KPMG

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)

Appendices

10 August 2015

Contents

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Appendix 1
NMC provisional revalidation model

Appendix 1 NMC provisional revalidation model

1.1 Introduction

We have set out below details of the NMC's provisional revalidation model that was piloted during 2015 and was in place during the period we carried out our work.

1.2 NMC provisional revalidation model

The NMC describes the revalidation process as the following:

"All nurses and midwives are currently required to renew their registration every three years. 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.

Revalidation is a continuous process that nurses and midwives will engage with throughout their career. It is not a point in time activity or assessment.

Revalidation is about promoting good practice across the whole population of nurses and midwives. It's not an assessment of a nurse or midwife's fitness to practise, and it's not intended to address bad practice amongst a small number of nurses and midwives. We already have fitness to practise processes in place for this."[1]

The NMC outlined the following timeline for revalidation:

"In October 2015 the NMC Council is expected to give the go ahead to launch revalidation. From this point nurses will need to familiarise themselves with the revalidation requirements and start to develop their portfolio. It has been proposed that the first nurses and midwives to revalidate will be those with a renewal date in April 2016."[2]

Each of the requirements have been outlined below.[3]

[1] NMC, What revalidation is and when it will being (as at 05 August 2015): http://www.nmc.org.uk/standards/revalidation/

[2] NMC, How nurses and midwives can prepare for revalidation (as at 05 August 2015): http://www.nmc.org.uk/standards/revalidation/how-nurses-and-midwives-can-prepare-for-revalidation/

[3] NMC, How to revalidate with the NMC, (as at 05 August 2015): http://www.nmc.org.uk/globalassets/sitedocuments/revalidation/how-to-revalidate-final-draft.pdf

1.2.1 Practice hours

The NMC requirements are:

- "You must practise a minimum number of hours over the three years preceding the date of your application for renewal of your registration:

Figure 1 - Practice hour requirements taken from 'How to revalidate with the NMC'[3]

Registration	Minimum total practice hours required
Nurse	450
Midwife	450
Nurse and SCPHN[4]	450
Midwife and SCPHN	450
Nurse and midwife (including Nurse/ SCPHN and Midwife/SCPHN)	900 (to include 450 hours for nursing and 450 hours for midwifery)

- If you have practised for less than the required number of hours in the three years preceding the date of your application for renewal of your registration, then you must successfully complete an appropriate return to practice programme approved by the NMC before the date of your application for renewal of registration;
- If you are practising as a midwife in the UK, you must file an intention to practise form annually with your Local Supervising Authority Midwifery Officer; and
- If you are a registered midwife only practising in a specialist community public health nursing role and are registered on the SCPHN part of the register, then you do not need to file an intention to practise form. However, you must successfully complete an appropriate return to midwifery practice programme approved by the NMC before you can serve an intention to practise form and return to practice as a practising midwife."

The NMC has suggested that this requirement can be met "whilst in a paid role that requires registration" through "a record of practice hours".

1.2.2 Continuing Professional Development (CPD)

The NMC requirements are:

- "You must undertake 40 hours of continuing professional development (CPD) relevant to your scope of practice as a nurse or midwife, over the three years prior to the renewal of your registration;
- Of those 40 hours of CPD, 20 must include participatory learning; and
- You must maintain accurate records of the CPD you have undertaken. These records must contain:
  - The CPD method;
  - A description of the topic and how it related to your practice;
  - The dates on which the activity was undertaken;
  - The number of hours (including the number of participatory hours);

[4] Specialist Community Public Health Nurse.

- The identification of the part of the Code most relevant to the activity; and
- Evidence that you undertook the CPD activity."

1.2.3 Feedback, reflection and professional development discussion (PDD)

The NMC requirements are:

- "You must obtain at least five pieces of practice-related feedback over the three years prior to the renewal of your registration;
- You must record a minimum of five written reflections on the Code, your CPD, and practice-related feedback over the three years prior to the renewal of your registration;
- You must have a professional development discussion with another NMC registrant, covering your reflections on the Code, your CPD, and practice-related feedback; and
- You must ensure that the NMC registrant with whom you had your professional development discussion signs a form recording their name, NMC Pin, email, professional address and postcode, as well as the date you had the discussion."

