

Revalidation evidence report

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Introduction

In September 2013, our Council committed to introducing a proportionate and effective system of revalidation by the end of 2015 in order to enhance public protection. Revalidation will require registered nurses and midwives to demonstrate that they remain fit to practise, and is based on the existing three-yearly registration cycle. This report provides a summary of the key evidence which will support the upcoming pilots and the continued development of the revalidation model and processes.

Revalidation

The primary aim of revalidation is to ensure that nurses and midwives continue to be fit to practise throughout their career. This will improve public protection and increase the public's confidence in the nurses and midwives caring for them.

Revalidation will enhance and strengthen the existing renewal requirements. All registrants will need to revalidate in order to renew their registration. Every three years, all registrants will be required to declare that they have:

- practised for at least 450 hours during the last three years
- undertaken at least 40 hours of continued professional development (CPD), with a minimum of 20 hours of these being participatory learning
- collected practice-related feedback from at least five sources
- reflected on their CPD, feedback they have received and the Code
- had an appropriate professional indemnity arrangement in place
- obtained confirmation from a third party about their compliance with the revalidation requirements and the absence of unaddressed concerns about their practice

The main changes between the current requirements and the proposed model for revalidation are:

- increasing CPD hours (from 35 to 40) and introducing a participatory element to CPD
- requiring collection and reflection on feedback on practice, CPD and the Code
- requiring third-party confirmation.

To support and evidence these declarations, all registrants will need to keep records of their participation in a portfolio. Each year we will audit a sample of portfolios, which will help us to enhance our understanding of risk and inform future phases of revalidation.

Evidence Sources

We collected feedback for developing a model for nurse and midwife revalidation, along with gathering information from a variety of sources. This included, but was not

limited to, formal consultation, stakeholder events, one-to-one meetings, and social media conversations. There were both qualitative (e.g. focus groups, stakeholder conversations) and quantitative (online survey) elements. Care should be taken in interpreting the evidence from these different sources.

The quantitative work included a large sample of respondents answering a series of questions. It was an open survey, so anyone could respond. The profile of registrants who responded to the online consultation is broadly similar to the profile of the population of registrants in terms of registration type (nurses, midwives and specialist community and public health nurses (SCPHNs)). It is necessarily high level and cannot go into too much detail.

The qualitative elements on the other hand have much smaller samples, but provide a far richer, deeper insight into the views of respondents. In combination, we believe that we have gained a sound evidence base on which to base decisions on the next draft of the revised Code.

This report does not go into detail for all evidence sources examined, however details are provided below on the most substantial sources that are directly referred to in this report.

Phase one of the formal consultation on Revalidation and the Code

In 2014, we ran a two-part consultation on the revalidation model along with the draft revised Code. The first phase of the revalidation consultation was conducted in the first quarter of 2014 by Alpha Research. The consultation explored how the proposed model of revalidation could be implemented in a variety of employment settings and scopes of practice. It also gathered some initial information to inform the development of a revised Code. The consultation involved two parts: an online questionnaire, completed mainly by professionals and organisations; and a much shorter questionnaire completed by members of the general public (the 'general population survey').

Phase two of the formal consultation on Revalidation and the Code

The second phase of consultation was undertaken on our behalf by Ipsos MORI between May-September 2014. The consultation was initiated to feed into both the development of a revalidation model and the revised Code. For the purpose of this report, only those results relevant to the development of revalidation are reported. The consultation included both quantitative and qualitative research:

- Quantitative research: An online response form was hosted on our website, from 19 May - 11 August 2014, which was accessible to anyone who wished to provide a response. In total we received 1,649 individual responses, with an additional 110 responses from organisations. Participating organisations included educators, employers, professional bodies, government departments, regulators and patient bodies, among others.¹
- Qualitative research: 16 discussion groups were held across the UK involving nurses and midwives from a range of roles, settings, and types of employment. Five in-depth interviews were conducted with nurses and midwives working

¹ Please note that data included in this report are not weighted and as the respondents were self selecting, certain types of people may be over or under represented.

overseas, one with an e-health nurse, and five with employers of nurses and midwives. We held four deliberative events, which hosted a demographically diverse range of patients and members of the public. These took place across the four countries with around 25 individuals attending each group. Interviews were also conducted with 16 organisations representing seldom heard audiences, such as elderly people and those with disabilities.

