



cutting through complexity

Revalidation of nurses and midwives

An independent report by KPMG on the
impact of revalidation on the health and
care system for the Nursing and
Midwifery Council (NMC)

Main Report

10 August 2015

Contents

1	Executive summary	2
1.1	Summary of the key findings	3
2	Introduction	13
2.1	Background	13
2.2	Objectives, scope and approach	14
3	Exploring readiness	16
3.1	Awareness and culture	16
3.2	Planning and implementation	21
3.3	Governance of implementation	27
4	Costs and benefits of revalidation	29
4.1	Approach to assessing costs and benefits	29
4.2	Limitations to the analysis	32
4.3	Benefits of revalidation	34
4.4	Organisations' estimated costs of supporting revalidation	38
4.5	Registrants' estimated costs of revalidation	49
4.6	Assessing costs against the potential benefits	53
5	Next steps	54
5.1	Clarifying the guidance	54
5.2	Developing a comprehensive communications plan	54
5.3	Evaluating revalidation	55
5.4	Combining these activities into a clear action plan for implementing revalidation in the current timescales	55
6	Glossary	56

Important notice

This Main Report dated 10 August 2015 has been prepared on the basis set out in our Engagement contract with the Nursing and Midwifery Council (NMC) ('the Client') dated 2 February 2015 (the 'Services Contract').

Nothing in this report constitutes legal advice or an audit or assurance opinion.

We have not verified the reliability or accuracy of any information obtained in the course of our work, other than in the limited circumstances set out in the Services Contract.

This Report is for the benefit of the Client only and only to enable the Client to give preliminary considerations to the findings available based on fieldwork carried out up to the date set out in the Report and for no other purpose.

This Report has not been designed to be of benefit to anyone except the Client. In preparing this Report we have not taken into account the interests, needs or circumstances of anyone apart from the Client, even though we may have been aware that others might read this Report. We have prepared this Report for the benefit of the Client alone.

This Report is not suitable to be relied on by any party wishing to acquire rights against KPMG LLP (other than the Client) for any purpose or in any context. Any party other than the Client that obtains access to this Report or a copy (under the Freedom of Information Act 2000, the Freedom of Information (Scotland) Act 2002, through the Client's Publication Scheme or otherwise) and chooses to rely on this Report (or any part of it) does so at its own risk. To the fullest extent permitted by law, KPMG LLP does not assume any responsibility and will not accept any liability in respect of this Report to any party other than the Client.

In particular, and without limiting the general statement above, since we have prepared this Report for the benefit of the Client alone, this Report has not been prepared for the benefit of any other organisation nor for any other person or organisation who might have an interest in the matters discussed in this Report, including for example external stakeholders or people who work in this sector.

Please note that the Services Contract makes this Report confidential between the Client and us. It has been released to the Client on the basis that it shall not be copied, referred to or disclosed, in whole or in part, without our prior written consent. Any disclosure of this Report beyond what is permitted under the Services Contract will prejudice substantially this firm's commercial interests. A request for our consent to any such wider disclosure may result in our agreement to these disclosure restrictions being lifted in part. If the Client receives a request for disclosure of the product of our work or this Report under the Freedom of Information Act 2000 or the Freedom of Information (Scotland) Act 2002, having regard to these actionable disclosure restrictions the Client should let us know and should not make a disclosure in response to any such request without first consulting KPMG LLP and taking into account any representations that KPMG LLP might make.

1 Executive summary

The Nursing and Midwifery Council (NMC) is planning to introduce revalidation¹ for nurses and midwives across the UK from October 2015 with the first registrants revalidating from April 2016. To support the NMC's Council in making a decision to proceed in October, the NMC commissioned KPMG to explore readiness for revalidation in the health and care system and among organisations employing registrants, and to carry out a cost benefit analysis of the revalidation model.²

KPMG's project has been carried out with the support of the NMC and representatives from the four countries' Revalidation Programme Boards responsible for implementing revalidation for nursing and midwifery across the UK.

We have engaged widely through this project to build our evidence base including:

- Interviewing 49 stakeholders within the health and care system across England, Scotland, Wales and Northern Ireland;
- Holding 14 focus groups with system stakeholders and representatives from revalidation pilot organisations and non-pilot organisations across the UK and with participation from across all main practice settings for nursing and midwifery;
- Surveying 271 organisations from all four countries online (with 119 responses) to gather readiness and cost benefit information³; and
- Obtaining cost and benefit information from an Ipsos MORI online survey of registrant participants from the 19 pilot organisations with 1,120 responses.⁴

With the support of the NMC and representatives from the four countries' Revalidation Programme Boards, we developed criteria for readiness. These criteria were used to develop the questions for our organisation survey, interviews and focus groups and as the basis for our exploration of readiness. The criteria were split into three different levels of organisational support: the 'minimum level' of support; support that is 'reasonably expected'; and 'highly supportive' measures.

¹ The NMC defines revalidation as "the new process by which nurses and midwives demonstrate that they practise safely" NMC website (as at 05 August 2015): <http://www.nmc.org.uk/standards/revalidation/what-revalidation-is/>.

² KPMG's report is one piece of evidence that will inform the NMC and four country Revalidation Programme Boards' decisions in October 2015 regarding the launch of revalidation, and is complementary to a report from Ipsos MORI and other analysis carried out by the NMC and the four countries' Revalidation Programme Boards.

³ We refer to this survey throughout this report as the "organisation survey" and to the participants in this survey as "organisation respondents" or "respondents to the organisation survey".

⁴ Ipsos MORI separately carried out both quantitative and qualitative research into the registrant experience of revalidation, including views on the guidance and tools, and mapping the registrant's journey through revalidation as part of the pilot. All analysis and interpretation of data supplied by Ipsos MORI appearing in this report was conducted by KPMG. However, KPMG has not verified the data supplied for accuracy or reliability. We refer to the Ipsos MORI online survey of registrant participants throughout this report as "the registrant survey", where appropriate and to the participants in this survey as "registrant respondents" or "respondents to the registrant survey".

The cost benefit analysis sought to identify all potential additional costs and benefits associated with revalidation and to obtain evidence of the scale of these through the organisation and registrant surveys, interviews and focus groups.

The main findings from the project are set out in this report, with detailed information on the approach, findings and data in a separate report of appendices.

1.1 Summary of the key findings

The themes we have identified through our interviews, focus groups and surveys in general apply to all four countries and across the regions of England.

1.1.1 Exploring readiness

1.1.1.1 Buy-in to revalidation is generally strong, particularly in pilot organisations

Our findings revealed a spectrum of support for revalidation, from many who were very supportive of its introduction through to a small number of others who retained a degree of scepticism that revalidation will fully deliver its intended aims.

The buy-in of the pilot organisations has increased over the course of the pilot exercise. And we noted that pilot organisations consistently said in focus groups and interviews that registrants tended to find revalidation easier than expected.

1.1.1.2 Awareness is good in large employers but gaps are perceived among smaller organisations

There is extensive activity across the UK to raise awareness of revalidation among registrants and organisations. However, stakeholders consistently raised the concern that awareness of revalidation may be more limited outside larger organisations, such as NHS Trusts and Foundation Trusts in England, Health Boards in Scotland and Wales, Health and Social Care Trusts in Northern Ireland and large independent providers of health and social care.

In particular, given the numbers of registrants working in the sector, social care was highlighted as requiring more focus and a concerted communications campaign to employers and registrants to ensure that there is strong awareness of revalidation and its requirements.

1.1.1.3 Organisations are making plans to support registrants but are awaiting the final model and greater clarity in the guidance

Almost all respondents to our organisation survey (98%) are planning to provide support for their registrants' revalidation. However, only 20% reported that they had started to implement these plans.

Organisations are keenly awaiting confirmation from the NMC of the finalised model of revalidation. Many indicated that they are holding back from starting preparations until the requirements of revalidation are finalised.

Stakeholders from the system and organisations we interviewed are seeking greater clarity on some aspects of the revalidation model. The current uncertainty is resulting in a wide range of interpretations of requirements, for example, in terms of what evidence is required for the practice hours of registrants in management roles. Clarifying the guidance to

employers and registrants should increase confidence in the revalidation model and make planning and estimation of likely costs simpler.

1.1.1.4 Roles and responsibilities for the governance of revalidation could be more clearly defined and communicated

We found that awareness of the four countries' Revalidation Programme Boards and their responsibilities was limited among organisation stakeholders and that some practice settings are better represented than others: specifically, NHS settings are well represented on the Boards, but non-clinical settings less so.

Greater clarity around the role and responsibilities of these Programme Boards, particularly relative to those of the NMC, might help raise awareness and understanding of the requirements of revalidation. Similarly, further consideration could be given to ensure all practice settings receive support and communication from the appropriate part of the system.

1.1.2 Cost benefit analysis (CBA)

The CBA follows the HM Treasury *Green Book for Appraisal and Evaluation in Central Government* (Green Book). Our analysis assesses the incremental costs and benefits of revalidation – i.e. the costs and benefits associated with the change from the current requirements under post-registration education and practice (Prep) to the requirements of revalidation. There is the potential that in providing their estimates of the costs, organisations factored in wider system and process changes they are planning to make alongside the introduction of revalidation and higher levels of support than strictly required for revalidation. Where this is the case, the cost estimates may be biased upwards.

The quantification of costs was based on organisation survey evidence: 110 organisation respondents provided cost information, of which 17 were pilots. The organisation costs were estimated for the initial one-off upfront implementation costs, the annual costs during the first three-year cycle of revalidation, and the ongoing annual costs thereafter. These are "point-in-time" estimates provided by organisation respondents to our survey based on what support they thought they would need to provide to registrants based on their understanding of the NMC's provisional guidance and model.⁵

Registrants' costs were drawn from the Ipsos MORI survey of registrants participating in the revalidation pilot (the registrant survey). This survey provided evidence of the additional time registrant respondents spent meeting the revalidation requirements compared to the time they previously spent meeting the requirements of Prep. The time spent was converted into financial values using average salary data.⁶

Given the complexity of quantifying the benefits of revalidation in monetary terms, particularly prior to its introduction, we have not undertaken a financial quantification of the

⁵ Organisation cost estimates are based on responses to a survey of 271 organisations conducted between 4 May and 4 June 2015.

⁶ Hourly wage figures for nurse and midwives were sourced from the *Office for National Statistics Annual Survey of Hours and Earnings, 2014*. We calculated a weighted average hourly wage for nurses and midwives (based on the relative proportions of nurses and midwives on the register as at February 2015) <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-337425>

benefits. However, we have undertaken an appraisal of the potential benefits, drawing on the qualitative and quantitative evidence we gathered.

1.1.2.1 Organisations and registrants recognise the benefits of revalidation

Across the interviews, focus groups and surveys many organisations and registrants strongly agreed that revalidation will deliver benefits⁷. Organisation survey respondents indicated that revalidation would:

- Raise awareness of the Code and standards expected of nurses and midwives (on average 90% agreed or agreed strongly);
- Encourage a culture of reflection and improvement because of the participatory continuing professional development (CPD) requirement (on average approximately 90% agreed or strongly agreed); and
- Lead to improved practice and therefore public protection benefits (on average over 80% agreed or strongly agreed).

Registrant survey respondents in the pilot organisations also agreed that there are benefits:

- On average across the benefits questions approximately 80% of registrant respondents agreed or strongly agreed that revalidation would raise awareness of the Code and standards that are expected of nurses and midwives;
- A similar proportion agreed or strongly agreed it would increase an awareness of the roles of the Code in practice; and
- On average over 75% agreed or strongly agreed that it would encourage a culture of sharing, reflection and improvement.

While in general stakeholders were strongly positive about the benefits of revalidation, there was some disagreement among a limited number of stakeholders in focus groups and interviews about the scale of potential benefits, particularly given the need identified by many for greater clarity within the NMC's guidance on how various requirements should be met.

A number of interviewees also considered that the benefits of revalidation could be more clearly articulated by the NMC and other system stakeholders when seeking to raise awareness of revalidation.

1.1.2.2 Organisations reported a wide variation in the costs of revalidation, but pilot organisations generally reported lower costs than non-pilots

Cost estimates on a per registrant basis of supporting revalidation from our organisation survey responses show significant variation. While approximately 15% of organisation respondents indicated that there would be no additional costs associated with meeting certain requirements, other organisations estimated a range of costs associated with supporting their registrants with each of the revalidation requirements.

⁷ In the surveys organisations and registrants were not asked about the benefits of revalidation overall. They were asked about the benefits linked to the individual requirements of revalidation. In the bullet points, the average level of agreement is calculated as the average level of agreement across the responses to the benefit questions for each of the revalidation requirements.

However, pilot organisation respondents, who are likely to have a better understanding of the requirements of revalidation and the support necessary, estimated significantly lower costs than non-pilot organisations. The cost estimates provided by organisations are shown in Figure 1 below.

Figure 1 - Organisation respondents' per registrant cost of revalidation⁸. *Number of respondents: 17 pilots and 93 non-pilots*

	Pilot average (£)	Non-pilot average (£)	Overall average (£)
One-off upfront costs per registrant before revalidation is introduced	173	239	225
Ongoing annual costs per registrant through the first 3 year cycle of revalidation	240	302	289
Ongoing annual costs per registrant after the first 3 year cycle of revalidation	86	286	245

All these average cost estimates, however, factor in organisation respondents' estimated costs for some measures that are considered highly supportive and not strictly required to support revalidation.

Furthermore, a small number of organisation respondents estimated overall costs of revalidation, on a one-off and ongoing basis, to be considerably higher than the majority of other organisation respondents. However, these organisations' costs estimates were not consistently higher across all of the areas of revalidation requirements than other organisation respondents. The inclusion of these organisations' higher cost estimates in the averages, drives the results up. For example, if the pilot and non-pilot organisations that estimated the highest overall costs are removed from the analysis, the average ongoing costs after the first cycle of revalidation for pilots would be £7 lower and for non-pilots would be £66 lower.

1.1.2.3 Costs of revalidation vary across the requirements and these are driven by the level of support envisaged

We found a wide range of responses to how organisations plan to support registrants: from a very light touch approach to implementing highly supportive measures. With only 20% of organisation respondents having already started to implement their plans, it is likely that the cost estimates may change as organisations get a deeper understanding of what is required from them.

The highest estimated ongoing costs across all organisation respondents on a per registrant basis are associated with the preparation and overall management of revalidation. This

⁸ Although no one organisation consistently predicted costs per requirement significantly higher than other organisations, there was one particular organisation that has above average costs for the majority of the requirements which affects the averages for non-pilot organisations. If this organisation is removed from the analysis, the non-pilot site average costs fall to £171 one-off, £227 annually through the first cycle of revalidation and £220 annually thereafter (the equivalent overall averages fall to £170, £229 and £192 respectively).

includes the project management of revalidation and monitoring renewal dates⁹ and the successful revalidation of registrants. However, again these estimated costs are significantly lower for pilot sites. For example, the annual average costs in the first cycle of revalidation are £33 per registrant for pilots compared with £163 for non-pilots. Some of the costs estimated by organisation respondents are also linked to highly supportive measures that are not necessarily required from organisations to support the requirements of revalidation.