The NMC guidance suggests that feedback could be "feedback in a formal or informal way. It could be written or verbal", and that sources could be "patients, service users, carers, students, service users or colleagues" or "through reviewing complaints, team performance reports and serious event reviews".

1.2.4 Confirmation from a third party

The NMC requirements are:

- "We will ask you for information for the purpose of verifying the declarations you have made in your application;
- This will be a declaration that you have demonstrated to an appropriate third party that you have complied with the revalidation requirements. We have provided a form online for you to use to obtain this confirmation from the third party; and
- We will ask you to provide the name, NMC Pin or other professional identification number (where relevant), email, professional address and postcode of the appropriate third party."

The NMC also states "Wherever possible we recommend that the third party you obtain confirmation from is an NMC registrant. It is helpful if they have worked with you or have a similar scope of practice, but this is not essential. If that is not possible, you can seek confirmation from another healthcare professional that you work with and who is regulated in the UK."

The NMC has suggested that "an appropriate third party confirmer is your line manager" who "does not have to be an NMC registrant."

1.2.5 Online submission

The NMC requires registrants to "have all the supporting evidence from your revalidation portfolio to hand when you start your online application. You must submit your application on or before the date we specify. Failure to submit your application on time will put your registration at risk". It also states that the NMC will "notify you at least 60 days before your application for revalidation is due" and that "you will then have 60 days to log into NMC Online and complete the revalidation application form."

Appendix 2
KPMG approach

Appendix 2 KPMG approach

2.1 Introduction

The NMC commissioned KPMG to explore organisational and system readiness for the introduction of nurse and midwife revalidation at the end of 2015 and analyse the associated costs and benefits of implementing the proposed model.

Our approach was as follows:

2.1.1 Define phase:

- We obtained a detailed understanding of the NMC's provisional revalidation model through discussions with the NMC and review of relevant documentation, and understood specifically what was changing through the model compared to current requirements;
- We worked closely with the NMC and representatives from the four countries' Revalidation Programme Boards to complete the following:
  - Defining nursing and midwifery setting groupings, and establishing an estimation of coverage of registrants and organisations across the four countries and setting groupings, to help ensure coverage of our assessment. See Section 2.2 for further information;
  - Agreeing the groupings of institutions and bodies that make up the health and care system. See Section 2.3 for further information;
  - Developing the organisation survey and the CBA questions of the registrant survey (carried out by Ipsos MORI on nurses and midwives who took part in the pilot study), including identification of organisation survey recipients. See Section 2.4 for further information;
  - Developing the approach for interviews and focus groups, including identification of stakeholders to engage. See Section 2.5 for further information;
  - Defining readiness criteria against which we would be able to consider organisation and system readiness. See Section 2.6 for the agreed readiness criteria; and
  - Identifying potential costs and benefits of revalidation. See Appendix 4 for the CBA methodology in more detail.

2.1.2 Assess phase:

We carried out our analysis and evidence collation with stakeholders to allow us to report our findings. Specifically, we:

- Issued a survey to 271 organisations covering readiness questions and CBA questions;
- Fed CBA questions into the Ipsos MORI survey which was sent to registrants who took part in the NMC pilots;
- Held 49 interviews with organisations and system stakeholders; and
- Held 14 focus groups with pilot and non-pilot organisations.

2.1.3 Report phase:

The output of this project is this independent report, detailing the key findings from our analysis exploring readiness for the introduction of revalidation and the associated costs and benefits.

2.2 Nursing and midwifery setting groupings

Nurses and midwives practise in a variety of different settings ranging from large urban Trusts and Health Boards through to small rural privately owned care homes. It was expected that that nurses and midwives practising in different settings would likely face different challenges when revalidating. This would result in organisations in these settings providing different levels of support to registrants and therefore they may experience different levels of readiness and different costs and benefits. The settings were grouped as set out in Figure 2 overleaf.