Stakeholder events

Over the spring and summer of 2014, we held five stakeholder summits across the UK. The summits brought together over 1,000 nurses, midwives, their leaders, educators and representatives to consider the draft revised Code and the revalidation model. Only the feedback relevant to the development of revalidation is reported here.

Social media monitoring

During the formal consultation period, social media was used to promote the online survey and invite participation in the qualitative elements. In addition to this, social media channels were monitored for conversations around revalidation. These insights were used to form part of the broader evidence base.

Review of research evidence on Continued Professional Development (CPD)

This was an internal paper written in April 2014, which considered research on CPD in nursing and midwifery, and other healthcare professions.

KPMG report – Revalidation of nurses and midwives

This was a piece of qualitative work that we commissioned, looking at six employer organisations in both NHS and non-NHS settings across the four countries of the UK.

King's Fund report – Medical Revalidation: From compliance to commitment

The NHS Revalidation Support Team commissioned this report as a qualitative assessment of the impact of medical revalidation on the behaviour of doctors and the culture of organisations, since revalidation began in December 2012. It included seven case study sites across England and was published in March 2014.

Feedback – key messages

Overall perceptions of revalidation

The concept of revalidation has broadly been welcomed by both professionals and members of the public, as a way of improving the regulation of nurses and midwives and ensuring improved patient safety.

In the first phase of consultation, respondents were asked whether they felt that revalidation would improve patient safety. Of the individual responses, 47 percent agreed that it would improve patient safety, and 65 percent of organisations agreed. There was a sense that revalidation may help improve standards and patient safety through more regular assessment, reflection and learning. Despite this, some respondents said they were unsure of what difference, if any, it would make to patient safety. There were concerns that it could turn out to be little more than a tick-box exercise or too removed from practice to improve standards of care. Some felt that it would be necessary to put in place measures to prevent abuse of the process, such as managers making decisions based on performance measurement, rather than clinical competence. Overall, respondents stressed the need for revalidation to be robust, simple, properly implemented and transparent:

“Revalidation of nurses and midwives has the potential to improve patient safety and compassionate care of patients. However, it is not possible at this stage of gestation to state that it will do so. The key to ensuring that it does is that the process of revalidation which is introduced is universally applicable, robustly implemented and quality assured at regular intervals. This will require a level of investment from the NMC to ensure that standards of revalidation across the UK are consistent and maintained.” – (Organisational response to a free text question in the phase one online consultation)

In the second phase of consultation, although there was broad agreement with the revalidation model, some nurses and midwives felt that it needed to be considerably better than existing Prep requirements. In the qualitative focus groups, it was suggested that the proposed model needs ‘more teeth’. There was also a view that we need to clarify what the benefits of revalidation are, and how it is going to be any different to Prep.

Participants in the qualitative groups also hoped that the model would move beyond requesting information on practice hours, to provide greater insight into the competency of nurses and midwives. It was felt that the confirmer could review the elements of revalidation, including reflective feedback accounts and continued professional development (CPD), with the nurse or midwife.

Third-party confirmation

Under the current registration system, nurses and midwives are required to make a self-declaration that they are fit to practise safely and effectively, as demonstrated in the Code. Under revalidation, the requirement to obtain confirmation from a third party will provide an additional layer of assurance about the registrant’s continued fitness to practise. It also provides an objective confirmation that there are no outstanding concerns about the registrant’s practice that are not being addressed locally. Confirmation will challenge those who work in professional isolation from other

colleagues by encouraging discussion about professional development and improvement. It will also increase professionalism by making registrants more accountable for their performance and improvement.

Both parts of the consultation have shown that the majority of nurses and midwives are likely to be able to confirm under one of the confirmation models detailed below. However, there is a significant number of nurses and midwives, particularly in some scopes of practice, who would have difficulty. This is mainly due to problems with accessing a registrant manager and/or a peer.

In the first phase of consultation, we explored registrant views around who the third-party confirmer should be. The person most frequently selected as being an appropriate third-party confirmer was an NMC-registered nurse or midwife who oversees the work of the nurse or midwife seeking revalidation. Of those consulted, 75 percent of individual respondents (who were mainly nurses and midwives) and 82 percent of organisations were in favour of this. Midwives were overwhelmingly in support of a Supervisor of Midwives being the third party confirmer (84 percent). In addition, the majority of respondents had access to an NMC registrant, either a manager or a peer, who could confirm their fitness to practise.