The second highest costs across all organisation respondents were linked to CPD and to feedback, reflection and the Professional Development Discussion (PDD). We found that the majority of costs associated with CPD, as reported by organisation survey respondents, were linked to supporting the participatory CPD requirement. Evidence from the registrant survey, however, suggests that organisations may not need to put additional support for CPD in place as the vast majority of registrant respondents were already meeting the revalidation requirements.

In general, as was the case for the overall average organisation costs per registrant, the pilot organisation respondents estimated lower costs of revalidation than the non-pilot respondents across the different areas of revalidation. This is shown in Figure 2 a and b below¹⁰.

Figure 2a – Average total cost of revalidation support reported by pilot organisation (on a per registrant basis). *Number of respondents: 17 pilots*

Pilot sites	Average organisation costs (per registrant basis)		
	One-off upfront costs before revalidation is introduced (£)	Annual costs through the first 3 year cycle of revalidation (£)	Ongoing annual costs after the first 3 year cycle of revalidation (£)
Continuing professional development	93	167	28
Practice hour requirements	7	4	3
Feedback, reflection and professional development discussion	11	10	7
Third party confirmation	16	15	8
Online revalidation application	13	11	10
Preparation for revalidation and overall management of revalidation	33	33	29
Total	173	240	86

⁹ Renewal itself is already a requirement of registration with the NMC. Under revalidation each registrant's current renewal date will be used as their date of revalidation.

¹⁰ Figures 7a,b,c in Section 4 provide further information in relation to the estimated costs by revalidation requirement reported by pilot and non-pilot organisation respondents.

Figure 2b – Average total cost of revalidation support reported by non-pilot organisation (on a per registrant basis). *Number of respondents: 93 non-pilots*

Non-pilot sites	Average organisation costs (per registrant basis)		
	One-off upfront costs before revalidation is introduced (£)	Annual costs through the first 3 year cycle of revalidation (£)	Ongoing annual costs after the first 3 year cycle of revalidation (£)
Continuing professional development	54	43	35
Practice hour requirements	25	23	17
Feedback, reflection and professional development discussion	55	39	42
Third party confirmation	32	24	22
Online revalidation application	17	10	9
Preparation for revalidation and overall management of revalidation	57	163	161
Total	239	302	286

Organisation respondents estimated costs for a range of different types of support for their registrants. However, the majority of the ongoing costs estimated by organisations were linked to HR and additional staff support: 50% of estimated ongoing costs for pilot sites and 71% for non-pilots. Organisation respondents also expect to incur costs, albeit to a lesser extent, for measures including IT system changes, training and preparing their own guidance.

Additionally, we found evidence that some organisations included cost estimates for support which are not directly associated with revalidation, for example to make performance improvement changes. It was not possible to separate out these costs fully within the organisations' survey responses, although there are some costs that can be linked to highly supportive measures, such as staff training, e-portfolio development and monitoring renewal dates¹¹.

It is possible that by providing more explicit guidance to organisations on what they might reasonably be expected to do to support their registrants to revalidate, the nature of support planned by organisations and the resulting costs will change and may reduce.

¹¹ See footnote 9.

1.1.2.4 Larger organisations generally estimated higher total costs but lower costs on a per registrant basis, which means total costs of revalidation cannot easily be estimated

The size of organisations (based on their number of registrants) is a factor in the scale of costs: in general, across organisation respondents, estimated total costs increase with the size of the organisation but decrease on a per registrant basis. This is likely to be due to the realisation of economies of scale.

Given the differences in the estimated organisation costs on a per registrant basis depending on the size of the organisation, the average organisation costs per registrant (either for pilots or non-pilots) cannot simply be multiplied by the number of nurses and midwives on the register to give a total cost of revalidation across the UK. As costs differ depending on the size of the organisation, detailed information on the number of organisations by their size would be required to scale the average costs up to a total across the UK. However, this information is not readily available to the NMC or the four countries' Programme Boards.

1.1.2.5 Registrants' costs are driven by the time required to revalidate

Registrants' costs are driven by the time required to revalidate over the three year period. As reported by registrant survey respondents, the additional time and costs per registrant associated with revalidation include:

- Familiarising themselves with the requirements: a one-off cost – e.g. reading and understanding the guidance – an average (mean) time of almost 12 hours (£200)¹²; median time of 5 hours (£84);
- Feedback, reflection and discussion: collectively the second highest cost – averaging just over 8 hours (£138) to collect feedback, write reflections and have a discussion; median time of 6 hours and 30 minutes (£110);
- CPD: an average of 4 hours (median of 2 hours) for recording CPD in line with the additional requirements of revalidation, for example to link the CPD to the Code. Although the large majority of registrant respondents already significantly exceed both the total CPD (40 hours) and participatory (20 hours) CPD revalidation requirements, and so will not incur additional costs, a small proportion of registrants will need to increase their CPD hours. The average additional time required, spread across all registrants, is 13 minutes, equivalent to £4 per registrant;
- Practice hour requirements: costs relate to the recording the information. On average (mean), registrant respondents reported that it took an additional 4 hours to record practice information, equivalent to a cost of £67 per registrant; median time of 1 additional hour (£17);
- Third party confirmation: on average (mean) the time associated with this was 1 hour, with an equivalent cost of £16 per registrant; median time of 30 minutes (£8);
- Online submission: costs were limited, equivalent to £23, on average (mean), per registrant; £8 per registrant based on the median response; and

¹² Registrant time costs were converted into a monetary value: additional staff hours x average hourly wage = total staff cost impact. Hourly wage figures for nurse and midwives was sourced from the Office for National Statistics Annual Survey of Hours and Earnings, 2013. We calculated a weighted average hourly wage for nurses and midwives (based on the relative proportions of nurses and midwives on the register as at February 2015). This gave us an hourly wage of £16.88 per registrant that was used throughout our analysis.

- Providing further information to the NMC as part of the revalidation submission: the average (mean) time for this among respondents to the NMC survey was just over 12 hours (median time of 8 hours) to prepare and submit further information, though this will apply to only a small proportion of registrants.

The estimates of additional time spent in meeting the revalidation requirements vary widely across individual registrant respondents and different requirements. As with organisations, it is likely that revised NMC guidance may change the interpretation of what is required by registrants and therefore the likely time and costs. Also, while there is evidence that some registrant respondents were not meeting the requirements under Prep, and so factored this into their estimates of additional time required to meet revalidation, others were exceeding the current requirements.

1.1.3 Next steps

The findings of both our readiness assessment and the cost benefit analysis suggest a series of next steps to be undertaken by the NMC, the four countries' Revalidation Programme Boards or their representatives, and/or by other stakeholders across the health and care system.

Where issues were identified in the early stages of our project by stakeholders, for example around the need to address certain perceived gaps in awareness, we shared these initial findings at that point in time with the NMC and four countries' Revalidation Programme Boards. We understand that activities are under way to address a number of these issues.

1.1.3.1 Clarifying the guidance

The variability in interpretation of the provisional guidance for registrants, and limited level of guidance available to employers, are likely to be key drivers in the variability of estimated costs of revalidation.

The NMC could prepare revised guidance to set out more explicitly what is required of both registrants and employers.

Clearer guidance should reduce the wide variability in interpretation of the requirements and support required from organisations, give greater consistency in implementation, influence what measures are put in place by employers and thus affect the likely costs of implementation.

Following feedback from the pilot organisations, the work of Ipsos MORI, and this report, we understand that the NMC is currently developing this revised guidance and plans to publish it in September 2015.

1.1.3.2 Developing a comprehensive communications plan

A significant number of stakeholders recommended that a comprehensive communications plan should be developed to raise awareness of revalidation across all areas of the system¹³. This could incorporate activities that are to be carried out by the NMC as well as by other parts of the health and care system. It should also cover the short, medium, and longer

¹³ See section 3.1.2.2 for activities that stakeholders suggested for increasing the reach to all practice settings.

term, for example to ensure the plan covers registrants that are not required to revalidate until the end of the first three year cycle of revalidation.

The communications plan needs to:

- Address all parts of the health and social care system, particularly those where there are perceived gaps in awareness, such as in smaller organisations; and
- Be coordinated, consistent and continuous, using all appropriate channels available, including quality and system regulators in the four countries, and employer representative bodies.

Importantly, the communications should not only explain what revalidation is, but also what it is not, giving practical examples where possible and seeking to communicate the benefits of the different elements of the model.

Stakeholders noted that, given the range of activities being carried out locally to communicate and provide guidance to registrants and employers regarding revalidation, it is important that a consistent 'single version of the truth' is used.

We understand that there are a number of communications plans in development across the UK. Bringing these together and sharing them widely and quickly as a single plan for engagement will give stakeholders greater confidence that gaps in awareness are being addressed.

1.1.3.3 Evaluating revalidation

Once the model and guidance are finalised, the framework to evaluate the impact of revalidation should be developed so that it is formally in place from revalidation's launch. It is important that the baseline is set at the launch so that the incremental impact of revalidation can be measured and the relevant information collected.

The evaluation should analyse a range of measures to assess the impact on registrants, organisations, patients and the public.

An evaluation should enable a more granular assessment of the actual (rather than estimated) incremental costs and benefits of revalidation. This would be based upon the actual experience of organisations and registrants going through the process with the finalised model and revised guidance.

1.1.3.4 Combining these activities into a clear action plan for implementing revalidation in the current timescales

Given the various activities outlined above, the view from stakeholders was that a clear action plan needed to be set out and agreed by the NMC working with the four countries' Revalidation Programme Boards. This should incorporate all of the relevant activities required for implementing revalidation, split out into three phases:

- **Phase 1: August – October 2015** – the period leading up to the decision being taken by the NMC Council and the four countries' Revalidation Programme Boards regarding whether to launch revalidation;
- **Phase 2: October 2015 – April 2016** – the period following the launch of revalidation (subject to it going ahead) prior to the first registrants revalidating; and
- **Phase 3: April 2016 onwards** – the commencement of revalidation by registrants.

This three phase action plan should be communicated to all relevant stakeholders, with clear roles and responsibilities for “owning” each activity, and with progress against the plan monitored and reported rigorously and transparently.

2 Introduction

2.1 Background

The NMC's governing council (Council) approved a draft model for nurse and midwife revalidation in September 2013.¹⁴

The NMC defines revalidation as: "the new process by which nurses and midwives demonstrate that they practise safely." Currently, in order to maintain their registration, all nurses and midwives must pay an annual fee and this renewal of registration is known as annual retention. Every three years (from the date of initial registration or last readmission) nurses and midwives must also submit a 'notification of practice' (NOP) form, declaring that they have met post-registration education and practice (Prep) requirements. This three-yearly process is known as periodic renewal. According to the NMC, "revalidation will strengthen the renewal process by introducing new requirements that focus on:

- Up-to-date practice and professional development;
- Reflection on the professional standards of practice and behaviour as set out in the Code; and
- Engagement in professional discussions with other registered nurses or midwives."¹⁵

Employers currently provide some support to registrants for Prep, such as in providing opportunities for registrants to meet their practice hours requirements and to carry out CPD. Employers are also expected to know the renewal dates of their registrant employees. However, the responsibility for periodic renewal sits with the registrant.

In January 2014, the NMC undertook a two-part, six month consultation on the proposed model of revalidation. The resulting model of revalidation¹⁶ was then piloted with 19 organisations representing a range of practice settings across the four countries of the UK between January and June 2015 (with pilot registrants submitting their revalidation forms through NMC Online between 01 April and 31 May 2015).¹⁷

The pilot was put in place to help test the system and processes underpinning revalidation. This was prior to a decision being taken by Council, planned for October 2015, on whether to introduce revalidation across the health and care system, starting with nurses and midwives whose renewal is due in April 2016.¹⁸ The four countries of the UK will also input into the NMC's decision through their Revalidation Programme Boards. In addition, these Programme Boards will play a vital role in implementing revalidation when it is introduced.

¹⁴ NMC Council papers, September 2013 (as at 05 August 2015):

<http://www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council2013/council-papers-12-september.pdf>

¹⁵ Explanation of revalidation (as at 05 August 2015): <http://www.nmc.org.uk/standards/revalidation/>

¹⁶ See Appendix 1 for the specific requirements of the NMC's provisional revalidation model that was piloted in 2015.

¹⁷ NMC news announcement (as at 05 August 2015): <http://www.nmc.org.uk/news/news-and-updates/first-nurses-and-midwives-to-pilot-the-system-of-revalidation-this-spring1/>

¹⁸ Revalidation FAQs (as at 05 August 2015): <http://www.nmc.org.uk/standards/revalidation/revalidation-guidance-and-resources/revalidation-faqs/>

As with Prep, the expectation is that the primary responsibility for revalidation is with the registrant themselves: the provisional model has been designed to be achievable by both employees within large organisations and the self-employed nurse or midwife.

2.2 Objectives, scope and approach

2.2.1 Objectives

The NMC commissioned KPMG to explore institutional and system¹⁹ readiness for the introduction of nurse and midwife revalidation at the end of 2015 and assess the associated costs and benefits of implementing the proposed model.²⁰

2.2.2 Scope

We have considered readiness for, and costs and benefits of, revalidation across the four countries within the UK. The cost benefit analysis (CBA) looks at the different costs and benefits associated with the revalidation model. For readiness we have considered this from the perspectives of organisations, for example employers and the broader health and care system. Our scope of work did not include consideration of readiness from the perspective of the registrant nor the NMC. In addition, our scope of work did not include the costs and benefits of revalidation to the NMC.

2.2.3 Approach

In order to explore perceptions around readiness and assess costs and benefits we broke down our approach (which is set out in detail in Appendix 2) into three phases – Define, Assess, and Report. In summary, they are:

2.2.3.1 Define phase

We reviewed the NMC revalidation model and worked with the NMC and representatives from the four countries' Revalidation Programme Boards to define all aspects required to carry out our work.

We identified six kinds of settings where nurses and midwives typically practice. We used this to make our analysis representative and to provide coverage of the different practice settings and geographical locations as far as possible. They are:

1. **All fixed location NHS or independent settings** – for example, acute hospital/secondary care/mental health trusts/Health Boards, acute providers in the independent sector and hospices;
2. **General practice settings** – for example, all general practice/primary care settings;
3. **Formal community settings** – for example, NHS community trusts, large independent community providers and public health bodies;
4. **Sole registrant or self-employed settings** – for example, self-employed nurses, small privately owned care homes, schools and prisons;
5. **Agency settings** – for example, nursing and midwifery agencies; and

¹⁹ The 'system' has been defined to include the bodies who support registrants and organisations to implement and enact revalidation.

²⁰ NMC 'Invitation to tender' document prepared for this project, January 2015.

6. **Non-clinical practice settings** – for example, academic or research organisations, government departments, non-departmental public bodies or executive agencies, third sector organisations and local authorities.

