Royal College of Nursing response to the Department of Health and Social Care consultation *Promoting professionalism, reforming regulation*

Key messages

– The Royal College of Nursing (RCN) is supportive of the ambitions of this consultation. We agree with the UK Government's five stated objectives for reforming professional healthcare regulation and believe this is a timely requirement to ensure a health service that is fit for future purpose. There is also commitment from the healthcare professions to work collaboratively on professional regulation.[i]

– There are currently profound changes proposed to the composition of health care staff across the UK: the emergence of assistant and associate roles working with the various professions, including the Nursing Associate role in the nursing sector. This is a unique opportunity to set up regulatory and educational standards for these new roles that best protect public safety, increase workforce flexibility and deliver improved productivity from the outset.

– We have concerns that the new roles are being introduced in a piecemeal fashion, such as the medical associate[ii] and the nursing associate, with consultations that are not related to each other and do not address wider issues around healthcare regulation. Within the nursing community, we have questioned the assumption that regulation suitable for Registered Nurses is proportionate for Nursing Associates, who are in a supporting role.[iii] At the same time, the Professional Standards Authority has been considering 'right touch reform' to move away from a punitive blame culture, and the Department of Health and Social Care (DHSC) is addressing the inconsistencies, inflexibility and inefficiencies of the UK system of professional healthcare regulation in this consultation. The latter provides evidence to support a more joined up approach to regulation, but the current proposals for the new roles replicate current regulatory systems, with all the disadvantages that have already been identified.[iv]

– Nurses are taking on more specialist roles across long careers to meet the increasingly complex needs of the population and their health service. We are concerned that restrictive roles tied into the complex regulatory arrangements of different professions will reduce the opportunities for our membership, and other healthcare professionals, to work flexibly.

– Any new regulatory system must assure that every profession has an equal voice and can continue to determine its professional and educational standards.

– Given the proposal to reduce the number of regulators, there is a question around the newly set up regulator Social Work England. As Scotland, Wales and Northern Ireland have a different regulatory mechanism for social care staff, it would be beneficial to clarify whether this is to align social work regulation as separate from healthcare UK-wide.

1. Do you agree that the PSA should take on the role of advising the UK governments on which groups of healthcare professionals should be regulated?

1.1. We agree that it is essential that a neutral body that has no inherent interest in carrying out regulatory activity itself takes on this role. This body should also be quality-assuring the regulators.

2. What are your views on the criteria suggested by the PSA to assess the appropriate level of regulatory oversight required of various professional groups?

2.1. We agree with these criteria in principle, however, we have a number of concerns and queries regarding their application and interaction: Will all criteria need to be met or just some of them? Will stage two criteria be able to overturn those of stage one? What is the weighting of the different criteria? It will be essential to get more clarity and information on this.

2.2. We note that there is a lack of international consensus around what constitutes effective quality regulation, with different countries adopting different strategies and legislative measures to ensure quality of care.[v] Whilst the overall evidence of the effectiveness of regulatory strategies for ensuring the quality and safety of care is scarce,[vi] the characteristics of effective healthcare regulation and the role of an effective regulator have been defined in the literature:

- Flexible and adaptive and targeted on the content and outcome of each regulatory encounter
- Require the involvement of stakeholders in the development and assessment of standards
- A mechanism for ensuring the regulator is independent and impartial, while being also accountable for the effects of regulation.

2.3. The complexity of activities and interventions would need to be defined and developed in conjunction with the professions themselves and based on evidence. We believe that the responses to the recent consultations on regulation of the new Nursing Associate role and Medical Associate Professions by the DHSC demonstrate some of challenges in applying criteria, particularly with new roles where the scope of practice is not yet tested.

2.4. The knowledge required to develop competence and apply it in a critical way should be taken into account in developing a new right-touch regulatory approach. Risk assessment cannot only consider competence in terms of tasks. This is demonstrated in the evidence around failure to identify and react to deteriorating patients on hospital wards, a major safety problem in the NHS. Clinical judgement and skills based on experience, competence and seniority are paramount to recognising and acting on patient deterioration.[vii] Competence in the task of measuring vital signs cannot substitute for skilled clinical judgement which is developed through experience over time.

