Introduction

With a membership of 410,000 registered nurses, midwives, health visitors, nursing students, healthcare 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.

We welcome the opportunity to respond to the Law Commission’s “Consultation on the regulation of health and social care professionals”.

This consultation response has been compiled by a small team of staff at the RCN who have engaged with the relevant directorates across the wider organisation and importantly, across our four country perspective. The RCN has a strong presence in England, Wales, Scotland and Northern Ireland. This response therefore reflects the diversity of views of the organisation as far as possible.

The RCN is concerned that the consultation document fails to adequately take into account particular arrangements made for the regulation of midwifery practice.

We reflect the draft response of the NMC, which notes that distinctive regulatory approaches were made for midwifery under the current Nursing and Midwifery Order 2001. These would appear to cease with the introduction of the Law Commission’s proposals to streamline the legislation. In particular, the current statutory approach sets out distinct standards for the exercise of the supervision of midwives – through a number of local supervising authorities. The standard for supervision is set and monitored by the NMC and each LSA provides an annual report to the NMC.
We support the NMC’s view that the current supervisory framework for midwives is underpinned by a strong public protection rationale, and that the current arrangements support the best standard of care for mothers and babies.

The RCN calls for the final proposals by the Law Commission to provide redress for these concerns and ensure a future regulatory framework mandates for the continuation of the current model of supervision for midwives.

Confidentiality

The Royal College of Nursing understands that responses to Law Commission consultations may be made public and is content for this response to be made so available.
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Part 2: The structure of reform and accountability

Provisional Proposal 2-1: All the existing governing legislation should be repealed and a single Act of Parliament introduced which would provide the legal framework for all the professional regulators.

Agreed.

Provisional Proposal 2-2: The new legal framework should impose consistency across the regulators where it is necessary in order to establish the same core functions, guarantee certain minimum procedural requirements and establish certain core requirements in the public interest. But otherwise the regulators should be given greater autonomy in the exercise of their statutory responsibilities and to adopt their own approach to regulation in the light of their circumstances and resources.

The RCN agrees that the need to provide consistency across all healthcare regulators is one of the central pillars of this consultation. The Consultation document itself shows the high degree of diversification between the nine regulators which does lead to inconsistencies across the board which are often difficult for Registrants and members of the public to understand and reconcile. The RCN accepts that each regulator must have a degree of autonomy in order to work effectively however, the government will be required to ensure that greater autonomy does not mean less accountability for the regulators. We have identified a number of policy and procedural safeguards in the response below which we consider make a proportionate balancing between the need to maintain public confidence in the regulators and the interests and rights of Registrants.

Provisional Proposal 2-3: The regulators should be given broad powers to make or amend rules concerning the exercise of their functions and
governance without any direct oversight, including Privy Council approval and Government scrutiny (subject to certain safeguards).

The RCN agrees that regulators should be given broad rule making powers to enable them to develop these reforms and to ensure their procedures and processes are kept up to date. However, we would welcome as an important safeguard, the government retaining a system for overseeing rules proposed by the regulators. We consider that the legal costs (for regulators and those who may challenge errors in newly drafted rules) and administrative costs often wasted by difficulties created by poorly devised or contradictory rule-making are not insignificant. Recent difficulties (highlighted by CHRE) with the Nursing and Midwifery Council have highlighted the reputational damage that a poor performing regulator can have on the public and its Registrants. Although judicial review is available to those seeking to challenge new rules; these proceedings can take many months to resolve and can be costly. Relying on the availability of judicial review via the Courts as a sole counter-balance, in inappropriate in our view. Although regulators would still be required to consult stakeholders on rule changes, we consider that the current system does provide a useful break in the system to allow the Government to test whether the proposals are fully in the public interest and to allow professional and patient groups to make representations. We consider that a form of independent oversight is essential to ultimately save cost and enhance the reputation of the regulators, moving forward. We also consider that this need not be a costly nor time consuming exercise.

Question 2-4: Would the perceived status of legal rules be less clear or certain without Parliamentary approval? Should the CHRE be given an active role in scrutinising new rules, or should a limited number of the rules be subject to Secretary of State approval and contained in a statutory instrument?

See comments in 2-3 above. See also our comments on the role of CHRE in section 10-1 below. We consider that the problems identified by the Commission in paragraph 2-33 (relating to CHRE taking on the role of ‘rule scrutineer’) are
legitimate and that it may simply be more cost effective and sensible to retain a degree of scrutiny by the Secretary of State or Privy Council.

**Provisional Proposal 2-5: The power of the regulators to issue standing orders should be abolished.**

Agreed.

**Provisional Proposal 2-6: The regulators should have the ability to implement their statutory powers by making rules, instead of a mixture of rules and regulations.**

We agree that the statute should provide that all the statutory powers of the regulators can be implemented by rules, instead of by a mixture of rules and regulations.

**Provisional Proposal 2-7: The statute should require the regulators to consult whenever issuing or varying anything which is binding, anything which sets a benchmark or standard, and a competency. The regulators should be required to consult such persons it considers appropriate, including:**

1. members of the public, patients and service users;
2. registrants (including business registrants);
3. employers of registrants;
4. the other health and social care professional regulators, the Council for Healthcare Regulatory Excellence, the health and social care inspectorates, the independent safeguarding authorities and any other regulatory bodies;
5. the Department of Health, Northern Ireland Executive, Scottish Government and Welsh Government;
6. professional bodies that represent registrants;
7. persons or bodies commissioning or funding the services provided by registrants or at a registered premises/business.
Agreed. Although the courts have been willing to find at common law that a failure by a public body to adequately consult its stakeholders can amount to an “abuse of process”, we consider that this duty is so significant that it should be set out in the Statute. The RCN has provided to the Commission independently of this response its experiences with NMC’s proposed changes to its Indicative Sanctions Guidance document. The legal action we were required to take and the delay in introducing up to date guidance for the NMC’s panels that arose, would have been avoided had the Regulator had a statutory duty to consult in the forefront of its mind. As the NMC has sought to respond to CHRE’s Interim and Final Reports, a high number of new procedures and processes have been introduced with a varying degree of consultation by the NMC (for example there was a marked difference in the recent consultation exercise undertaken by the NMC in relation to the introduction of Consensual disposal and the introduction of the Standard Operating Procedure guidance for Panels when making Interim Conditions of Practice or the Indicative Sanctions Guidance). The proposed duty to consult set out above is very clear and has the full force of being a statutory duty.

Provisional Proposal 2-8: The formal role of the Privy Council in relation to health and social care professional regulation should be removed entirely.

Agreed unless the government or the Commission considered that the Privy Council was the appropriate body to provide the scrutiny we identify in 2-3 above.

Provisional Proposal 2-9: The House of Commons Health Committee should consider holding annual accountability hearings with the regulators which should be coordinated with the Council for Healthcare Regulatory Excellence’s performance reviews. The Scottish Parliament, National Assembly for Wales and Northern Ireland Assembly should also consider instituting similar forms of accountability.

Agreed. It has been the experience of the RCN in Scotland that recent discussions on the Welfare Reform Bill in Scotland have started to highlight some of the tensions
about how cross-border issues are dealt with by the different legislative bodies with accountability for different parts of statute. Early discussions on the Scotland Act 2012 suggested a move towards a far more collaborative approach between Westminster and Scottish administrations. The RCN therefore wonders whether this approach could be extended here, so that Scottish/Welsh/Northern Irish Ministers can engage in accountability hearings with Westminster.

Provisional Proposal 2-11: The statute should place a duty on each regulator to provide information to the public and registrants about its work.

Agreed.

Provisional Proposal 2-12: Each regulator and the CHRE should be required to lay copies of their annual reports, statistical reports, strategic plans and accounts before Parliament and also in all cases the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly.

Agreed.

Provisional Proposal 2-13: The statute should not require the regulators to send a copy of their accounts to the Comptroller and Auditor General or to the Auditor General for Scotland.

Agreed.

Provisional Proposal 2-14: The order making power in section 60 of the Health Act 1999 should be repealed and instead the Government should be given Regulation-making powers on certain issues.

Agreed.
Provisional Proposal 2-15: The Government should be given a regulation making power to abolish or merge any existing regulator, or to establish a new regulatory body. This power would also enable the Government to add new professional groups to, or remove professional groups from, statutory regulation.

Agreed.

Question 2-16: Should the CHRE be given a power to recommend a profession for statutory regulation, or the removal of a profession from statutory regulation? If the Government decided not to comply, it would be required to issue a report setting out its reasons.

Agreed.

Provisional Proposal 2-17: The Government should be given powers to issue a direction in circumstances where a regulator has failed to perform any of its functions, and if the regulator fails to comply with the direction, the Government may itself give effect to the direction (see also provisional proposal 13-2).

We agree.

Provisional Proposal 2-18: The Government should be given powers to take over a regulator which is failing to carry out its functions.

Agreed.

Provisional Proposal 2-19: The Government should not have express powers in the statute to initiate a public inquiry. This would continue to be provided for under other existing Government powers.

Agreed.
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Part 3 – Main Duty and General Function of Regulators

Question 3-1: Should the statute specify the paramount duty of the regulators and the Council for Healthcare Regulatory Excellence is to: (1) protect, promote and maintain the health, safety and well-being of the public by ensuring proper standards for safe and effective practice; or (2) protect, promote and maintain the health, safety and well-being of the public and maintain confidence in the profession, by ensuring proper standards for safe and effective practice?

