Royal College of Nursing response to Nursing and Midwifery Council’s consultation on a draft revised code and our proposed approach to revalidation

With a membership of around 415,000 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.

The draft Code: introduction and general comments

The nursing and midwifery professions have been under intense public scrutiny in recent years, with the events and subsequent public inquiries into care failings at Mid Staffordshire hospital perhaps being the most high profile example of failure to deliver safe care to all patients. This scrutiny has raised pertinent questions about the role of effective professional regulation in protecting patient safety. The RCN supports the NMC’s work to ensure that it fulfils its function as a professional regulator in the most effective and efficient manner possible, as this benefits both patients and the nurses and midwives who care for them.

However, the RCN has significant concerns that despite best intentions, the NMC’s work to develop the new model of revalidation and associated Code, has been too heavily influenced by recent public and political discourse. In seeking to address all recent and any future criticism of nursing and its professional regulation, the current draft Code lacks cohesion, clear purpose and strong, authoritative identity.

The RCN believes the professional Code must be a document which nurses and midwives feel is a reasonable and accurate representation of their professional accountabilities and obligations, and which they can be proud of and proud to uphold. In developing the Code and a revalidation model, the NMC should start from a position of trust in the nursing profession and design these to promote a culture of ongoing professional development and learning.
Key recommendations

- The Code should be much shorter and focus on high level principles.
- The content of the Code should be grouped into clear, easy to use, thematic domains.
- RCN’s Principles of Nursing Practice should form the organising themes around which the content of the Code is based.
- NMC should produce and signpost registrants to guidance on more complex issues.

Length and specificity

The RCN believes the current draft code is too long and contains too much detail, much of which is role or setting specific, or would be more appropriate in guidance.

Feedback from our members suggests that excessive or unnecessary details also risk the Code being viewed as patronising, which could be detrimental to the overall esteem in which registrants hold the Code. The RCN believes that each of the included paragraphs needs to be a matter of critical - and stand alone - principle.

The RCN can see a number of problems with an overly prescriptive, wordy approach.

Firstly, as noted above, registrants may resent a Code which they feel is derisive to their professionalism. The RCN has received feedback from multiple sources which criticise the current draft for being overly prescriptive. The result of this is a document which feels ‘paternalistic’, ‘negative’ or ‘patronising’ – all words used by nurses describing the document to the RCN. In the words of one, “it’s [meant to be] a code of practice, not a job description”. (Paragraph 7 is a good example of this, and we are unconvinced that the requirement to ‘manage time’ has a place in a professional Code.)

Another potential area of concern with an overly prescriptive approach is the risk that in future the NMC will be overwhelmed with fitness to practise cases based on a poorly constructed professional Code. This would be an unacceptable outcome not only for the individual registrants concerned but also for the efficient working of the NMC.
We recognise that in some respects the issue of whether a professional Code should be short, concise and based on top line principles, or a more detailed and descriptive document, is a matter of personal preference.

The RCN has considered this question carefully and on balance, we believe that the most useful format for the professional Code is one that is concise and based on clear undisputed principles. This should be supported by authoritative, up-to-date guidance, available evidence and worked examples to support registrants put those principles into practice.

We and our members believe that the professional Code is most useful as a clear, concise set of expectations and requirements which govern what it means to be a nurse and/or midwife. These should represent the foundations of the nursing and midwifery professions. We urge the NMC to resist the temptation to seek to address the myriad of professional issues within this one document. For example, references to the fundamentals of care stray into the area of specific tasks, roles and settings, which are not universal to all nurses and midwives. We therefore do not believe the Code is the right setting for this level of detail.

We note also that there is a significant amount of repetition of themes and ideas within the new Code. This may be a result of the attempt to make one document fit the role of “all things to all people”. Again, we suggest that the NMC removes repetitive paragraphs in order to make the Code a more concise, helpful document.

An example which demonstrates both the above points is the new paragraph on social networking. RCN agrees that with the constant advancement of technology and its prevalence in day to day lives, nurses and midwives are in need of guidance about appropriate use of social networking. However, we believe that primary obligations relating to the protection of patients’ confidentiality are the overriding principles of relevance within the Code. Social networking is one of many ways in which a registrant could breach patient confidentiality and the NMC should focus on providing useful examples and case studies as supportive materials, rather than attempt to address this in a substantive clause.