2.2.3.2 Assess phase

We carried out our analysis and evidence collation to allow us to report our findings. This included:

- Carrying out 49 interviews;
- Holding 14 focus groups; and
- Issuing an organisation survey to 271 organisations, and feeding into a registrant survey (issued by Ipsos MORI) and a survey of registrants at the pilot organisations who were asked to provide further information to the NMC as part of their revalidation application (issued by the NMC).

For the purpose of this report, we define stakeholders as being individuals that we have engaged with either as:

- ‘System stakeholders’ – individuals representing parts of the health and care system; or
- ‘Organisations’ – individuals representing organisations that either employ nurses and midwives or represent nurses and midwives, such as membership organisations.

2.2.3.3 Report phase

The output of this project is this independent report, detailing the key findings from our analysis of exploring readiness for the introduction of revalidation and the associated costs and benefits. This report highlights and provides insight into the consistent messages drawn from engagement with stakeholders across the health and care sector.

We have used the readiness criteria²¹, developed in the first phase of work, to shape our readiness findings (Section 3) in the following areas:

- Awareness and culture (Section 3.1);
- Planning and implementation – including resources, systems and processes, guidance, tools and support (Section 3.2); and
- Governance of implementation (Section 3.3).

We have also set out our findings relating to the costs and benefits of revalidation within Section 4.

The supporting evidence for the cost benefit analysis can be found in Appendix 4.

²¹ Readiness criteria are set out in Appendix 2.6. Also, an NMC document based upon this work sets out the first two categories for employers (as at 05 August 2015): <http://www.nmc.org.uk/globalassets/sitedocuments/revalidation/preparing-for-revalidation.pdf>

3 Exploring readiness

3.1 Awareness and culture

3.1.1 Buy-in is generally strong for revalidation, particularly in pilot organisations

Awareness of the model and buy-in to its objectives are an essential foundation for the implementation of revalidation.

Our findings revealed a spectrum of support for revalidation, from many who were very supportive of its introduction through to a small number of others who retained a degree of scepticism that revalidation will fully deliver its intended aims. Similarly, stakeholders identified a range of overall benefits from introducing revalidation (see Section 4.2 for further information on the benefits of revalidation).

Stakeholders thought that awareness of revalidation was relatively high on the whole, but views were mixed about the detailed knowledge of the model. Some stakeholders believed that there was still some confusion between the model for medical revalidation (for doctors²²) and that being proposed for nurses and midwives, particularly among employers who are not registrants themselves. However, we found little direct evidence of this among the stakeholders we spoke with.

A number of stakeholders in interviews and focus groups suggested that to date the communications around revalidation “undersell” its benefits. In particular, they argued, positive messages around improved personal development discussions could be emphasised more, along with messages highlighting how revalidation can give greater confidence in professional practice. They commented that this would complement messaging about the risks to registrants of not being ready and improve overall awareness and engagement.

Many stakeholders commented that the benefits to registrants as professionals and to the standing of the profession as a whole need to be highlighted and reinforced by senior nurses and midwives which they felt would help strengthen awareness and buy-in. They felt this should form a major part of a communications campaign between now and the start of revalidation.

3.1.1.1 Support among pilot organisations

Pilot organisations have been particularly valuable to our analysis as they can speak from the experience of having tested the model. Early in this project our team attended the Revalidation Pilot Group, a meeting of pilot leads from across the 19 pilot organisations. We listened to a variety of these pilot organisations share with us their hopes for the pilots, but also concerns about how revalidation would work for them and their registrants.

In meeting many of the same pilot leads in focus groups, interviews, and in subsequent Revalidation Pilot Group meetings since taking part in and completing the pilots, we

²² Introduced by the General Medical Council in December 2012.

identified that confidence in the model and the perception of value from revalidation has increased over the period. They stated that they learnt a lot about revalidation in the process and all of those we engaged with were supportive of revalidation.

Many pilot organisations we spoke with were keen to support the implementation beyond the pilots: contributing their experience, materials they had developed, and engaging with target groups of registrants and employers. Indeed, some, such as Aneurin Bevan University Health Board (ABUHB) in Wales, is already sharing its materials and roadshows beyond the bounds of the Board, and is encouraging registrants across its region to learn about what they will be required to do to revalidate. The experience of the ABUHB is particularly instructive as it was the largest pilot, with over 800 registrants completing revalidation and demonstrates that the model is able to work at scale.

It appeared that among pilot organisations, those where senior leadership was highly committed to introducing revalidation had the most engaged workforces and in focus groups and interviews tended to identify the most benefits from the exercise and from the process of revalidation.²³

We also observed that some pilots representing smaller practice settings were particularly supportive of revalidation and highly motivated for its introduction as they saw it as a 'mark of professionalism'.

One specific observation from pilots was that registrants found the process of revalidation simpler than many expected. Many commented that initial thoughts around revalidation were based on the medical revalidation model, and they tended to be quite anxious about what revalidation was and what it entailed.

We have been told a number of times by pilot organisations that the best way to understand and realise the benefits of revalidation for nurses and midwives is to do it. A number of stakeholders also mentioned that the guidance and communications from the NMC needed to be simpler and plainer, using more positive language as this would help allay concerns about revalidation.

3.1.1.2 Concerns for registrants considering leaving rather than revalidating

One concern expressed to us by many stakeholders, particularly system stakeholders, was that registrants close to retirement, particularly those working part time, might consider revalidation too great a burden and decide instead to leave the profession.

We did not, however, find direct evidence that nurses and midwives intended to leave rather than revalidate. Moreover, at least one stakeholder suggested that it might provide evidence that standards are rising if nurses and midwives leave because they are unwilling to carry out the requirements. We note also that pilot organisations consistently said in focus groups and interviews that registrants tended to find revalidation easier than expected.

Nonetheless, stakeholders suggested that if registrants choose to allow their registration to lapse rather than carrying out the revalidation requirements, it should be based on a

²³ Some pilot organisations reported that their pilots may have potentially been more successful if they had had a higher degree of senior sponsorship.

reasonable knowledge of what is required, hence it will be necessary to continue to challenge myths and explain the model as clearly and consistently as possible. Registrants may be able to gauge for themselves the likely work required if communications feature individuals who have been through the process.

3.1.2 Awareness is good in large employers but gaps are perceived among smaller organisations

We found evidence that there were significant activities underway or planned to prepare for the launch of revalidation across many parts of the health and care system; in particular, at this stage, around raising awareness²⁴. However, this has not been consistent across all practice settings. The evidence from our interviews and focus groups was that senior stakeholders²⁵ widely considered there to be an imbalance between larger organisations (both in the NHS²⁶ and independent sector) and smaller organisations. This said, it cannot be assumed that registrants working in these kinds of settings are unaware of the introduction of revalidation or even unprepared for it; rather, finding evidence of readiness is more difficult.

We also note that views were raised that there remain pockets of low awareness within large NHS organisations, particularly in 'front line' staff. Additionally, we heard in some interviews that awareness is low with those outside the professions and, in particular, amongst some Human Resources (HR) staff. However, our organisation survey did not support this assertion with approximately 71% of respondents stating their HR staff had either a medium or high level of awareness.

Through interviews and focus groups senior stakeholders consistently identified the following types of registrants or groups of practice setting as those where awareness, and therefore potentially readiness, was unknown or less certain:

- General practice nurses;
- Care sector settings – in particular small privately owned care homes or nursing homes, especially those not affiliated with large membership organisations;
- Sole registrant or self-employed registrants – including school and prison nurses;
- Agency staff; and
- Non-clinical practice settings – in particular registrants in managerial-type roles or roles that do not require nursing or midwifery registration to carry out the role.

We also experienced this while carrying out our assessment: we had significantly lower responses to the organisation survey and to requests to join focus groups and interviews from these kinds of settings, so it is more difficult to understand levels of awareness.

²⁴ See Appendix 3.2.1 for further examples of awareness raising activities being undertaken by system stakeholders and organisations.

²⁵ We define senior stakeholders as individuals with senior management responsibilities for nurses and midwives. These are likely to be people responsible for divisions or multiple teams of people.

²⁶ Note throughout the report when the term NHS is used this also refers to Health and Social Care (HSC) in Northern Ireland where appropriate.

While this was an issue in all four countries of the UK, the impact could potentially be greater in England where more nurses (and midwives to a much lesser extent) work outside large NHS organisations²⁷.

The concerns raised relating to these smaller organisations are specifically that:

- There does not tend to be the equivalent 'chain of command' from the Chief Nursing Officers (CNOs) down and the existing networks that are present with large NHS organisations. As a result, ownership of awareness-raising with these settings has not always been clear. Furthermore, there is limited understanding of which organisations employ registrants and where they are based.
- Opportunities to use representative bodies, such as The Care Provider Alliance for the independent adult social care sector, or quality and system regulators as channels to these groups have yet to be fully explored.
- Management in these types of organisations are less likely to be registrants than in large NHS organisations and therefore less likely to have been contacted directly by the NMC or system leaders close to the four country Revalidation Programme Boards.

There were views expressed that, whilst the levels of awareness may not be known in these settings, this may not impact on their readiness.

3.1.2.1 Midwives are considered well-positioned for revalidation

Midwives constitute 6% of the NMC register.²⁸ We looked specifically to see if there were any differences in relation to revalidation for midwives compared to nurses. We found no evidence that there was a particularly higher or lower level of awareness of revalidation among midwives than nurses. Midwives typically work for large, mainly NHS, organisations.

Most stakeholders we spoke with suggested that midwives are well-positioned for the introduction of revalidation as, midwives have been the subject of midwifery supervision for a number of years²⁹, which has some similarities to revalidation. An opposing view, and one we heard less frequently, is that rather than complementing supervision, revalidation places an additional burden on midwives.

²⁷ Anecdotal information from interviews and focus groups suggests that c.10-20% of registrants are not based in the NHS in Scotland, Wales, Northern Ireland, but c.60% are not based in the NHS in England. One stakeholder estimated that there might be approximately 1,000 nursing homes in England which are not members of one of the main employer representative bodies or owned by a large provider. We could not validate these suggestions as these data are not readily available to the NMC or the four countries' Revalidation Programme Boards.

²⁸ Register of effective practitioners as at 25 February 2015. We note that a number of registrants are registered as both nurses and midwives and the register cannot be divided straightforwardly between nurses and midwives. For the purposes of estimating the relevant proportions we used the proportion of registrants that held some form of midwifery registration (including those with dual registration) as the proportion of midwives.

²⁹ Supervision is a statutory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK. At least once a year, a supervisor of midwives meets each midwife for whom they the named supervisor of midwives to review the midwife's practice and to identify education needs; further explanation available here (as at 05 August 2015): <http://www.nmc.org.uk/standards/what-to-expect-from-a-nurse-or-midwife/how-midwives-are-regulated/how-midwifery-regulation-works/>

3.1.2.2 Widening the reach of revalidation to all practice settings

Stakeholders identified opportunities to increase the reach to all practice settings and in particular to these smaller organisations including:

- Mapping the likely size of the challenge – for example, the number of registrants in specific organisations in specific settings – to prioritise efforts and resources around awareness raising;
- Engaging with their management via quality and system regulators in the four countries as these are the institutions most likely to have current data on employers in health and care (for example CQC in England, Care Inspectorate Scotland (CIS), Regulation and Quality Improvement Authority (RQIA) in Northern Ireland, and Healthcare Inspectorate Wales (HIW) and CSSIW (Care and Social Services Inspectorate Wales)³⁰;
- Engaging more with employers through third-party employer and registrant representative bodies to reach management through these channels; and
- Providing registrants with practical tools and information for them to take to their employers to raise their awareness of revalidation and what support they might provide to their registrant employees.

The evidence from interviews and focus groups conducted in Wales and Northern Ireland suggested that, where possible, using existing networks can be very positive. The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) has been instrumental in leading much of the engagement activity in the country, while the reach of Wales' Health Boards and their role as both a commissioner and provider of health and care appears to give significant leverage outside their immediate employee base.

Timeframes for establishing these new channels and developing communications will be tight but there appears to be support and willingness from these third party organisations to support the NMC and the four countries' programme boards in this.

Stakeholders are generally of the view that if these steps are brought together in a focussed communications campaign, awareness can be raised sufficiently by April 2016. This should be led by the NMC in concert with the CNOs and the Revalidation Programme Boards of the four countries, with the support of influential third parties such as representative bodies. Stakeholders also commented on the importance of having senior professional (both registrants and non-registrants) voices backing and explaining revalidation.

Many stakeholders indicated that having this focussed communications campaign bringing together these elements could also help to ensure all stakeholders within the system are clear on what their roles and responsibilities are and that there is clarity on where registrants or organisations can go to find additional support.

³⁰ Note the CSSIW does not hold complete data as registration is not mandatory.

3.2 Planning and implementation

3.2.1 Organisations are making plans to support registrants, but awaiting the final model and are seeking greater clarity in the guidance for the model

Where organisations in the health and care system were engaged in the topic and understood the requirements of revalidation, the consistent message we heard was that organisations would ensure they will be ready to support registrants, simply because they have to be.

At the start of this project we worked with the NMC and representatives from the four countries' Revalidation Programme Boards to develop criteria for organisation readiness ("readiness criteria")³¹. These readiness criteria, based on the NMC model and guidance, set out the types of activities that organisations could carry out to support registrants to revalidate. They have been split into three different degrees of support.

- **The 'minimum level' of support** – the basic foundations of support that organisations could provide to enable nurses and midwives to be able to revalidate;
- **'Reasonably expected' activity** – the core building blocks of support that organisations might be 'reasonably expected' to put in place which would assist nurses and midwives to successfully revalidate and contribute to greater professionalism; and
- **'Highly supportive' measures** – additional elements of increased support that would enable even greater benefit to be achieved from revalidation.

Almost all organisations which responded to the survey appeared to be putting measures in place to prepare for revalidation (more than 98% of survey respondents) and most were doing more than the minimum to support their registrants to revalidate. Also, all organisation stakeholders we have engaged to date were planning to provide support to their registrants.

Technically, in the absence of legislation, the NMC has no statutory mandate to instruct employers to support revalidation (unlike the Responsible Officer (RO) legislation in medical revalidation³²) and the model of revalidation is designed to be achievable for registrants in all types of settings. This was acknowledged by stakeholders with most recognising that the responsibility for revalidation lay with registrants themselves. In reality, however, through our organisation survey we found that all but a small fraction of employers were planning to provide some support – the view we frequently heard was that not to do so might jeopardise the workforce and put staffing levels at risk. Also, organisations and pilots in particular told us that to derive the benefits sought from the model, preparation, investment and support from employers is required.

These examples highlight differing views on the level of support from organisations that is 'reasonably expected' or 'highly supportive' (as described above), which also has implications for the potential costs and benefits of revalidation.

³¹ See Footnote 21.

³²The GMC stated that "The RO role was introduced in the UK by the Medical Profession (Responsible Officers) Regulations 2010 and the Medical Profession (Responsible Officers) (Northern Ireland) Regulations 2010. The RO regulations that apply to England, Scotland and Wales were made by the Department of Health (England)." (As at 05 August 2015) <http://www.gmc-uk.org/doctors/revalidation/13696.asp>.