The RCN supports the Commission’s provisional view that a single primary duty for all the regulators should be established to encourage a consistent approach to decision-making, and provide registrants and the public with a clear statement of the purpose of professional regulation. We also agree that the reasoning behind the draft duty set out in the Consultation document is pragmatic and that it will help regulators, registrants and the public to understand regulation in more positive terms as ensuring proper standards of practice and reducing the need to protect the public from professionals whose fitness to practise is impaired. We consider that this amounts to a very sound and sensible principle to underpin these reforms namely, that all the statutory functions of the regulators – registration, setting standards for education, conduct and practice, and taking action where the standards are not met – would flow from this duty.

Regarding the two forms of wording proposed in the Consultation, we do reluctantly consider that the protection of the public and maintenance of confidence in the profession have become interlinked in the minds of the regulators, Courts and the public that it can be very difficult for these concepts to now be looked at entirely separately. We consider therefore that the proposed wording at (2) above should be taken forward in statute. However, we have set out below some concerns and suggested safeguards which we consider would ensure that the second limb of the duty (namely maintaining confidence in the profession) can be interpreted fairly and proportionately. Please see sections 7-1 and 9-17 below.
Part 4: Governance

Question 4-1: should the statute (1) reform the existing structure to encourage councils to become more board-like; and/or (2) reform the existing structure by establishing a statutory executive board consisting of the chief executive and senior directors; and/or (3) establish a unitary board structure which would move away from a two-tier approach based on a council and officials?

The RCN is committed to working alongside the Department of Health and the NMC, to support efforts to ensure the NMC governing council is as effective as possible. However, RCN does not believe that the statute should be prescriptive about which type of council regulators should form and therefore we do not support the use of legislation to support the introduction of a mandatory new form of council for the NMC.

The consultation document references the paper Trust, Assurance and Safety: enhancing confidence in healthcare professional regulators: final report and the recommendations contained in relation to smaller, more board-like councils for professional regulators. This paper recommended the councils be between 9 and 15 members in size. As stated in the consultation document, the recommendations made in Trust, Assurance and Safety were approved by the DH in 2008. The RCN is not convinced that there is any new evidence made available in the 2011 CHRE report, Board size and effectiveness: advice to the department of health regarding professional regulators, which justifies a recommendation that the size of councils should be even lower than was agreed to be the optimum in 2008.

We note that the DH is currently consulting on changing the size of the council and favours the lowest number in the range recommended by the CHRE, which is 8. The NMC is currently in a state of flux as it seeks to implement the results of the CHRE strategic review. The RCN is anxious therefore that now may not be the best time to further re-organise the governing council. We note further that the NMC council is already one of the smaller councils compared to other professional
regulators, having only 14 members of council. This falls within the size recommended in 2008.

The RCN is currently consulting with members and will respond to the DH consultation on the NMC constitution in full. Our initial view however is that we are concerned that an organisation with a remit as broad as the NMC – encompassing the full range of nursing and midwifery practice as well as the four countries of the UK – may not be best served by such a small council as 8 members.

We note that council’s role is to set strategy and exert leadership. But in order to do this, the council must be in a position to have a full, meaningful and informed debate, based on understanding of the health systems across the UK and the full range of nursing and midwifery practice.

Size is not the only important factor in a successful council. Equally as important is ensuring that the right appointments are made, so that council members (and also the executive staff of the regulators) have the right skills, competencies and experience to undertake the role.

We note that there are a number of other principles which are important to maintaining public and professional confidence in the regulator. We agree that public protection is the key duty of the NMC, but believe that in order to maintain public protection it is vital that registrant leadership is maintained within the organisation. We therefore believe it is essential to ensure that registrant members continue to account for half (and no less) of the council – this is a principle which should not be undermined by any new legislation. The RCN also believes that registrants who are suitably qualified and experienced should not be barred from occupying key leadership roles within the regulator, e.g. registrar, chair or council or chief executive.
We also believe there should be parity between the regulators in rules about registrants in leadership roles. For example, the NMC should not be prevented from having suitable registrants in such roles if other regulators are allowed to do so.

Provisional proposal 4-2: the statute should establish each council as a body corporate. The regulators should continue to be able to apply to become registered with the Charity Commission if they wish to do so.

No comment, but this should extend to the Charity Commission for Northern Ireland and Office of the Scottish Charity Regulator if accepted as a proposal.

Provisional proposal 4-3: the statute should require that each council must be constituted by rules issued by the regulators.

No comment.

Provisional proposal 4-4: each regulator should be required to issue rules on the appointment of council members and chairs, terms of office, duration of membership, grounds for disqualification, quorum for meetings, circumstances in which members (including chairs) cease to hold office, are removed or are suspended, education and training of council members, and attendance requirements of council members.

The RCN agrees with this proposal, assuming that regulators will issue such rules based on publicly available and relevant guidance about existing good practice.

Question 4-5: is an additional form of oversight required over the appointment of the general Council members: for example, should the government have powers to remove them in certain circumstances?

No comment.
Question 4-6: should (1) the statute specify a ceiling for the size of the
councils and the proportion of lay/registrant members; or (2) the government
be required to specify in regulations the size of councils and the proportion of
lay/registrant members; or (3) the regulators be given general powers to set
the size and composition of their councils and the government be given
default powers to intervene if this is necessary in the public interest?

As noted above, the RCN is committed to a number of high level principles
determining the role of registrants in the NMC. We believe that public protection will
be best served by ensuring that registrants continue to play a role in setting the
future strategy of the organisation and holding to account executive staff members.
We believe it is essential to ensure that registrant members continue to account for
half (and no less) of the council. We would strongly resist this principle being
undermined in new legislation.

As also noted above, the RCN is currently carrying out a consultation exercise with
our members to inform our thinking on the appropriate size of councils. We will
respond in full to the DH consultation.

Provisional proposal 4-7: the statute should define a lay member of the council
as any person who is not and has not been entered in the register of that
particular regulatory body, and a registrant member as any person who is
entered in the register of that particular regulatory body.

We agree.

Question 4-8: should council members be prohibited from concurrent
membership of another council?

No comment.
Provisional proposal 4-9: the regulators should be given broad rule-making powers to determine their own governance arrangements, including the ability to establish committees if they wish to do so.

Yes, we agree.

Provisional proposal 4-10: the regulators should be able to make rules for committees or any other internal groups it establishes, including their size and membership.

No comment.

Provisional proposal 4-11: each council should be given powers to delegate any of its functions to any council member, office or internal body. Any delegations must be recorded in publicly available scheme of delegation. There should continue to be a prohibition on delegating any power to make rules.

No comment.
Part 5: Registers

Provision proposal 5-2: the regulators should have the ability but not a duty to appoint a Registrar.

The RCN believes that there should continue to be a Registrar role within the NMC. We believe it is appropriate for this role to be carried out by a registrant, in order to maintain public and professional confidence in the NMC and its functions.

Provisional proposal 5-3: the statute should specify which registers must be established by the regulators, including any different parts and specialist lists. The government would be given a regulation-making power to add, remove or alter parts of the register and specialist lists.

The RCN believes that it is desirable in the future for the NMC to have the capacity to hold a specialist list of advanced practitioners/nurses working to advanced practice. Nurses are increasingly extending their scope of practice beyond initial registration across healthcare settings, and it is important that patients are able to understand and verify that the nurse caring for them is competent to practise at an advanced level. The RCN believes it is an issue of public safety and protection that advanced practice is standardised by regulation, with set standards for proficiency. We believe advanced nursing practice is a level of practice rather than a role or a job title, and that it should be subject to revalidation by the NMC.

We accept that under the proposals in the consultation document there would be a route in which to achieve this, should the Government decide to implement specialist lists for nursing advanced practice.

Provisional proposal 5-4: the government should be given a regulation-making power to introduce compulsory student registration in relation to any of the regulated professions.
No comment

**Question 5-5:** should student registration be retained in the new legal framework, and/or how can the legal framework help to ensure that the principles and practices of professionalism are embedded in pre-registration training?

The RCN supports the retention of student registration in the new legal framework and strongly supports student indexing for nursing students. We believe student registration is an important public protection function, in that it will help education providers to ensure that they do not enrol students who have been removed from other courses due to concerns about their conduct. We were disappointed when the NMC halted its project to implement an index of nursing students earlier this year.

**Question 5-6:** should the regulators be given powers to introduce voluntary registers?

We agree.

**Protected titles and functions**

**Provisional proposal 5-31:** all the existing protected titles and functions that are contained currently in the governing legislation should be specified in the new statute.

The RCN notes that Appendix D does not contain Specialist Community Public Health Nurse in the list of protected titles. We assume this is an error within the consultation document and that this will be rectified in the final proposals.
Part 6: Education, Conduct and Practice

Provisional proposal 6-2: the statute should require the regulators to make rules on:

(1) Which qualifications are approved qualifications for the purposes of pre-registration and post-registration qualifications?

(2) The approval of education institutions, course, programmes and/or environments leading to an award of approved qualifications and the withdrawal of approval;

(3) Rights of appeals to an individual or a panel against the decision of the regulator to refuse or withdraw approval from an institutions, course or programme;

(4) The quality assurance, monitoring and review of institutions, courses, programmes and/or environments;

(5) The appointment of visitors and establishment of a system of inspection of all relevant education institutions

The RCN agrees with these proposals.

Provisional proposal 6-3: the statute should require the regulators to establish and maintain a published list of approved institutions and/or courses and programmes, and public information on any decisions regarding approvals.

The RCN agrees with these proposals.

Provisional proposal 6-4: the statute should require education institutions to pass on to the regulator in question information about student fitness to practise sanctions.