Based on these findings, we proposed in the second phase of the consultation that the person(s) confirming fitness to practise should oversee the nurse or midwife's practice. They should be a UK registered nurse or midwife who is familiar with the registrant's practice, or has discussed their practice with them. These elements could come from either:

- One person who is both an NMC registrant and oversees the practice of the nurse or midwife being revalidated. or
- Two people: both someone who oversees the nurse or midwife's practice but is not an NMC registered nurse or midwife (e.g. a GP); and an NMC-registered peer who is familiar with the registrant's practice or has discussed it with them.

In the phase two online consultation, 64 percent of individuals and 74 percent of organisations agreed with this proposed approach to third-party confirmation.

In the second phase of the consultation, 77 percent of nurses said that they have access to an NMC registrant who oversees their practice and so could act as a third-party confirmer. Since phase two of the consultation, we have adapted the proposed model to outline that the person overseeing the registrant should be their line manager. This adaptation was not explored as part of the research and so it is not clear if all 77 percent were referring to their line manager, meeting the current model proposed by the NMC. An additional 7 percent of nurses said they would be able to meet the two person model and 6 percent said that they didn't know/preferred not to say.

Among midwives, 86 percent said that they had access to a Supervisor of Midwives who is familiar with their practice and could provide confirmation. Those in the qualitative research also identified SoMs as suitable confirmers under the definition of the one-person model used during the research. However, as outlined above, our current proposed model states that the person overseeing the registrant should be their direct line manager; therefore a SoM providing confirmation under the one person approach is not currently an option. 77 percent of midwives said that they have

access to an NMC registrant manager who could act as a third-party confirmer, which would meet the current one person approach.

When considering this data, caution is required regarding the level to which it is representative. The survey was self-selecting and, therefore, we cannot know the profile of those that did not choose to respond. It may be that those who would find revalidation challenging might be more likely to respond to the consultation. On the other hand, the research suggests that those who may find revalidation more challenging may work in more remote settings or varied scopes of practice. This could make them less likely to feel engaged by the consultation. Despite this, the data does provide some insight into the estimated reach of the proposed model and areas which could be considered in greater detail.

The qualitative research in part two of the consultation demonstrated the extent to which nurses and midwives can access a one-confirmer or two-confirmer model could depend on a number of factors. Those factors which generally enable nurses and midwives to confirm through the one-confirmer model include:

- Belonging to a hierarchical team with at least one tier of registrant managers
- Having established line management relationships with a named registrant line manager
- Having access to other registrant senior managers who can step into a management role if their direct line manager is not available.

We did find that there were some scopes of practice that challenged the confirmation model, often because they do not have access to the enabling factors above. The second phase of the consultation identified several types of nurses and midwives who would have difficulty confirming under either model including agency nurses (particularly those who move frequently between different jobs), nurses and midwives working in independent practice (school nurses and aesthetic nurses), and nurses and midwives working overseas. The reason why these nurses and midwives would find confirmation challenging included:

- their manager is not a UK registrant
- they have no manager
- they would have difficulty accessing a peer registrant who is familiar with their practice, as they are often working in situations where they are professionally isolated.

Other scopes of practice and work settings which nurses and midwives discussed in the stakeholder summits as presenting a challenge include:

- practice nurses (especially those working in small practices)
- occupational health nurses
- mental health nurses working in multi-disciplinary teams
- nurses or midwives in senior positions (who may not have access to a registrant who is more senior to them)
- nurses or midwives in geographically remote areas

Participants in the qualitative groups and stakeholder summits explored possible solutions regarding the issue of confirmation for nurses and midwives who would find this aspect of revalidation challenging. Suggested solutions included:

- making the confirmation model more flexible, for example, by requiring access to a single peer confirmer
- for overseas nurses, using healthcare professionals registered outside the UK
- establishing groups of official confirmers, for example for the self-employed or agency nurses, or establishing networks with other registrants in the same scope of practice.