Based on our organisation survey:

- 52% of respondents are planning to put additional staff in place to manage revalidation within the organisation;
- 95% plan to monitor rates of revalidation internally; and
- 85% plan to use their current appraisal programme to support the professional development discussion and confirmation discussion for the majority of their nurses and midwives.

In addition, other common measures identified through interviews and focus groups that organisations plan to put in place include:

- Developing and providing additional guidance and training;
- Setting out the roles and responsibilities and the process for professional development discussions and confirmation; and
- Ensuring all staff have access to the necessary IT equipment.³³

All of these measures meet the definition of ‘highly supportive’ within our readiness criteria. Many organisations report planning measures which go beyond what the NMC considers to be ‘reasonably expected’, such as in implementing e-portfolios for employees.

System stakeholders are also supporting revalidation, with most system institutions putting in place resources to lead on revalidation, although these typically are not full time roles. Some were issuing their own surveys or questionnaires to understand what organisations are doing to prepare for revalidation.³⁴

3.2.1.1 Stakeholders are keen to see the final model for revalidation

A significant proportion of individuals we spoke to, including system stakeholders and representatives of pilot and non-pilot organisations, stressed the importance of the revalidation model being finalised as soon as possible.

We identified a widespread view that, while pilots were being carried out, the model of revalidation might be subject to change³⁵ and so they were holding back from making extensive preparations and communicating widely on requirements. Organisation stakeholders explained that they do not wish to waste effort and resources or confuse registrants with misinformation, and that registrants will not engage until it is clear that the model is final.

While 98% of respondents to the organisation survey suggested that they have considered what may be needed to deliver revalidation, only approximately 20% have begun to implement the measures they expect to require.

³³ See Appendix 3.3.2 for examples of activities being undertaken by organisations to support revalidation.

³⁴ See Appendix 3.3.1 for examples of activities being undertaken by the system stakeholders to support revalidation.

³⁵ The NMC has stated that “The pilot will help identify any ways in which we should refine the model, guidance and forms before its introduction at the end of 2015.” (As at 05 August 2015): <http://www.nmc.org.uk/news/news-and-updates/first-nurses-and-midwives-to-pilot-the-system-of-revalidation-this-spring1/>.

We found that it is widely expected that learnings from the pilots will be shared and revisions made to the guidance, and possibly also the model.

This has implications for readiness: the sooner the model is finalised the more time registrants and managers have to be aware of it, understand it, work out how it will work in practice, and put the required support in place.

3.2.1.2 Registrants and employers are seeking clarification of the guidance

While stakeholders reported queries and minor concerns about different elements of the model, for the most part they were more concerned about clarification in the guidance rather than the model itself. The concern raised was that the guidance in its current form would result in different perceptions of the relative complexity of revalidation and therefore the likely costs, as well as inconsistencies in the implementation of the model. Many stakeholders believe that to derive full benefits from revalidation, it needs to be implemented in a consistent manner.

Stakeholders consistently highlighted a desire for clearer guidance to better address concerns regarding the model and guidance. They were looking to the NMC to remove some of the uncertainty around them, with an emphasis less on what the requirements are and more on how registrants can meet them, including:

- More examples, including ones tailored to different settings;
- Case studies;
- Practical guidance, including showing how things registrants are already doing counts towards revalidation;
- Completed templates; and
- 'What if' scenarios set out as part of some 'frequently asked questions', for example what to do if someone is unable to revalidate.

This may also help organisations to estimate the likely costs of implementation and ongoing revalidation.

In the pilot organisations there is now a wealth of experience, examples and tailored guidance building on the NMC guidance which others can use. Many stakeholders, and pilot representatives in particular, specifically requested the sharing of these resources. As the NMC model or guidance evolves, ensuring there is 'one version of the truth' will become increasingly important.

Some particular areas that were consistently highlighted during our analysis as requiring further clarity and guidance have been set out below.

A Interpreting the requirements for practice hours

We regularly heard that there was confusion regarding the practice hours requirements:

- There were variations in how practice hours (already a requirement of registration) was being interpreted as a requirement of revalidation and, in particular, what work contributes towards a registrant's practice hours. This was highlighted as being a particular issue for registrants in roles such as those not in patient-facing or clinical roles, academia, local authorities, third sector organisations and public health.

- Many stakeholders were also unclear what evidence was necessary to support the practice hour requirements. We heard from pilot registrants who used timesheets and online diary records to try to identify what parts of their working days were spent engaged in professional activity as opposed to activities that did not require them to be on the NMC register. In contrast, others argued that so long as being a registered nurse or midwife, or even a registered professional, is a requirement of a role, irrespective of how much patient care is given, all hours in the role can contribute to the 450 hours minimum requirement, and therefore the job description was sufficient evidence.
- Particular concerns were raised for dual registrants and how they differentiate and evidence their nursing hours versus their midwifery hours, as well as for direct entry midwives currently working as health visitors.
- There were also HR policy queries being raised where organisations currently were not clear on how certain aspects should be dealt with and impact on revalidation requirements. Examples included staff on maternity / paternity leave, staff on long-term sickness leave, or staff currently suspended whilst under investigation.

A number of senior registrants with whom we engaged from across the four countries were concerned that uncertainty about the requirements or a requirement being considered as unachievable might see some senior registrants leaving the register. One example was given of where a nurse is Director of Strategy – a role for which clinical experience may be an asset but not a prerequisite³⁶.

To remedy these issues, clarification from the NMC through more guidance and examples on what constitutes practice hours should help registrants (and their employers) and allay their concerns.

B Meeting the requirements for Continuing Professional Development (CPD)

Few stakeholders thought that registrants would need to complete more CPD or specifically more participatory CPD to meet the 20 hours minimum requirement. Some system stakeholders were concerned that agency nurses and midwives and the self-employed may find it more challenging, though evidence from the registrants' survey suggests this may be unfounded³⁷.

Nonetheless, a number of stakeholders reported that the biggest concern was what could constitute CPD and what evidence was required for this, and that more examples around this would be welcome.

C Feedback, reflective practice and professional development discussions (PDD)

We consistently heard apprehension about feedback, reflective practice and PDD. Specifically, these related to:

- Uncertainty about whether the reflection should be separate from and additional to the feedback (and CPD);

³⁶ The parallel was made with medical revalidation where there is an intermediate step of relinquishing a doctor's licence to practise without leaving the GMC register. The revalidation model for nursing and midwifery has no equivalent.

³⁷ We note that registrants involved in the pilots are likely to be the more engaged registrants (hence being involved in the pilot), so they may be biased towards already meeting CPD requirements.

- Uncertainty about the levels of detail and sophistication of the feedback, the reflections, and how these are to be documented³⁸;
- Queries over what the PDD should cover and in what level of detail; and
- The roles and responsibilities of both parties involved in the PDD.

Stakeholders were particularly concerned for registrants employed or managed by a non-registrant, or for registrants not familiar with reflective practice, such as overseas-trained registrants or those who trained before this was taught to trainee nurses and midwives.

Some were concerned that registrants would simply ask friends to hold their PDD so as solely to meet the requirement rather than be challenged and supported on their professional development.

Stakeholders were requesting examples of feedback and reflective accounts and how they might be recorded by registrants.

D Clarifying the role of confirmers

Interviewees and focus group members regularly raised with us the need for greater clarity on the role of the confirmer in terms of who can do it and what should they do.

Stakeholders fear that without further guidance there is a risk the confirmer role will become a 'tick box exercise' or that registrants will not be able to revalidate as their confirmer would not approve a piece of feedback or a reflective account, for example.

An additional significant concern that was raised on multiple occasions was the responsibility of the confirmer around fitness to practise. Whilst the NMC has set out in the guidance that there are no responsibilities for confirmers in relation to this, many stakeholders still believe there to be a link, even if indirect. A small number expressed the opinion that the confirmer role loses its value if it is not linking revalidation to fitness to practise.

E Understanding the NMC 'request for further information' or audit

A number of stakeholders contrasted the proposed model for revalidation with the current Prep requirements with regards to the sampling and auditing of portfolios. They noted the very limited number of registrants to have their portfolio requested by the NMC for review under the current model and argued that revalidation will require a more visible and extensive audit process, including setting targets and reporting findings, if it is to be treated as more than a 'tick box exercise'.

Some stakeholders indicated that it would be important to understand how the NMC planned to implement the requests for further information to ensure the process will be more robust than Prep. This includes clarity on the number of registrants from whom more information will be requested and its risk-based approach to selecting them.

Additionally, stakeholders, including those who were selected to provide further information in the pilot, were consistently uncertain about how the NMC's 'requests for further information' would work in practice. This was both in terms of what additional information

³⁸ Some interviewees have noted that doctors have time built into their contracts for reflective practice and that nurses and midwives are currently at a disadvantage in having to carry out their reflective practice within existing timeframes.

registrants would need to have and provide, as well as what information the NMC would be reviewing (for example, whether the NMC's process would review the quality of CPD undertaken, check the hours had been met, or check that evidence was present). They were seeking further clarity to ensure registrants could be supported to complete the full revalidation process, which might include providing further information.

3.2.2 Implementing revalidation

3.2.2.1 IT system support

Registrants can currently apply for renewal of their registration by post. Revalidation will only be possible via application through NMC Online.

Stakeholders on the whole thought most registrants should be able to set up NMC Online accounts and use the system to revalidate³⁹. However, there were some concerns raised about the process being fully online:

- Technical barriers could cause issues with revalidating – experiences from some pilots where there were incompatibility issues with unsupported system software or the security systems (including firewalls); and
- Some registrants may find online revalidation (and supplying online further information as requested by the NMC) more challenging⁴⁰ – in particular where registrants are less IT literate, where access to IT equipment is limited, such as those in small care homes, or where registrants do not have work email addresses (this is particularly an issue in Northern Ireland)⁴¹.

Stakeholders stated that they would like some assurance from the NMC that these various challenges are:

- Identified and recognised by the NMC and the four countries' Revalidation Programme Boards;
- Being addressed with milestones that meet the timetable for the implementation; and
- Alternative measures are being put in place if necessary.

3.2.2.2 Timing of implementation

Many stakeholders in interviews and focus group volunteered their perspectives on the timing of implementation for revalidation in nursing and midwifery scheduled for April 2016. Some considered that more time was needed to work through all of the various potential consequences of bringing in revalidation for registrants in April 2016. However, others thought that revalidation is too important to delay, and that doing so is unlikely to result in greater readiness.

³⁹ Though many pilot registrants and organisations provided advice and feedback on how to make this a simpler and more efficient experience.

⁴⁰ The NMC indicates it will make reasonable adjustments for registrants who cannot access NMC Online, for example due to a disability.

⁴¹ The NMC indicates that the revalidation model does not require registrants to have access to IT equipment at work or a work email address to be able to revalidate.

For those stakeholders who suggested that more time might be helpful, the reasons given included:

- With limited engagement so far with some significant groups of employers, such as adult social care providers, there may be too little time to fully engage with them prior to the launch of revalidation or to engage sufficiently to ensure they will be ready for revalidation;
- More time is needed to digest the learning from the pilot organisations and ensure that sufficient levels of registrants and management understand the model;
- There may be registrants, particularly outside the NHS, who are unable to revalidate – for example through having too restricted a period to meet practice hours requirements. However, given the limited reach to date into these settings, the scale of this is unknown; and
- Some stakeholders were requesting more time to fully understand the potential unintended consequence of registrants who are close to retirement age leaving the professions rather than revalidating.

Some stakeholders suggested various solutions to the issues they raised with regard to the timing of implementation such as:

- Presenting the first one-to-three years as an ongoing pilot, ‘soft launch’ or ‘action learning’ project, so that potential consequences could be worked through as it is being implemented;
- Postponing the implementation of revalidation starting with nurses and midwives with renewals due in April 2016 to a later date; or
- Creating a ‘safe harbour’ for registrants so that they can test the process without anyone losing their registration for a particular period.

3.3 Governance of implementation

3.3.1 Roles and responsibilities for the governance of revalidation could be more clearly defined and articulated

System stakeholders and organisations explained to us that the implementation of revalidation is a responsibility shared between the NMC and the four countries. In each a Revalidation Programme Board has been convened, chaired by the CNO of that country and is attended by representatives of different stakeholder groups. Each country has taken its own approach to appointing members and defining terms of reference for the Board.

The CNO role covers the whole profession in each country. However, a challenge for CNOs, identified by various stakeholders, was that the levers they have available differ between NHS funded care and other settings. This impacts how messages and support can be disseminated to all parts of the profession, and risks it being focused largely on NHS settings.

In Wales, Scotland and Northern Ireland three factors mitigate this risk. Firstly, health and care providers and commissioners are typically incorporated under the Trusts and Health Boards in these three countries, whereas in England they tend to be split out. Secondly, the size of independent and social care provision in the three countries is smaller proportionately than in England. Finally, they are much smaller in terms of population, number of registrants and number of employers.

One challenge that all four countries' Revalidation Programme Boards face is dedicated resource to support implementation. None of the leads for revalidation in each country is full time on revalidation and supports it in addition to other responsibilities.

We found that awareness of the four countries' Revalidation Programme Boards and their responsibilities was limited among organisations. Furthermore, it may be that some practice settings were receiving more support from the Programme Boards than others – for example, large NHS organisations are typically easier to reach collectively than other practice settings.

Similarly, we also found that some practice settings are better represented on Programme Boards than others: specifically NHS settings are well represented on the Boards, non-clinical settings less so.

Greater clarity of the role and responsibilities of these Programme Boards, particularly relative to those of the NMC, might help raise awareness of revalidation to all practice settings.

4 Costs and benefits of revalidation

The model for revalidation in nursing and midwifery has been developed by the NMC with the intention that it can be applied to all kinds of practice settings – from the wards of a major university teaching hospital to the self-employed cosmetic nurse. It is also designed to build largely upon existing requirements by which approximately 680,000 registrants currently self-certify that they meet the requirements of Prep.

In the absence of additional legislation for revalidation, the responsibilities lie with the registrant. These responsibilities are to ensure they have carried out all the requirements of the model, found a confirmer and, if not the same person another registrant with whom to have a professional development discussion, and finally that they have made the application to revalidate on time. However, the NMC has also recommended that employers support registrants. Where possible they have recommended that organisations use existing systems and processes, such as learning and development, line management and appraisals.

Revalidation will result in some costs for organisations and registrants, but will also result in the realisation of benefits.

The NMC commissioned KPMG to conduct a Cost Benefit Analysis (CBA) of its proposed model for the revalidation of nurses and midwives. The aim of this is to understand the potential impact of revalidation on the healthcare system. It considers the economic costs and benefits from an organisation and registrant perspective. It does not consider the costs and benefits to the NMC itself as a result of the introduction of revalidation.

This section of the report sets out:

- Our approach to conducting the cost benefit;
- Key limitations to our analysis and points to note when interpreting the findings; and
- The cost benefit analysis findings.

Additional evidence supporting the analysis and technical notes are provided in Appendix 4.