As noted above, the RCN supports the principle of student indexing, which we believe will contribute to public protection. We support the principle that students who have been subject to serious sanctions which put the public at risk should be
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prevented from joining new programmes or courses. We therefore cautiously welcome this proposal but note that we have some concerns about how it will work in practice.

Firstly, the proposal appears to place the onus for action on the education institution without providing clarity as to what the regulator should do with this information. For example – is the regulator expected to create what amounts to a ‘blacklist’?

We also note that the sanctions included in these proposals cover a wide spectrum – including students subject to warnings – and the RCN is concerned that this is too stringent.

Question 6-5: should the powers of the regulators extend to matters such as national assessment of students?

The RCN would not support this. We believe that this is within the remit of higher education institutions and organisations which provide assessment of students. It is the role of these organisations to ensure that students meet the standards of competency required by the professional regulator.

Question 6-6: should the regulators be given powers over the selection of those entering education?

The RCN would not support this. As above, we believe this is a role for the education institutions (using the core standards set by the professional regulator) and beyond the direct remit of the regulator itself.

Question 6-8: is too much guidance being issued by the regulators and how useful is the guidance in practice?

The RCN believes that there are certain topics on which the NMC issues guidance – for example vulnerable adults, medicines management, accountability – which are very important and helpful to practicing nurses.

We do note however that it is difficult to know how consistently such guidance is implemented and therefore what impact it has.
Provisional proposal 6-9: the statute should require the regulators to issue guidance for professional conduct and practice.

The RCN supports this proposal, which is in line with current practice and core duties of the NMC.

Provisional proposal 6-10: the statute should provide for two separate types of guidance: tier one guidance which must be complied with unless there are good reasons for not doing so, and tier two guidance which must be taken into account and given due weight. The regulators would be required to state in the document whether it is tier one guidance or tier two guidance.

The RCN agrees that there can be confusion between various types of guidance and standards. Regulators should be clear about the purpose and ‘weight’ of communications which they issue, for example being clear about how they expect registrants to use them.

The RCN therefore supports greater clarity in relation to types of guidance and what regard registrants must take of guidance.

Provisional proposal 6-12: the statute will require the regulators to ensure ongoing standards of conduct and practice through continuing professional development (including the ability to make rules on revalidation).

The RCN agrees with this proposal. An effective revalidation system must ensure that registrants continue to meet core standards of conduct and practice through continuing professional development (CPD). This will ensure that registrants remain fit to practice and therefore this is essential to public protection. The RCN believes therefore that revalidation must be considered a core function of the professional regulator.

The RCN is aware that nurses do not always receive CPD and we work hard to encourage employing organisations to protect the time and resources necessary for nurses to undertake CPD. We are particularly concerned that in the current difficult economic climate, there is an increased risk that a greater number of nurses will not
be able to access CPD. This represents a real risk to public protection. We believe that ensuring nurses receive CPD will help to limit future fitness to practice cases.

We note therefore that any system of revalidation will also be dependent on employers investing in proper processes of clinical supervision and appraisal.

It is also concerning that the NMC is currently not able to effectively monitor registrants’ completion of CPD required for re-registration. As stated in the consultation document, the RCN is aware that currently the NMC does not routinely check individual nurses’ PREP portfolios. We note that at its annual accountability hearing with the Health Select Committee, the NMC reported that they have looked in more detail at the registration renewal evidence of around 115,000 nurses and midwives over the last five years, which equates to an average of 23,000 per year or less than 4% of all registrants annually (Annual accountability hearing with the Nursing and Midwifery Council - Health Committee 2012).

It is essential that the revalidation system developed by the NMC is proportionate. The RCN looks forward to working with the NMC in the future to develop an appropriate, proportionate and fit for purpose system for revalidation.
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Fitness to Practise – Impairment

Question 7-1: Should the statute: (1) retain the existing two-stage approach for determining impaired fitness to practise; or (2) implement the recommendations of the Shipman report; or (3) remove the current statutory grounds which form the basis of impairment and introduce a new test of impaired fitness to practise based on whether the registrant poses a risk to the public (and that confidence in the profession has been or will be undermined)?

Question 7-2: If a list of statutory grounds of impaired fitness to practise is retained, should it refer to a broader range of non-conviction disposals?

Question 7-3: How adequate are the powers of the regulators to require disclosures from the Independent Safeguarding Authority and Disclosure Scotland? What practical difficulties, if any, arise as a result of differences between the protection of vulnerable groups schemes in England, Wales, Northern Ireland and Scotland?

The RCN agrees with the broad proposition that the current system of statutory grounds is not really satisfactory. In our view, the difficulties identified by the Commission in paragraph 7.45 cause problems for members of the public and registrants alike. In our opinion, the definition of misconduct is now so wide and diluted that a large category of activity is caught by it. It also does not help in the strict legal analysis of cases either.

The RCN has considered the three options outlined by the Commission for consideration at this Consultation. The RCN would support the removal of the statutory grounds for impairment altogether and the introduction of a simplified test of impaired fitness to practise based on whether the registrant poses a risk to the health, safety or well-being of the public (and whether confidence in the profession has been or will be undermined). The RCN has highlighted in part 3 of this
Consultation response that it supports a main duty of the regulators and so it is sensible that a test for “impairment” is linked to that duty.

The RCN considers that the approach advocated by the Commission in paragraph 7.49 is a good starting point. The test is set out as:

“(1) the regulator would need to consider whether the facts alleged are proved and if so, whether they indicate that the Registrant is a risk to the health, safety or well-being of the public (and whether confidence in the profession has been or will be undermined). A wide range of evidence could be gathered as evidence and would not be restricted to any predetermined categories; and 
(2) the regulator would need to consider on the basis of those facts, whether the registrant’s fitness to practise is impaired.”

It is described as a “two-stage” test, but it is really a 3 stage one namely a test addressing the facts, risk to the public/reputation of the profession and finally addressing the Fitness to Practise of the Registrant

Dealing with the risk ground in paragraph 1, the RCN would support this approach provided that the ground is worded in the present tense (“is a risk….”) and the concept of making a judgment at the date of hearing (and thus talking into account remedial steps, remorse, reflection, etc.) is maintained.

The RCN would suggest an alternative approach of “whether by reason of the facts proved or admitted the registrant poses a significant risk to the health safety or well-being of the public in the course of their professional activities as a healthcare professional…”

The advantages of this approach are that this limits sanctions to being imposed to current significant risks arising solely out of professional activities, which in our view encapsulates the role of the regulator in FtP proceedings.
On this basis, the additional threshold of impaired Fitness to Practise would seem quite unnecessary and therefore the RCN is unsure whether there is merit in maintaining the concept of fitness to practise at all in this scheme.

In relation to the reputation ground the RCN is concerned by recent outcomes in NMC hearings where panellists have effectively sought to end the nursing careers of registrants that they simply disapprove of, where that nurse poses no real threat to patients or the public. In these cases, Panels are able to use “the reputation of the profession” limb and the general view that “conduct of a morally culpable or otherwise disgraceful kind which may or may not be related to the exercise of professional skills, but which brings disgrace upon the practitioner and thereby prejudices the reputation of the profession” amounts to misconduct [R (Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin), [2010] Med LR 330 at [37].]

Recent examples of this approach by Panels include the striking off of a Registrant with an impeccable background as a nurse, who has inadvertently allowed video footage of herself having sexual relations at a party to appear on the internet, or a Registrant who admitted engaging in her own time in prostitution removed from the register. We are currently defending a case for a nurse who had formerly treated a family, who then many years later strikes up a friendship with family members outside a school gate (where both parties’ children attend). She now faces charges of forming an inappropriate friendship even though there is no sexual element to it. In the absence of any NMC guidance for nurses in this situation, the nurse runs the risk of being found guilty of damaging the reputation of the profession and receiving a sanction in light of the above test.

The RCN would therefore suggest a possible alternative approach which it believes strikes the right balance, namely:

“Whether by reason of the facts proved or admitted confidence in the profession has been, or will be, significantly undermined.”
Furthermore the RCN can see no reason to import a Fitness to Practise concept in here and it is particularly inapt to cover this sort of allegation. If significant undermining of the profession has occurred/will occur, then it’s pretty obvious in our view that “Fitness to practise” is or will be “impaired” in the sense that “something must be done”, which is really how the inappropriate concept of impaired FTP is now interpreted. On this basis, if the Option 4 approach is adopted, the RCN considers that the traditional concept of “Fitness to Practise” is arguably rendered redundant.

In relation to cases where allegations touch and concern “reputational damage” to the profession (as outlined above), the RCN invites the Commission to consider making reference in its final report to the sanctions for “reputational damage” alone not being used overzealously by Regulators.
Part 8 Fitness to Practise – Investigation

Question 8-1: Should the new legal framework remove the concept of an allegation entirely and instead give the regulators broad powers to deal with all information and complaints in such manner as they consider just (subject to a requirement that cases where there are reasonable prospects of proving impairment must be referred for fitness to practise proceedings)?

We agree with removal of the requirement for a formal allegation as a cumbersome inflexible way of commencing the process. We agree with the view that formal proceedings are not always necessary and the traditional concept of the allegation being a “gateway to the fitness to practise process” fails to recognise the need to adopt a proportionate approach to managing risk or regulator's caseloads. The RCN considers that by granting broad powers to Regulators as envisaged would allow them to deal with minor or trivial issues (being cases where the impairment test is not met) without the cost (both financial and human) of instigating the fitness to practise process. We welcome the flexibility and discretion this approach would create but this approach does emphasise the need for there to be a robust test for impairment. Without such a test, the threshold would be set very low and the advantages anticipated above would be lost (see the RCN’s comments on the wording of the impairment test under heading Para 7.1-7.3 above).