A number of concerns were also expressed regarding the overall purpose and meaning of confirmation. For example, some were concerned about the risk of bias and collusion if nurses and midwives are allowed to choose their own peer confirmer. In such cases, how could the confirmer and therefore the confirmation be trusted? Others questioned what constituted ‘familiarity’ with a nurse or midwife’s practice, and how well would the confirmer need to know the registrant and their practice? Similar views about the importance of ensuring the robustness of confirmation were expressed by some of the organisations responding to the consultation:

“You will need to assure against friends/family/conflict of interest as well as the potential for commercial opportunities.” – (Response to phase two of the consultation – General Medical Council)

In the qualitative groups conducted as part of phase two of the consultation, it was felt that the further away from the one-confirmer approach the nurse or midwife was required to move, the more she or he felt that accountability for confirmation was reduced and the potential for bias increased. There were also questions raised in the groups about what exactly the confirmer was confirming. Participants wanted clarity on what confirmation is aiming to achieve and wanted us to produce guidance for nurses and midwives on this.

On a positive note, there were various groups of participants who saw the benefits in confirmation, the main one being that it brings a level of accountability to the two professions. Patients, the public and representatives of seldom heard groups felt reassured by the idea of someone who oversees a nurse or midwife’s work providing confirmation. Patients and the public felt that the confirmer should be someone senior to add gravitas and authority to the confirmation.

Appraisals

We are proposing that, where possible, confirmation should take place during appraisal. This would allow revalidation to build on the existing practices of employers, and therefore minimise any potential burden in terms of staff time and cost.

The consultation has shown that the majority of nurses and midwives receive annual appraisals. However, in some settings and scopes of practice, appraisals do not happen or only happen infrequently. It was suggested that the introduction of revalidation may encourage employers to ensure that appraisals are carried out more regularly.

In both phases of the consultation, appraisal was generally found to be commonplace. Of the respondents in the second phase, 79 percent of nurses and 88 percent of midwives said that they had been appraised in the last 12 months. However, 17 percent of nurses and midwives reported that they had not received an appraisal in the last 12

months. In the first phase of the consultation, those less likely to have appraisals included:

- people working outside the UK
- bank staff
- agency staff
- self-employed people
- those working in the voluntary sector
- those working in the independent sector

The second phase further explored the feasibility of using appraisals for confirmation amongst nurses in different scopes of practice. In the online questionnaire, the proposal of integrating the third-party confirmation process in the current appraisal system was relatively well received by employers who responded, with 69 percent agreeing. Only 13 percent of individuals who were employers said that their organisation would not be able to integrate confirmation within appraisals.

In the qualitative groups, nurses and midwives discussed the reasons why this may not be possible for some groups. For example, it was not feasible for some agency nurses to receive an appraisal due to their work circumstances. Other nurses and midwives do not currently have their appraisal with the person identified as being their confirmer. (However, it is a legal requirement in Wales for agencies to provide nurses with annual appraisals, as was pointed out in the Cardiff stakeholder summit.) The Recruitment and Employment Confederation likewise emphasised the difficulties of agency staff working in a variety of settings. They particularly highlighted the importance of providing adequate support and guidance to them:

“[It is] crucial that the NMC supports joint appraisal/confirmation between clients of recruitment agencies and recruitment agencies themselves...the NMC needs to issue specific guidance.” – (Response to phase two of the consultation – Recruitment and Employment Confederation)

Some participants in the qualitative research also had concerns about the quality of current appraisals. It was suggested that some organisations viewed appraisals as a ‘tick-box’ exercise, rather than an opportunity to assist meaningful professional development.

In terms of appraisal content, 92 percent of nurses and midwives, who responded to the phase two questionnaire and had had an appraisal in the last 12 months, said that they receive and review feedback on their performance as part of their current appraisal process. By contrast, only 34 percent currently review their practice against the Code as part of their annual appraisal process.

In the stakeholder summits and at other events, nurses and midwives from different scopes of practice highlighted that their current appraisals focused more on performance management, rather than clinical supervision relating to the Code. There was disagreement about whether appraisals should integrate fitness to practise issues and reviewing practice against the Code; currently appraisals are more about fitness for purpose and ability to do a specific role. For example, some were concerned that employers could misuse the process of confirmation and constructively dismiss staff. Similarly, the Royal College of Nursing (RCN) expressed concerns about the perceived risks associated with unifying employer processes (such

as appraisal) with professional regulation processes (such as revalidation). They felt that there was a high risk of confusion of purpose and the potential for poor decision-making under such a system.

However, findings from the qualitative research suggested that the introduction of confirmation could encourage greater regularity in appraisals. Nurses, midwives and some employers felt that if confirmation had to happen during appraisals, then it could encourage employers to carry out regular appraisals.