2.5. We welcome that this consultation recognises the importance of context, organisational culture and conditions within which clinical competent behaviours take place. Evidence[viii] [ix] is clear that aside from competence at the individual level, the willingness, knowledge of how and when to apply the skill, as well as an environment that allows effective application of skill and prevents negative conduct, are necessary. Professional regulation of the individual must take this into account.

2.6. Shortage of certain occupations must not be a criterion for less rigorous regulation. Risk assessment should be on the basis of risk to patients from individuals who are not appropriately competent. Dilution of skill is linked with adverse impact.[x]

3. Do you agree that the current statutorily regulated professions should be subject to a reassessment to determine the most appropriate level of statutory oversight? Which groups should be reassessed as a priority? Why?

3.1. The RCN has long called for regulation of the nursing and health support workforce, which should be proportionate in line with the roles that these different individuals undertake.

3.2. A robust framework that sets the criteria for public protection in terms of risk and fitness to practise and on the basis of which to determine the appropriate level of statutory oversight must be developed as a first step to a new regulatory framework. This would enable appropriate judgement to be made against any potential changes to professional regulation across healthcare professions.

3.3. We believe that nursing and midwifery should continue to be statutorily regulated.

4. What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals?

4.1. It is difficult to respond to this question without knowing more about how prohibition orders would work. We have had dealings with vetting and barring schemes. Barring is utilised by the Disclosure and Barring Service (DBS), for very serious safeguarding issues. There also used to be Alert Letters in the NHS and POVA. Various local authorities have safeguarding hearings. Wales has Care and Social Services Inspectorate Wales (CCSIW) and Northern Ireland has a system for regulating HCAs.

4.2. We have encountered problems with vetting and barring in the past. It is essential that such schemes are governed by fair rules and that those affected can challenge their findings. In 2009 the case of Wright v Secretary of State for Health was heard in the House of Lords. That case involved RCN members who had been provisionally placed on the POVA barring list, so that the individuals concerned were immediately prevented from working. The Judges confirmed that the right to earn a living formed a part of Article 8 of the European Convention on Human rights, the right to respect for private and family life. By preventing these individuals from earning a living without a proper process, the scheme had not been devised to prevent an interference with the respect for private life and was found to be incompatible with the European Convention on Human rights. The process in the POVA scheme was insufficiently rigorous to meet the requirements of Article 6, the right to a fair trial. It failed to protect individuals from draconian consequences. We would want any future scheme to respect the human rights of workers by incorporating a fair process.

4.3. There is also a concern that it is not clear what standards staff will be held to, and who pays for any process to bar them. Presumably, the prohibition orders would need to sit somewhere below the DBS (where there can be ten year bans for behaviour that has caused, or might cause harm, to patients). We query whether that would be for clinical errors, or boundary breaches short of criminal behaviour and whether it would be a less rigorous process than that for statutory regulation.

5. Do you agree that there should be fewer regulatory bodies?

5.1. Yes, we agree. There are regulators with a small registrant base and these could be absorbed either into one of the existing regulators or new larger regulators could be created. Previous work on cost effectiveness undertaken by the PSA[xi], which specifically looked at regulatory bodies in Australia, indicated that several savings can be made through merging regulators and centralising and sharing functions. Evidence from the HCPC and the Australian Health Practitioner Regulation Agency is cited as demonstrating that multi-professional regulators can be efficient and cost effective.[xii]

5.2. The need for greater consistency will increase as we move to more integrated models of care and the care workforce. Fewer regulatory bodies are more likely to provide consistency, equity and parity in standards. We would expect it to also offer better value for money.

6. What do you think would be the advantages and disadvantages of having fewer professional regulators?

6.1. Fewer regulators could create potential economic efficiencies. Done right, this could also enable consistency, equity and parity in terms of regulation of healthcare professions as well as ease of understanding and reassurance for the public.

6.2. Fewer regulators would be an opportunity to avoid any requirements for double registration where registrants have more than one regulated qualification. Given the requirement for a flexible workforce to meet increasingly complex population need, this could also be increasingly the case (for example, a nurse who chooses to work in a Physician Assistant role.)