Question 8-2: The statute should provide that all the regulators will be able to consider any information which comes to their attention as an allegation and not just formal complaints.

We agree that the statute should enable all the regulators to allow information which comes to their attention to be treated potentially as an allegation. This could be a useful and often important provision allowing all regulators to adopt a proactive role towards allegations. However, we recognise that this blanket approach could throw up some difficulties for regulators. Defining where a regulators duty ends and ensuring consistency between regulators would be needed so that the Public
confidence is retained. For example, we are aware that senior nurses and other staff have been requested by the NMC to examine at length past complaints and patients records in healthcare settings where there some issues have been identified. This fishing exercise can be an onerous and costly one for employers and can lead to unmeritorious complaints being advanced in the name of public protection. In further examples in a South West and South Wales Police investigations involving the allegation of neglect in relation to a patient in a Nursing home, the NMC required the referral of all nurses who had been working on the day and night shifts either side of the incident to be referred to the FtP process. Many of the nurses had no contact with the particular patient and their cases were later dropped, but only after considerable anguish and cost had been expended.

It would be helpful if the statute or a form of statutory guidance could define the principles of responsible investigation versus fishing exercises to prevent the overzealous and disproportionate “digging” and the shifting the burden to the registrants and their advisers to fact find and make sense of the broad brushed allegations.

**Question 8:3: The statute should contain a clear statement that there is no set format for allegations**

We agree that any statute should not create a set format for allegations or be prescriptive as to how allegations should be made. We consider that it is important that the legal framework does not adopt a restrictive approach to the making of allegations and instead ensures that a wide range of information can be considered by the regulators. This sits well with the proposed wider powers for regulators to consider alternative sanctions; for example warnings, undertakings or an advisory role. However, we are clear that the counter balance for this will be that the statute will require the regulators to set up comprehensive systems that allow for cases to be screened robustly.
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Question 8-5: Should the statute prohibit the regulators from setting a time limit for bringing an allegation against a registrant or should there be a consistent time limit for allegations across the regulators (and if so, what should it be)?

We consider that the approach adopted by the General Medical Council is the best approach, namely that an allegation cannot proceed if more than five years have elapsed since the most recent events giving rise to the allegation with the exception that “it is in the public interest, in the exceptional circumstances of the case, for it to proceed”. The RCN has had little success in challenging in High Court as abuses of process the very stale cases (which also involve long delays to advance them due to the availability of witnesses or poor recollection of events after such a time). Similarly we acknowledge the difficulties placed on regulators in advancing stale cases as above. It is also anachronistic to run such stale cases when the adjudicating Panel is required to judge the registrants current impairment and not focus on the level of that person fitness to practice up to a decade ago.

For these reasons we are clear that it is not proportionate to deal with stale cases where facts giving rise to the allegations are older than 5 years.

Question 8-5: All the regulators should have the power to establish a formal process for the initial consideration of allegations (such as screeners).

We agree with the general proposition that regulators should have power to establish a screening process but disagree with the Commission’s provisional view that consistency between the regulators is less important on this issue than giving each regulator sufficient flexibility to decide how to manage allegations in the light of their individual circumstances.

We have seen cases arising from the same incident in a workplace, where the GMC has decided that no action is needed against a doctor at the screening stage where the doctor faces similar charges to a nurse, whose case is referred on to an NMC
Investigating Committee. The Doctor is spared the anxiety and cost of defending himself at this early stage by a screening process which examines the early evidence. The Nurse or her representatives are obliged to fully investigate and respond to the early allegation (which will inevitably include collecting statements and testimonials) and will have had to suffer the impact of reporting the referral to her employers (with the associated stigma). In the end, generally, no case will be found against the Nurse and so both professionals arrive at the same outcome, but the differing screening process of their respective regulators will result in a far more detrimental experience for the Nurse.

This inconsistency causes issues between the health professions but must also appear inexplicable for members of the public who have an interest in the referral.

As a membership organisation, mindful of spending its member’s money, we would welcome the requirement of a robust screening process for Nurses. In the past, it has been the case that the RCN has had to go to considerable expense to carry out a function which properly belonged to the NMC (although the NMC has had the power to develop its screening function and yet has chosen not to). As a result the NMC has seen approximately 50% of its cases result in a no case to answer finding at Investigating Committee stage and considerable investment had been made by the RCN in the majority of those cases.

**Question 8-6: The regulators should have the power to prohibit certain people from undertaking the initial consideration of allegations and specify that only certain people can undertake this task.**

The RCN has a neutral view on this issue but we can see the advantage in prohibiting certain individuals from the initial consideration of cases such as fitness to practise committee members, Council members and members of the regulators legal team. This would give the public and registrants the appearance of independence at that early stage where a considerable level of judgment may be exercised.
Question 8-7: The regulators should have powers to establish referral criteria for an investigation and specify cases which must be referred directly to Fitness to Practise Panel.

We agree that it is proportionate for screeners and other decision makers to have greater flexibility to decide not to refer some allegations, to prioritise serious cases or to refer cases to another organisation, to sift out vexatious allegations and refer certain allegations e.g. arising from a criminal conviction, resulting in a custodial sentence, directly to a Fitness to Practise Panel.

Question 8-8: Should the statute impose more consistency in relation to the criteria used by regulators to refer cases for an investigation or the cases that must be referred directly to a Fitness to Practise Panel?

The RCN would prefer the statute to impose more consistency on the regulators for the reasons set out in paragraph 8-5 above.

Provisional Proposal 8-9: The statute should enable but not require the regulators to establish an Investigation Committee.

The RCN disagrees with the proposition and consider that the role of the investigation committee is a central role in a fair and independent FtP process. We can see a role for a robust investigation overseen by suitably qualified/trained case examiners who have the confidence to screen out cases that do not meet the real prospect test and empowered to do so by the statute or the regulators rules. Our experience with teh NMC is that although the regulator has had powers since 2001 within its rules to operate a screening system, it was slow to introduce a system and even now, appears reluctant to screen out unmeritorious cases with the result that approximately 50% of cases that proceed to an Investigating Committee are dismissed at this stage.
Our view is that there is considerable benefit to all parties in the process (registrant, regulator, investigating agents, witnesses) in having a “fresh pair of eyes” conducting a balancing or restraining exercise at the front end of the investigation.

Our concern is that if there is no independent Investigating Committee intervening, a significant number of the cases which are considered and dismissed by the Committee currently will be escalated to a Panel and final hearing. We have noted the General Dental Councils estimated costs of £1,500 for preparing a case for an Investigating Committee; we are surprised at the extent of the estimate but in any event, we consider that the potential costs saving could be swamped by the additional costs of having to process and hear unmeritorious cases.

We are very conscious from our Registrant facing role, of the stress that a referral to regulator can pose for registrants. Those anxieties can be escalated if the process of investigation feels like a “foregone conclusion”, especially as the same regulator investigating a case, will often arrange to hear it. Anything which can be done at an early stage to reassure registrants that the process is as fair as possible would be valuable. It is important that the investigation and “creation” of a case against a registrant is kept separate from the adjudication of the decision to escalate the case to the next stage in the process.

**Provisional Proposal 8-10: The regulators should be given broad rule making powers concerning how and by whom an investigation is carried out.**

We would have no issue with regulators being given broad rule making powers concerning how and by whom an investigation is carried out provided the regulators are required to establish a consistent system (and as above, that should still include an investigating committee). Consistency is key. We are aware from cases involving registered nurses and other clinicians, that the GMC appears to adopt a far more thorough screening process leading to cases against doctors being closed at an early stage whereas the linked case against a nurse involved in the same set of facts
will often proceed to a lengthy and costly investigation before being considered months later by the Investigating Committee.

The statute should also set out the test which needs to be applied during the investigation for escalating any case to a panel for a hearing. As we set out in our response to question 7-1, we have suggested that the bar to a finding of impairment should be set suitably high. Currently at the NMC, we have seen examples where overzealous in-house investigators are using wider powers of investigation to “fish” for wider and often trivial allegations than were set out in the initial complaint/referral. The suitably high bar would hopefully discourage this and set clear boundaries for investigators across the healthcare regulators.

**Provisional Proposal 8-11:** The statute should give all the regulators a general power to require the disclosure of information where the fitness to practise of a registrant is in question.

We accept that the statute should give all the regulators a general power to require the disclosure of information where the fitness to practise of a registrant is in question as this is the only way in which an expeditious and appropriate investigation can be conducted. We note particularly the comments of the Administrative Court in GDC v Savery [2011], namely that the public interest in the regulator being permitted to undertake an investigation overrides the private interests of preserving confidentiality.

**Question 8-12:** Are the existing formulations of the power to require disclosure of information useful and clear in practice?

The current principles would appear to be as follows:

a) a person authorised by the Council may require information relevant to its fitness to practise function from any other person (other than the registrant from whom the information is sought); the RCN accepts that this power is
necessary to enable a fair and thorough investigation but that such a power must be exercised proportionately (especially when it involves the handling of sensitive patient’s records or information).

b) as soon as reasonably practical after the matter has been referred to a fitness to practise committee, the Council can require from the registrant the details of their employer or any other person with whom they have an arrangement to provide services; this is accepted by the RCN.

c) nothing in this power requires any disclosure of information which is prohibited by any enactment, but where the prohibition relates to information which allows for the identification of an individual, the information can be put in an anonymised form; this is accepted by the RCN as a proportionate step balancing the anonymity of patients with the public interest in regulation.

d) nothing in this provision permits the supplying of information which a person could not be compelled to produce in civil appeals against fitness to practise decisions; this provision sets a sensible and workable boundary for the regulators. The RCN considers that the procedure protection afforded by the comprehensive civil law precedents is clear and useful.