“Because we struggle with getting appraisals done, this could be another driver to make it happen.” – (Response to phase two of the consultation – NHS employer, Belfast)

Similarly, the King’s Fund report on medical revalidation suggested that the implementation of revalidation had increased investment and time in organisations, in order to ensure all doctors were undertaking appraisal. It was found that in the sites included in the study, appraisal rates had increased. This was particularly evident in sites where appraisals had not been universal, or for those doctors who had not previously engaged in appraisals.

Continued Professional Development (CPD)

Under the current post-registration education and practice standard (Prep) for continued professional development (CPD), nurses and midwives must declare at registration that they have completed at least 35 hours of CPD in the last three years. In phase two of the consultation, it was proposed that the CPD requirement for revalidation should be increased to 40 hours. Of this, 20 hours should be ‘participatory’, i.e. involving interaction with others.

The consultation showed broad support for the inclusion of a CPD requirement in the revalidation model. However, nurses and midwives called for clarity about what we considered to be CPD for the purposes of revalidation.

Those who participated in the qualitative research in phase two welcomed the inclusion of a CPD requirement in the revalidation model. Nurses and midwives thought that CPD could have a positive impact on the patients in their care, as it is aimed at improving the level of care they deliver. Patients and the public also viewed CPD as contributing to the provision of the highest standards of care.

“It’s an opportunity for nurses and midwives to diversify their skills and focus on their own career and move forward.” – (Qualitative research from phase two of the consultation – Patient/public deliberative event, Edinburgh)

Both phases of the consultation have shown that nurses and midwives currently undertake a wide range of CPD activities. The CPD activities most frequently undertaken in the last 12 months by nurses and midwives who responded to the phase two online questionnaire were:

- learning events such as workshops/conferences (84 percent of respondents)
- reading/reviewing relevant publications (81 percent)
- internet research (74 percent)
- mandated non-clinical training at place of work (65 percent)

- group or practice meetings (61 percent).

There has been debate in the stakeholder summits and phase two consultation about what constitutes CPD for the purposes of revalidation. For example, nurses and midwives discussed whether mandatory training in the workplace should be counted as CPD hours for revalidation. Some mandatory training might be seen as contributing to a nurse or midwife's professional development, such as basic life support skills, while other types, such as fire training, do not. Because of this, nurses and midwives requested detailed guidance about what we consider as CPD for revalidation. In the second phase online questionnaire, 65 percent of individuals and 64 percent of organisations agreed that the requirement of 40 hours of CPD over three years was about the right number. This was generally agreed with by the participants in the qualitative groups and the stakeholder summits; the extra five hours was not seen as a problem.

Nurses and midwives in both the stakeholder summits and qualitative groups identified a number of barriers and challenges to completing CPD. They highlighted the fact that it could be difficult to get protected learning time for CPD from employers. Another issue was the cost of CPD, particularly for nurses and midwives whose employers would not pay for any CPD beyond mandatory training. Nurses and midwives working for an agency or in independent practice, who had to pay for their own CPD, may also experience difficulties.

It was pointed out that nurses in some scopes of practice have greater difficulty accessing CPD. This included part-time workers, those on maternity leave and those working permanent night shifts. For these people, fitting CPD around their work patterns and families might be more difficult. There might also be greater problems accessing CPD for people working in remote parts of the UK or abroad. For these people, accessing face-to-face training might be difficult in practical terms or due to cost. For this reason, it was felt that online learning was an acceptable form of CPD and a practical solution for such workers.

We proposed a participatory element to CPD after considering research in both nursing and other healthcare professions (see *Review of research evidence on CPD*). This has suggested that the elements of CPD which were found to be effective include sustained, repeated or longer term CPD activities that involve interactive methods of delivery. The literature also highlights the importance of planning, self-directed learning and reflective practice for CPD. Some research advocates the importance of a 'participatory' rather than a 'didactic' approach. For example, interactive workshops, rather than lectures and academic instruction, have been suggested as better ways to influence changes in professional practice.

The inclusion of 'participatory' CPD in the revalidation model was generally well received amongst nurses, midwives, members of the public and patients. In the second phase 65 percent of individuals and 80 percent of organisations responding to the questionnaire agreed with the inclusion of a participatory element. In the qualitative groups, several nurses and midwives felt it was important to learn with others and share practice.

There was some disagreement about whether a minimum of 20 hours of participatory CPD was appropriate. Of those who responded to the online consultation, 49 percent of individuals agreed that this was about the right number of hours. However, 30

percent of individuals felt that it was too many. There were only 10 percent of individuals who felt it was too few.