6.3. The arguments made by the PSA are made primarily on an economic basis. However, when examining impact of the existing system, the increasing need for a system to enable responsiveness to future workforce configurations and changes in professional roles and ways of working must be considered. It is important that the regulatory system reflects the reality of clinical practice which is increasingly multi-professional team-based.

7. Do you have views on how the regulators could be configured if they are reduced in number?

7.1. We do not have a specific preference. However, we would point out that the HCPC already functions as a multi-professional regulator. This model and their systems could be utilised.

7.2. Any new system must assure that every profession has an equal voice and can continue to determine its professional and educational standards.

7.3. If there was a move to more multi-professional regulators, we believe it likely that the setting of education standards for the different professions would need to be managed differently from Fitness to practise (FTP) procedures.

8. Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases?

8.1. We agree that all regulatory bodies should be given the fullest possible range of powers for resolving Fitness to practise cases so that the fastest proportionate resolution is available. In particular, we would wish to see at the NMC the continuation of the recently acquired ability of Case Examiners to resolve cases with Warnings and Undertakings at an early, pre-tribunal stage. Any powers that encourage the two sides to seek consensual resolution at an early point, such as the Consensual Panel Determinations utilised by the NMC, incentivise the two sides to share information and can help to focus upon the real issues and arrive at an early and fair outcome.

8.2. We would like to see the fullest range of potential resolutions available to all the regulators and if they could be reviewed from scratch, rather than rely on the historic General Medical Council (GMC) choices. We think that this could be a useful exercise. For example, the use of cautions has been a useful 'case to answer' outcome at the NMC where the panel does see the need to note that impairment has been found, but does not consider it necessary to interfere with a nurse's actual practice at the time of the hearing. The GMC model has no such outcome at the tribunal stage between a finding of 'no action' and 'agreed undertakings.'

9. What are your views on the role of mediation in the fitness to practise process?

9.1. We would like to see a more inquisitorial approach rather than adversarial approach to resolving Fitness to practise cases, and in general support mediation rather than the punitive feel of a tribunal hearing (which leaves practitioners feeling accused of a crime even when they are actually accused of having made a mistake). The NMC rules allow for mediation, but the rule has never been utilised.

9.2. We see the adversarial approach as a disincentive to health care professionals immediately owning up to having made mistakes, which increases risk to patients. For those already under investigation, the adversarial approach deters the registrant under investigation from sharing their knowledge of events and their opinions for fear of incriminating themselves further, even though cooperation could lead to the matter being resolved sooner. We have had direct experience of this occurring at the NMC with reflection pieces prepared by nurses to demonstrate their insight being used by the prosecution team at the NMC to formulate further charges. Any change of approach that encourages collaboration to arrive at a shared understanding about what has gone wrong will enable there to be learning and improved safety for the public.

9.3. We find it somewhat difficult to imagine how mediation would work, given that the Regulator is investigating how safe a practitioner is to practise, rather than seeking an outcome that each side finds acceptable (which is the way that mediation works in resolving civil law disputes, for example).

9.4. We have tried to imagine any situations where mediation might help. If the complainant is a member of the public, then we have always had a concern that the Regulator has seen its role, in part, to provide closure for the complainant. Whilst this can be an understandable objective and a useful exercise in itself, it is not necessarily the job of a Regulator. We also thought about whether there is a role for mediation if the employer is the complainant. Ideally, if the registrant has not been dismissed, the employer can be a part of the regulator's laudable objective of bringing the registrant back into safe practice, and this could be a part of a mediation process.

9.5. We also see some risks with mediation. We find that many nurses, who are on the whole extremely decent people whose vocation is to help others, often have a tendency towards self-flagellation if criticised. They are usually empathetic towards those in distress. A mediation situation involving a member of the public who feels aggrieved to the extent that their objectivity has been damaged, can be dangerous for such registrants. We could picture those meetings turning into an exercise to manage the distress of the 'victim', which departs from the Regulator's task of fairly and dispassionately deciding whether action needs to be taken in the interest of the protection of the public.