In addition, and a matter of real concern, is that if the Code begins to be seen as a primary source of specifics such as this, any new form of media or outlet that is not specifically identified in the Code, may be treated in a different way. In being overly specific, the Code will be time limited. For these reasons, the RCN advises that the NMC design a Code which sets out top line principles of professional behaviour, rather than seeking to determine numerous examples of ‘what might go wrong’.
Structure of the Code

Further work is required to create a better structure for the content of the Code. Particular examples include the inclusion of a contents table; restructuring the content into clear ‘domains’ or thematic chapters; and ensuring that each paragraph is located in the correct thematic area. For example, the paragraph on social networking appears to be ‘bolted on’ at the end. If it remains, it would be better placed in the context of other points on confidentiality.

Longevity of the Code

It is important that the NMC Code is future-proof. The RCN is concerned that the current wording of the document means it will be out of date quickly. The NHS and independent and voluntary health sectors are changing rapidly in terms of service models and the development of quality and safety standards. If the Code is too specific in focus on any one model of care or area of ‘political concern’, it will not have the adaptability or durability required to stand the test of time.

We believe there should be thorough and up-to-date standards on key issues, which the Code should relate to without detailing specifically.

Conclusion

In conclusion, the RCN believes the current draft to be too long; repetitive; overly prescriptive; and fails to strike the right balance between top line principles governing the nursing and midwifery professions and specific, role or task based activities. We also have significant concerns about specific paragraphs, for example on delegation (see below).

The Code must also reflect where an individual nurse or midwife’s responsibilities for a patient or service user end, such as in relation to the responsibilities of the wider team or organisational governance. This includes for example, setting and maintaining appropriate staffing levels (where relevant) and appropriate support for ongoing professional development. The Code must also take into account that there will be occasions where individual registrants fulfil all their obligations but final outcomes may be determined by the decisions and choices made by patients.

We believe the Code should be a positively framed, high level document which every nurse and midwife can make applicable to their particular circumstances or role.
The RCN’s Principles of Nursing Practice\textsuperscript{1} describe clearly and succinctly what everyone can expect from nursing practice. The principles were developed after comprehensive engagement with multiple stakeholders.

They are as follows:

- **principle A**: nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally

- **principle B**: nurses and nursing staff take responsibility for the care they provide and answer for their own judgments and actions – they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law

- **principle C**: nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care

- **principle D**: nurses and nursing staff provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care

- **principle E**: nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about

- **principle F**: nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care

- **principle G**: nurses and nursing staff work closely with their own team and with other professionals, making sure patients’ care and treatment is co-ordinated, is of a high standard and has the best possible outcome

- **principle H**: nurses and nursing staff lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.

\textsuperscript{1} \url{http://www.rcn.org.uk/development/practice/principles/the_principles}
The RCN suggests these are domains/thematic areas which could usefully frame the code and its contents.

Finally, we note that non registrants will be required to use and understand the Code. This is another reason to ensure the document is clear and well structured and fit for purpose.

Consultation questions

C. How would you rate the draft Code on each of the following:

C1. A) language and tone

The RCN agrees that the Code must be written in plain language which is clear and easy to understand.

However, we note there are some terms which may be commonly used ‘lay’ terms, which, without definition, are not appropriate for inclusion within the Code. For example, on page 6, there is reference to the concept of a ‘near miss’. We are aware that the NMC is working with other regulators and stakeholders on the Duty of Candour requirements. A concept such as ‘near miss’ (which has significant implications should a registrant be required to explain or be held accountable for this ‘near miss’ to the patient), must not be included in the Code without reference to a clear and usable definition.

As noted above, some RCN members have commented that a ‘negative’ tone is pervasive in the draft Code, which gives the feel that it has been designed as an instrument to ‘use against’ registrants. We suggest that headings such as “how will I know that I am working to standard on [a given area]” could be a more helpful way to frame the content.

Another example of this is the reference – almost at the very start of the document – to a principle duty to “do no deliberate or avoidable harm”. This is very negative and does not reflect the scope of good nursing and midwifery practice. We note this concept is not included in the current Code. Greater clarity is needed about how ‘harm’ is defined – the nature of clinical practice will inevitably result in occasions when judgements are made about levels of harm versus potential benefit.

The requirement to uphold rights (page 5) would also benefit from clarification – rights defined by whom and how then are competing rights to be managed?

The RCN also believes that parts of the draft Code are repetitive and lack coherence. For example, on page 9, the section on providing leadership and
managing time is convoluted and repetitive. Paragraphs 28 and 29 are also examples of paragraphs which cover the same key issue. Paragraph 51 is also covered by paragraphs 48-50.

