wendibraithwaite@suffolk.ac.uk**

- Wolverhampton University For Programme Details Contact:
    - Paniagua Hilary

Appendix

Mapping exercise – The NMC Advanced Nurse Practitioner competencies, the NHS Knowledge and Skills Framework, and the proposed MCP curriculum

NMC Competence Domain	KSF Dimension	MCP Curriculum
ASSESSMENT AND MANAGEMENT OF PATIENT HEALTH/ILLNESS STATUS		
Health promotion/health protection and disease prevention		
Assesses individuals health education/promotion related needs	HWB1 L4 HWB2 L4 HWB4 L4	1c 1e 4a 16a
Plans, develops and implements programmes to promote health and wellbeing and address individual needs	HWB1 L3 HWB2 L4 HWB3 L3 HWB4 L4 HWB5 L4 HWB6 L4	1e 4a 7a 16a
Provides health education through anticipatory guidance and counselling to promote health, reduce risk factors, and prevent disease and disability	HWB1 L3 HWB3 L3 HWB4 L4 HWB5 L4	1e 9a
Develops and uses a follow-up system within the practice workplace to ensure that patients receive appropriate services	HWB3 L4 HWB5 L4 HWB7 L4 IK1 L2	4a 7a 10a 10b 10c
Recognises environmental health problems affecting patients and provides health protection interventions that promote healthy environments for individuals, families and communities	C3 L4 HWB3 L3	2c 17a
Assessment and Management of patient illness		
Obtains, analyses and interprets history, presenting symptoms, physical findings, and diagnostic information to develop the appropriate differential diagnoses	HWB6 L4 HWB7 L4	1c 2a 2b 3b 4a 4b 4c 4d 5a 5b 5c 5d

Diagnoses and manages acute and long term conditions while attending to the patients response to the illness experience	C3 L4 HWB3 L4 HWB5 L4 HWB6 L4 HWB7 L4	1c 4a 4b 4c 4d 5a 5b 5c 6e 7a 16a
Prioritises health problems and intervenes appropriately, including initiation of effective emergency care	C3 L4 HWB3 L4 HWB5 L4 HWB7 L4	1c 4a 4b 4c 4d 7a 9a
Employs appropriate diagnostic and therapeutic interventions and regimens with attention to safety, cost, invasiveness, simplicity, acceptability, adherence, and efficacy	C5 L3 IK3 L4 HWB5 L4 HWB7 L4 HWB8 L3 HWB10 L3	1b 1c 4a 4b 4c 4d 6a 6b 6c 6d 6e 7b 11a 11b 12b
Formulates an action-plan based on scientific rationale, evidence-based standards of care, and practice guidelines	HWB5 L4 HWB6 L4 HWB7 L4	1b 1c 4a 4b 4c 4d 5a 5b 5c 5d 6a 6b 7a 12b 16b
Provides guidance, counselling, advice and support regarding management of the health/illness condition	CI L4 HWB1 L4 HWB3 L4 HWB5 L4	1a 4a 4d 6e 7a
Initiates appropriate and timely consultation and/or referral when the problem exceeds the nurse's scope of practice and/or expertise	C1 L4 IK1 L3 HWB6 L4	4a 4b 4c 4d 5c 5d 7a 10a 10b 10c 13c 16e

Assesses and intervenes to assist the patient in complex, urgent or emergency situations:		
A. Rapidly assesses the patient's unstable and complex health care problems through synthesis and prioritisation of historical and immediately-derived data	HWB2 L4 HWB6 L4 HWB8 L4	1b 1c 2a 2b 2c 3a 3b 4a 4b 4c 4d 5a 5b 5c 9a
B. Diagnoses unstable and complex health care problems using collaboration and consultation with the multi-professional health care team as indicated by setting, speciality, and individual knowledge and experience	C1 L4 IK1 L3 HWB8 L4	1b 1c 4a 4b 4c 4d 5a 5b 5c 9a 10a 10b 10c 16e
C. Plans and implements diagnostic strategies and therapeutic interventions to help patients with unstable and complex health care problems regain stability and restore health, in collaboration with the patient and multi-professional health care team	C1 L4 C3 L4 IK1 L3 HWB3 L4 HWB5 L4 HWB7 L4 HWB8 L4	1b 1c 4a 4b 4c 4d 6a 6e 7a 7b 9a 10a 10b 16e
D. Rapidly and continuously evaluates the patient's changing condition and response to therapeutic interventions and modifies the plan of care for optimal patient outcome	C3 L4 HWB3 L4 HWB5 L4 HWB7 L4 HWB8 L4 HWB10 L3	1b 1c 3b 4a 4b 4c 6a 6e 7c
For health promotion /health protection and disease prevention, and management of patient illness		
Demonstrates critical thinking and diagnostic reasoning skills in clinical decision-making	HWB5 L4 HWB6 L4 HWB7 L4	1b 4a 4b 4c 4d 5a 5b 5c 5d 6a
Obtains a comprehensive problem focused health history from the patient or carer	C1 L4	2a 2b 2c