9.6. In relation to involving an employer, we would support the idea of an employer being more accountable for assisting in bringing a registrant back into safe practice. However, we would prefer that this is done by the employer utilising its own processes rather than relying on the Regulator to facilitate this. It is a strange aspect of the current regime that sometimes employers refer nurses whilst continuing to employ them, and sometimes even before they have carried out their own investigation. There is even a suspicion that employers sometimes effectively delegate their own management responsibilities on to the NMC. If the employer has dismissed the registrant, then there does not seem so much to gain from mediation.

9.7. We wonder if there is a way to use a mediation style investigation to prepare the case in a more inquisitorial manner. This could have potential provided that the process is rigorously fair and even-handed to both sides and the mediator is unquestionably independent, so safeguards would need to be carefully considered. This would not be, so much, a mediation as an inquisition perhaps with the 'mediator' having access to all sides involved at the same time, so that evidence could be tested at an early stage.

10. Do you agree that the PSA's standards should place less emphasis on the fitness to practise performance?

10.1. We would like to see the PSA evaluate the Regulators' role in supporting registrants to practise safely and effectively rather than the current emphasis on correcting under-prosecution. We have been encouraged by the NMC's recent strategy proposal for their FtP department, which prioritises supporting nurses and midwives to be fit to practise safely and professionally over the removal of unsafe practitioners.

10.2. There have been some possibly unexpected consequences at the NMC that have arisen as a result of the PSA emphasis on under-prosecution. The first (experienced by other regulators as well) has been an increasingly hard line on dishonesty. Dishonesty is often charged simply because there is a discrepancy found in clinical records even though there is no evidence of there being any potential gain for the registrant for having changed the record, so that 'mistake' is the only plausible explanation. For many nurses, to be accused of dishonesty has been extraordinarily distressing. When challenged about adding such charges, the NMC has indicated that they are under pressure to charge dishonesty from the PSA.

10.3.   There has been another recent development in charging allegations that has also been attributed to the PSA. We now see charges being added that our members' actions have 'contributed to' a patient outcome (such as death, amputation or even suicide). We find ourselves now having to obtain medical reports to refute that the action of our member 'caused' or 'contributed to' the patient outcome. Whether it did or not seems to us to bear little relevance to the real question of whether the registrant is safe to practise. However, the arguments about causation are prolonging hearings and increasing costs. Again, the NMC has justified this development as required by the PSA. In a recent case, our member faced charges that deficiencies in her care plans had contributed to the suicide of a patient. In the end, at the hearing, the NMC offered no evidence in support. Such a charge is immensely distressing and usually prevents registrants making full admissions that assist in resolving cases. If the PSA was more involved in the more positive side of regulatory work, this may avoid the perception among the regulators that they are focussed on under-prosecution, and more proportionate case preparation strategies can be achieved.

11. Do you agree that the PSA should retain its powers to appeal regulators' fitness to practise decisions to the relevant court, where it is considered the original decision is not adequate to protect the public?

11.1.   We do think that the PSA needs to retain its powers to appeal fitness to practise decisions, in order that there is balance. However, there is a risk that individual regulators can be reluctant to properly oppose the appeal when they are aware that the PSA will also be auditing and making findings about that regulator's effectiveness. An effective alternative could be that the Regulator itself can appeal a result that they consider to be wrong, but for this there would need to be an independent adjudicator.

12. Do you think the regulators have a role in supporting professionalism and if so how can regulators better support registrants to meet and retain professional standards?

12.1.   Yes, we believe that they do. The means include code of conduct, professional standards, standards for education and training and revalidation of registrants.

12.2.   In our view, professionalism can be supported with appropriate guidance documents. We would like to see more of these developed by the NMC. For instance, the NMC brings cases involving the breach of boundaries with patients, but does not give guidance about what relationships and behaviours might be acceptable. We have seen registrants charged with sharing a mobile phone number with a patient even when there was no suggestion of sexual impropriety, yet this is not forbidden in any guidance document. We are not asking for detailed and prescriptive rules, necessarily, but some indication, perhaps through case studies, of the sorts of behaviour that breach boundaries.

12.3.   The GMC has more detailed guidance in several areas. When the NMC and GMC produced a detailed guidance document about the Duty of Candour,[xiii] we found it very useful and we preferred that the guidance was joint, so that the rules were the same for different professionals in the same setting.