The RCN notes that the requirements to disclose information often are not backed by explicit sanctions (for example seeking a court order for disclosure). The NMC has a power set out in Article 25(1) of the Nursing and Midwifery Order 2001 which does not specify any method of enforcement for non-compliance. The NMC has often not enforced requests made. The RCN would welcome this as an opportunity to provide clarity for the regulators that the usual course for disclosure would be to seek to enforce any request in the civil courts for the reasons set out in (4) above.

The same provisions should be equally applicable to registrants to ensure “equality of arms”. For example in relation to (1) above the NMC can compel any
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witness who is also a registrant to provide a statement or evidence in relation to
an investigation as nurses have a duty under their code. Requests similarly made
by registrants or their representatives’ carry far less weight.

The RCN considers that it would be helpful for the powers to contain a statement
that the disclosure of personal data is required for the purposes of section 31(1) of
the Data Protection Act 1995, which sets out the disclosures required by law
made in connection with legal proceedings.

Provisional Proposal 8-13: The power to require information should be
extended to include the registrant in question.

The RCN would be content for the rules to permit a regulator to ask a registrant for
disclosure with the request expressly stating that the failure to assist may result in a
number of outcomes. Firstly, the case may take longer to be resolved while the
reason for the request is investigated. Secondly, that the failure to assist may be
brought to any panels’ attention if the case continues to a hearing and the registrant
may face certain consequences from having refused a reasonable request to do so.
However, the registrant should not be compelled to make disclosure.

Once again this limits the overzealous regulator tempted to conduct a fishing
exercise, but allows regulators to make reasonable and proportionate requests
where the case clearly necessitates it. The obvious battleground here would be in
relation to obtaining disclosure of registrant’s medical records.

Question 8-14: Should any enforcement powers be attached to the power to
require information?

Please see our response under 8-12 above regarding requests made to third parties.

If as a result of this consultation exercise it is decided that the power to require
information or disclosure should be extended to registrants, we are concerned that

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some regulators favour powers granting them the ability to make interim suspension orders or pleading new charges of failure to co-operate with a regulators investigation. While many regulators continue to be investigators and adjudicators, we would be very concerned if such wide powers were freely handed to regulators as that would produce an abuse of their role by virtue of being able to effectively obtain any documents/disclosure by compulsion. Once again, our main concern revolves around the regulators potential access to a registrant’s medical history via their medical notes.

**Question 8-15: The statute should provide that the test for all referrals to a Fitness to Practise Panel across the regulators is the real prospect test.**

The RCN agrees that the statute should state clearly that the test for referrals to all Fitness to Practise Panels is whether there is a real prospect that the registrant’s fitness to practise will be found to be impaired. We agree that it is entirely sensible that this test will be consistent across the regulators. However, we reiterate the views we expressed in relation to question 7-1; this view is predicated on the basis that the bar for the new impairment test is set at a suitably high level to prevent cases continuing in the FtP process which are trivial or would be capable of being disposed of at an earlier stage if the real prospect test is not met. The RCN’s comments on the role of CHRE in scrutinising this process are set out under section 10 (below).

**Question 8.16 - The regulators should have powers to issue or agree the following at the investigation stage: (1) warnings; (2) undertakings; (3) voluntary erasure; and (4) advice to any person with an interest in the case.**

We agree that all the regulators should have access to the same range of powers at the investigation stage to dispose of cases. This would provide consistency, certainty and can still ensure that the public can be protected.

We agree that the regulators should have statutory powers to issue or agree the following at the investigation stage:
As an organisation that represents Registrants, we anticipate that the availability of these new sanctions at an early stage would encourage Registrants and their representatives to engage in the FtP process earlier. There are cases that we see at the current time, where the lack of lesser sanctions available to the NMC at this stage, mean that it would not be in the registrants best interests to make admissions and share information. This means that these less serious cases therefore proceed on into the FtP process incurring time and costs of investigation. All parties would therefore be encouraged to explore a more practical outcome in these less serious cases.

It may act as a further incentive to registrants if an assurance was built into this process that admissions made in the consideration of an early consensual disposal of a case, could not be revealed at the final FtP hearing; i.e. admissions or information would be provided by the Registrants effectively “without prejudice”. This would also work in favour of the Regulator in that a Registrant would not be able to bring to a panels attention the fact that the regulator had considered consensual disposal at an earlier stage in the case, but decided against it.

**Question 8-17:** Should the statute require that any decision to use any power listed in provisional proposal 8-16 at the investigation stage must be made or approved by a formal committee or Fitness to Practise Panel? Alternatively, should the powers of the CHRE to refer decisions of Fitness to Practise Panels to the High Court be extended to cover consensual disposals?

The RCN favours a system where a matter can be concluded consensually at the case examiner stage without the need for an investigating committee stage or a
Fitness to Practise Panel to approve the issue of the lesser sanction. This would save time and costs and public protection could be afforded by the issuing of suitable indicative sanctions guidance for case examiners. We accept that some oversight of the system would be necessary to reassure the public and ensure consistency/transparency. We agree that CHRE could be an appropriate body to perform this role. We note that it is suggested that the alternative would be for an independent body to conduct a form or audit trail. We question (in terms of costs and duplication) the need for this further layer of scrutiny and believe that CHRE’s role would provide sufficient confidence for the public.

**Question 8-18: The Government should be given a regulation making power to add new powers to those listed in provisional proposal 8-16, and to remove any powers.**

We agree that in order to future proof the new legal framework, there should be a mechanism to allow new powers to be added and for powers to be removed. We agree that the Government should be given a regulation making power to add new powers to the above list, or remove any powers. Furthermore, since any such regulations must take the form of a statutory instrument, it is sensible Parliament would have oversight over such matters.

**Paragraph 8-19: Does the language used in the proposed list of powers contained in provisional proposal 8-16 convey accurately their purpose?**

We have no objection to the terminology proposed for the consensual disposal sanctions. In terms of the terms “caution” or “warning”, the NMC currently uses “cautions” but we see no difficulty using either term as long as the definitions are clear. We do agree that the term “voluntary erasure” has a semi-critical tone and is old fashioned. We would suggest that “removal by consent” or some other such modern, neutral term is used.
Paragraph 8-20: Is the use of mediation appropriate in the context of fitness to practise procedures?

Mediation will only be appropriate for use in a limited number of fitness to practise cases. The NMC has powers allowing it to explore the use of mediation in a referral but we are not aware of any occasion when it has been used. The NMC has sought to justify their stance by saying that it is not considered their role to assuage complaints by the public; and yet we see many such complaints simply being elevated to FtP cases especially where they lack merit but where the complainant is persistent.

We agree that mediation can be a useful option in certain cases, and so it is our view that all regulators should be given rule-making powers to introduce a system of mediation if they wish to do so, should be encouraged to use it where it is appropriate and no adverse inference should be drawn by any party agreeing (or not) to take part in the mediation process. In our experience certain complainants can conduct a personal campaign against a registrant where the registrant may be entirely justified in not attending a face to face meeting with the complainant. We would not want adverse inferences drawn in cases where a registrant has reasonably refused a request for mediation.

The contents of any mediation should remain confidential, should the case still proceed to a further stage in the FtP process.

Paragraph 8-21: All regulators should be given rule and regulation making powers to introduce a system of mediation if they wish to do so.

See comments in paragraph 8-20 above.

Paragraph 8-22: The statute should provide for a right to initiate a review of an investigation decision in relation to decisions: (1) not to refer a case for an investigation following initial consideration; (2) not to refer the case to a
Fitness to Practise Panel; (3) to issue a warning; or (4) to cease consideration of a case where undertakings are agreed.

The RCN supports the position that Regulators should have the ability to initiate a review when a decision is made following an investigation:

a) not to refer a case for an investigation following initial consideration;
b) not to refer the case to a Fitness to Practise Panel;
c) to issue a warning; or
d) to cease consideration of a case where undertakings have been agreed.

Paragraph 8-23: Anyone who has an interest in the decision should be able to initiate a review of an investigation decision, including but not limited to the Registrar, registrant, complainant and CHRE.

The RCN considers it important to protect the registrant from vexatious review requests, the ability to initiate a review would not be of right but would require an application to the a senior member of the regulator who has had no day to day involvement in the decision making process under review, (perhaps the Registrar) who would consider the merits of the request and provide written reasons for a decision either way, as a safeguard.

Paragraph 8-24: The grounds for a review of an investigation decision should be that new evidence has come to light which makes review necessary for the protection of the public or the regulator has erred in its administrative handling of the case and a review is necessary in the public interest.

We agree that the grounds for review should be exercised narrowly as some complainants often seek to re-open past referrals which have been closed, by submitting slightly modified versions of the initial evidence and claiming that this represents new evidence. We suggest that the test be:
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Part 9 Fitness to Practise - Adjudication

Paragraph 9-1: Should the statute require the regulators to ensure that they establish a structure which is compliant with Article 6 of the European Convention on Human Rights without taking into account the role of the higher courts?

It is essential that the fitness to practise process secure the requirements of procedural fairness guaranteed by Article 6. The RCN supports the view that it is best for the statute to ensure that all structures within the FtP proceedings are Article 6 compliant without taking into account the right to appeal to a court of full jurisdiction.