4.1 Approach to assessing costs and benefits

4.1.1 Overarching approach

CBA is used by the Government and other organisations to appraise policy interventions. It allows policy options to be reviewed by assessing their costs and benefits. The *HM Treasury Green Book for Appraisal and Evaluation in Central Government* presents the techniques and issues that should be considered when conducting these assessments. For the purposes of our CBA we adopted the principles of “*The Green Book*”.

We have assessed the net costs and benefits of revalidation. In order to do this, we:

- Established the current regulatory requirements placed on nurses and midwives (the baseline position) under Prep;⁴²
- Identified the changes proposed by the NMC for the introduction of revalidation of nurses and midwives; and
- Compared the current requirements to the proposed model to determine the incremental requirements of revalidation.

The organisation survey, Ipsos MORI survey of registrants taking part in the revalidation pilot (the registrant survey⁴³) and, interview and focus group questions were designed to capture evidence on the incremental requirements. This would provide us with the evidence required to assess the net costs and benefits.

Each of the requirements of revalidation was considered individually. It should be noted, however, that we agreed with the NMC that some areas of the revalidation requirements did not need to be considered within our analysis, specifically:

- The change in practice hour requirements for specialist community public health nurses (SCPHN) who are also midwives, from 900 hours to 450 hours, given that the number of registrants affected are small (less than 1% of the register);
- Professional indemnity arrangement requirements, as the changes under revalidation are minimal; and
- Health and wellbeing requirements, as these are unchanged under revalidation.

4.1.2 Cost methodology

The organisation survey asked respondents to estimate the costs of each of the requirements of revalidation and, where relevant, the staff time (in hours and minutes) required to meet the requirements.

Given the range in size of organisations (by number of registrants) responding to our organisation survey, we have presented our analysis of the organisation costs of revalidation on a per registrant basis. This better allows comparisons to be made across individual organisations and types of organisations.

Also, given that pilot organisations are likely to have a better understanding of the requirements of revalidation and have had the experience of supporting their registrants through the pilot, we present the cost estimates provided by pilot and non-pilot organisations separately.

The registrant survey largely collected evidence for the CBA in terms of the additional time requirements. Given that our CBA sought to quantify the financial cost of revalidation, time costs were converted in to a monetary value:

$$\text{additional staff hours} \times \text{average hourly wage} = \text{total staff cost impact}$$

⁴²NMC Prep Handbook (as at 05 August 2015): <http://www.nmc.org.uk/standards/additional-standards/prep-handbook/>

⁴³ See footnote 4.

Hourly wage figures for nurse and midwives were sourced from the Office for National Statistics, *Annual Survey of Hours and Earnings, 2014*.⁴⁴ We calculated a weighted average hourly wage for nurses and midwives (based on the relative proportions of nurses and midwives on the register as at February 2015).⁴⁵ This gave us an hourly wage of £16.88 per registrant that was used throughout our analysis.

It should be noted, that this salary cost is unlikely to be the same as the potential opportunity cost of the time. However, it can serve as a proxy for costs for the purpose of our CBA, given that this would be the cost of employing additional staff to backfill registrants who are diverted away from this to meet the revalidation requirements.

We have sought to assess the timing of costs associated with revalidation by analysing one-off upfront costs, ongoing annual costs through the first 3 year cycle of revalidation, and ongoing annual costs thereafter. In general, CBAs usually assess the costs and benefits over a certain period of time, with costs and benefits discounted over time to reflect time preference and the net present value (NPV) of the proposed regulatory changes measured. The *Green Book* sets out that costs and benefits should normally be extended to cover “the period of the useful lifetime of the assets”.⁴⁶ However, in this case, rather than conduct an NPV analysis, we present the costs (one-off and ongoing) at a point in time.

4.1.3 Benefits methodology

By their nature, benefits are often harder to quantify and in particular to place monetary values on. This is especially the case in the context of benefits relating to healthcare policy changes. As noted in the *Green Book*, the full value of goods such as health cannot be inferred from their market price. There are also important social benefits that should be taken in to account.

Given the complexities around quantifying the benefits of revalidation in monetary terms, particularly prior to its introduction, we have not undertaken a financial quantification of the benefits. However, we have undertaken an appraisal of the potential benefits drawing on evidence from the interviews and focus groups conducted with organisations and system stakeholders and based on quantitative analysis of the organisation and registrant survey responses.

Furthermore, the timing of benefits is less clear than the timing of costs. They may take more time to fully materialise. Our analysis does not assess the timeframe over which benefits will arise.

Further details of the methodology and assumptions made for the purposes of our quantitative analysis of both and costs and benefits are set out in Appendix 4.

⁴⁴ Office for National Statistics (2014) Annual Survey of Hours and Earnings, 2014 Provisional Results. Table 14.6a Hourly pay – Excluding overtime (£) – For all employee jobs: United Kingdom, 2014. (As at 05 August 2015: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-337425>)

⁴⁵ We note that a number of registrants are registered as both nurses and midwives and the register cannot be divided straightforwardly between nurses and midwives. For the purposes of estimating the relevant proportions we used the proportion of registrants that held some form of midwifery registration (including those with dual registration) as the proportion of midwives.

⁴⁶ *HM Treasury Green Book for Appraisal and Evaluation in Central Government*, paragraph 5.10.

4.2 Limitations to the analysis

By nature, the CBA and the inferences that can be drawn from the analysis are dependent on the quality and representativeness of the evidence collected. Therefore, before presenting the results of our analysis we set out below limitations and key points to note in relation to the analysis. These should be borne in mind when interpreting the results.

4.2.1 Limitations to the data collected from organisations

4.2.1.1 Representativeness of the data collected from organisations

Our organisation survey was issued to 271 organisations across the UK. These organisations were selected to provide a broadly representative coverage across the four countries of the UK and across different practice settings.

We received 119 completed responses to our organisation survey. Organisations in England and Wales proportionally accounted for the largest share of respondents relative to the number of surveys sent out. Scotland and Northern Ireland were less well represented.

In the majority of cases, survey responses were not complete. In particular, the organisations that responded to the survey were not always able to provide quantification or a breakdown of the costs associated with the different areas of revalidation. If we take into account all cost categories, 110 out of 119 organisations provided cost estimates for at least one area of revalidation. Of the complete responses in England, 80 were able to provide cost data. All completed responses from Northern Ireland and Wales included some cost estimates and 7 out of 8 completed responses in Scotland did.

Given that organisation costs estimates from the survey were limited both by country and practice setting we are unable to draw conclusions, and conduct detailed organisation cost and benefit analysis, at the country or practice setting levels.

4.2.1.2 Accuracy of the cost estimates provided by organisations

It should be noted that, whilst nearly all organisations surveyed plan to put some support in place, only 20% have started to take action to prepare for revalidation. Therefore, it is highly likely that organisations are not yet fully clear on the scale of costs they may incur and that the estimates provided in their survey responses will not be fully accurate.

Furthermore, our analysis draws on organisations' estimates of the costs of the support they thought they would need to put in place to support registrants based upon their understanding of NMC draft model and guidance in May 2015. A key finding of our readiness assessment is that there is a need for greater clarity in the guidance of the requirements and the obligations on organisations to support registrants. When the NMC's guidance is revised to provide this greater clarity it is likely that organisations' estimates of costs will change.

Also, we understand that some organisations are using the introduction of revalidation as an opportunity to make wider changes to their systems and processes. Some organisations plan to be highly supportive, putting measures in place for their registrants which are not strictly required to enable registrants to revalidate. And some organisations may not be fully supporting their registrants to meet the current requirements of Prep so are having to make more significant changes within their organisations to support revalidation. Therefore, although our organisation survey questions were designed to focus on the costs of the

incremental changes between Prep and revalidation, it is likely that organisations factored the cost of any wider organisational changes they plan to make in to their cost estimates for revalidation. This may bias the results in the following ways:

- Where organisations plan to make wider system and process changes, put high levels of support in place for their registrants, and/or are not fully supporting their registrants to meet the requirements of Prep there is the risk that organisations overestimated the costs of moving from the requirements under Prep to those under revalidation. This would bias the cost estimates upwards.
- Where organisations are already doing more than is required to support their registrants with Prep, and/or do not plan to put any additional support in place to support registrants to revalidate (even that support which the NMC considers to be reasonably expected) there is the risk that organisations' cost estimates are an underestimation. This would bias the cost estimates downwards.

Where we have evidence of the potential bias in cost estimates, we consider the possible impact of this when drawing conclusions about the scale of costs resulting from revalidation.

Despite the limitations of the data collected through the organisation survey, it should be noted that our CBA does not only draw on the survey evidence but also on the considerable broader evidence gathered through interviews and focus groups. While we were not provided with quantitative data in these sessions, we discussed costs and benefits and so we report on this and highlight whether there is a divergence of views. Our CBA considers the evidence in the round and not the survey data in isolation.

4.2.2 Limitations to the data collected from registrants

4.2.2.1 Representativeness of the data collected from registrants

The evidence collected from registrants was drawn from participants to the Ipsos MORI survey at the pilot sites (the registrant survey). No evidence was collected from registrants at non-pilot sites.

While the NMC selected the organisations to pilot revalidation from across the four countries of the UK and to cover a broad range of practice settings, given that there were only 19 pilot sites the number of registrants covered by the pilots could not be directly proportionate to the number of overall registrants by country, size of organisation or practice setting.

Within the pilot organisations, registrants were asked to volunteer to pilot revalidation or were required by their organisation to participate. Therefore, it is unclear whether the registrants going through the pilot would have the same experience of revalidation as all registrants might. This may impact on the results in the following ways:

- Some registrants may have signed up to pilot revalidation as they considered that they were already broadly meeting the requirements so would not need to do much additional work. If this is the case for the majority of registrants at the pilot sites (but not the case for all registrants across the UK) this risks leading to an underestimation of the additional time (and cost) associated with revalidation.
- Some registrants may have signed up to pilot revalidation as they thought they would need to undertake considerable extra work to meet the requirements and/or were not fully meeting the requirements of Prep, so wanted a 'practice run' before revalidation

goes live. If this is the case for the majority of registrants at the pilot sites (but not the case for all registrants across the UK) this risks leading to an overestimation of the additional time (and cost) associated with revalidation.

Additionally, registrants piloting revalidation had to meet the requirements and submit their revalidation application within a much shorter timeframe than will be the case when revalidation is introduced. While registrants will only need to revalidate every three years and so meet the requirements over this timeframe, pilot registrants had to submit their revalidation application between 1 April and 31 May 2015. This may impact on the time they spent in meeting the new requirements.

There are also limitations to data collected by the NMC from its survey of those registrants at the pilot sites asked to provide further information to the NMC as part of the revalidation application process. As only a sample of registrants are asked to provide further information, the survey was necessarily sent out to fewer registrants. There were only 57 respondents to the NMC's survey which limits the inferences that can be drawn from the results. Furthermore, based on the range of responses provided there may be variation in the way the questions were interpreted. However, it is difficult to determine if this is due to differences in the time registrants actually spent or a misinterpretation of the question and/or the requirements.

4.3 Benefits of revalidation

4.3.1 Organisations recognise the potential benefits of revalidation

Across the interviews, focus groups and surveys there was general consensus that revalidation will deliver a range of benefits. Respondents were positive about the impact of revalidation and generally highly supportive of its introduction. The benefits cited included:

- Encouraging greater reflection and continuing professional development within professional practice;
- Allowing registrants to feel there is a greater focus on their personal development;
- Increased engagement of nurses and midwives in appraisals and professional development processes;
- Giving nurses and midwives a greater sense of professionalism and providing greater assurance to employers and the public on the level of professionalism;
- Providing greater protection to registrants themselves; and
- Increasing awareness among registrants of the role of the new NMC Code.

The organisation survey results indicate that organisations most strongly agreed that revalidation will increase awareness of the Code in practice. Organisation respondents were most strongly in agreement that revalidation would⁴⁷:

- Raise awareness of the Code and standards expected of nurses and midwives. On average approximately 90% agreed or strongly agreed; and
- Increase an awareness of the role of the Code in practice. On average over 90% agreed or strongly agreed.

⁴⁷ The average level of agreement is calculated as the average level of agreement across benefits questions asked in relation to each of the revalidation requirements; the survey did not ask respondents for their overall view regarding the benefits of revalidation.

The proportions of organisation survey respondents who strongly agreed or agreed that there would be benefits from each revalidation requirement are presented in Figure 33.

Figure 3 – Proportion of organisation survey respondents that strongly agreed or tended to agree with the benefit statements⁴⁸. *Number of respondents: 117*

	Continuing professional development	Feedback, reflection and professional development discussion	Third party confirmation
Give nurses and midwives a stronger professional identity	74.2%	75.0%	75.3%
Improve nurses and midwives' ability to keep their knowledge and skills up to date	86.0%	N/A	N/A
Encourage a culture of reflection and improvement because of the participatory CPD requirement	91.3%	N/A	N/A
Lead to improved practice and therefore public protection benefits	81.7%	83.9%	79.6%
Ensure that, through the participatory CPD requirement, nurses and midwives do not work in professional isolation	72.0%	N/A	N/A
Raise awareness of the Code and standards that are expected of nurses and midwives	N/A	94.6%	87.1%
Give nurses and midwives a stronger professional identity	N/A	N/A	N/A
Encourage identification or resolution of practice concerns early before they escalate or require referral to the NMC	N/A	73.1%	71.4% ⁴⁹
Encourage a culture of sharing, reflection and improvement	N/A	90.3%	83.9%
Increase an awareness of the role of the Code in practice	N/A	95.6%	91.2%
Ensure that nurses and midwives do not work in professional isolation	N/A	72.8%	75.0%

It was felt, in general, that certain of the revalidation requirements would particularly deliver specific benefits. For example:

- Organisation respondents saw the greatest benefits arising from CPD to be associated with the reflection and improvement linked to participatory CPD (approximately 90% of organisations agreed or strongly agreed with this);
- It was most strongly felt among organisation respondents that the benefits of feedback, reflection and discussion requirements would be linked to raising awareness of the Code

⁴⁸ Organisation survey respondents were not asked to provide their view on all the benefit statements in relation to each of the revalidation requirements. Where a question was not asked, this is noted as N/A in the Figure.

⁴⁹ For third party confirmation, this benefit was "encourage the early identification and resolution of concerns about a nurse or midwife's practice, before they escalate or require referral to the NMC"

and its use in practice (95% of organisation respondents agreed or strongly agreed). This finding is consistent with the views expressed in our interviews; and

- Awareness of the role of the Code in practice was seen by more than 85% of organisation respondents to be a benefit of third party confirmation.

In our interviews and focus groups views were somewhat varied on the impact of revalidation on public safety. Some thought it would inevitably increase public safety through the raising of professional standards. However, some interviewees commented that it would not stop instances of poor practice, nor prevent similar failings to those seen at the Mid-Staffordshire NHS Foundation Trust Hospitals⁵⁰. Across our survey, however, over 80% of organisations agreed or strongly agreed that revalidation would lead to improved practice and therefore public protection benefits.