12.4. Evidence from dentistry shows that a combination of Clinical Audit, Multi-Source Feedback, Patient Feedback and Case-based Discussion evidence is likely to be the most useful approach to supporting professionalism. The key is to maintain as much flexibility as possible in order to ensure that practitioners are allowed to submit evidence of their continuous fitness to practise which addresses the different areas within the regulators standards.[xiv]

13. Do you agree that the regulators should work more closely together? Why?

13.1. Yes, to ensure equity and parity in public protection across healthcare professions as well as to ensure that healthcare professions with similar scopes of practice are treated consistently and fairly.

13.2. We would also expect efficiencies and access to better information if the regulators worked more closely together at setting standards and we were pleased by the results of the GMC and NMC working together on the Duty of Candour guidance. We think that the Candour guidance could be even more helpful if the needs of the whole range of health care staff were taken into account. For example, that particular guidance gives high levels of personal responsibility to doctors and nurses to inform patients if a mistake is made. However, if the guidance is adopted for Nursing Associates, it could be necessary to consider whether that level of personal accountability is still appropriate for someone in a supporting role. There is a note in the guidance about who should take primary responsibility for speaking to a patient in a multi-disciplinary team, which is helpful. We can see potential for much more effective guidance for the complexities of delivering care in modern settings if various roles are considered alongside each other in a single guidance document.

13.3. A danger of regulators working separately is that they become inconsistent in the treatment of different healthcare workers. We have seen some erratic outcomes between different medical staff involved in the same incident. For example, we have recently concluded a case in which our member was the second checker of a controlled drug (i.e. she countersigned to confirm that the amount prescribed had been given) and the charge was that she failed to notice that the prescription was an overdose (as did the emergency team called when the patient became more unwell). This was in the context of an acutely understaffed shift with very unwell patients. Whilst the panel eventually found no misconduct on the part of our member, she had endured 3.5 years of investigation and a three day-hearing. The doctor who mis-prescribed the insulin had a finding of 'no case to answer' against him at the Case Examiner stage at the GMC. If there had been the same approach by the different regulators, the NMC may have felt more confident in concluding the case earlier.

14. Do you think the areas suggested above are the right ones to encourage joint working? How would those contribute to improve patient protection? Are there any other areas where joint working would be beneficial?

14.1. We agree with a single organisation conducting back office functions given the obvious economic efficiencies this would create.

14.2.   We also agree with a single adjudicator. There is a tension when the adjudicator is also investigating and prosecuting cases. On occasions, the ability to schedule cases at times inconvenient to the registrant, ignore directions without consequence and to treat the registrant differently to other witnesses and so forth gives the appearance of unfair advantage to the Regulator as prosecutor. If there was an independent adjudicator, however, we would ask that there was sufficient nurse representation on the panels to be sure that the nursing role was properly understood.

14.3.   We would support a single set of standards where appropriate, but believe this may be too aspirational given the breadth across all professional roles.

14.4.   We also believe that the standards form part of professional identity and are a mark of professionalism. Caution therefore needs to be exercised when considering these in a new regulatory approach. We are clear that any more generic standards must still recognise the identity and contribution of individual professional's expertise in delivering care within the multi-professional team.[xv]

14.5.   There is an important difference between education standards, professional standards and professional conduct. We believe that a single set of values would be beneficial embedded in the same code. However, the professional standards must be different and proportionate to the role. There must be a differentiation regarding the requirements and expectations of registered healthcare professionals and those in a registered role that supports that profession – for example, the measures to identify appropriate delegation of work.

15. Do you agree that data sharing between healthcare regulators including systems regulators could help identify potential harm earlier?

15.1.   Yes, we agree. This is particularly the case as registrants may increasingly specialise and fall under the remit of more than one regulator. We also agree that greater data sharing could lead to earlier and better identification of risks to the public, for all the reasons given. We are pleased to note that the NMC has recently undertaken greater analysis of its own data to identify whether nurses from different groups are being treated equally. We would like to see this work being coordinated to find out if there are particular organisations that show signs of systemic difficulties which may be resulting in higher than expected numbers of referrals of nursing or other staff.