The RCN has challenged in recent years the article 6 compliance of the POVA/POCA provisional listing scheme and the Independent Safeguarding Authority’s auto-barring scheme. Both challenges have been successful and radical changes made to both regimes. Both schemes arose from statute where this basic Art 6 requirement was not made explicit. Had a similar requirement existed in the Safeguarding Vulnerable Groups Act 2006 for example, following criticism of the analogous provisional listing scheme in the House of Lords judgment in Wright, this would have avoided the significant detriment to healthcare professionals caused by the auto-barring scheme, the time and cost of challenging the scheme not to mention the governmental time taken to remedy the defect in the Protection of Freedoms Act.

Paragraph 9-2: Should the new legal framework ensure the separation of investigation and adjudication, and if so how?

The RCN is concerned by the following themes which have arisen in the current handling of FtP adjudication/case management at the NMC:

- Many of the RCN’s members and members of the public do not see the “judge, jury and sanctioning” roles adopted by the NMC (or other regulators)
delivering independent or fair investigation and decision making in fitness cases. The Registrants view the decisions as being made by panellists, retained and paid by the regulating organisation, which is the same organisation that drafted the very charges they are facing. Although some work has been undertaken by the regulators to improve the situation, registrants continue to query the independence of the current process. In contrast, members of the public, dissatisfied with an outcome in a particular case, can often be overheard saying that the result was inevitable when “the profession judges its own”. An independent panel comprising panel members from the nursing community with up to date experience and practice (akin to the Medical Practitioners Tribunal Service at the GMC), would eliminate these perceptions.

- The RCN is concerned about the inconsistency of procedure and decision making. The RCN has been concerned over a number of years by the inconsistent approach to cases by the various panels of the NMC. For example, we have struggled to understand the apparent inconsistency around the seeking of interim measures by the NMC and also in the management of cases where there may be an issue regarding the health of the registrant – in this respect, there is not always consistency in assigning which cases are dealt with by Health Committees and which cases can be referred to Conduct Panels for disposal. The importance for a registrant in being heard by the appropriate panel cannot be overstated.

- The RCN is also anxious to avoid the inconsistency in the legal advice given to the panels by the Legal assessors. A move to create independent adjudicators (with a Legal Chair), with a uniform set of rules, indicative sanctions and legal advice (across all regulators) would prevent this inconsistency.

- There is a common perception by registrants and members of the public that different regulators deliver differing levels of justice or fairness to those
appearing before their fitness to practise panels. The Shipman Inquiry highlighted the commonly held belief that the GMC was more concerned with fairer treatment of its registrants than protection of patients. The converse is the view of registrant nurses appearing before the NMC. Such inconsistency in public perception does not allow “justice to be seen to be done”.

**Question 9-3: Should the statute allow for the option of the regulators’ adjudication systems joining the Unified Tribunals Service?**

The RCN considers that the statute should allow for such an option to be made available to regulators but in practical terms, the number of Fitness to Practise cases referred to the larger regulators, requiring hearings, may make this step impractical.

**Provisional Proposal 9-4: The statute should give all the regulators a broad power to establish rules for case management.**

Another of the concerns of the RCN (echoed by CHRE in its Annual reports of the NMC) is the length of time it can take for an investigation and adjudication to be completed by the NMC. This arises not only because of the number of cases entering the system (as discussed above at paragraph [8-5]) but also the absence of case management (akin to directions hearings in the Second tier tribunal). Frequently hearings will over run and significant delays can be experienced before the same panel can reconvene to decide a part heard case. The RCN has noted an increase in the average number of days required for the hearing of a conduct panel case. One recent RCN member’s case has been adjourned part-heard on no less that 3 occasions and a decision on sanction is only expected at the fourth reconvened hearing date. The RCN considers that an independent organisation responsible for case management, able to develop specialist panel members to narrow down the issues in a case and to set and adhere to time estimates for final hearings would reduce wasted time and costs. In addition, registrants and their representatives have, where delays are unacceptable, no avenue for redress (other than perhaps the High Court on a costly abuse of process application). When there
are other issues between the parties around process or evidence these cannot be resolved until the hearing, wasting valuable hearing time. An independent case management function would address this issue.

**Provisional Proposal 9-5: The statute should provide that the overriding objective of the Civil Procedure Rules – that cases must be dealt with justly – is made part of the regulators’ fitness to practise procedures.**

The RCN considers that the statute should provide that the overriding objective of the Civil Procedure Rules – that cases must be dealt with justly – is made part of the regulators’ fitness to practise procedures. This enables the interests of the registrant and the regulator to be dealt with in a fair manner during the course of the preparation of the case, and enables case management to be carried out in a way that is fair and proportionate to the Registrant whilst protecting the public interest. This approach can acknowledge any balancing exercises that may be needed to create equality of arms. This will encourage consistency and transparency across the Regulators, and a body of case law can be developed with an underlying principle at its heart. For example, the difficulty of an individual registrant obtaining documentation from a Trust compared to the ease with which such documents may be obtained by a Regulator should be acknowledged when directions for disclosure are made.

**Provisional Proposal 9-6: The statute should require each regulator to establish Fitness to Practise Panels of at least three members for the purpose of adjudication.**

We agree that the existing systems of statutory committees could be abolished with the regulators able to determine their own governance arrangements, including powers to establish committees, Fitness to Practise Panels, interim order hearing and review panels of three members for the purpose of adjudication. This would ensure that one member of the panel is a lay member, one a registrant member with the appropriate degree of knowledge pertinent to the issues in the case and we
would favour a legally qualified Chair. To exceed three panellists can be daunting for registrants and can lead to unnecessarily long hearings.

**Provisional Proposal 9-7:** The statute should: (1) require the regulators to establish a body which is responsible for all aspects of the Fitness to Practise Panel appointment process and which is separate from the Council; and (2) prohibit Council members and investigators from membership of Fitness to Practise Panels; and (3) require that each Fitness to Practise Panel must have a lay member.

It is the view of the RCN that the existence of an appointments committee separate from Council is desirable for impartiality and independence and endorses Article 6. We agree that the rules should prohibit Council members and investigators from membership of Fitness to Practise Panels.

There should be a balance between lay and registrant members of panels. There should be sufficient panel expertise (ie from Registrant panellists) to ensure that ordinarily there is no need for expert evidence on either side in the hearing. There should always be at least 1 lay member to represent the interests of the public.

In addition we would like to see a rule that the Chair should be legally qualified. This would remove the requirement for a legal Assessor at every hearing, which is costly for the Regulator. The interventions of the Legal Assessor can be time consuming, as they have to repeat the standard advice that they will be giving to the panels, without necessarily adding valuable insights. The involvement, engagement and value-added of Legal Assessors in cases can be variable. We think that appropriately trained legal Chairs would be confident enough to create more efficient hearings and advise the panel on the legal aspects relevant to the subject case.

**Provisional Proposal 9-8:** Other than on those matters specified in provisional proposals 9-6 and 9-7, the regulators should have broad powers to make rules on the constitution of their Fitness to Practise Panels.

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We agree that (other than the issues outlined above) the regulators should have broad powers to make rules on other issues for example the appointment of advisers (including legal and professional advisers), deputising arrangements, pay, and additional prohibitions on membership of the panel.

**Provisional Proposal 9-9: All regulators should be given broad rule-making powers on most procedural aspects of fitness to practise hearings.**

We agree that it would be impractical for a single set of rules to be prepared that would be used by all regulators, so we agree that regulators should be given rule-making powers on most procedural aspects of fitness to practise hearings. However, we are concerned that there should be safeguards that ensure that the regulators observe underlying principles of fairness and proportionality if they set their own rules in Fitness to Practise proceedings. We are of the view that the statute should endorse the procedural safeguards of Art 6 as although any procedures which are viewed as being unlawful, unreasonable or irrational can be tested in the courts if necessary, Registrants and their representatives should not be required to benchmark the requirements of a fair hearing via High Court litigation.

1. We also consider that rules that are compliant with Article 6 will ensure the development of consistent rules across the regulators.

2. On a practical level, we would like to see statutory guidance to the regulators about safeguards as they formulate their rules. For example, there could be a requirement to consult all stakeholders in any rule changes or proposals on guidance akin to Art 3 (14) Nursing and Midwifery Order 2001.

**Question 9-10: Should the statute require that fitness to practise hearings must take place in the UK country in which the registrant is situated or resides?**
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We consider the statute should require that hearings must take place in the UK country in which the registrant is situated or resides (unless it is clearly disproportionate to do so e.g. the registrant has moved). This makes practical sense (in our experience most of the witnesses will live near the Registrant), will enable the panels to have some local knowledge and intelligence, will limit the often exorbitant travel and accommodation costs being laid at the door of the Registrants and will prevent Regulators simply listing hearings for their own administrative convenience.

Provisional Proposal 9-13: The statute should require the civil standard of proof in fitness to practise hearings.

Agreed

Provisional Proposal 9-14: The statute should require that all fitness to practise hearings must be held in public unless one or more of the exceptions in the Civil Procedure Rules apply.

At the NMC the rules permitting hearings in private are unspecific, simply requiring that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest. The Civil Procedure Rules set out more specific instances, but we suspect that the overall effect is similar to that of the NMC rules and we have no particular preference.