	HWB2 L4 HWB6 L4	4a 4b 4c 4d 5a 5b 5c 5d
Performs a comprehensive problem focused age appropriate physical examination	HWB2 L4 HWB6 L4	1c 3a 3b 4a 4b 4c 4d 5a 5b 5c 5d
Analyses the data collected to determine health status of the patient	C1 L4 HWB2 L4 HWB6 L4	1b 1c 4a 4b 4c 4d 5a 5b 5c 5d
Formulates a problem list and prioritised management plan	HWB2 L4 HWB6 L4	1b 1c 4a 4b 4c 4d 5a 5b 5c 5d 7a
Assesses, diagnoses, monitors, co-ordinates, and manages the health/illness status of patients during acute and enduring episodes	HWB2 L4 HWB5 L4 HWB6 L4 HWB7 L4 HWB8 L3	1b 1c 2b 3a 3b 4a 4b 4c 4d 5a 5b 5c 7a 7b 9a
Demonstrates knowledge of the patho-physiology of conditions commonly seen in practice	HWB6 L4	1a 4a 4b 4c 4d 5a 5b 5c 5d 6a 6c
Communicates the patient's health status using appropriate terminology, format, and technology	C1 L4 IK1 L3 HWB2 L4 HWB3 L4	4a 6b 8a
Applies principles of epidemiology and demography in clinical practice by recognising populations at risk, patterns of disease, and effectiveness of prevention and intervention	IK1 L3 HWB2 L4 HWB3 L3 HWB6 L4 HWB7 L4	4a 4b 4c 4d 5a 5b 5c 5d 6a 17a
Acquires and uses community/public health assessment information in evaluating patient needs, initiating referrals, co-ordinating care and programme planning	HWB2 L4 HWB6 L4	4a 4b 4c 4d 5a 5b 5c 5d

		10a 10b 10c 17a
Applies principles of evidence-based practice pertinent to their area of practice.	C5 L4 IK2 L3 IK3 L4 HWB7 L4	1b 4a 4b 4c 4d 5a 5b 5c 5d 9c 12b 16b
Provides information and advice to patients and carers concerning drug regimens, side-effects and interaction, in an appropriate form	C1 L4 HWB1 L4 HWB5 L4	1a 1b 1d 1e 4a 6a 6b 6e 16a
If legally authorised – prescribes medications based on efficacy, safety, and cost from the formulary	HWB3 L4 HWB5 L4 HWB7 L4 HWB10 L4	1b 4a 4b 4c 6a 6b 6c 6d 6e
Evaluates the use of complementary/alternative therapies used by patients for safety and potential interaction	HWB5 L4 HWB10 L4	4a 4b 4c 6a 6d 6e 12b
Integrates appropriate non-drug-based treatment methods into a plan of management	HWB1 L4 HWB5 L4 HWB7 L4	1b 4a 4b 4c 6a
Orders, may perform, and interprets common screening and diagnostic tests	HWB2 L4 HWB6 L4 HWB8 L3	1c 4a 4b 4c 4d 6a 7b 10b
Evaluates results of interventions using accepted outcome criteria, revises the plan accordingly, and consults/refers when needed	C1 L4 IK1 L3 HWB3 L4 HWB5 L4 HWB7 L4 HWB8 L3	4a 4b 4c 4d 5a 5b 5c rd 6e 7c 10a 10b 10c
Works collaboratively with other health professional and agencies as appropriate	C1 L4 C4 L3	4a 4d 5d

	IK1 L3	7a 10a 10b 10c 16e
Plans and conducts follow-up visits appropriately to monitor patients and evaluate health/illness care	HWB3 L4 HWB5 L4 HWB7 L4	4a 4b 4c 4d 6e 7c 16b