15.2.   To share data to support better regulation at the system level is helpful, provided the data exists, is of good quality and is accessible. There are issues with the data generated and shared within the NHS with regards to information security[xvi], data quality[xvii], availability, usability and accessibility, compounded by the fragmented nature of the various IT systems.[xviii] These will need to be carefully considered.

15.3.   In addition, at system-level there are issues with definition and identification of safety outcomes such as mortality rates and avoidable deaths for the purposes of regulation,[xix] in that agreement can be low between case reviewers and hospital-wide metrics may not reflect individual performance.

15.4. We also consider that there is potential for better coordination between organisations to address system faults that are poorly identified and addressed under the current system. We particularly see this in relation to cases involving registered Nursing Home Managers. It is a common scenario that a competent nurse takes on a post as manager in a Nursing Home that has been underfunded and neglected by the owners. After a few months, something happens or there is a CQC inspection and the Manager is then referred to the NMC for a host of charges relating to 'failing to' put in place adequate provisions to care for the residents. There is no way for a panel at a Regulator like the NMC to work out whether it was realistic for someone to have turned around a struggling Home with the resources available. However, the fact that care plans were missing, say, or that other measurable failings can be identified is enough for a sanction to be applied. It would be far better if the CQC and other regulators responded to concerns by working together to address underlying problems and, at the same time, took the opportunity to examine the reality of conditions in which health professionals are working. In this way, competent staff who are unfortunate to find themselves in high risk situations will only be investigated further if there is actual evidence of poor practice on their part.

16. Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?

16.1. We have noted that when policy teams at the NMC have identified better ways of conducting Fitness to practise cases, such as introducing 'Warnings and Undertakings', the process for obtaining changes to the rules has been laborious. We would want the Regulators to be able to set their operating procedures in ways that avoid these cumbersome processes in the future.

16.2. However, we have on occasion seen that the NMC does not necessarily apply the spirit of the rules when it has a freer hand in setting operational processes. For example, we saw this when the NMC developed a process known as 'Rule 7A'. Under this system, a case determined as 'no case to answer' can be returned for further investigation if the complainant objects to that outcome. When under investigation initially, the registrant is given a good indication about what is being investigated and there is a process enabling the registrant to respond. Under the R.7A process, we have seen the Registrar refer cases to hearing when there is an absence of witness evidence and the usual checks and balances no longer seem to apply.

16.3. To avoid the regulators introducing unfair new procedures that favour the prosecution, we would ask that any new legislation requires the Regulator to be held accountable against principles that enshrine fairness to the registrant whilst setting their processes.

17. Do you agree that the regulatory bodies should be more accountable to the Scottish Parliament, the National Assembly for Wales and the Northern Irish Assembly, in addition to the UK Parliament?

17.1. Yes, we agree. This is already the case for the NMC, and any future bodies must be equally accountable to all parliaments and the existing system of accountability to the UK Government mirrored across all four countries of the UK.

18. Do you agree that the councils of the regulatory bodies should be changed so that they comprise of both non-executive and executive members?

18.1. Yes, this is in line with ensuring a strong public voice and confidence and would also mirror health authorities and Trusts in England. We believe that changes in Councils should reflect good practice and be based on available evidence, including the principles which underpinned the Consultation to change the NMC constitution in 2012.[xx]

19. Do you think that the views of employers should be better reflected on the councils of the regulatory bodies, and how might this be achieved?

19.1. We agree that employers need to be consulted, but believe that this needs to be done with caution. The responsibility for public protection must sit firmly with the regulator and must not be diluted by other interests, in particular in the light of severe staff shortages.

20. Should each regulatory body be asked to set out proposals about how they will ensure they produce and sustain fit to practise and fit for purpose professionals?

20.1. Yes, this should be explored as part of the new model as the current model is punitive and reactive rather than supportive and proactive.

20.2. In Fitness to practise cases, we would like to see the NMC become more involved in advising registrants what action to take to put right deficiencies in their practice, as a part of helping them back to safe practice, and we were pleased to see that this is a priority in the proposed new strategy for the Fitness to practise directorate.

21. Should potential savings generated through the reforms be passed back as fee reductions, be invested upstream to support professionalism, or both? Are there other areas where potential savings should be reinvested?