Nurses and midwives also expressed some uncertainty about what 'participatory learning' actually included. In phase two of the consultation, some nurses and midwives taking part in the qualitative focus groups interpreted participatory learning as nurses and midwives attending organised events with others. There were therefore calls for clarity about what kinds of CPD activity we would count as 'participatory'.

In the qualitative groups, two key needs emerged. Firstly, participants stressed the need for CPD activities to be of adequate quality. Nurses and midwives felt that high quality CPD is often not dependent on the way it is undertaken (for example, online learning or a face-to-face course), but what learning was taken from it. Similarly, nurses and midwives in the stakeholder summits stressed the importance of an outcomes-focused, reflective approach to CPD, rather than an 'inputs' approach which focuses on the number of hours undertaken. This very much echoes the research findings on CPD detailed above regarding the importance of reflection. The RCN also stressed the importance of quality, and having an outcomes-focused, rather than an inputs-based, approach. They highlighted the wide variation of CPD hours carried out in different countries, which they feel demonstrates the lack of evidence for a minimum number of hours.

"Therefore, the conclusions we draw from this are that a fixed number of hours is only part of the equation. While a minimum level may help to demonstrate the importance of CPD, equally as important is that the learning opportunities are fit for purpose, effective, and supported by employers. Again...it is the outcome of CPD, not the process or reaching a target number of hours, that is most important." – (Response to phase two of the consultation – Royal College of Nursing)

The second key need identified by participants in the qualitative groups was that CPD activities for revalidation should be evidenced in some way. Nurses and midwives, patients and the public, as well as representatives of seldom heard groups, suggested that those undertaking revalidation should provide reflective accounts to demonstrate learning. It was also requested that we provide a pro-forma or template for nurses and midwives to record their CPD.

Of those responding to the phase two questionnaire, 67 percent of individuals and 76 percent of organisations agreed with the proposal in the revalidation model, that CPD should be linked to the Code and the nurse or midwife's scope of practice. However, nurses and midwives in the qualitative research indicated that they were not usually influenced by the Code when choosing CPD. They were more likely to choose to develop specific skills that they need in their scope of practice.

Reflection and feedback

In phase two of the consultation, we proposed that as part of revalidation, nurses and midwives should produce at least five reflective accounts on feedback received from patients, carers and/or colleagues. Many revalidation models of healthcare professionals across the world emphasize the importance of practitioners reflecting on their practice. For example, nurses in Alberta, Canada, are expected to take part in a learning cycle, which involves reflection on their practice and subsequent planning of relevant learning to improve practice. Feedback from patients, carers and colleagues is also a common element of revalidation. For example, the General Medical Council's

(GMC) model requires doctors to reflect on feedback, and discuss this at appraisal, highlighting good performance and identifying areas which might need improvement. Our proposal to include reflective accounts on feedback as part of revalidation is very much in line with these models.

In phase two of our consultation, support for reflective practice was strong. However, there was some feeling that reflection should not have to be based on feedback alone, but also incorporate other appropriate elements, such as experiences as a nurse or midwife.

As noted above, nurses and midwives in the stakeholder summits were in agreement with a reflective approach to enable continued professional development. In the qualitative groups, nurses and midwives generally accepted that reflective practice was a common and useful activity, which aims to continually improve skills. The inclusion of a reflective element in the revalidation model was therefore welcomed by many.

It was suggested that for some nurses and midwives, reflection was a continuous process, whilst for others it takes place in response to a particular incident or adverse event. For many, reflection is an informal inner process which is not recorded, however some keep a formal record. Formal accounts of reflection are often carried out only when required, for example, as a result of an incident or as part of a training course. At the stakeholder summits, there were also comments that some nurses already collect evidence in portfolios (used for Prep) which feeds into reflection on their practice. This evidence could be aligned with the requirements for revalidation.

Nurses and midwives felt that gathering feedback from patients to assist in the development of their service is of value, and this was felt to be more commonplace than feedback on them as individuals. Patients and the public also welcomed the opportunity to feed back on the care they have received.