NMC Competence Domain	KSF Dimension	MCP Curriculum
THE NURSE PATIENT RELATIONSHIP		
Creates a climate of mutual trust and establishes partnerships with patients, carers and families.	C1 L4	1a 1b 4d 6e 16a
Validates and checks findings with patients.	C1 L4	1a 1b 4a 4b 4c 4d 5a 5c 6e 16a
Creates a relationship with patients that acknowledges their strengths and knowledge and enabling them to address their needs	C1 L4 HWB4 L4	1a 1b 1d 4a 15b 16a
Communicates a sense of 'being there' for the patient, carers and families and provides comfort and emotional support	C1 L4	1a
Evaluates the impact of life transitions on the health/illness status of patients, and the impact of health/illness on patients' lives (individuals, families, carers, and communities)	C1 L4	2c 4a 4d 6e 7c 17a
Applies principles of empowerment in promoting behaviour change	C1 L4	1b 1d 6e 16a 17a
Develops and maintains the patient's control over decision-making, assesses the patient's commitment to the jointly determined plan of care, and fosters personal responsibility for health	C1 L4 HWB4 L4	1b 1d 4a 6e 16a 17a

Maintains confidentiality, while recording data, plans, and results in a manner that preserves the dignity and privacy of the patient	C1 L4 C3 L4 HWB2 L4	4d 8a 14a
Monitors and reflects on own emotional response to interaction with patients, carers and families and uses this knowledge to further therapeutic interaction	C1 L4 C2 L4	4a 4b 4c 12a
Considers the patient's needs when bringing closure to the nurse-patient relationship and provides for a safe transition to another care provider or independence	C1 L4 HWB4 L4	1d 4a 6e 10b 10c 16a

NMC Competence Domain	KSF Dimension	MCP Curriculum
THE EDUCATION FUNCTION		
Timing		
Assesses the on-going and changing needs of patients, carers and families for education based on the following:		1e
A. needs for anticipatory guidance associated with growth and the developmental stage	C2 L4 HWB4 L4 G1 L3	1e 4a
B. care management that requires specific information or skills	C2 L4 G1 L3	1e 4a 6e
C. the patients understanding of their health condition	C2 L4 G1 L3	1a 1e 4a 4d 6e 16a
Assesses the patient's motivation for learning and maintenance of health-related activities using principles of change and stages of behaviour change	C2 L4 G1 L3	1c 1d 1e 4a 6e 16a 17a
Creates an environment in which effective learning can take place	C2 L4 G1 L3	1e 6e 13f
Eliciting		
Elicits information about the patient's interpretation of health conditions as a part of the routine health assessment	HWB2 L3 G1 L3	1a 2a 2c 4a 6e 16a 17a
Elicits information about the patient's perceived barriers, supports, and modifiers to learning when preparing for patient's education	G1 L3	1a 2a 2c

		4a 6e 16a
Elicits the patient's learning style to facilitate an appropriate teaching approach	G1 L3	1e 4a 6e 16a
Elicits information about cultural influences that may affect the patient's learning experience	G1 L3	1e 2a 2c 4a 6e
Enabling		
Enables patients by displaying a sensitivity to the effort and emotions associated with learning about how to care for one's health condition	C2 L4 G1 L3	1d 6e
Enables patients in learning specific information or skills by designing a learning plan that is comprised of sequential, cumulative steps, and that acknowledges relapse and the need for practice, reinforcement, support, and re-teaching when necessary	C2 L4 G1 L3 HWB1 L3 HWB4 L4	1d 1e 6e
Enables patients to use community resources when needed	C2 L4 HWB4 L4	1d 1e 6e 17a
Providing		
Communicates health advice and instruction appropriately, using an evidence based rationale	C1 L4 HWB1 L3 G1 L3	1b 1e 6e 12b
Negotiating		
Negotiates a jointly determined plan of care, based on continual assessment of the patient's readiness and motivation, re-setting goals, and optimal outcomes	C2 L4 HWB4 L3 G1 L3	1a 1b 1d 4a 6e 7a 16a 17a

Monitors the patient's behaviours and specific outcomes as a guide to evaluating the effectiveness and need to change or maintain educational strategies	C2 L4 HWB5 L4	4a 6e 16b
Coaching		
Coaches the patient by reminding, supporting and encouraging, using empathy	C2 L4 G1 L3	1b 1d 1e 6e