21.1. These should be initially frozen and considered in the longer-term when it is clearer to what extent any potential savings would have been swallowed up by the changes and the new systems. If there are stable long-term savings then these should be passed back to registrants.

22. How will the proposed changes affect the costs or benefits for your organisation or those you represent?
  - **an increase**
  - **a decrease**
  - **stay the same**

Please explain your answer and provide an estimate of impact if possible.

22.1. Too little detail has been provided for us to be able to confidently comment. This would entirely depend on the details of the proposal.

23. How will the proposed changes contribute to improved public protection and patient safety (health benefits) and how could this be measured?

23.1.   Equity and parity between professions, and therefore clarity for patients, would appear to be increased. However, there is insufficient evidence around regulatory models to enable an assured answer to this question. The arguments for strengthening professional regulation come from evidence of systemic underperformance and publicised cases of inappropriate behaviour in individuals[xxi]. Despite the international prevalence of physician licensure, there is little evidence available about its impact on quality of care[xxii]. It has been argued[xxiii] that regulation and accreditation has been observed to be effective in promoting good safety practices, but do not seem to be directly contributing to care quality improvement.

23.2.   In addition to the initial licensure or registration, professional registration bodies consider continuing qualifications over a lifetime of practice and have some form of revalidation process. In the case of GPs' revalidation, for example,[xxiv] neither the GMC or the Department of Health were able to point to any evidence that revalidation has reduced avoidable deaths, harm caused by doctor or litigation costs, as claimed before revalidation was rolled out. Impact of revalidation for nurses and midwives is still to be evaluated in the future so it is too early to comment.

23.3.   As the overall availability and strength of evidence is low (see Q2), any change in regulation should be accompanied by improved monitoring and evaluation of both intended and unintended consequences.

23.4.   To ensure patient safety in light of changing population health need, there is a need for models of regulation to enable flexibility and timely response to the development of professions and professionals to meet current and future population need. This includes the move from reactive and punitive models to proactive, supportive and preventative models.

23.5.   Generally, if the changes introduce strategies for addressing systemic problems in healthcare rather than focussing exclusively upon the individual, then we would expect better public protection, learning from mistakes and fewer referrals of nurses to their regulator. At the RCN, supporting members who have been referred to the NMC is a significant cost. The costliest cases are those that end up in a tribunal hearing. These are also the most distressing cases for our members. Streamlined processes that can deal with cases at the earliest stage compatible with maintaining public protection and greater use of consensual disposals would reduce the trauma of being involved in a fitness to practise case for our members and the RCN would experience a saving from reduced numbers of hearings.

23.6.   However, to properly examine the bigger picture when things go wrong and then to follow up on the learning that arises is not necessarily less expensive, but should be seen as a good investment in public safety. This was the experience of the airline industry in undertaking such thorough investigations into crashes, with great benefits for safety in the long term. We would prefer that the extra time is spent on investigations if this better outcome can be achieved.

24. Do you think that any of the proposals would help achieve any of the following aims: Eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010 and Section 75(1) and (2) of the Northern Ireland Act 1998?

Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?
Fostering good relations between persons who share a relevant protected characteristic and persons who do not share it?

24.1.   The proposals could seek to address some of the current concerns and apparent negative impact of current regulatory models on persons with a relevant protected characteristic. This is particularly pertinent around the issue of ethnicity, as demonstrated in recent research focusing on BME nurses and the NMC.[xxv]

24.2.   This showed that ethnicity appears to be related to the risk of referral to the NMC, where BME nurses (as well as those of unknown ethnicity) are disproportionately represented in the population of referrals to the NMC, with employers rather than the public disproportionately referring in the first instance. However, the authors do caution that ethnicity is only known for 60% of referrals, and as such it is not possible to conclude with certainty that some ethnics groups are at risk of greater referral.

24.3.   There is further evidence suggesting there are a disproportionate number of BME professionals' being referred to regulators,[xxvi xxvii xxviii xxix] although the reasons are generally not agreed on. The available research suggests that this may be the result of a lack of knowledge and a lack of confidence of managers to deal with matters locally. We believe there is a need for better data collection, analysis and dissemination of results across regulators and sharing with employers.

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The Royal College of Nursing

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

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