However, nurses and midwives taking part in the qualitative research also expressed concerns about preparing reflective accounts based on feedback. They noted both practical and ethical concerns about collecting feedback from some groups of patients and carers. These groups include vulnerable patients who perhaps cannot speak for themselves, or relatives that have been recently bereaved. Some questioned the usefulness of patient feedback as a basis for reflection, pointing out that some patients did not provide constructive feedback. In addition, a number of feedback tools that patients fill out are at organisational/team level rather than individual level.

“We sometimes have questionnaires done about the trust – it’s more about what the trust cares about.” – (Qualitative research from phase two of the consultation – Community midwife, Belfast)

Another concern raised was that feedback is open to bias and partiality. It was pointed out that nurses and midwives would be motivated to select only positive feedback for the revalidation process, because their registration was at stake. Likewise, colleagues and patients who give feedback, knowing that it has a bearing on a nurse or midwife’s revalidation, might feel obligated to be complimentary rather than constructive.

There were also concerns expressed about the amount of work that gathering and reflecting on feedback would involve. In the phase two consultation, opinions were

divided about whether five reflective accounts was an appropriate number, with 42 percent of individual respondents saying it was about the right number, and 40 percent of individuals saying it was too much. However, in the qualitative research, these responses to providing five reflective accounts were generally related to the format of the accounts, and the time and effort that would be needed to complete them. Nurses and midwives in the qualitative research often assumed that the 'reflective accounts' would be formal essays.

The RCN also pointed out in their response to phase two of the consultation, that there was no evidence base underpinning the proposal for setting a minimum number of reflective accounts. They emphasised the importance of quality over quantity, and pointed to the example of Canada's provincial regulators. In Canada the focus is strongly on entrusting nurses with individual responsibility for self-improvement through reflection.

There was some indication from the qualitative groups that the credibility of using reflective accounts as part of revalidation could be strengthened by including them in the confirmation process. In the phase two online questionnaire, 64 percent of individuals and 83 percent of organisations agreed with the proposal that the confirmer should discuss the nurse or midwife's feedback as part of the revalidation model. Both free-text responses to the online consultation, and the qualitative groups, showed that many nurses and midwives thought that discussing feedback with the confirmer might help to provide a layer of validation to the approach.

Participants in the qualitative groups wanted clear guidance on the format of reflective accounts that we would require, and the comprehensiveness of the accounts. There was a request that we provide a template to guide the reflective account. They wanted the template to:

- be short and easy to complete
- have headings to help structure the response
- not be academically referenced
- include guidance about the types of topics that would be appropriate

Impact on the system

In the first phase of the consultation, a number of the free-text organisational responses that were submitted to us expressed concern about the impact of revalidation on both employers and individual nurses and midwives. The impact was discussed in terms of financial cost, time, and the practicalities of changing or adapting existing systems to fit with the proposed revalidation model.

Several organisations were concerned about the financial costs of revalidation to employers, for example, investing in appraisal systems for revalidation.

"RCN believes that considerable additional resources will be required to make revalidation fit for purpose. This includes investment in systems for appraisal and training for assessors, investment in systems for collating and recording feedback on practice and – critically – support for registrants to undertake CPD. This must include protected time to carry out CPD." – (Royal College of Nursing)

Some organisations pointed out the need for us to consider some of the practicalities of fitting revalidation around existing employer processes. For example, the NHS Trust Development Authority (TDA) highlighted that there needs to be some flexibility with regards to employers integrating their appraisals, which often happen at the beginning of the financial year with revalidation.

The Professional Standards Authority (PSA) warned that a possible consequence of revalidation might be that large numbers of nurses and midwives would be unable to revalidate and therefore lapse from the register. This would mean that a large number of nurses and midwives were unable to practise.

In the qualitative research in the phase two consultation, employers had concerns that confirmation might have too great an impact on the workload and responsibility of their senior staff and managers. (It should, however, be noted that the qualitative research was only able to engage with five employers). The free-text responses to the phase two online questionnaire similarly highlighted that many felt that revalidation and third-party confirmation will be time consuming, and employers will need more support.

The KPMG report on the potential implications for employers of revalidation, found that the six employer organisations included were largely able to use their existing mechanisms to support revalidation. These employers included both NHS and private, and employers across the four UK countries. However, due to the limited number included, caution should be used when drawing any wider conclusions from this report.