Figure 2 – Nursing and midwifery setting groupings

Practice setting group	Example registrants captured by this setting group	Potential revalidation advantages	Potential revalidation difficulties	Example settings
1. Fixed location multidisciplinary settings	Nurses and midwives who practice routinely from a large multidisciplinary location as part of a team (including NHS and independent settings).	■ Structured annual appraisal ■ Formal CPD ■ Structured feedback processes in place ■ Access to other registrants for reflection discussions and confirmation	■ None specific to the setting	■ Acute hospital/secondary care Foundation Trust/non-Foundation Trust (including Heath Boards and Health Trusts) ■ Mental health Foundation/non-Foundation Trust ■ Other NHS Foundation/non-Foundation Trust (care trust, ambulance trust, etc.) ■ Special health authorities (Health Education England, NHS Litigation Authority, NHS Trust Development Authority, NHS Blood and Transplant, etc.) ■ Clinical Commissioning Group ■ Hospice ■ Independent sector acute provider ■ Independent sector mental health provider
2. General practice settings	Nurses and midwives who practice in primary care from GP surgeries. Registrants are likely to practice on their own in this setting, although they will work alongside other healthcare professionals and may work in the same location as other registrants.	■ Some will possibly have a structured annual appraisal and access to third party confirmers	■ Limited formal CPD ■ Possibly limited access to other registrants for reflection discussion ■ No structured feedback	■ General Practice/Primary care
3. Formal community settings	Nurses and midwives who practice in a community setting, often on their own, although they will be part of a larger	■ Structured annual appraisal ■ Formal CPD	■ Possibly limited feedback arrangements	■ Community Health Foundation/non-Foundation Trust ■ Independent sector community provider

Practice setting group	Example registrants captured by this setting group	Potential revalidation advantages	Potential revalidation difficulties	Example settings
	structured organisation who will likely provide access to appraisals and CPD	■ Access to other registrants for reflection discussion and confirmation		■ Armed forces ■ Public Heath England/Scotland/Wales and Northern Ireland
4. Sole registrant or self-employed settings	Nurses who often practice on their own without access to other healthcare professionals.	■ None	■ No structured annual appraisal ■ No formal supported CPD ■ No structured system of feedback ■ Limited access to other registrants for reflection discussion and confirmation	■ Care homes ■ Schools ■ Self-employed
5. Agency settings	Nurses and midwives who often practice in fixed term posts as part of bank or agency staffing arrangements. Nurses and midwives are unlikely to have formal structures in place for appraisals, feedback or CPD.	■ Access to other registrants for reflection discussion ■ Possible access to structured CPD	■ Possibly no structured annual appraisal with managers from their practice setting ■ Possibly no structured system of feedback from patients or colleagues direct to the nurse or midwife ■ Possibly limited access to confirmers	■ Nursing/Midwifery agency
6. Non-clinical practice settings	Nurses and midwives who practice in non-typical practice settings, often not directly linked to their registration.	■ Structured annual appraisal	■ Likely to be limited formally supported CPD ■ Possibly no structured system of feedback ■ Limited access to other registrants for reflection discussion and confirmation	■ Academic or research organisation ■ Government department, non-departmental public body or executive agency ■ Charity/voluntary sector organisation ■ Local Authority ■ Social enterprise

2.3 System stakeholders

In carrying out our analysis of system readiness we needed to identify the main system stakeholders. The health and care systems are made up of various different types of institutions or bodies. We grouped these as follows:

Figure 3 – System stakeholder groupings

Regulators	Representative groups	Commissioners	Government	Education
■ Professional regulators (e.g. NMC, GMC, GOsC and GPhC) ■ System regulators (e.g. CQC, HIW, HIS, RQIA, Monitor, TDA) ■ Professional Standards Authority[5]	■ Professionals (e.g. RCN, RCM, Unison, Unite) ■ Employers (e.g. NHS Employers, NHS Professionals, AIHO, Care Council for Wales) ■ Patients (e.g. National Voices, Patient and Client Care Council)	■ NHS England ■ NHS Boards/Trusts in Scotland, Wales and Northern Ireland ■ Clinical Commissioning Groups in England ■ Local authorities in England ■ Association of Directors of Adult Social Services	■ UK government ■ Four countries' governments ■ Chief Nursing Officers/LSAMOs	■ Council of Deans ■ Practice Educators (e.g. NES, HEE, CEC)

Each country has its own systems for health and care and this is reflected in the membership of the four countries' Revalidation Programme Boards. Also, each type of system stakeholder plays a different role in revalidation. The system readiness criteria[6] are designed to cover the system as a whole, and were not split out by the system groupings outlined above.

2.4 Approach to the organisation survey

The online organisation survey was designed to capture the information on the elements of support set out in the readiness criteria and the potential costs and benefits of revalidation.

We developed the survey questions based on the agreed readiness criteria[7] and potential costs and benefits and tested these with the NMC and representatives from the four countries' Revalidation Programme Boards.