NMC Competence Domain	KSF Dimension	MCP Curriculum
PROFESSIONAL ROLE		
Develops and implements the role		
Acquires and uses evidence and research to implement the role of the advanced nurse practitioner	IK3 L4	16b
Functions in a variety of role dimensions: advanced health care provider, co-ordinator, consultant, educator, coach, advocate, administrator, researcher, role model and leader	C2 L4 HWB2 L4 G7 L3	15b 16b
Interprets and markets the role to the public, legislators, policy-maker, and other health care professions	C4 L3 G8 L2	16e 13e
Directs care		
Prioritises, co-ordinates, and meets multiple needs for culturally diverse patients	HWB5 L4 HWB7 L4	4a 6e 15a 15b
Uses sound judgement in assessing conflicting priorities and needs	HWB2 L4 HWB6 L4 HWB7 L4	4a 6e
Builds and maintains a therapeutic team to provide optimum therapy	C1 L4 C4 L4 C5 L4 G7 L2	4a 10a 13d 16e
Obtains specialist and referral care for patients while remaining the primary care provider	C1 L4 C4 L3 HWB7 L4	4a 5d 7a 10a 10b 10c 16e
Acts as an advocate for the patient to ensure health needs are met consistent with patients' wishes	C6 L3 HWB3 L2	4a 14a 15b
Consults with other health care providers and public/independent agencies	C1 L4 C4 L3	4a 5d 10a 10b 10c

		16e 17a
Incorporates current technology appropriately in care delivery	HWB6 L3 HWB7 L3	6b 6c 6d
Uses information systems to support decision-making and to improve care	C5 L4 IK3 L4	6d 9c 16b
Provides leadership		
Is actively involved in a professional association	C2 L3	
Evaluates implications of contemporary health policy on health care providers and consumers	C4 L3 HWB1 L4 G2 L2 G7 L2	16f 17a
Participates in legislative and policy-making activities that influence an advanced level of nursing practice and the health of communities	C4 L3 HWB1 L4 G2 L2	16f 17a
Advocates for access to quality, cost-effective health care	C4 L3 C6L3	9c 14a 15b
Evaluates the relationship between community/public health issues and social problems as they impact on the health care of patients (poverty, literacy, violence, etc.)	C4 L3 HWB1 L3	17a
Actively engages in continuous professional development and maintains a suitable record of this development	C2 L3	9c 12a 12b 15c 16b

NMC Competence Domain	KSF Dimension	MCP Curriculum
MANAGING AND NEGOTIATING HEALTH CARE DELIVERY SYSTEMS		
Managing		
Demonstrates knowledge about the role of the advanced nurse practitioner	C3 L3	
Provides care for individuals, families, and communities within integrated health care services	C5 L3 HWB7 L4	10b 17a
Considers access, cost, efficacy, and quality when making care decisions	C5 L3	4a 11a 11b 16b 16d
Maintains current knowledge of their employing organisation and the financing of the health care system as it affects delivery of care	C5 L3 G4 L2	11b
Participates in organisational decision-making, interprets variations in outcomes, and uses data from information systems to improve practice	C5 L3 IK2 L2	16b 16d
Manages organisational functions and resources within the scope of responsibilities as defined in a job description	C5 L3 IK2 L2 G5 L3	11a
Uses business and management strategies for the provision of quality care and efficient use of resources	C5 L3 G5 L3	11a 11b 16b 16d
Demonstrates knowledge of business principles that affect long term financial viability of an organisation, the efficient use of resources, and quality of care	C5 L3 G4 L2	11b 16b 16c 16d
Demonstrates knowledge of, and acts in accordance with, relevant regulations for this level of practice and the NMC Code of Professional Conduct; standards for conduct, performance and ethics	C3 L3 C5 L3	5c 5d 8a 12a 13c 14a 15a 15b 15c 15d
Negotiating		
Collaboratively assesses, plans, implements, and evaluates care with other health care professionals, using approaches that recognise each one's expertise to meet the comprehensive needs of patients	C1 L4 HWB5 L4	5c 5d 9c 10a 10b 10c 16b 16e
Undertakes risk assessments and manages risk effectively	C3 L4	9a 9b