In the vast majority of NMC cases, interim orders are heard in public, despite the fact that the case has often only been with the NMC such a short time that there has been no investigation and there are no actual allegations. The NMC does not screen out many cases at the very early stages. The complaint may have been made maliciously. Often, interim order hearings are held about cases within a week or two of the complaint reaching the NMC, and then those cases are dismissed at the investigating committee stage. The press frequently publishes information about interim order hearings. Accordingly, we see damaging coverage of nurses due to press coverage of interim order hearings before there has been any attempt to
establish that there might be an arguable case at all. We would prefer a standard presumption that interim order hearings should be held in private unless there is a public interest in holding them in public. This would protect the privacy of those against whom no allegations have even been formally made let alone proven, and who find themselves the subject of public curiosity due to a modern fascination with the behaviour of nurses.

**Provisional Proposal 9-15:** The statute should provide that a witness is eligible for assistance if under 17 at the time of the hearing if the Panel considers that the quality of evidence given by the witness is likely to be diminished as a result of mental disorder, significant impairment of intelligence and social functioning, physical disability or physical disorder. In addition, a witness should be eligible for assistance if the Panel is satisfied that the quality of the evidence given by the witness is likely to be diminished by reason of fear or distress in connection with testifying in the proceedings.

We have no particular view, but this seems sensible.

**Question 9-16:** Should the statute provide for special measures that can be directed by the Panel in relation to witnesses eligible for assistance, such as screening witnesses from the accused, evidence by live link, evidence in private, video recorded evidence, video cross examination, examination through intermediary, and aids to communication?

We have no particular view, but this seems sensible.

**Provisional Proposal 9-17:** The statute should require the regulators to establish a system for imposing and reviewing Interim Orders.

Yes, subject to the following procedural safeguards which we would ask the Commission to take into consideration in its final report.

The Royal College of Nursing has historically been very concerned about the unfairness of the way in which interim orders are made by the NMC. The RCN has...
sought judicial guidance on the issue in a recent High Court appeal (judgment awaited) but the RCN would also seek to raise its concerns as part of this consultation process.

The proposed wording in Para 9-20 below is that an Interim Order should be imposed if “necessary to protect, promote and maintain the health safety and well being of the public (and to maintain confidence in the profession)

The current case law in this area states that it should be rare for such an order to be necessary for maintaining public confidence in the profession – this was confirmed in the Sheikh case. In this case where the dentist had been convicted of conspiracy to defraud, Davis J terminated an interim suspension order made by the GDC on grounds that no good reasons had been provided for making such an order.

The RCN considers that the wording in brackets within the suggested statutory test should be qualified to reflect case law.

A further area of concern for the RCN which could be clarified in a new statutory process for Interim Orders concerns whether panels are not making findings of fact nor making findings as to whether the allegations are or are not established. Current NMC Guidance for Panels states clearly that is sufficient for the panel to act, if they take the view that there is “a prima facie case and that the prima facie case, having regard to such material as is put before them by the registrant, requires the public to be protected by an interim order”. Reliance is placed by the NMC on George at [42] for that statement. The George case was a statutory appeal in which Dr George successfully sought a declaration that the NHS Trust to consider his dismissal as a ground for interim suspension by the GMC. In that case an interim order had been made pursuant to section 41A (1) of the Medical Act 1983 which is in similar terms to Article 31(2) of the 2001 Order.

The comments of Collins J at [42] on which the June 2010 guidance is based were not part of the ratio of the case nor do they appear to have been the subject of
argument by the parties. The rationale for the comments of Collins J are however clear. At this interim stage no final findings of fact are to be made and so the decision has to be based on something less than a full consideration of the allegations. There was no art 6 argument in this case. Prima facie obviously means “at first sight”. We are not sure that this terminology is helpful. Clearly the level of inquiry necessary to establish a proper case to go forward will vary according to the nature of the allegations and the circumstances. The inquiry must be proportionate. It is clearly insufficient to accept the allegations at face value. The RCN are keen that as part of any new statutory Interim order process, the comments of Collins J should not be treated as though they are a statutory test; there is no indication that Collins J intended them to be elevated to the status they have attained by the NMC and other Regulators. We consider therefore that the Commission should ensure that the new statute should ensure that the Regulators should use their powers to ensure:

(i) The Interim Orders process is not contrary to the common law;
(ii) The Interim Orders process is not Contrary to art 6 ECHR; and
(iii) The Interim Orders process is not Contrary to art 8 ECHR.

In relation to these we would add:

Common law.

The requirements of the common law underpin any statutory provisions and absent their express exclusion will be applied by the courts. But the RCN would welcome the Commission using this Consultation Process to ensure key safeguards are available to registrants as part of this process.

The Interim Order procedure can be contrary to the common law if it fails to provide the Registrant with a proper opportunity of dealing with the allegations made against him/her. In the case of \textit{Ridge v Baldwin}, the Court concluded that:
“.... before attempting to reach any decision they (the committee) were bound to inform him of the grounds on which they proposed to act and give him a fair opportunity of being heard in his own defence”

We would invite the Commission to use the statute to insure that a proportionate weighing up of the evidence is conducted in all Interim Orders hearings and to avoid them becoming a one-sided hearing where panels are not required to put a Registrant’s evidence in the balance before making a suspension/order that he/she can/not work in their chosen profession. Very often an order made at an Interim stage can act as “a killer blow” for a practitioner. Such an order can prevent them being given any opportunity prior to a final hearing to remedy any shortfall in their fitness to practice. This can considerably narrow down the available sanctions to a panel at a final hearing often such that the ultimate sanction of striking off is available.

Articles 6 and 8 ECHR

Interim Order processes can be contrary to art 6 ECHR if they fail to provide the Registrant with a full merits review in the determination of his civil rights.

In the Wright v Secretary of State for Health (2009) case, House of Lords decided that provisional listing on the POVA and POCA lists pursuant to the Care Standards Act 2000 and the Protection of Children Act 1999 without a hearing (opportunity to be heard) was contrary to articles 6 & 8 of the convention. Declarations of Incompatibility granted re the specific provision in the 2000 Act that permitted provisional listing on POVA list.

In the RCN and Others v Home Office Case (2010) the High Court, following Wright, found that automatic barring of people with a conviction or caution under the Safeguarding Vulnerable Groups Act 2006 was incompatible with articles 6 and 8 of the Convention [61]. A declaration of incompatibility was granted. The High Court however found the barring scheme as a whole to be compatible with art 6 due to safeguards and appeal rights. The RCNs concern is that the lack of a fair hearing at an interim stage will be incompatible with Article 6 because:
1. That the interim suspension of a Registrant from the nursing register is a determination of his civil rights – see Wright and the RCN case.

2. In both of those cases interim or provisional measures which preventing nurses from working were found to be determinations of their civil rights for the purposes of art 6.

3. Without Registrants knowing the nature of the case they face at an Interim order hearing or without their version of events being weighed up proportionately by a panel, the Registrant may be denied “a fair” hearing in the determination of his civil right to work as a nurse, in breach of art 6 rights. As Baroness Hale said in Wright at [28], “the process does not begin fairly, by offering the care worker an opportunity to answer the allegations made against her, before imposing upon her possible irreparable damage to her employment or prospects of employment”. The same analysis applies to Interim Order hearings.

An Interim Order procedure can also be contrary to art 8 ECHR if it denies the Registrant a fair hearing. The procedural obligations inherent in art 8 are well-established, see for example W-v-UK (AB/8) which at [62] places particular importance on decision-making not being “one-sided” and “is fair and affords due respect to the interests protected by Article 8.” In the past Regulators have sought to justify interference with Art 8 on the grounds of necessity to “protect public safety”. However, it is not necessary to have an unfair hearing in order to protect public safety.

The RCN would therefore welcome the Commission seeking to ensure that any Interim order process is Art 6 and 8 compliant by requiring the Regulators to have these procedural safeguards in their minds when drafting or exercising any new statutory powers. We consider that the best way of doing this would be to ensure these are captured in the statute.
Provisional Proposal 9-18: The statute should require each regulator to establish panels of at least three members for interim order hearings (including a lay member). In addition, Interim Order panels must be appointed by a body which is separate to the Council and there would be a prohibition of Council members and investigators from sitting on such Panels.

Agreed, to ensure as fair a hearing as possible.

Question 9-19: Should the statute prohibit Interim Order Panellists sitting on a Fitness to Practise Panel (either in relation to the same case or more generally)?

Agreed to ensure as fair a hearing as possible.

Provisional Proposal 9-20: The test for imposing an Interim Order should be that it is necessary to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).

See comments above under 9-17.

Provisional Proposal 9-21: On all procedural matters in relation to Interim Order hearings (except for those specified in provisional proposal 9-18) the regulators should have broad rule-making powers.

See comments above under 9-17.

Provisional Proposal 9-24: All Fitness to Practise Panels should have powers to impose the following: (1) erasure from the register; (2) suspension; (3) conditions; and (4) warnings.
We agree. As discussed under Question 9.31 below, we would prefer the use of the term ‘removal’ rather than erasure. We would like to see all regulators use the same terminology for consistency.

Provisional Proposal 9-25: The Government should be given a regulation making power to introduce systems of financial penalties and cost awards.

We do not think that financial penalties are suitable as a sanction against the registrant in relation to healthcare regulation. Such penalties would suggest that the purpose of the proceedings is punitive, undermining the message that the regulator’s purpose is public protection. It would also undermine the presumption that professional reputation is highly valuable in its own right.

In some limited situations we consider that the use of costs orders to impose discipline on both sides during case management might be warranted. On occasion, as representatives of registrants, we have been frustrated by the lack of any available sanctions against the NMC in individual cases for failure to comply with requests for documentation or information to which they have access by nature of the authority conferred by their role as regulator. We think that carefully utilised costs orders would assist in achieving equality of arms.