4.3.2 Registrants also recognised the benefits, albeit less so than organisations

In general, registrant respondents at the pilot sites who participated in the Ipsos MORI survey agreed with the statements about the benefits of revalidation but on average less strongly than organisation survey respondents. Registrant respondents did agree that there are benefits associated with revalidation:

- On average across the benefits questions approximately 80% agreed or strongly agreed that revalidation would raise awareness of the Code and standards that are expected of nurses and midwives;
- A similar proportion agreed or strongly agreed it would increase an awareness of the role of the Code in practice; and
- On average approximately 75% agreed or strongly agreed that it would encourage a culture of sharing, reflection and improvement.

The proportions of registrant survey respondents that strongly agreed or tended to agree that there would be benefits from each revalidation requirement are presented in Figure 4.

⁵⁰ Mid Staffordshire NHS Foundation Trust Public Inquiry 2013, published 6 February 2013 (as at 05 August 2015): <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>

Figure 4 – Proportion of registrant survey respondents that strongly agreed or tended to agree with the benefit statements⁵¹. *Number of respondents: 1120*

	Continuing professional development	Feedback	Written reflective accounts	Professional Development Discussion	Third-party confirmation
Give nurses and midwives a stronger professional identity	60.6%	53.7%	53.7%	59.5%	55.4%
Improve nurses and midwives' ability to keep their knowledge and skills up to date	79.2%	N/A	N/A	N/A	N/A
Encourage a culture of reflection and improvement because of the participatory CPD requirement	79.6%	N/A	N/A	N/A	N/A
Lead to improved practice and therefore public protection benefits	69.2%	64.2%	67.3%	74.4%	68.8%
Ensure that, through the participatory CPD requirement, nurses and midwives do not work in professional isolation	76.2%	N/A	N/A	N/A	N/A
Raise awareness of the Code and standards that are expected of nurses and midwives	N/A	77.9%	82.9%	82.6%	N/A
Increase an awareness of the role of the Code in practice	N/A	78.4%	84.0%	83.0%	75.9%
Encourage the early identification and resolution of concerns about a nurse or midwife's practice, before they escalate or require referral to the NMC	N/A	58.3%	56.2%	71.6%	67.4%
Encourage a culture of reflection and improvement	N/A	76.4%	N/A	N/A	N/A
Encourage a culture of sharing, reflection and improvement	N/A	73.6%	77.8%	82.0%	75.1%
Ensure that nurses and midwives do not work in professional isolation	N/A	N/A	62.6%	77.6%	70.7%
Support registrants to actively maintain their fitness to practise by providing increased access to consistent appraisal	N/A	N/A	N/A	N/A	77.9%

From the registrant survey, the greatest benefits from feedback, reflection, professional development discussions and confirmation were seen to be raising awareness of the Code and the standards expected of nurses and increased awareness of the Codes use in practice:

⁵¹ Registrant survey respondents were not asked to provide their view on all the benefit statements in relation to each of the revalidation requirements. Where a question was not asked, this is noted as N/A in the Figure.

- On average across the three areas, approximately 80% of registrants who participated in the survey agreed or strongly agreed that feedback, reflection and the professional development discussion would raise awareness of the Code and the standards expected of nurses and midwives; and
- Approximately 75% of registrant respondents agreed or strongly agreed that third party confirmation would increase an awareness of the role of the Code in practice.

Similarly, the individuals from the pilot organisations partaking in our interviews and focus groups said that registrants had found these elements of revalidation the most useful. Interviewees said these discussions encouraged good practice and reflection on the Code.

4.3.3 There is a degree of uncertainty over the scale of benefits

Despite general agreement that there would be a wide range of benefits arising from revalidation, in the interviews and focus groups there was some disagreement about the potential scale of the benefits. It was felt that this would depend on the implementation model and the support given by organisations.

Some interviewees thought that the lack of clarity about how some of the requirements should be met, and the flexibility in the support that organisations may provide could lead to costs being incurred but without the benefits materialising to the extent that they could. For example, if revalidation was focused only on the registrants complying with the requirements but nothing more, such as registrants not adequately reflecting on their feedback or practice, then the full value to practice that these revalidation requirements could bring would not be realised.

Furthermore, as the revalidation model has not yet been finalised, and as there is variability in the understanding of the proposed requirements, it is not surprising that there is uncertainty of the scale of the benefits and some mixed views about the extent to which they will be realised.

4.4 Organisations' estimated costs of supporting revalidation

Our analysis indicates that there is a wide range of cost estimates for organisations due to a number of factors including:

- Organisations' understanding of what is required to implement revalidation;
- What measures organisations plan to put in place to support their registrants;
- Whether organisations are pilot sites; and
- The size of organisations in terms of the number of registrants that practise within them.

4.4.1 There is significant variation in organisations' estimates of costs on a per registrant basis but pilot organisations generally reported lower costs than non-pilots

Organisation survey responses show significant variation in the estimated cost of revalidation across organisations on a per registrant basis. While approximately 15% of organisation respondents indicated that there would be no additional costs associated with meeting certain requirements, other organisations estimated a range of costs associated with supporting their registrants with each of the revalidation requirements.

On average the pilot organisations responding to our survey estimated considerably lower costs of revalidation. This is an important finding given that these organisations have had the benefit of piloting revalidation, and so are likely to better understand what will be required of them. Therefore, it may be the case that their responses more accurately reflect the costs that organisations will face. It should be noted, however, that despite having piloted the revalidation model, a number of the pilot organisations surveyed indicated that they were still unable to accurately estimate the costs of revalidation at this stage.

Figure 5 below sets out the average costs estimated by pilot organisations, non-pilot organisations and all organisations responding to our organisation survey.

Figure 5 – Organisation respondents per registrant cost of revalidation⁵². *Number of respondents: 17 pilots and 93 non-pilots*

	Pilot average (£)	Non-pilot average (£)	Overall average (£)
One-off upfront costs per registrant before revalidation is introduced	173	239	225
Ongoing annual costs per registrant through the first 3 year cycle of revalidation	240	302	289
Ongoing annual costs per registrant after the first 3 year cycle of revalidation	86	286	245

Within the pilot organisation responses, non-pilot organisation responses, and overall, there was significant variation in the cost estimates. This was the case across the one-off upfront costs and the ongoing costs. Of the organisations that gave an estimate of the cost associated with each of the requirements, approximately 15% reported no additional cost at all, while others envisaged significantly higher costs both on a one-off and ongoing basis.

A small number of organisations responding to the organisation survey estimated overall costs of revalidation, on a one-off and ongoing basis, to be considerably higher than the majority of other organisations. However, their costs estimates were not consistently higher across all of the areas of revalidation requirements than other organisation respondents. The inclusion of these organisation respondents' higher overall cost estimates in the averages, drives the results up. For example, if the average organisation costs on a per registrant basis did not include the estimates for the pilot and one non-pilot organisations that estimated the highest overall costs, the average ongoing costs after the first cycle of revalidation for pilots would be £7 lower and for non-pilots would be £66 lower.

Further details and analysis of the variation in cost estimates provided by pilot and non-pilot organisations is provided in Appendix 4.

⁵² Although no one organisation consistently predicted costs per requirement significantly higher than other organisations, there was one particular organisation that has above average costs for the majority of the requirements which affects the averages for non-pilot organisations. If this organisation is removed from the analysis, the non-pilot site average costs fall to £171 one-off, £227 annually through the first cycle of revalidation and £220 annually thereafter (the equivalent overall averages fall to £170, £229 and £192 respectively).

The variation in costs reported is likely to be a result of a number of factors, such as:

- The wide range of different approaches organisations are taking to supporting revalidation – from little or no additional support to being highly supportive of their registrants, with commensurate differences in costs.;
- The wide range of different systems and processes organisations currently have in place and into which revalidation will be incorporated;
- The limited extent to which organisations have developed their detailed thinking and plans for supporting revalidation and therefore their lack of detailed and accurate costing analysis for it at this stage; and
- Because the NMC's revalidation model is not yet final and as there are indications that organisations require further clarity on the requirements and their role in providing support, different organisations may be interpreting what is required in different ways.

4.4.2 Reported costs vary across the revalidation requirements, based on the expected support required

In the focus groups and interviews, there was a consistent view of where organisations thought costs from revalidation would arise. In general, the incremental changes associated with the CPD and practice hour requirements were areas thought to add little to organisation costs. In most cases it was assumed that registrants would largely already be meeting the requirements. However, there was some concern among NHS Trusts about the lack of clarity over who would incur costs for the CPD of Bank staff. As we outline below, there is a discrepancy between the views expressed by interviewees and the costs estimated by respondents to the organisation survey. This is particularly the case in relation to CPD.

Feedback, reflection, discussion and third party confirmation were thought by those interviewed to involve higher organisational costs given the time associated with meeting these requirements for both revalidating nurses and midwives and those supporting them. There was concern that this could divert staff from their day to day practice and place strain on those managers overseeing multiple nurses and midwives. These requirements were thought to be more challenging for registrants practising in more isolated settings, such as in the community or GP practices.

Assessing the average costs across all organisations (again on a per registrant basis) by each area of the revalidation requirement presents a slightly different picture to the views expressed by those individuals we interviewed and were involved in the focus groups.

Figure 6 below shows the average one-off cost, annual cost through the first cycle of revalidation and annual cost thereafter for all organisation respondents to our survey.

Figure 6 - Average cost per organisation for revalidation (per registrant basis), all organisation respondents. *Number of respondents: 17 pilots and 93 non-pilots*

Overall	Average organisation costs (per registrant basis)		
	One-off upfront costs before revalidation is introduced (£)	Annual costs through the first 3 year cycle of revalidation (£)	Ongoing annual costs after the first 3 year cycle of revalidation (£)
Continuing professional development	61	67	34
Practice hour requirements	21	19	14
Feedback, reflection and professional development discussion	45	33	34
Third party confirmation	28	22	19
Online revalidation application	16	10	9
Preparation for revalidation and overall management of revalidation	52	137	135
Total	225	289	245

As the interviewees also suggested, the feedback, reflection and discussion and third party confirmation requirements are expected by many organisation respondents to involve higher costs to support registrants (particularly one-off, up-front costs) than other areas of the revalidation requirements. However, approximately 35% of organisation respondents envisaged no additional costs associated with feedback, reflection and discussion and almost 40% of respondents envisaged there to be no additional costs associated with third party confirmation.

For the feedback, reflection and discussion requirements:

- On average, the use of line managers and additional staff to manage the process made up approximately 35% of the one-off upfront costs estimated by organisation respondents rising to almost 50% of the ongoing cost; and
- Use of existing appraisal processes within organisations and additional training accounted for a further 30% of the organisation respondents' costs associated with these requirements in terms of both one-off upfront and ongoing cost.

In terms of the average cost across all organisations associated with the third party confirmation requirement, training for confirmers and additional staff to manage the confirmation processes together accounted for almost 60% of the one-off and ongoing costs estimated by organisation respondents. Training for confirmers is a highly supportive measure that organisations may put in place. The NMC considers that it is not strictly necessary for organisations to train confirmers and that revalidation could take place successfully without this. Therefore, by including these costs in their estimates, organisations may be overestimating the true costs of revalidation.

Unlike the interviewees, organisation survey respondents expect the highest one-off cost to be associated with the CPD requirements. There are a number of factors driving this:

- On average, the costs associated with participatory learning made up approximately 60% of the overall cost on both a one-off and ongoing basis; and
- Training of staff and the development and provision of the e-portfolio together make up approximately 20% of the overall cost of CPD on average.

However, 20% of organisation respondents envisaged no additional cost associated with the CPD requirements and almost 45% projected there would be no additional ongoing costs after the first cycle of revalidation. Furthermore, as, on average, results from the registrant survey suggest that registrants at the pilot sites already meet the requirement to undertake 40 hours of CPD, including 20 hours of participatory CPD, it is unclear that the additional support envisaged by organisations (and factored in to their cost estimates) would be required. If the costs associated with supporting participatory CPD were not included in the overall organisation respondents' cost estimates, the average ongoing cost for pilot organisations after the first cycle of revalidation, on a per registrant basis, would fall to £65, and for non-pilot organisations would fall to £266.

Furthermore, the NMC does not consider that training staff to support revalidation is required. This is considered a highly supportive measure that organisations may choose to put in place. They do not need to incur this cost to support their registrants to successfully revalidate. As noted above, the NMC's model for revalidation in nursing and midwifery has been developed with the intention that it can be applied to all kinds of practice settings, including those where nurse and midwives practice independently with little or no support. In these circumstances, organisation-led training of staff would be unlikely to be in place yet the registrants would be expected to still be able to revalidate. The development of e-portfolios is another highly supportive measure that organisations may choose to put in place, but is not strictly required to support revalidation. Therefore, by factoring these costs in to their estimates organisation respondents are likely to be overestimating the required costs of the changes from Prep to revalidation. If the costs associated with supporting staff training and the development of e-portfolios were not included in the overall organisation cost estimates, the average ongoing cost after the first cycle of revalidation for pilot organisations, on a per registrant basis, would fall by £10, and for non-pilot organisations would fall by £27.

The majority of organisation survey respondents reported high costs associated with preparing for, and particularly managing, the revalidation process. These reported costs were particularly on an ongoing basis through the first cycle of revalidation and beyond. However, despite significant costs reported by many organisations, more than a quarter of organisations reported no additional cost associated with either preparation or the overall management of revalidation on a one-off or ongoing basis.

As was the case for the overall average organisation costs per registrant, the pilot sites in general estimated lower costs of revalidation than the non-pilot sites across the different areas of revalidation. This is shown in Figures 7 a, b and c below.