		16b 16d
Participates as a key member of a multi-professional team through the development of collaborative and innovative practices	G2 L3	5d 10a 10b 10c 16e
Participates in planning, development, and implementation of public and community health programmes	HWB1 L3	17a
Participates in legislative and policy-making activities that influence health services/practice	HWB1 L3	16c 16f 17a
Advocates for policies that reduce environmental health risks	C3 L4 HWB1 L4	16c 16f 17a
Advocates for policies that are culturally sensitive	C3 L3 C6 L3	15b 17a
Advocates for increasing access to health care for all	C3 L3 C6 L3	15b 17a

NMC Competence Domain	KSF Dimension	MCP Curriculum
MONITORING AND ENSURING THE QUALITY OF ADVANCED HEALTH CARE PRACTICE		
Ensuring quality		
Incorporates professional/legal standards into advanced clinical practice	C5 L4	12b 13c 14a 16b 16c
Acts ethically to meet the needs of the patient in all situations however complex	C5 L4 HWB5 L4	14a
Assumes accountability for practice and strives to attain the highest standards of practice	C4 L3 C5 L3	9c 14a 16b
Engages in clinical supervision and self-evaluation and uses this to improve care and practice	C2 L4 C5 L2	9c 12a 15c 15d 16b
Collaborates and/or consults with members of the health care team about variations in health outcomes	C5 L3 HWB5 L4	5d 9c 10a 10b 10c 16b 16e
Promotes and uses an evidence-based approach to patient management that critically evaluates and applies research findings pertinent to patient care management and outcomes	C5 L3 HWB7 L4 G2 L4	5a 5b 9c 12b 16b
Evaluates the patients' response to the health care provided and the effectiveness of the care	HWB5 L4	4a 9c 16b
Interprets and uses the outcomes of care to revise care delivery strategies and improve the quality of care	C4 L3 C5 L3 HWB7 L4	4a 9c 16b
Accepts personal responsibility for professional development and the	C2 L4	5c 5d

maintenance of professional competence and credential	C5 L2	9c 12a 15c 15d 16b
Monitoring quality		
Monitors quality of own practice and participates in continuous quality improvement	C5 L4	5c 9c 12a 16b
Actively seeks and participates in peer review of own practice	C2 L4	5c 5d 9c 16b
Evaluates patient follow-up and outcomes, including consultation and referral	C5 L3 HWB7 L4	4a 4b 5d 9c 16b
Monitors current evidence based literature in order to improve quality care	C5 L3 G2 L4	5c 9c 12b 16b

NMC Competence Domain	KSF Dimension	MCP Curriculum
RESPECTING CULTURE AND DIVERSITY		
Demonstrates respect for the inherent dignity of every human being, whatever their age, gender, religion, socio-economic class, sexual orientation, and ethnic or cultural group	C6 L4 HWB4 L4	1a 2c 3a 13a 14a 15a 15b 15c
Accepts the rights of individuals to choose their care provider, participate in care, and refuse care	C6 L4 HWB4 L4	1d 4a 6e 14a 15a 15b
Acknowledges their own personal biases and actively seeks to address them whilst ensuring the delivery of quality care	C2 L4 C6 L3	15c 15d
Actively promotes diversity and equality	C6 L4	15a 15b
Incorporates cultural preferences, health beliefs and behaviours into management plans as appropriate	C6 L4	2c 4a 6e 15b 17a
Provides patient-appropriate educational materials that address the language and cultural beliefs of the patient	IK3 L3	1d 4a 6e 15b
Accesses patient appropriate resources to deliver care	C5 L2 C6 L4	4a 6e 15b

Supports patients from marginalized groups to access quality care	C6 L4	1d 4a 14a 15b 17a
Spiritual competencies		
Respects the inherent worth and dignity of each person and the right to express spiritual beliefs	C6 L4 HWB5 L4	13a 15a 15b
Assists patients and families to meet their spiritual needs in the context of health and illness experiences, including referral for pastoral services	C6 L4 HWB4 L4 HWB5 L4	15a 15b
Assesses the influence of patients' spirituality on their health care behaviours and practices	C6 L4 HWB4 L4 HWB5 L4	1c 2c 4a 15b 17a
Incorporates patients' spiritual beliefs in the care plan	C6 L4 HWB4 L4 HWB5 L4	4a 15b
Provides appropriate information and opportunity for patients, carers and families to discuss their wishes for end-of-life decision-making and care	C6 L3 IK3 L4 HWB L4	1d 15b
Respects wishes of patients and families regarding expression of spiritual beliefs	C6 L4 HWB4 L4 HWB5 L4	15b