C1. B) easy to read

The RCN believes this document would be more user friendly if a number of alterations were made. Firstly, we believe the document is too long. We are concerned that if the Code is too long it will be more cumbersome for registrants to find the key points and principles and that those key principles will get lost in detail which may be more appropriate sited elsewhere, for example in guidance documents.

We suggest also that a table of contents is included and organising the obligations into thematic domains would improve the document’s usability.

C2. C) easy to understand

Please see the points made in the questions above, which are also relevant to this question.

Where there are individual examples of paragraphs which we believe to be incorrect or unclear, we have provided detail later in this response.

C2. D) easy to apply in different roles, settings and scopes of practice

While some of the principles set out in the document are relevant and applicable to all nurses and midwives, we believe there is a substantial amount of detail which clearly relates to specific settings and roles. Frequently, these appear to be designed for registrants working in the acute sector or in large healthcare organisations/institutions; and to the exclusion of those in management roles, academic, public health or community settings, or the self-employed. For example, a number of paragraphs found in the section on the fundamentals of care, which we provide more detail on later in this response.

We believe that including levels of details which are clearly not relevant to all settings, roles and scopes of practice is not helpful and could result in confusion amongst many registrants.

The content of the Code also fails to deliver adequately on concepts such as leadership.

C2. A) patient and public expectations

The RCN welcomes the principle behind this, as we agree that it is important that patients and the public more generally understand the nature and extent of nurses
and midwives obligations towards them. This will help to both inform and empower patients and the public in their experience of health services.

However, we would like to note that it is important that the Code does not set unrealistic or untenable expectations. For example, sometimes the expectations set out may not be met but this may not be the registrant’s fault. There needs to be recognition that patient experiences may also be reliant on wider teams, or organisational processes and priorities, which are beyond the control of individual nurses and midwives.

Specifically, we suggest that references on page 8 to “fundamental aspirations” be reworded. These are not aspirations which are desirable, but rather duties which must be fulfilled.

The RCN also seeks a clear statement from the NMC about whether this section and the requirements contained are part of the Code.

**C2. C) the fundamentals of care**

As stated above, the RCN does not think these paragraphs are appropriate for inclusion in the Code, for a number of reasons.

While there is no question that ensuring adequate hydration and nutrition are (where relevant and appropriate) absolutely fundamental to patient care in clinical settings, this does not mean that the professional Code needs to specifically refer to this.

We are concerned that they may cause confusion, because they represent highly specific tasks; and do not relate to every registrant’s role or setting. Many registrants do not deliver hands on patient care, while others are not responsible for the delivery of hydration and nutrition. For example, an individual working for an organisation as the only registered nurse in an occupational health role, should not be considered accountable for nutrition and hydration. Neither should a registrant working in research. For those registrants that do work in relevant roles, other high level paragraphs relating to professional practice cover the general principle of delivering suitable care and interventions for patients in a nurse’s care.

On a matter of principle, many nurses have told the RCN that they believe the inclusion of these paragraphs to represent a ‘reductionist’ approach to nursing. Modern nursing and midwifery practice in clinical settings often requires nurses to deliver increasingly complex and sophisticated care and decision making, which is not adequately reflected in this task based approach to the professions.

The inclusion of these paragraphs might also be seen as a very overt response to the current ‘political’ priorities in the wake of the Francis report. While the RCN absolutely agrees that there are many changes which must take place in order to
protect patient safety, the Code is not the right setting to address and detail all of these concerns.

Furthermore, the RCN believes that including some specific tasks such as this, serves to highlight those which are not included. For example, there is no reference to managing pain in these paragraphs. The risk of being overly prescriptive is that those themes which are not included may be seen as of secondary importance. We reiterate that we do not believe it is useful or appropriate to have these paragraphs in the Code.

There are many strands of work taking place in many organisations to guarantee patient safety and standards of care, not least the fundamental standards of care that will be used by the Care Quality Commission, subject to the passage of legislation in April 2015. The NMC Code cannot and should not attempt to reflect all of these.

C2. D) amended section on maintaining clear professional and sexual boundaries

The RCN agrees that the Code should stipulate that a nurse maintain clear professional boundaries with people in their care (and their families). It would be useful for the NMC to provide further guidance about how to determine these boundaries, now that the addition of “sexual, personal and emotional” has been added to the Code. This is a common subject for fitness to practise cases, which demonstrates that it can be a complex issue. We note that the General Medical Council’s requirement is, “you must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them”. The GMC’s guidance then provides criteria which can help the registrant work out if a developing relationship could be deemed improper.