We worked with the NMC and the four countries Revalidation Programme Board representatives to get an indicative view of the size and scale of nursing and midwifery practice, and we agreed the sample size for the organisation survey.

We agreed to survey all 19 pilot sites, whilst recognising that these were not representative of all organisations across the UK. The survey was sent out across the UK as set out in Figure 4.

[5] The Professional Standards Authority for Health and Social Care oversees statutory bodies that regulate health and social care professionals in the UK.

[6] As set out in section 2.6 (Figure 7).

[7] See section 2.6.

Figure 4 – Geographical split of organisations surveyed

	Surveys sent out	Completed responses
England	201	96
North	*54*	*24*
Midlands and East	*50*	*30*
London	*49*	*11*
South	*48*	*31*
Wales	23	11[8]
Scotland	24	8[9]
Northern Ireland	23	4[10]
Total	**271**	**119**

The distribution of the survey across the six setting groupings is shown in Figure 5 below:

Figure 5 – Practice setting split of organisations surveyed

	Surveys sent out	Completed responses
1. Fixed location multidisciplinary settings	163	86
2. General practice settings	*26*	6
3. Formal community settings	*37*	15
4. Sole registrant or self-employed settings	*15*	5
5. Agency settings	*15*	2
6. Non-clinical practice settings	*15*	5
Total	**271**	**119**

Having agreed the total number and the split of organisations to send the survey to by setting and location, we selected at random the specific organisations we would send the survey to.

The online survey was sent out to the selected organisations on 4 May 2015 onwards and organisations were given until 4 June 2015 to respond (the initial deadline was extended from the 22 May 2015). Organisations were contacted by KPMG, the NMC, and representatives for the four countries' Revalidation Programme Boards to encourage as high a response rate as possible.

[8] Completed responses accounted for 17 of the original organisations the survey was sent to – Health Boards provided one return to cover multiple sites.

[9] Completed responses accounted for 13 of the original organisations the survey was sent to – Health Boards provided one return to cover multiple sites.

[10] Completed responses accounted for 10 of the original organisations the survey was sent to – Health and Social Care Trusts provided one return to cover multiple sites.

2.5 Focus groups and interviews

We worked with the NMC and four countries' Revalidation Programme Board representatives to define and agree the numbers and types of stakeholders to engage through interviews and focus groups.

We held the following interviews and focus groups:

Figure 6 – Geographical split of interviews and focus groups held

	System		Organisations	
	Interviews	Focus Groups	Interviews	Focus Groups
England (and UK-wide)	20	1[(a)]	9	7
Wales	5		1	2
Scotland	5		2	2
Northern Ireland	6		1	2
Total	**36**	**1**	**13**	**13**

Note: (a) Covering all countries.

The focus groups were held face-to-face between 14 May and 12 June 2015. Participants were asked open questions to gather information on:

- Levels of awareness and understanding of revalidation;
- The impact of revalidation requirements;
- Any plans in place to support nurses and midwives to meet each of the requirements; and
- The associated costs and benefits of revalidation.

The individual requirements of revalidation were discussed in depth in order to fully understand its impact.

All interviews were conducted by KPMG either in person or by teleconference. They were in-depth qualitative interviews, lasting approximately 60 minutes and were conducted between 7 May and 1 July 2015.

It was made clear to participants that comments would not be attributed in the report unless permission was granted. The full list of interview and focus group participants is detailed in Appendix 5.

2.6 Readiness Criteria

Working closely with representatives of the four countries' Revalidation Programme Boards and the NMC we developed a set of readiness criteria based on the NMC's revalidation model and guidance. We identified the separate sets of readiness criteria for organisations and the wider system:

- The wider system readiness criteria are set out in Figure 7; and
- Organisations' readiness criteria are set out in Figure 8.

The readiness criteria were used to develop questions for the organisation survey, interviews and focus groups, in order to explore readiness within organisations and the wider system.

We split the readiness criteria across two dimensions:

- **Themes** – The themes under which the various activities, plans or preparations required to support revalidation can be grouped; and
- **Levels** – Various degrees of possible support provided by organisations and the wider system to assist nurses and midwives to revalidate.

Awareness and culture was agreed with the NMC to be a key theme identified within the readiness criteria. For the purposes of our assessment we defined low, medium and high awareness as set out below. These descriptions were included within the organisation survey, as agreed by the NMC and the four countries' representatives.