Figure 7a – Average total cost of revalidation support reported by pilot and non-pilot organisations (on a per registrant basis). Number of respondents: 17 pilots and 93 non-pilots

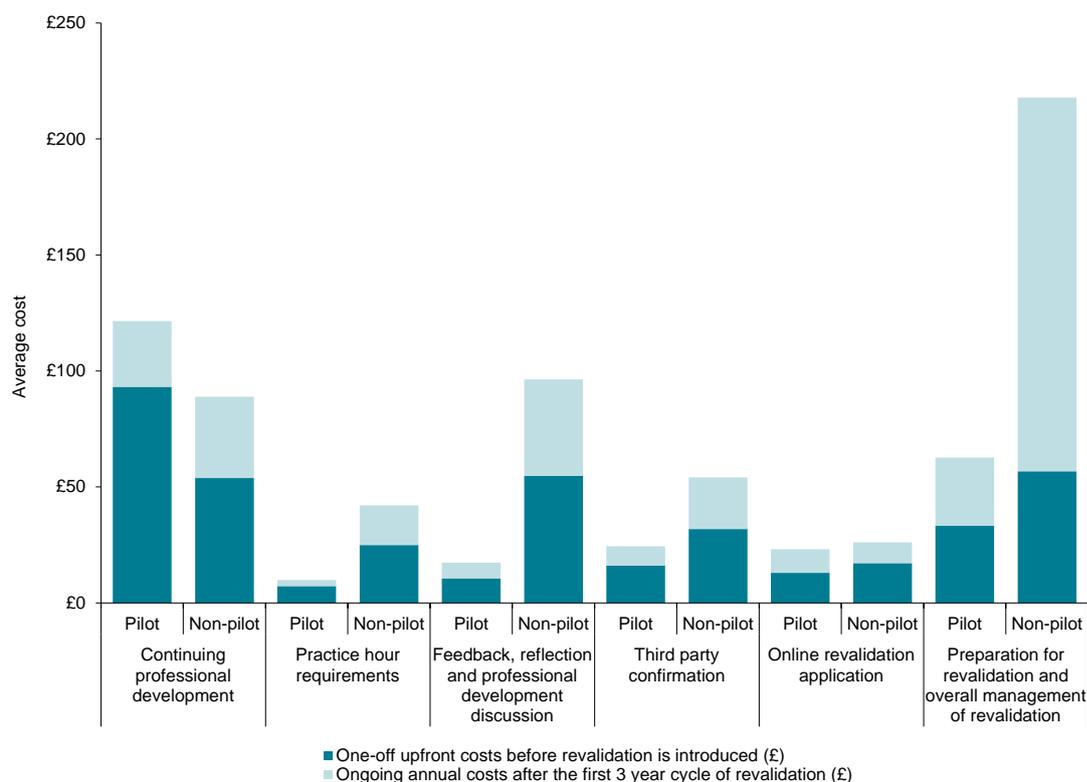


Figure 7b – Average total cost of revalidation support reported by pilot organisation (on a per registrant basis). Number of respondents: 17 pilots

Pilot sites	Average organisation costs (per registrant basis)		
	One-off upfront costs before revalidation is introduced (£)	Annual costs through the first 3 year cycle of revalidation (£)	Ongoing annual costs after the first 3 year cycle of revalidation (£)
Continuing professional development	93	167	28
Practice hour requirements	7	4	3
Feedback, reflection and professional development discussion	11	10	7
Third party confirmation	16	15	8
Online revalidation application	13	11	10
Preparation for revalidation and overall management of revalidation	33	33	29
Total	173	240	86

Figure 7c – Average total cost of revalidation support reported by non-pilot organisation (on a per registrant basis). *Number of respondents: 93 non-pilots*

Non-pilot sites	Average organisation costs (per registrant basis)		
	One-off upfront costs before revalidation is introduced (£)	Annual costs through the first 3 year cycle of revalidation (£)	Ongoing annual costs after the first 3 year cycle of revalidation (£)
Continuing professional development	54	43	35
Practice hour requirements	25	23	17
Feedback, reflection and professional development discussion	55	39	42
Third party confirmation	32	24	22
Online revalidation application	17	10	9
Preparation for revalidation and overall management of revalidation	57	163	161
Total	239	302	286

As shown in Figures 7 a, b and c above, pilot organisation respondents on average estimated lower costs for all areas of revalidation with the exception of the CPD requirement.⁵³ Pilot organisations expected higher one-off and ongoing costs through the first cycle of revalidation on average for this requirement. This was largely driven by their reported higher average costs associated with supporting participatory learning, staff training and HR/other team support.

The largest difference in estimated costs (both one-off and ongoing), however, between the pilot and non-pilot organisation respondents is in the costs associated with preparing for and the overall management of revalidation. While the pilot site respondents estimated the ongoing costs to be around £30 per registrant annually, the non-pilot site respondents provided average estimates of the ongoing costs of over £160 annually per registrant. The costs of this revalidation requirement are a key driver of the differences in cost estimated by the pilot and non-pilot organisation respondents, given that for the non-pilot organisations these costs account for over half of the ongoing costs of revalidation. This requirement is where the experience of the pilots is more likely to have influenced their costs estimates. They should have a better understanding of what was required to manage their registrants

⁵³ We note that the average size of respondent pilot organisations (approximately 2150 registrants) was bigger than the average of non-pilot organisation respondents (approximately 1500 registrants). Although, on average, respondent organisations with over 2000 registrants had lowest costs per registrant (see Figure 10), we consider that this is not significantly skewing the analysis and the impact of this is not sufficient to explain the difference in cost between pilot and non-pilot organisations.

successfully through the pilot of revalidation, so may have been in a position to more accurately estimate the costs of management of revalidation when it is fully launched.

Additionally, it should be noted that the estimated costs for the preparation for, and overall management of, revalidation capture the costs organisations expect to incur to monitor the renewal dates of their registrants⁵⁴. For the pilot site respondents these accounted for around 10% of the estimated costs of this area of revalidation and around 5% of the non-pilot organisations' estimates.

4.4.3 Organisations plan to put in place a range of support measures, with associated cost implications, particularly associated with the support staff required

In order to support their registrants to revalidate, in general, organisations plan to put a range of support mechanisms in place. The types of support that organisations indicated that they are planning include:

- IT system changes;
- Training;
- Preparation and provision of material and guidance; and
- Staff to support and manage revalidation.

In particular, those interviewed indicated that there would be costs associated with the additional staff time required to manage the revalidation process. The pilot sites indicated that they had either employed a full or part-time revalidation lead and extra administration staff to provide support, or would need to do so when revalidation is introduced. This was echoed in the organisation survey responses where HR and additional staff costs accounted for around 50% of the ongoing costs of revalidation (after the first cycle) estimated by pilot organisations and around 70% for non-pilot organisations.

As noted above in relation to the support for different areas of the revalidation requirements, some types of support that organisations plan to put in place may go above and beyond the minimum levels required, and expected from the NMC, to support registrants with revalidation. For example, some organisations noted in interviews that while implementing e-portfolio systems may not strictly be necessary⁵⁵, it might save greater costs on an ongoing basis through better coordination, monitoring and ease of completion for registrants. Some also noted that it assists organisations with registrants distributed over wide geographic areas.

We have analysed the organisation survey responses to assess the proportion of total one-off and ongoing costs organisations indicated they would incur for the different types of support across all the revalidation requirements, as set out in Figure 8 below.

⁵⁴ See footnote 9

⁵⁵ The largest pilot sites at ABUHB in Wales and Guy's & St Thomas' NHS Foundation Trust used paper based systems for the pilot, but a number of pilots noted that to roll out revalidation to all registrants electronic systems may be beneficial.

Figure 8 – Elements of the overall organisational cost of revalidation. *Number of respondents: 17 pilots and 93 non-pilots*

Cost element	Proportion of overall cost of revalidation in each category					
	Proportion of one-off upfront cost before revalidation is introduced (%)		Proportion of annual costs through the first 3 year cycle of revalidation (%)		Proportion of ongoing annual costs after the first 3 year cycle of revalidation (%)	
	Pilot sites	Non-pilot sites	Pilot sites	Non-pilot sites	Pilot sites	Non-pilot sites
IT systems and website development	10%	18%	4%	7%	8%	8%
Use of NMC guidance and preparation of material and guidance	5%	7%	2%	3%	2%	1%
Staff training, workshops or information sharing events	10%	23%	16%	5%	7%	5%
HR and additional staff costs	11%	19%	30%	71%	50%	71%
Participatory learning	50%	11%	39%	7%	19%	7%
Use of line managers and the appraisal process	3%	9%	1%	5%	2%	5%
Other ⁵⁶	12%	13%	8%	2%	13%	2%

There are significant differences in the composition of the one-off and ongoing costs associated with revalidation as estimated by organisation respondents. They estimated HR and additional staff costs as the most significant cost driver, particularly for non-pilot organisations:

- On average, the largest estimated ongoing annual costs after the first cycle of revalidation are associated with HR and additional staff costs. This was the case for both pilots (50% of total costs) and non-pilot respondents (71%).
- For the pilot site respondents, however, the main driver of one-off estimated costs and ongoing costs through the first cycle of revalidation are associated with supporting participatory learning (39% of total annual ongoing costs through the first cycle of revalidation) followed by HR and additional staff cost (30%).
- HR and additional staff costs account for only 11% of the one-off upfront cost of revalidation for pilot respondents and 19% for non-pilots.

⁵⁶ This includes the 'other' cost category for each requirement as well as costs associated with: access to job descriptions and provision of attendance records for the practice hours requirement; identifying people for discussions to be held with for feedback; identifying confirmers and assigning registered nurses and midwives to confirmers for third party confirmation; and review and familiarisation with the requirements, speak to each nurse and midwife, use existing records to maintain information, maintain a manual log of renewal dates and development of existing governance mechanisms for the preparation and overall management of revalidation.

- Non-pilot organisation respondents estimated that the greatest proportion of one-off costs (23%) would be associated with staff training, workshops or information sharing events. This may be expected given that their registrants will be going through revalidation for the first time and raising awareness and supporting their staff understand the requirements could be considered as reasonably expected from organisations. However, staff training to support revalidation may be considered to be a highly supportive measure.

As outlined in Section 3.2, some organisations plan to put in place measures including:

- Additional guidance and training;
- Setting out the roles and responsibilities and the process for professional development discussions and confirmation; and
- Ensuring all staff have access to the necessary IT equipment.

These measures would be considered as ‘highly supportive’ within our readiness criteria. Many organisations also report planning other measures which go beyond what the NMC considers to be ‘reasonably expected’, such as in implementing e-portfolios for employees. These measures are likely to lead to additional costs that may not be borne by all organisations. An improved understanding of what is required of organisations under revalidation could lead to less variable cost estimates. This could be helped by the issuing of further guidance from the NMC. This is discussed further in Section 5.1.

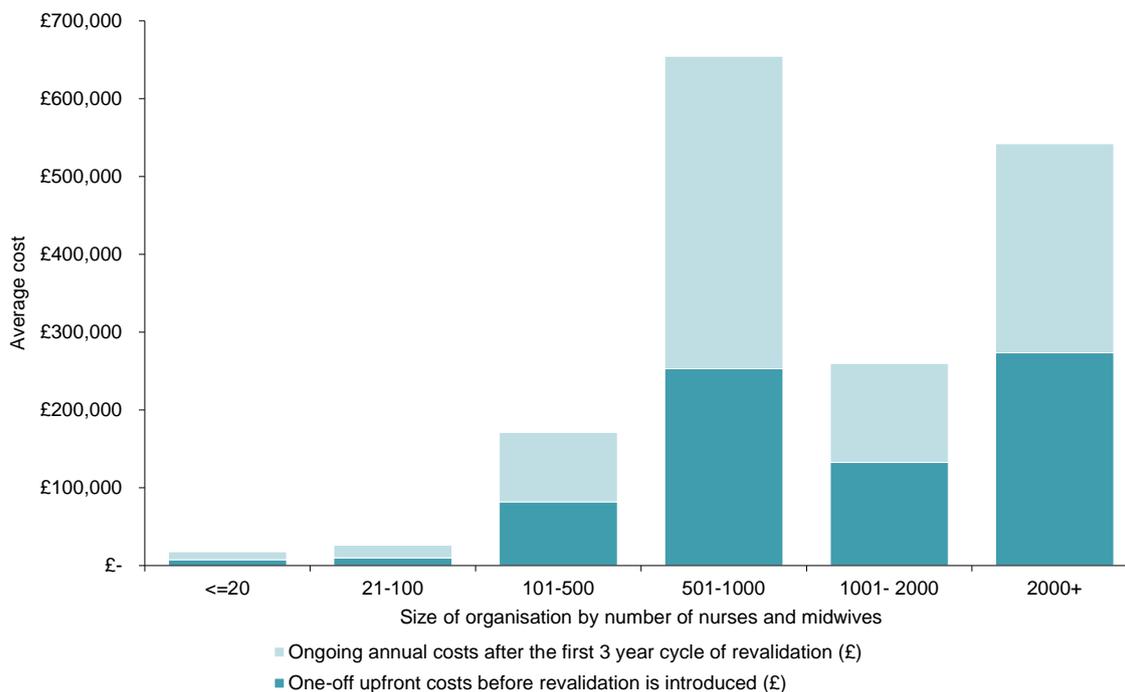
4.4.4 Larger organisations will generally incur higher total costs but lower costs on a per registrant basis, which means total costs of revalidation cannot easily be estimated

In the interviews and focus groups, in general, most large organisations indicated that they already had systems in place, such as those for appraisal, into which they felt revalidation could easily be incorporated for relatively small set up costs. Also, for smaller organisations, the costs of system implementation were not felt to be large due to the small number of registrants.

As may be expected, analysis of the organisation survey responses indicates that the average total cost per organisation in general increases with the number of registrants they employ (see 9)⁵⁷. There is no one requirement which is the main driver of these cost differences across organisation respondents of different sizes; costs for each requirement generally increase with the size of the organisation.

⁵⁷ A lower proportion of organisation in the 501-1000 registrants bracket responded indicating zero cost for any of the requirement; this has resulted in a higher average total cost than those organisations with over 1000 registrants.

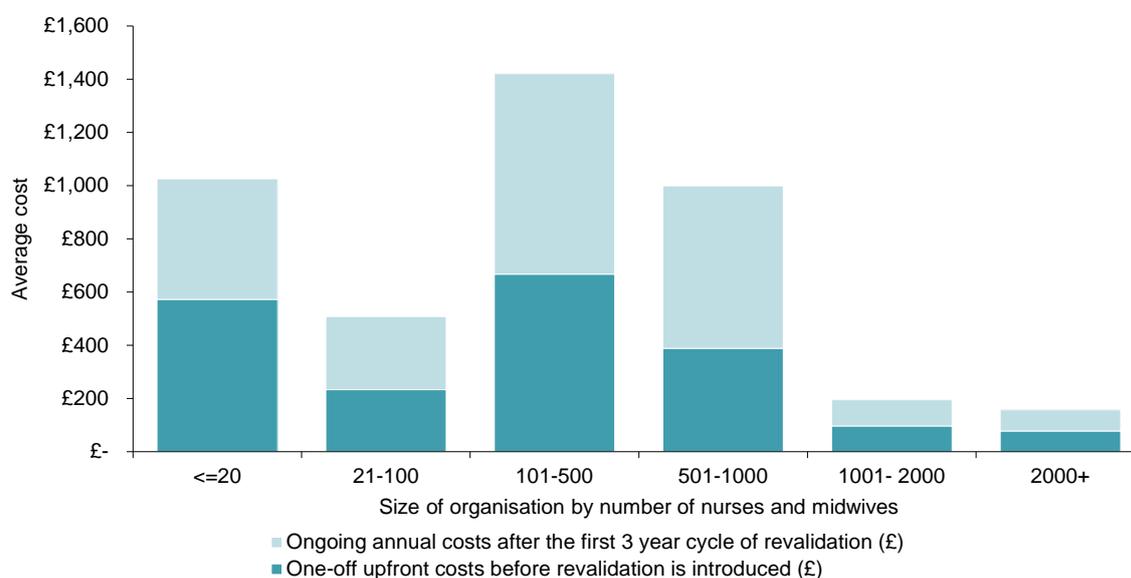
Figure 9 – Average total cost per organisation for revalidation. *Number of respondents: 17 pilots and 93 non-pilots*



However, on a per registrant basis the average organisational costs basis (both one-off and ongoing) generally fall as the number of registrants increases.⁵⁸ This is likely to be linked to the economies of scale that can be achieved at larger organisations. The results are set out in Figure 10 below.

