Royal College of Nursing - Response to the Nursing and Midwifery Council's consultation on the registration fees for nursing associates

1. The Royal College of Nursing (RCN) welcomes the opportunity to respond to this consultation. We have wider concerns about the approach that has been taken in developing the new nursing associate (NA) role, namely that it has been devised and implemented at great speed and without the appropriate preparation, testing and consultation. The present consultation and its questions are wholly based on the premise that the regulatory approach for this new role proposed by the Department for Health and Social Care (DHSC) will continue to mirror the current regulatory model used for registered nurses and midwives. However, the consultation on this approach only closed on 26th December 2017 and no analysis and outcome has yet been communicated by the DHSC. In light of this, we consider this a very initial response, whilst we understand the real cost of regulating this role as it is being rolled out in the system.

2. As set out in our response to the DHSC consultation on the regulation of the NA role,[1] we disagree with the proposed regulatory approach as we do not believe that this role requires the same model of regulation as that of a registered nurse. We reiterate that the regulatory framework for this role should be proportionate, reflecting that this is a role that supports the registered nurse. For example, the current approach to fitness for practise (FtP) tends towards being reactive, punitive and resource intensive - we would question if perpetuating this model is an appropriate means of ensuring continuing competence for this role. Whilst we recognise that the NMC is limited by its current legislative framework in how it can innovate to regulate differently, and is addressing some of these concerns in its proposed new fitness to practise strategy, perpetuating current approaches will not allow professions to respond flexibly to future population and system health needs.

3. We continue to be concerned that the NA role is being described as a new profession (paragraph 7 and 20). Indeed, this is contradicted in paragraph 8 where the role is explained as a 'bridge between healthcare assistants and graduate registered nurses'. NAs, who are a supporting role for registered nurses (RNs), are therefore a new professional role within the nursing profession but are not a new profession. This is an important distinction, and not merely semantics. The everyday use of the terms 'profession' is significant because it forms: *"…part of the cultural backdrop against which the current debates about role and governance of professions is conducted."*[2] To enable public understanding of this role and its relationship with registered nurses, the populist use of the term profession is unhelpful.

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[1] Royal College of Nursing, *Response to the Department of Health's consultation on the Regulation of Nursing Associates in England*, December 2017, https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/policies-and-briefings/consultation-responses/2017/december/conr-4217.pdf

[2] *Jones, L. and Green, J. (2006) '*Shifting discourses of professionalism: a case study of general practitioners in the United Kingdom'. *Sociology of Health and Illness, 28 (7) pp. 927-950*

4. We agree that, for public protection purposes, the NMC should ensure that all NAs hold approved qualifications, have appropriate indemnity arrangements, are able to evidence that their practice is safe and effective, that they have necessary knowledge of English and pay the relevant fee. However, we do not think that the necessary work has been done to establish, or at least estimate, what the real cost of regulating the NA role will be. Given the purpose of professional regulation is public protection, this cost will depend on the risk of this role to the public. For example, given that the cost of FtP hearings is the largest cost to regulators (including the NMC[3]) there is a question of whether this role will increase the number of FtP cases the NMC will have to handle. This is not understood at this point and we do not believe that sufficient work has been done to realistically estimate the basis for the proposed regulatory fees. This is acknowledged in para 20, where the untested assumption that regulation of NAs will not be markedly different for that for RNs and midwives is stated. The argument that nurses and midwives might subsidise NAs (para 21) is important, but conversely NAs may be subsidising regulatory processes if the fee does not reflect actual costs of regulation for them.

5. A total of 2,838 RCN members responded to a RCN survey on this consultation, 21.4% of these were either a health care assistant/health care support worker, Trainee Assistant practitioner, Assistant practitioner or Trainee nursing associate. This group currently represents 4.4% of the total RCN membership population so those RCN members most affected by this issue have engaged well with our survey. 77% of members in this group disagreed with the proposed fee model. Looking at all respondents, 53% agreed that the cost of registration for a nursing associate should be the same as a nurse or midwife, but 47% did not. Of those that disagreed, 1,321 members gave a reason for their response. 83% stated that the fee model was not proportionate to the scope and the responsibility of the role, 18% said they would not be able to afford it and 24% gave other reasons. Most prominent among these was the proportionality of the fee to level of income.

6. Considering that evidence from the Professional Standards Authority (PSA) makes a clear link between complexity and risk of activities of a professional group and cost[4] and given that NAs have more limited scope of practice than RNs and that their practice is supervised by RNs, the risk for harm is lower and therefore the cost to the regulator should be lower. We understand the costing for registration and education standard setting will be the same across all professional roles, but revalidation and FtP models may not. The NMC and DHSC must do more work to estimate this cost, for example through gathering evidence from other regulated supporting roles and through an open and transparent true cost-modelling.

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[3] Department of Health and Social Care, *Promoting professionalism, reforming regulation. A paper for consultation*. October 2017, https://consultations.dh.gov.uk/professional-regulation/regulatory-reform/supporting_documents/Promoting%20professionalism%20reforming%20regulation.pdf

[4] Professional Standards Authority, *Rethinking regulation*, August 2015, https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/rethinking-regulation-2015.pdf. Regulatory force is defined as "*the increased quantum of regulatory intervention required as the risk and complexity of the regulatory task increases. It turns on factors like the frequency and extent of harm linked to a profession and the type of allegations made about impaired fitness to practice and the maturity of a profession.*"

7. Regarding applicants to the nursing associates' part of the register who trained in EEA and non-EEA countries as well as in Scotland, Wales and Northern Ireland, the same point applies. The calculations for the EEA fee, for example, have been made on the basis of the historic EEA data, setting the fee in recognition that the majority of applicants come through the automatic recognition route rather than the 'general systems' route. However, the Professional Qualifications Directive does not have any provisions for a support role like the NA. Any applicants therefore are likely to need to be assessed through the more expensive 'general systems' route, but this has not been considered in the proposal. In this context, it also seems odd that, for a non-harmonised support role, EEA applicants should be paying less than UK applicants from the devolved administrations. Again, the NMC and DHSC must do more work to estimate the real cost for these types of applicants through real cost-modelling.

8. Given the shortcomings we have identified with the proposed costing model, we expect a review of the fee model as soon as sufficient evidence of the NA role's impact on the NMC's costs is available.

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The Royal College of Nursing

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