	Description
High awareness	A high level of understanding and awareness of the proposed changes to current requirements and how it will impact registered nurses and midwives in the organisation.
Medium awareness	Some understanding and awareness of the proposed changes to current requirements and how it will impact registered nurses and midwives in the organisation.
Low awareness	Very little understanding and awareness of the proposed changes to current requirements and how this might impact upon registered nurses and midwives in their organisation.
No awareness	No awareness of revalidation.

Figure 7 – System Readiness Criteria

System readiness criteria		Level and description		
		Minimum level of support	**Reasonably expected activity**	**Highly supportive measures**
Theme and Example		*The basic foundations of support that organisations and the system should provide to enable nurses and midwives to be able to revalidate.*	*Core building blocks of support that organisations and the system might be 'reasonably expected' to put in place which would assist nurses and midwives to successfully revalidate and contribute to greater professionalism.*	*Additional elements of increased support that would enable even greater benefit to be achieved from revalidation.*
Awareness and culture	*Is there clear leadership for and commitment to revalidation?*	■ An awareness of revalidation	■ Supportive of revalidation aims ■ Basic plans in place to raise awareness of revalidation	■ Significant plans in place to raise awareness of revalidation, and drive compliance and consistency, including communications, awareness events, issuing guidance
Resources: capacity and capability	*Are the confirmers identified, trained and ready?*	■ Ensure nurses and midwives are able to revalidate, and there are no significant blocks to this from the system perspective	■ Consideration of the funding or additional resources required to implement revalidation across all settings ■ Lead member of staff/team has been identified to oversee the implementation of revalidation	■ Additional resource in place to support revalidation
Systems and processes	*What processes are in place to support registrants?*	■ Ensure that revalidation has been successfully implemented and there is consistency and compliance across the system	■ A process in place to allow assurance to be provided to minsters or other bodies on an ongoing basis that revalidation is successfully being completed	■ Consideration of the development of an e-portfolio ■ System in development to monitor the success of revalidation ■ Processes in development to monitor the progress of nurses and midwives to revalidate and provide additional support to resolve difficulties
Guidance, tools and support	*What support and training is available?*	■ Nurses, midwives and organisations should know where to go for further information to assist with revalidation	■ Some guidance created to support revalidation in the local system, for example guidance on roles, responsibilities,	■ Ongoing guidance, tools, and training in place to support revalidation across the full range of practice settings in the local system

System readiness criteria		Level and description		
		Minimum level of support	Reasonably expected activity	Highly supportive measures
			and expectations for nurses, midwives and confirmers	■ Commitment and support to answer ongoing queries or concerns throughout the process

Figure 8 - Organisation Readiness Criteria

Organisation readiness criteria		Level and description		
		Minimum level of support	Reasonably expected activity	Highly supportive measures
Theme and Example		*The basic foundations of support that organisations and the system should provide to enable nurses and midwives to be able to revalidate.*	*Core building blocks of support that organisations and the system might be 'reasonably expected' to put in place which would assist nurses and midwives to successfully revalidate and contribute to greater professionalism.*	*Additional elements of increased support that would enable even greater benefit to be achieved from revalidation.*
Awareness and culture	*Is there clear leadership for and commitment to revalidation?*	■ Activities undertaken to raise awareness of revalidation among nurses and midwives	■ Proposed changes to current requirements are understood and consideration of how revalidation will impact registered nurses and midwives in the organisation ■ The changes and new requirements under revalidation have been communicated to your nurses and midwives ■ Basic plans in place to support revalidation and present these to your organisation's senior leadership	■ Leadership commitment to revalidation ■ Full clarity over revalidation requirements and how this will impact upon the organisation ■ Communications around revalidation sent out and awareness activities planned ■ Significant plans in place to support nurses and midwives and these have been presented to your Board (or equivalent)