⁵⁸ No organisation with fewer than 20 registrants provided an estimate of the ongoing annual cost of preparing for and managing revalidation. This has resulted in a lower cost per registrant for this group of organisations. In aggregate for all organisations, this requirement was greater than 60% of the ongoing annual cost of revalidation. A relatively large proportion of organisations with between 21 and 100 registrants indicated that there would be no additional cost associated with many of the revalidation requirements.

Figure 10 – Average organisational cost per registrant for revalidation. *Number of respondents: 17 pilots and 93 non-pilots*



Given the differences in the estimated organisation costs on a per registrant basis depending on the size of the organisation, the average organisation costs per registrant (either for pilots or non-pilots as set out in Figure 6 and Figure 7 a, b and c) cannot simply be multiplied by the number of nurses and midwives on the register to give a total cost of revalidation across the UK. As costs differ depending on the size of the organisation, detailed information on the number of organisations by their size would be required to scale the average costs up to a total across the UK. However, this information is not readily available to the NMC or the four countries' Programme Boards. There is no information, for example, on the number of organisations employing fewer than 20 registrants. The introduction of revalidation may address this gap as more information will be collected from registrants in relation to their practice setting.

4.5 Registrants' estimated costs of revalidation

4.5.1 Registrants' costs of revalidation relate to additional time spent meeting the requirements

Nurses and midwives will incur costs associated with revalidating. The nature of the costs of revalidation for nurses and midwives themselves are different from those incurred by organisations. While for organisations the costs relate to the support they plan to put in place (as outlined above), for registrants the costs largely involve the time spent to complete the requirement, including collecting and recording information, and to then complete the NMC application and provide any further information required.

As explained in Section 4.1.2, for the purposes of our analysis we have converted the additional time associated with revalidation reported by registrants at the pilot sites into financial costs using average salary data.

Similar to the costs reported by organisations, there was a relatively wide range in the additional amount of time respondents to the Ipsos MORI registrant survey reported they had spent to meet the revalidation requirements. Figure 11 below sets out the median and

mean additional time reported by registrant respondents to meet each of the requirements of revalidation, and our associated estimates of costs.

Figure 11 - Average total additional time and cost per registrant for the requirements of revalidation⁵⁹. *Number of respondents: 1061*

	Median	Mean
Total additional time (hours)	10.5	18.5
Total additional cost (£ per registrant)	177.2	313.0

As the median values are lower than the means, this demonstrates the variation in additional time estimates given by registrant respondents at the pilot sites and the impact that the higher time estimates have on the mean values. We understand from the wider research conducted by Ipsos MORI that there was variation in participants' interpretation of the requirements of revalidation and that there were a large number of different registrant journeys through revalidation. This is likely to explain the variation in the additional time it took registrant respondents to meet the requirements.

There is also variation in the average additional time registrant respondents spent meeting each of the revalidation requirements, as shown in Figure 12 below. It should be noted that the additional time associated with meeting the revalidation requirements (and associated costs) would be spread over three years given that this is the frequency at which registrants will be required to revalidate. These are not annual costs.

⁵⁹ These figures do not include the time and cost associated with registrants familiarising themselves with the revalidation requirements as this is a one-off cost that will only be incurred when implementing revalidation. The mean time associated with familiarisation is 11.8 hours, equivalent to a cost of £200 per registrant. Additionally, these figures do not include the time and cost of preparing and submitting further information to the NMC to support a revalidation submission. This has been excluded because only a small proportion of registrants will be asked to submit further information. The exact proportion of registrants that will be required to do this are not yet known so a weighted average time and cost across all registrants cannot be estimated. The reported mean time spent preparing further information in support of a revalidation application was 8 hours, with a further 4.2 hours spent submitting the information. This is at a cost of £135 and £71 per registrant respectively.

Figure 12 - Average time and cost per registrant for the requirements of revalidation.
Number of respondents: 1061

Requirement	Median		Mean		Total responses
	Additional time (hours per registrant)	Additional cost (£ per registrant)	Additional time (hours per registrant)	Additional cost (£ per registrant)	
Familiarisation	5.0	84	11.8	200	905
CPD	0.0	0	0.2	4	640
Portfolio - Recording CPD hours	2.0	34	3.9	65	727
Portfolio - Recording practice hours	1.0	17	4.0	67	654
Practice-related feedback	0.5	8	2.3	40	396
Written reflections	5.0	84	4.5	77	N/A
Professional development discussion	1.0	17	1.3	21	937
Third party confirmation	0.5	8	1.0	16	815
Online submission	0.5	8	1.4	23	822
Preparing further information to support revalidation submission	5.0	84	8.0	135	57
Submitting further information to support revalidation submission	3.0	51	4.2	71	57

Although registrants who participated in the Ipsos MORI survey reported the largest amount of time to familiarise themselves with the revalidation requirements (on average 11.8 hours), these costs would not be borne by registrants each time they need to revalidate. These can be considered one-off upfront costs.

Equally, although the amount of time (and associated costs) spent by registrant respondents preparing and submitting further information to the NMC to support their revalidation submission was high compared to the other requirements (over 12 hours on average), this would only be borne by a small proportion of registrants. Not every registrant will be asked by the NMC to provide further information.

Costs associated with the practice hour requirements relate to the recording the information. On average, Ipsos MORI survey participants reported that it took an additional 4 hours to record practice information, equivalent to a cost of £67 per registrant over a three-year period. The median reported time was 1 hour, equivalent to £17 per registrant. It is arguable whether these estimates of the additional time factor in some time to record information that registrant respondents should already be recording under Prep. If this is the case, then these costs are likely to be overestimates of the impact of revalidation alone.

Feedback, reflection and discussion costs were collectively the second highest cost area, particularly for registrant respondents in organisations of a size of 501-1,000 and 1,001-2,000 registrants. Registrant respondents in larger and smaller pilot organisations reported lower costs on average. In terms of the average costs across all organisations:

- 76% of registrant respondents had to increase the number of actively sought pieces of feedback normally collected in order to meet the revalidation requirements;⁶⁰
- In the three years before the pilot, registrant respondents reported writing on average two reflective accounts, taking an average of 1 hour and 38 minutes to write each;
- Registrant respondents reported their personal development discussion took, on average, 1 hour and 16 minutes. The median reported time was 1 hour; and
- Half of registrant respondents reported that their PDD occurred during work hours, thus incurring an organisational cost of diverting them from clinical practice.

Third party confirmation involves time costs for both the registrant and confirmer. This is a new requirement that does not build on something currently in place for Prep, although many organisations have indicated that they plan to incorporate this in to the appraisal processes already in place for their registrants. On average across registrant respondents, the additional time associated with third party confirmation was 1 hour, with an equivalent cost of £16 per registrant. There is also a reported additional 2 hours (£33) per registrant associated with the confirmers' time which is not included in this cost.

Based on the registrant survey responses, online submission costs were limited, equivalent to £23, on average, per registrant. As the previous renewal application for nurses and midwives was very short requiring minimal information from registrants, for the purposes of our analysis, and as agreed with the NMC, we assume that all the time associated with the online submission is additional and resulting from the introduction of revalidation.

4.5.2 There are discrepancies between organisations' and registrants' cost estimates for CPD

There is a clear discrepancy between organisations' and registrants' survey responses on the impact of the CPD requirements of revalidation. While organisation respondents generally estimated high costs to support their registrants to meet the requirements, particularly in relation to participatory CPD, it appears that on average registrants in the pilot sites who participated in the Ipsos MORI survey are already meeting the requirements and generally going above and beyond what is required under Prep.

- On average the revalidation CPD time requirements are already met or exceeded by the majority of registrant respondents;
- 95% of registrant respondents indicated that they currently exceed or meet 40 hours of CPD in total and 97% of registrant respondents indicated that they currently exceed or meet 20 hours of participatory CPD;
- Of those registrant respondents not currently meeting the CPD revalidation requirements, on average they undertake 34 hours of CPD in total and 12 hours of participatory CPD; and
- To meet the revalidation requirements, the 5% of registrant respondents not undertaking 20 hours of CPD would need to undertake, on average, an additional 5.8 hours of CPD.

⁶⁰Actively seeking feedback refers to actively looking at or consulting a source of feedback, such as a complaints log, patient survey or approaching colleagues directly for practice-related feedback. It does not include occasions where registrants may receive spontaneous feedback, for example from colleagues or patients who comment on their practice.

The equivalent time and costs of this spread across all registrants is 0.2 hours and £4 per registrant.

Registrant survey responses suggest that there are costs to registrants associated with the recording of CPD. Although registrants were required to undertake and record CPD as part of Prep, under revalidation additional reporting requirements are placed on registrants, including linking their CPD to the Code.

Registrant respondents reported that on average 4 hours of additional time was taken to meet CPD reporting requirements, equivalent to an average cost of £65 per registrant.

4.6 Assessing costs against the potential benefits

The purpose of a cost benefit analysis is to assess costs relative to benefits over a set period of time, with costs and benefits discounted over this period to reflect time preference and the net present value (NPV) of the proposed regulatory/policy change. In this case, we have not quantified the benefits in monetary terms and there is a lack of clarity on the timing of the benefits. Therefore, it is not possible to weigh up the evidence we have obtained on the benefits of revalidation against the estimated costs for organisations and registrants.

However, as set out in Section 5.3, assessing the costs of revalidation against the benefits, in a detailed evaluation after its launch is one of the next steps that the NMC may wish to consider.

5 Next steps

The findings of both our exploration of readiness and the cost benefit analysis suggest a series of next steps for the NMC, the four countries' Revalidation Programme Boards or their representatives, or by other stakeholders across the health and care system.

Where issues were identified early on by stakeholders, for example around the need to address certain perceived gaps in awareness, we shared these initial findings at that point in time with the NMC and four countries' Revalidation Programme Boards. We understand that activities are underway to address a number of these issues.

5.1 Clarifying the guidance

The variability in interpretation of the provisional guidance for registrants and limited level of guidance available to employers were found to be key drivers in the variability of costs.

The NMC could prepare revised guidance to set out more explicitly what is required of both registrants and employers.

Clearer guidance should reduce the wide variability, give greater consistency in implementation, influence what measures are put in place by employers and thus affect the likely costs of implementation.

Following feedback from the pilot organisations, the work of Ipsos MORI, and this report, we understand that the NMC is currently developing this revised guidance and plans to publish it in September.

5.2 Developing a comprehensive communications plan

A significant number of stakeholders recommended that a comprehensive communications plan should be developed to raise awareness of revalidation to all areas of the system⁶¹. This should incorporate activities that are to be carried out by the NMC as well as by other parts of the health and care system. It should also cover the short, medium, and longer term, for example to ensure the plan covers registrants that are not required to revalidate until the end of the first three year cycle of revalidation.

The communications plan needs to:

- Address all parts of the health and social care system, particularly those where there are perceived gaps in awareness, such as in smaller organisations; and
- Be coordinated, consistent and continuous, using all appropriate channels available, including quality and system regulators in the four countries, and employer representative bodies.

⁶¹ See section 3.1.2.2 for activities that stakeholders suggested for increasing the reach to all practice settings.

Importantly, the communications should not only explain what revalidation is, but also what it is not, giving practical examples where possible and seeking to communicate the benefits of the different elements of the model.

Stakeholders noted that, given the range of activities being carried out locally to communicate and provide guidance to registrants and employers regarding revalidation, it is important that a consistent 'single version of the truth' is used.

We understand that there are a number of communications plans in development across the UK. Bringing these together and sharing them widely and quickly as a single plan for engagement will give stakeholders greater confidence that gaps in awareness are being addressed.

5.3 Evaluating revalidation

Once the model and guidance are finalised, the framework to evaluate the impact of revalidation should be developed so that it is formally in place from revalidation's launch. It is important that the baseline is set at the launch so that the impact can be measured and the relevant information is collected.

The evaluation should analyse a range of measures to assess the impact on individuals, organisations, patients and the public.

An evaluation should enable a more granular assessment of the actual (rather than estimated) incremental costs and benefits of revalidation. This would be based upon the actual experience of organisations and registrants going through the process with the finalised model and revised guidance.

5.4 Combining these activities into a clear action plan for implementing revalidation in the current timescales

Given the various activities outlined above, the view from stakeholders was that a clear action plan needed to be set out and agreed by the NMC working with the four countries' Revalidation Programme Boards. This should incorporate all of the relevant activities required for implementing revalidation, split out into three phases:

- **Phase 1: August – October 2015** – the period leading up to the decision being taken by the NMC Council and the four countries' Revalidation Programme Boards regarding whether to launch revalidation;
- **Phase 2: October 2015 – April 2016** – the period following the launch of revalidation (subject to it going ahead) prior to the first registrants revalidating; and
- **Phase 3: April 2016 onwards** – the commencement of revalidation by registrants.

This three phase action plan should be communicated to all relevant stakeholders, with clear roles and responsibilities for "owning" each activity, and with progress against the plan monitored and reported rigorously and transparently.

6 Glossary

Abbreviation	Description
ABUHB	Aneurin Bevan University Health Board
AIHO	Association of Independent Healthcare Organisations
AOHNP	Association of Occupational Health Nurse Practitioners
BACN	British Association of Cosmetic Nurses
CBA	Cost Benefit Analysis
CCG	Clinical Commissioning Group
CI	Care Inspectorate (Scotland)
CMUH	Central Manchester University Hospitals
CNO	Chief Nursing Officer
CPD	Continuing Professional Development
CQC	Care Quality Commission
CSSIW	Care and Social Services Inspectorate Wales
DH	Department of Health
DMU	De Montfort University
ESR	Electronic Staff Records
FtP	Fitness to Practice
GDC	General Dental Council
GMC	General Medical Council
GOsC	General Osteopathic Council
GP	General Practice
GPhC	General Pharmaceutical Council
GSTT	Guy's and St Thomas' NHS Foundation Trust
HSC	Health and Social Care (NI)
HIS	Health Improvement Scotland
HIW	Health Inspectorate Wales
HR	Human Resources
IT	Information Technology
LSAMO	Local Supervising Authority Midwifery Officers
MCT	Mersey Care Trust
NHS	National Health Service
NHSE	NHS England
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
NMC	Nursing and Midwifery Council
NOP	Notification of Practice

Abbreviation	Description
PB	Programme Board
PDD	Professional Development Discussion
PHE	Public Health England
PIAPA	Private Independent Aesthetic Practices Association
Prep	Post-registration Education and Practice
PSA	Professional Standards Agency
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RPG	Revalidation Pilot Group
RQIA	Regulation and Quality Improvement Authority
RSAG	Revalidation Strategic Advisory Group
SCHPN	Specialist Community Public Health Nurse
TDA	Trust Development Authority
UK	United Kingdom
WHSCT	Western Health and Social Care Trust



© 2015 KPMG LLP, a UK limited liability partnership, is a subsidiary of KPMG Europe LLP and a member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative, a Swiss entity. All rights reserved.

The KPMG name, logo and "cutting through complexity" are registered trademarks or trademarks of ("KPMG International").