C2. E) new paragraphs on prescribing and medicines management

We welcome the inclusion of paragraphs on this area. Paragraph 62 should specifically reference, which guidance the registrant must comply with. However, on a related point, the RCN believes that medicines management guidance is currently out of date. If the Code is to reference supporting guidance which nurses must be aware of and comply with, it is essential that guidance is authoritative and up to date.

C2. G) new paragraph on when to take emergency action

There was some confusion about the meaning and relevance of this paragraph amongst RCN members. The NMC may wish to clarify with more explanation. For

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example, every nurse should be able to apply fundamental emergency care and life support, so what does the paragraph mean by “emergency action”?

The RCN suggests that the wording should be explicit as to whether this refers only to situations at work or also in public or private spaces (when a registrant is off duty).

C2. H) new paragraph on social networking

As detailed above, this paragraph is illustrative of one of the major flaws in this draft Code, in that it appears at the end of the document, almost as a ‘bolt on’ because use of social networking and media has been an area of concern in recent years. The RCN agrees that nurses do need to understand the implications of their use of social networking within the context of their professional roles. However, we are not convinced that it should be a standalone paragraph in the professional Code, as it deals with issues of confidentiality for example, which are amply covered elsewhere in the Code.

The current wording in itself is also problematic – for example, some nurses and midwives work in organisations where mentioning and promoting their employer is essential, for example those working in policy, research or leadership roles. As currently worded, these individuals would be breaching the Code by referencing their employer.

If the paragraph remains the NMC should reword this to reflect that it relates to irresponsible use of social networking.

Other comments

Page 17 paragraphs relating to clear and accurate records. This should reference patients accessing and contributing to their records. This should also be reflected in references to guidance.

Paragraphs 22 and 23: respect confidentiality. The RCN considers these paragraphs to be poorly worded and confused. Paragraph 23 is simply not correct. If as currently worded, the registrant has already obtained the ‘necessary consent’ then confidentiality is not being breached. There will be occasions when registrants will feel that in the interests of public protection or patient safety a difficult decision will have to be made and they must share information without consent. It is important that the Code reflects that conflicts of interest may occur, but the registrant must be aware of the relevant law when making decisions. The NMC should make clear reference in this section to guidance which supports registrants when making these judgement calls. Such guidance would also be helpfully referenced in paragraph 33, to help put decisions about confidentiality into context.
Paragraph 34: work constructively with the people in your care. It would be helpful to be clear about what conscientious objection means and covers. Currently this paragraph reads as a licence to refuse almost anything a nurse considers against their conscience.

Paragraph 47: share information with your colleagues. The RCN supports the principle that all parties should be transparent and open in the sharing of information. However, there should be reference to the privilege against self-incrimination.

Paragraph 56: delegate effectively. This paragraph is not correct and should be removed. The RCN is clear that a nurse is responsible for delegating appropriately and safely, but once the task has been delegated, it is the person who has accepted that task that is accountable for performing it correctly.

Paragraph 70: managing risk. The intentions behind this paragraph are welcomed and the RCN agrees that nurses should take reasonable steps to mitigate any health risk they may pose to people in their care. We note that the current wording could be read to include uptake of the flu vaccine. We would not wish for this paragraph in the Code to become a means by which employers can place nurses under duress in relation to taking the vaccine. We also note that in the case of flu vaccination, nurses will be reliant on their employer to facilitate their access to the vaccination.

Paragraph 97: acting with integrity. The RCN has concerns about the meaning and interpretation of this paragraph. We believe there is ambiguity about what a ‘formal complaint’ actually is. Currently, a nurse must tell their employer if their FtP is called into question, but not the NMC unless they are charged, cautioned or convicted of something. We note that the NMC has interpreted that requirement very rigidly at times (ie you must tell your employer if there has been a complaint of any type even if it appears malicious, etc.). Does this new requirement mean that a nurse must tell the NMC even if their employer is launching their own investigation and then sees no need to make a referral themselves because the accusation was baseless? It means that registrants are being asked to refer themselves in situations when their employer would not have to (we note that the NMC advice to employers is: Can this be managed at a local level, or do you need to refer?). At the very least, the NMC must more clearly define the requirements so that registrants are clear about when they have to refer.