Organisation readiness criteria		Level and description		
		Minimum level of support	**Reasonably expected activity**	**Highly supportive measures**
Resources: capacity and capability	*Are the confirmers identified, trained and ready?*	■ Action taken to ensure employee nurses and midwives are able to revalidate, and there is no significant block this from the organisation's perspective	■ Assessment made of action needed to support revalidation, including what level of support staff may require, along with plans to address this ■ Line managers (or other individuals) have been made available to undertake confirmation roles and, where relevant, professional development discussion roles ■ Space and time provided to nurses and midwives to hold their professional development and confirmation discussions (if separate from an appraisal process)	■ A lead member of staff identified and in place to oversee the implementation of revalidation, with any required additional time provided to fulfil this role ■ Additional time provided to staff to support them to meet revalidation commitments
Systems and processes	*What processes are in place to support registrants?*	■ Action taken to ensure that all employees are on the register (this is a current requirement)	■ Renewal dates identified for all nurses and midwives ■ Nurses and midwives encouraged to register for NMC Online ■ Plans in place for all nurses and midwives to receive confirmation as part of an appraisal process, or an alternative process ■ Access to feedback provided where it already exists (including audits, satisfaction surveys, complaints and the nurse or midwife's individual appraisal)	■ Processes and systems in place to assist with the identification, recording, and monitoring of appraisals and confirmations ■ An IT system in place to monitor the submission of revalidation returns and track revalidation compliance
Guidance, tools and support	*What support and training is available?*	■ Knowledge of where to go for further information to assist your nurses and midwives	■ Nurses and midwives signposted to the NMC's standards, guidance, information and materials on revalidation ■ Further information provided about roles, responsibilities, and expectations for nurses, midwives and confirmers within organisation (including clinical and non-clinical)	■ Plans in place to provide training for nurses, midwives and confirmers

Organisation readiness criteria	Level and description		
	Minimum level of support	Reasonably expected activity	Highly supportive measures
		■ Further information provided about who in the organisation can perform the confirmer role as detailed in the NMC's requirements ■ Information and examples developed setting out the expectations for registered nurses and midwives regarding each aspect of revalidation. These could include: an example of a note of feedback received, an example of a written reflection or evidence of having undertaken a development in clinical practice as per the NMC's requirements ■ Review of whether informal organisation systems could be implemented to allow for participatory (joint/team) CPD learning ■ A view taken locally about issues such as reflective models that could be adopted by or suggested within your organisation to support and guide reflective processes ■ Job descriptions or other relevant information made available for nurses and midwives across bands, to assist with additional reporting requirements on practice hours, should these be requested ■ Plans in place to communicate requirements for online revalidation submission and timing for this submission ■ Nurses and midwives reminded of their obligations of confidentiality under the Code and Data Protection legislation	

Appendix 3
Exploring readiness: supporting evidence

Appendix 3 Exploring readiness: supporting evidence

3.1 Introduction

In our main report we set out the key readiness findings in Section 3. This appendix provides our detailed evidence on readiness following the same structure as in the main report.

3.2 Awareness and culture[11]

3.2.1 Examples of awareness-raising activities by system stakeholders

Most system stakeholders and their respective institutions are currently involved in seeking to raise awareness among their members[12] through:

- Roadshows and events;
- Emails to members;
- Online forums; and
- Social media – for example Facebook and Twitter.

They also mentioned using the NMC's presentation materials as the basis for their communications which had been well received.

We heard examples of stakeholders supporting awareness-raising activities including:

- Institutions were supporting the education activities of health providers such as National Education Scotland (NES), which has representatives on all Health Boards, and the Northern Ireland Practice and Education Council for Nursing and midwifery (NIPEC), whose networks gives it significant reach across their countries; and
- The Royal Colleges and unions were engaged in raising awareness of revalidation and can reach many registrants directly. Similarly, professional representative bodies like the Private Independent Aesthetic Practices Association (PIAPA) were engaging extensively with members.

3.2.2 Organisation survey data relating to awareness and culture

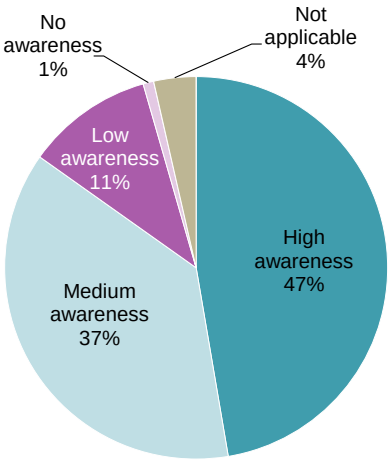
Awareness of revalidation was found to be highest among the executive leadership of organisations. 47% of the organisations who responded to the survey thought that their executive leadership had a high level of awareness of revalidation compared with just 19% of organisation respondents who said the same of their registered nurses and midwives (Figures 9 and 10). 71% of respondents reported awareness among HR staff as being either high or medium (Figure 11).