Participants in the KPMG focus groups and interviews felt that there would be a number of costs of implementation of revalidation for employers, for example:

- Large employers expected to need some central dedicated resource to support the initial implementation of revalidation, for example a senior nursing officer plus admin support.
- Appraisees and third-party appraisers would need to be trained to ensure that they are aware of what is expected of them.
- Some participants had concerns about the additional time and resources required to carry out the confirmer role, for example through longer appraisals and new systems to support appraisals.
- Some felt that there would be greater pressure on employers to provide more training and release nurses and midwives for courses.

At the same time, a number of benefits of revalidation were identified by participants:

- Senior stakeholders felt that a significant benefit of revalidation may be increasing engagement in appraisal.
- It was felt that if revalidation encourages some nurses and midwives to consider their professional development more seriously, it could improve the quality of care for patients.
- Both reflection on CPD and on feedback might improve professional practice and provide greater safety for patients.

Practice hours and scope of practice

At present, nurses and midwives need to declare at registration that they have completed at least 450 hours of practice in the previous three years. As part of the revalidation model, we are proposing that:

- Those registered as a nurse or midwife will still be required to undertake 450 practice hours over three years.
- Those with dual registration as both a nurse and a midwife will be required to undertake 900 hours over three years.
- Practice hours for those who are specialist community public health nurses (SCPHNs), as well as being registered as nurses and/or midwives, will count towards those required to maintain their registration as a nurse and/or midwife.

The proposal is intended to bring the practice hours of midwives who are also SCPHNs in line with nurses who are SCPHNs. Currently midwife SCPHNs have to do 900 practice hours, whilst nurse SCPHNs do only 450. This proposal would mean that both of these groups have to do 450 hours.

In the second phase of the consultation, participants in the qualitative groups generally agreed with the 450 hours practice requirement. It was felt that this was achievable over a three year period. However, some people in the online questionnaire felt that the number of practice hours were too low. There were also comments that we need to clearly define what is meant by practice, especially for those that do not provide direct patient care:

“The NMC need to define what they mean by ‘practice’, as practice differs. Some nurses in management and education may struggle with ‘practice’ hours, for example an educator may teach practice to a maximum of 450 hours a year but never lay a finger on a client/patient – would that count?” – (Response to free-text question in the second phase online questionnaire)

There was no specific question in the online questionnaire relating to the number of hours that those with dual registration should undertake. However, there were 47 free-text comments that suggested that the number of hours required should not be double for dual registrants, or that this number of hours would not be achievable.

In their response to phase two of the consultation, NHS Employers thought that while it was appropriate to require the minimum number of hours to be undertaken in both roles to retain both registrations, the impact of this needed to be considered and worked through. They wanted us to explore any unintended consequences. They also questioned whether this is designed to be an input measure only, or if we are ‘planning to determine the outcomes they expect to see demonstrated from the practice hours’.

In the second phase online consultation, 62 percent of individuals and 65 percent of organisations agreed that SCPHN practice hours should count towards those required to maintain registration as a nurse or midwife. Around 10 percent of individuals and 9 percent of organisations disagreed. The SCPHN practise hours requirement were welcomed by 92 percent of SCPHNs. Midwives were significantly less supportive with 24 percent disagreeing.

Appeals process

In phase one of the consultation, a number of organisations stressed the need for the revalidation model to include a robust and fair appeals process:

“The RCN requires urgent clarification from the NMC about the route of appeal for registrants whose fitness to practise is not confirmed under the revalidation process. It is absolutely unacceptable to the RCN that registrants might be removed from the NMC register via an administrative process.” – (Royal College of Nursing)

The PSA likewise noted that we need to clarify what the appeals system would be for registrants who have been removed through the revalidation process. They also suggested that the number of appeals would also be likely to increase under revalidation, and wanted to know how we are proposing to prepare for this.

Our current legislation enables a nurse or midwife to appeal an unfavourable decision within 28 days. Under the current renewal and appeals process, the registrant can only receive an unfavourable decision (and therefore appeal) once they have completed a notification of practice form but then cannot show that they meet the Prep standards.

For revalidation, we are recommending that the current appeals process will be available where:

- A valid revalidation request has been submitted to us, *and*
- Under further investigation the registrant cannot prove that they have met the requirements for revalidation, *and*
- The Registrar decides that the revalidation request is denied and the registrant is lapsed from the register.

Next steps

This document collates the key evidence that has been collected and reflected upon in the first and second phases of the consultation on the proposed revalidation model. Further research will be carried out to strengthen the evidence base for and support the continued development of the revalidation model. This will include using the revalidation pilots to help fill the gaps in our current knowledge.