Paragraph 101: dealing with complaints and reflecting on feedback. It is not clear what ‘details’ need to be given. For example, details of what may have gone wrong or contact details of your employer, professional or system regulators, or complaints bodies?
Paragraph 105: dealing with complaints and reflecting on feedback. We note that the level of harm which requires nurses to take these steps is left open and undefined, which is not helpful for registrants.

Paragraph 106: dealing with complaints and reflecting on feedback. The RCN supports the principles of openness and transparency in relation to complaints and raising concerns. However, this should be subject to legal rules in relation to self-incrimination.

Paragraph 109: be impartial. This paragraph is a useful addition to the Code. We believe that this is an area which could benefit from the development of further guidance to support nurses who we believe will be increasingly exposed to relationships with commercial organisations (such as pharmaceutical companies) in the course of their work (for example, nurses working as nurse prescribers).

Paragraph 113: displaying professionalism. There will need to be guidance around when disclosure of an NMC PIN number is deemed appropriate and to whom.

C3. How well, if at all, do you feel the draft revised Code addresses the recommendations raised in the Francis report relating to nursing and midwifery practice?

The RCN supports the NMC’s efforts to become a robust, effective and efficient professional regulator. We also support many of the recommendations in the Francis report to strengthen the professionalism of nursing. For example, those on revalidation, staffing levels and the regulation of healthcare support workers.

However, as noted above, there are many organisations taking forward work to improve the quality and safety of patient care. Not all of this work can, or should, be referenced in the NMC Code. We would encourage the NMC to be assertive on this issue and to resist developing a Code which is overlong and unusable in order to ‘be seen’ to be addressing all issues.

Revalidation model

General comments

The RCN is and has long been clear that we support the principles behind revalidation.

In developing our response to this consultation, the RCN has returned to critical and fundamental questions about the purpose of revalidation and what it is intended to
achieve. We have also carried out research into the models of revalidation and associated concepts within professional regulation from an international perspective.

There are some elements of the NMC’s proposals which appear to the RCN to be more useful than others. For example, we agree that the concept of reflecting on third party (including where relevant, patient) feedback is important to maintaining a strong sense of professionalism and commitment to ongoing learning and improvement. We also strongly support the importance of an emphasis on ongoing professional development in the form of continuing professional development (CPD). The RCN has long championed the importance of CPD and called for greater investment and commitment to provision and support of nurses undertaking CPD. Indeed, the RCN believes that investment in this area would be one of the most effective and efficient ways to ensure the ongoing fitness to practise of the nursing profession. It should be a critical component of revalidation.

Supporting nurses to undertake CPD and to use reflection would deliver on the key aim of revalidation – fostering and nurturing professionalism and allowing nurses to take ownership of, and pride in their practice. In turn, this will benefit patient safety.

The RCN therefore suggests that these are the elements of revalidation that the NMC should focus on building, supporting and investing in - including by working with employing organisations - rather than the more bureaucratic and untested elements of the revalidation proposals.

**Structure of the Code**

As noted above in the section on the structure of the Code, the RCN feels that the Code should be restructured into clearer domains. This will help revalidation as registrants would be clear about which domains are relevant to their practice when revalidating.

**Feedback and reflection on practice**

In principle, the concept of gathering feedback from users (including patients, where appropriate) and reflecting on that feedback to improve individual practice is sound and to be welcomed.

However, there are a number of practical issues which need to be resolved if this proposal is to work in practice, and to deliver genuine professional and patient benefits rather than become an administrative exercise.
The NMC must provide clarification on what the criteria will be for demonstrating that reflection has taken place to a suitable standard. The RCN is not clear how the NMC will construct a model that monitors and measures this in a meaningful way. This model must be clear on the criteria and standards, which NMC expects nurses to meet in order to carry out this exercise successfully but must not be overly burdensome or onerous on nurses. At the same time if the process is reduced to an over simplified ‘tick box’ exercise, this will not deliver the intended outcomes, the most important of which is giving nurses a mechanism to understand how to reflect on the feedback they have received and to carry the results of this reflection into their future practice.

Done well, reflection on practice will help to promote a culture of lifelong learning and accountability in the nursing profession. But in order to be effective and fit for purpose, much more thought will have to be given on how to support nurses in this process. The work undertaken by the NMC during the pilot stage will give crucial information about how workable these proposals are.

**Consultation questions**

**D. Getting confirmation**

**D1. To what extent do you agree with the proposed model for who should provide confirmation for a nurse or a midwife?**

The response from RCN members was overwhelmingly clear – nurses and midwives believe that only a fellow registered nurse or midwife is an appropriate person to provide confirmation on ongoing fitness to practise.