We do think that if costs orders were too commonly imposed, time would be wasted in argument and litigation about them, and unrepresented registrants could too easily find themselves intimidated by the possibility of costs being awarded against them. We would want to see the use of costs orders limited to situations in which one of the parties has behaved highly improperly, unreasonably and has repeatedly failed to rectify an unsatisfactory situation. If a system is adopted, the RCN would support the procedural approach adopted by the Civil Procedure Rules (Part 48.7) regarding the need to establish a causal link between the conduct and any wasted costs and parties being given the opportunity to answer an allegation that they have wasted costs in a particular case.
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Provisional Proposal 9-26: All Fitness to Practise Panels should have powers to agree undertakings and voluntary erasure.

We strongly support this proposal. Currently, the inflexible menu of sanctions available at the NMC requires even trivial cases to be run to a final hearing where there is no public interest in that hearing, and the distress caused to the registrants and the drain on resources to the NMC and registrants’ representatives is considerable. Similarly, when the registrant just wants to retire with dignity and the issue is health or competency in a long-serving nurse who has begun to show signs of failing to keep up to date, the current arrangements are inhumane. Providing a mechanism to take such cases out of the system will free up the NMC’s resources to focus upon the cases that should be heard in public. We also think that involving the registrant in finding a suitable resolution in less serious cases will require the registrant to take responsibility for their actions that will aid their insight and reduce the sense of bitterness about the sanction that we frequently observe at the end of a case.

Provisional Proposal 9-27: The regulators should have powers to introduce immediate orders (or use Interim Orders for this purpose).

Agreed.

Provisional Proposal 9-28: The test for imposing any of the sanctions listed in provisional proposal 9-24 and consensual disposals in 9-26 should be to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).

Agreed

Provisional Proposal 9-29: The regulators should be given broad powers to make rules in relation to the sanctions listed in provisional proposal 9-24 and consensual disposals in provisional proposal 9-26.

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Agreed, but we would like to see a mechanism for oversight so that there is consistency. Currently, there is no voluntary erasure available at the NMC, by reason of their rules, and this seems very unfair to nurses who always have to endure a hearing even if they simply want to retire. If leaving the rule making to individual regulators meant that similar anomalies remained in practice, this would undermine the benefits of the single statute.

Provisional Proposal 9-30: The Government should be given a regulation making power to add new sanctions and consensual disposals to those listed in provisional proposals 9-24 and 9-26, and to remove any sanctions and consensual disposals.

We agree.

Question 9-31: Does the language used in the proposed list of sanctions and consensual disposals contained in provisional proposals 9-24 and 9-26 convey accurately their purpose?

We think that ‘removal’ is a less judgmental word than ‘strike off’ or ‘erasure’. Thought should be given to any form of words that might be applied to someone who has been removed due to ill health, and voluntary removal seems acceptably neutral. We have no particular opinion about ‘warnings’, ‘undertakings’ and ‘cautions’ which all indicate practical sanctions that will be applied to less serious breaches of the code. ‘Conditions’ and ‘suspension’ accurately describe their effect.

Provisional Proposal 9-32: The statute should require all the regulators to establish a system of review hearings for conditions of practise and suspension orders. In addition, the regulators should have powers but would not be required to establish review hearings for warnings and undertakings.
We agree that Regulators should be required by statute to establish a system of review hearings for conditions of practise, suspension orders or (if introduced) to revoke or vary the terms of an undertaking (although the requirement should not extend to a review of warnings). We consider that it is important part of the process for the public and Registrants to know when the sanctions will be reviewed/removed.

Provisional Proposal 9-33: The regulators should have broad rule-making powers to establish the procedures for review hearings.

Agreed. The RCN would support a system that requires a Regulator to hold a review hearing, only when there is a dispute regarding the continuation of the existing sanction.

Question 9-34: Should the regulators be given an express power to quash or review the decision of a Fitness to Practise Panel where the regulator and the relevant parties agree that the decision was unlawful? If so, should complainants and other interested parties are able to prevent or contribute to any decision to use this power?

The High Court has recently reviewed the law set out in R (Jenkinson) v NMC (2009), in a case brought by the RCN on behalf of one of its members, “B”. In the case of R (B) v NMC (2012) the High Court considered that a tribunal does not have a power analogous to that of the High Court to reopen proceedings, beyond the limited power “to correct accidental errors which do not substantially affect the rights of the parties or the decision arrived at”. We refer to the cases of Akewushola v Home Secretary [2000] 1 WLR 2295 and R (B) v NMC [2012] EWHC 1264 (Admin); the latter case sets out at paragraph 34 a useful summary of the law in this area from Wade & Forsyth: Administrative Law (10th ed.). The RCN would not therefore support Regulators being given powers beyond those set out in R (B).
Provisional Proposal 9-35: All professionals should continue to have a right of appeal against the decision of a Fitness to Practise Panel to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.

Agreed.
Part 10 – The Council for Healthcare Regulatory Excellence

Question 10-1: How effective is the CHRE in performing the role of scrutinising and overseeing the work of the regulators?

The RCN acknowledges that CHRE performs a valuable role in providing oversight of the health care regulators; however, the RCN is concerned by the current apparent lack of accountability of the CHRE. We are further concerned that following the Health and Social Care Bill Act 2012, when CHRE becomes the Professional Standards Authority for Health and Social Care, this position will be compounded as the organisation will no longer come under the ambit of the Department of Health or any other department whatsoever and will no longer be a non Departmental Body.

By way of an example, the RCN sees the recent Interim and Final Reports produced by the CHRE in relation to the NMC are valuable assessments of the challenges that face the Nursing regulator. However, the CHRE has been monitoring work of the NMC since 2008 and arguably could have acted sooner to prevent the severity of the issues with the NMC now faces. During 2008-2012, there has been very little improvement in the case management of Fitness to Practise cases within the NMC (meaning long delays for RCN members who have been referred) and Registrants are now facing significant fee increases to fund the cost of remedying these issues. The RCN is not aware of any Government body or other monitoring organisation holding CHRE to account for its strategic role in this.

The RCN would therefore like to see improved accountability of CHRE in the new scheme for health professions regulation.

Provisional Proposal 10-2: The current powers and roles of the CHRE (including those introduced by the Health and Social Care Bill 2011) should be maintained as far as possible.

Agreed, subject to our response in Paragraph 10-1 above.
Provisional Proposal 10-3: Appointments to the CHRE’s General Council should be made by the Government and by the devolved administrations. Appointments would be made in accordance with the standards for appointments to the health and social care regulators made by the CHRE.

Agreed

Provisional Proposal 10-4: The CHRE’s general functions should be retained, but modernised and reworded where appropriate.

We agree that the general functions of CHRE should be retained and modernised. This includes the power to issue directions to regulators. CHRE’s investigation in relation to the NMC is a recent example of when such a power could be useful. (Please see our response in 10-1 above).

Provisional Proposal 10-6: The existing power for Government to make regulations for the investigation by the CHRE into complaints made to it about the way in which a regulator has exercised its functions should be retained.

Agreed. We agree that Government oversight would become one of the ways in which the regulators can be held to account and would place an appropriate pressure to retain independence from the paying regulators.

Question 10-7: Should the CHRE’s power to refer cases to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland: (1) be retained and exercised alongside a regulator’s right of appeal, in cases when the regulator’s adjudication procedure is considered to be sufficiently independent; or (2) be removed when a regulator’s right of appeal is granted in such circumstances; or (3) be retained and rights of appeal should not be granted to regulators, although regulators should have a power to formally request the CHRE to exercise its power?
The RCN would welcome independent adjudication (as Para 9-2 above). In the event that the Commission endorses separate regimes for the investigation and adjudication of Fitness to Practise cases, then in our view option 2 seems the most appropriate as it (i) would prevent unnecessary costs being incurred (especially relevant if CHRE’s costs will be funded by a Regulators levy, which in turn will be funded by the Registrants themselves) (ii) any decision to appeal a decision of an independent Adjudicator, could then be made objectively by the Regulator and so CHRE’s right to appeal becomes academic.

If separation of investigation and adjudication is not a recommendation of this Consultation, then Option 1 (the status quo) should inevitably remain the case.
Part 13 Cross Border Issues

Provisional Proposal 13-1 The statute should require regulators to specify in rules which qualifications would entitle an applicant to be registered including overseas qualifications

The RCN would support the view that specifying the more detailed requirements of the EU directive on mutual recognition of professional qualifications should be a requirement for the regulators rather than detailed in primary legislation. Currently proposals for revising the directive are being discussed in Brussels which may give regulators greater powers to control for language ability and could change the minimum training requirements for nurses, for example. The RCN also supports proposals from the European Commission to move for the long term towards specifying competencies in the directive rather than purely a list of content for nurse education programme¹. All of these requirements would be better outlined in detail by the regulators.

Provisional Proposal 13-2 The default powers of the Government should include the ability to intervene in case where there is likely to be or has been a failure to implement the Qualifications Directive properly

The RCN supports this proposal, given the responsibilities of member state governments to ensure that EU legislation is implemented.

Provisional Proposal 13-3 The statute should include broad powers for the regulators to register those from non-EEA countries, including powers to set requirements as to the language, practice and education requirements.

The RCN would support this approach in recognition that the UK regulators already carry out these functions, that the UK has traditionally been a destination country for large numbers of health professionals from outside the EU, and because it is important that migrants are treated fairly and transparently.