Therefore, in principle we are pleased that the NMC has accepted that a non registrant should not be able to perform this role in isolation. However, we retain significant concerns about how third party confirmation will work in practice. As set out comprehensively in our response to the first consultation, the RCN has significant concerns about the use of employer processes (appraisal) in revalidation. Briefly, these include whether employers are set up to deliver what is required, and the potential for confusion about and unacceptable intermingling of employer and professional regulation functions.

The issue of those registrants working in more ‘unusual’ teams (for example as the only registered nurse within an organisation, in very senior roles, self-employed or bank staff) has also been discussed extensively. We note the NMC’s proposals to deal with this, involve the use of two individuals for confirmation – for example, one non registrant manager and a peer registered nurse. The RCN anticipates that this
system could become complex and unwieldy and in addition, could be open to abuse or at the very least not deliver the intended outcome. The principle behind confirmation is to provide an extra layer of assurance about the individual undertaking revalidation’s fitness to practise, that assurance may not be adequate in some cases because some nurses – due to the nature of their employment/role - may find it near impossible to find a peer who can confidently pass judgement on their fitness to practise.

D2. Based on what you understand of who would provide third party confirmation and how it will work with appraisals, please provide any comments you have on the proposed revalidation model.

We believe that use of employer process (appraisal) as a means to achieve third party confirmation for revalidation purposes can only be one option. As referenced above and discussed at length in the RCN’s response to the NMC’s first revalidation consultation, there has been a lot of debate about how third party confirmation will work for nurses who do not receive regular, well constructed appraisals (for example bank staff or self-employed nurses). The NMC must urgently provide clarity on what the alternative model would look like for nurses for whom the use of appraisal is not available.

The RCN’s position on the use of appraisal in revalidation has been detailed at length in our first consultation response. We have a number of concerns about the risks associated with conflating employer and professional regulation processes. Therefore, where appraisal is the method by which nurses receive third party confirmation, the RCN reiterates that it is absolutely essential that there be clear and authoritative guidance from the NMC. This guidance must be explicit about the separation of the employment and revalidation functions in this process.

We also envision that significant resources will also be required to train individuals responsible for providing third party confirmation to ensure this process is fair and consistent.

F. Using feedback

F1. As part of the proposed revalidation model, a nurse or midwife will need to provide the NMC with evidence that they have reflected on feedback they have received, rather than providing the feedback itself to the NMC. To what extent do you agree or disagree with this approach?

3 http://www.rcn.org.uk/support/consultations/responses/revalidation
We agree that in relation to gathering evidence of feedback, providing evidence of reflection is a better approach than simply providing evidence that feedback has been collected. It is more useful and important to focus on the learning outcome, rather than the process of collecting the feedback itself.

We note however, that tools will have to be developed to support registrants in this process, to ensure consistency and allow for some level of scrutiny of the registrants' reflective process.

**F2. As part of the proposed revalidation model, a nurse or midwife will be required to provide a minimum of five reflective accounts over three years. Do you think this is too many reflective accounts, too few reflective accounts or about the right number of reflective accounts?**

The main concern the RCN has with setting a minimum number for reflective accounts is the lack of evidence base underpinning the proposal.

Factors such as the demands of a particular role or area of practice as well as the learning preferences and styles of individuals will play a role in how each registrant will benefit from reflecting on feedback.

The RCN’s international comparative research shows that a large number of Canada’s provincial regulators focus strongly on self-reflection and the use of feedback as a means of identifying areas for professional improvement. This approach enjoys widespread support among nurses, the public and political leaders, but it is notable that none of Canada’s regulators specify a minimum number of reflections. The nature of self-reflection in this context is to entrust each nurse with individual responsibility for self-improvement through reflection.

Given the number of questions yet to be answered about how reflective accounts will work in practice, the RCN does not believe that at this stage we are in a position to specify the number of accounts which nurses should be required to provide. This issue (and others) must be revisited in a further consultation, after the revalidation pilots when the NMC can provide more information about how nurses will be supported to undertake and provide meaningful evidence reflection on feedback.

**F3. As part of the proposed revalidation model, the person who provides confirmation will need to discuss with the nurse or midwife any feedback that the nurse or midwife has received. To what extent do you agree or disagree with this approach?**

This proposal would seem to be common sense, but must be subject to the safeguards referenced above in relation to developing clear guidance about the separation between the revalidation functions and employment functions of appraisal.
should the person providing confirmation be conducting the individual’s appraisal). Even for those circumstances where revalidation is being undertaken outside the appraisal process, it is important for guidance and training to be delivered for third party confirmers. It should be clear that the discussion of the feedback is not about making a judgement on the nurse but discussing the reflective process. Again, guidance will be important here to ensure consistency and fairness in taking this forward.

G. Declaring continuing professional development

G1. In order to revalidate, a nurse or midwife will be required to complete 40 hours of CPD over a three year period. Do you think this requirement for CPD is too many hours, too few hours or about the right number of hours.

The RCN has long argued for CPD to be protected. The RCN believes the introduction of revalidation to be an opportune moment for all stakeholders to work together to agree principles on the importance of CPD for individual nurses’ ongoing fitness to practise and therefore for patient safety overall. This should translate into a commitment from all stakeholders to support nurses’ participation in relevant, timely and high quality CPD.

The RCN’s international research has demonstrated that there is huge scope in terms of the number of hours of CPD undertaken – even within those countries which do not formally mandate that nurses undertake CPD. Portugal is one such example of a voluntary approach where the average number of learning hours is about 105 hours per year (315 every three years)⁴. In Norway and the Netherlands (again where CPD is optional) average hours undertaken are approximately 38 hours per year (114 every three years) and 25 hours per year (75 hours every years) respectively⁵. Additionally, a selection of countries which operate mandatory CPD structures tied into revalidation requirements (similar to the UK) also suggests that the UK 40-hour requirement is comparatively modest. China (the People’s Republic of) requires that nurses undertake over 120 hours per year (over 360 hours every three years)⁶, Malawi approximately 25 hours per year (75 hours every three years)⁷ and Australia requires 20 hours per year (60 hours every three years)⁸.

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⁵ Information of average number of hours of CPD undertaken for the Netherlands and Norway provided by respective national nursing associations
To be clear, the RCN does not advocate or recommend that the 40 hour UK requirement be increased. The RCN does however point out that the variety of learning hour options evidenced above indicates that additional support measures (such as protected time and funding) are needed in order to make CPD effective.

The vast difference in the number of hours different countries set for CPD perhaps demonstrates the lack of evidence as to a minimum suitable number of CPD hours. We are also unclear as to how many CPD hours individual nurses actually undertake, regardless of mandatory or desirable minimums.

Therefore, the conclusions we draw from this are that a fixed number of hours is only part of the equation. While a minimum level may help to demonstrate the importance of CPD, equally as important is that the learning opportunities are fit for purpose, effective, and supported by employers. Again, the RCN emphasises, it is the outcome of the CPD not the process or reaching a target number of hours, that is most important.

Additionally, the RCN is concerned about the unintended consequences of tying revalidation to a minimum number of CPD hours without a clear funding model. We know that access to CPD can be a problem for some nurses, for example in getting funding and time away from work to undertake CPD. It is of extreme importance that the NMC ensures that the healthcare system as a whole is able to support nurses’ CPD requirements. Without these assurances, and if CPD requirements appear too onerous, there is a risk that some registrants will be unable or unwilling to remain on the register. This could have serious implications for the sustainability of the nursing and midwifery workforce.

G2. As part of the proposed revalidation model, at least 20 hours of the required 40 hours of CPD will need to be participatory. This means at least 20 hours must involve interaction with others, for example: being mentored during practice and group training courses. In general, to what extent do you agree or disagree with the inclusion of a participatory element to CPD?

As noted above, the RCN believes there are a number of problems with developing fixed quotas for CPD. However, we do believe that participatory learning and mentoring can be very helpful and desirable forms of ongoing learning and development for nurses.

We note that none of the international case studies we have considered require that a specified percentage of CPD time be allocated to participatory learning activities. A
number of these countries recognise and permit participatory learning activities (usually more affluent countries with better care outcomes – for example, Australia, the Netherlands, Norway and Portugal), whereas others do not (usually less economically developed with lower care outcomes – China, Malawi and South Africa are notable examples). This indicates that participatory learning can help to improve learning quality which, in turn, might translate into improved care outcomes. This is only an observation however as care outcomes are influenced by a very wide variety of variable factors aside from CPD.

However, research from Australia shows that nurse employers, especially in an era of restricted budgets, are increasingly focusing on cheaper CPD options such as e-learning, which tend to be less participatory in nature. There have been calls for greater investment in widening participatory access for those nurses who feel that this format of learning is more effective for them. Consequently, the NMC’s proposal of a mandated participatory learning requirement might help to prevent this problem emerging in the UK, although focus will need to be given towards ensuring that appropriate funding and other support structures by employers are developed to deliver this.

G3. Do you think that the requirement for at least 20 hours of the required 40 hours to be participatory is too many hours, too few hours or about the right number?

We are not clear on the evidence base for 20 hours of participatory learning. As noted above, from the international case studies looked at, participatory CPD activities are not officially required to constitute a set percentage of learning time; so there is no evidence to indicate whether 20 hours participatory learning is either too low or excessive.

We suggest that if the NMC gathers further evidence and evaluation on this during the pilot process, the RCN and other stakeholders may then be better placed to comment on whether 20 hours seems to be appropriate.

G4. The proposed revalidation model requires that all CPD undertaken must be directly linked to the Code and the nurse or midwife’s scope of practice. To what extent do you agree or disagree with this requirement?

Internationally, none of the case studies looked at by the RCN require nurses to revalidate against their professional code. Australia for example does have a professional code but this is entirely removed from the process of revalidation and does not underpin the professional regulatory model. Additionally, several other international examples do not even have uniform professional codes (the Canadian
province of Alberta for example holds different professional codes for Licensed Practical Nurses and Psychiatric Nurses, but none for Registered Nurses). As such, there is no international precedent from which to gauge as to how effective the NMC’s proposed approach might be.

Revalidating to scope of practice is slightly more evidenced, but again not consistently applied. New Zealand for example requires that nurses submit to a competence assessment by one of their peers as part of revalidation and this is directly connected to their scope of practice. By contrast, the Australian revalidation approach is far more generic, requiring that nurses self-declare that their personal details on file are up-to-date and correct, that they have completed the minimum requirement of 20 hours of CPD, that they have no criminal record, that they can speak English to a good level and that they have proper indemnity insurance arrangements in place.\(^9\) Canada’s approach (although this differs between the various provinces) generally falls in the middle of the New Zealand and Australian approaches. A nurse revalidating in Alberta for example is required to seek feedback (not necessarily related to their specific practice) from a colleague (or someone they generally trust) and then informing the regulator how they intend to reflect on this in order to improve their overall performance.\(^10\)

This may support RCN’s suggestion earlier in this response that the NMC restructure the Code into domains, making it easier for nurses to revalidate against the Code in a way that is relevant for them and their practice.

G5. Overall, to what extent do you agree or disagree that the proposed revalidation model will help to ensure CPD undertaken by a nurse or midwife is of the right level of quality to assure their continued fitness to practise?

As noted above, the RCN has long called for greater investment in and support for nurses to undertake CPD, including through protected time and financial support.

We know that not all nurses are currently able to undertake the CPD that they need. We are concerned that a new model of revalidation which requires them to do this without putting the right support in place could be setting nurses up to fail.

There has been a collective failure for years to support nurses in this way. We call on the NMC to provide assurances that all nurses who want to undertake CPD will be


supported to do so, otherwise this may impact on their ability to meet the NMC’s revalidation requirements.

Internationally, there does not appear to be a direct correlation between CPD compliance and the imposition of a mandatory learning requirement. It appears that a voluntary, employer-employee negotiated approach to CPD can be as effective in helping to incentivise learning uptake as a mandatory learning requirement. In Portugal for example, CPD engagement is very high in large part because nursing employers and unions are strongly engaged with tying career progression to CPD learning – negating the need for a mandatory learning requirement.

The evidence collected suggests that effective learning from CPD is enhanced when a variety of different learning vehicles (including online learning modules, mentoring and workshops) are recognised and well-funded. Feedback from Australia and Norway particularly, has highlighted the risk that employers and providers can misuse this breadth of recognition to focus on the cheapest CPD learning options (such as e-learning and internet modules).

A lack of financial and time support from employers for CPD-related learning has been consistently found throughout all of the case studies. Focusing on improving these systems could have a significant impact on compliance with CPD and in improving learning outcomes.

We therefore emphasise again the need for investment and commitment in high quality CPD, alongside the more arbitrary, process based measures such as number of hours and ratios of types of learning; all of which must be underpinned by a clear assessment of likely costs and proposals for a suitable funding model.

H. practice hours

H1. To what extent do you agree or disagree with the proposed model of SCHPN practice hours counting towards those required for revalidation as a nurse or midwife?

The RCN agrees with this proposal.