[11] This section relates to 3.1 in main report

[12] By members we mean the registrants for whom they hold some responsibility, either direct employees, members or other groups.

Figure 9

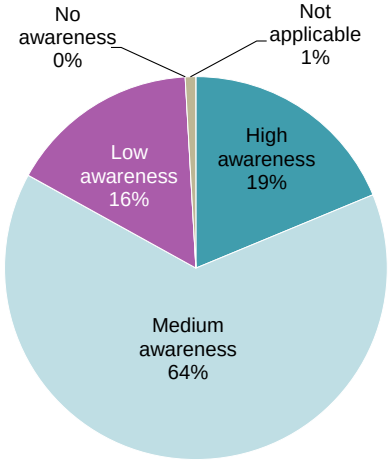
Q37a. Please use the scale below to indicate your perception of the level of awareness of the requirements of revalidation of the following groups: The executive leadership of your organisation e.g. Executive team?



Number of respondents: 112

Figure 10

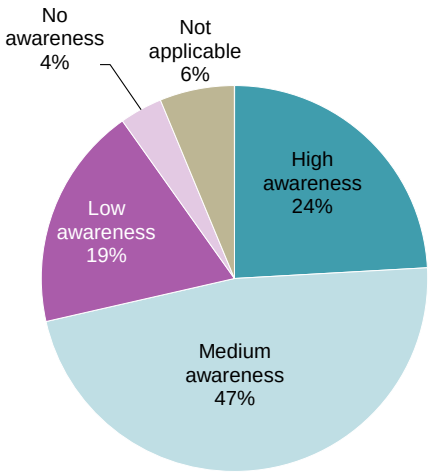
Q37b. Please use the scale below to indicate your perception of the level of awareness of the requirements of revalidation of the following groups: The registered nurses and midwives that work as part of your organisation?



Number of respondents: 112

Figure 11

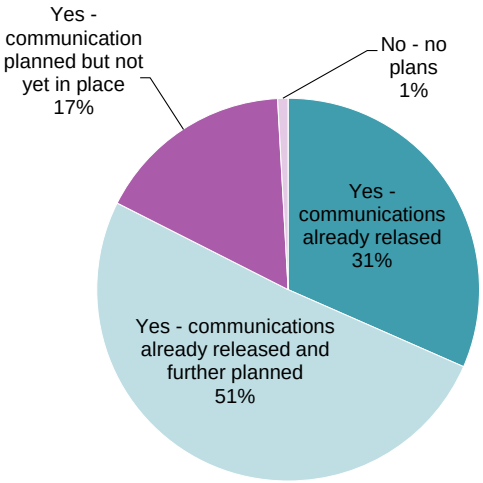
Q37d. Please use the scale below to indicate your perception of the level of awareness of the requirements of revalidation of the following groups: HR staff within your organisation?



Number of respondents: 112

Figure 12

Q11. In order to support your registered nurses and midwives to meet the new CPD requirements, do you have plans to release any communications about the changed requirements?



Number of respondents: 114

We asked organisations if they were planning to communicate with their staff over the changes to CPD requirements and 99% of organisation respondents had already released communications in this area or had plans to do so (Figure 12).

3.3 Planning and implementation[13]

3.3.1 Examples of activities to support revalidation being undertaken by system stakeholders

Some system stakeholders have created their own organisation surveys designed to provide a better understanding of the level of support registrants might require and provide a clearer picture on whether organisations in their areas are ready to implement revalidation.

Organisations responsible for education within the workforce also reported plans to integrate the requirements for revalidation into their wider programmes. For example, we heard from a system stakeholder that they are planning to support registrants with reflection and feedback. Similarly, another was preparing revalidation master-classes for other organisations.

3.3.2 Examples of activities to support revalidation being undertaken by organisations

3.3.2.1 General organisation support activities

Organisations shared their models for governing the implementation and ensuring their senior leadership were aware and bought in. This included:

- Setting up steering committees with Board members included; and
- Having regular updates from those leading revalidation in organisations in Board meetings/papers.

Some organisations had a dedicated person accountable for revalidation, other organisations had individuals who were supporting revalidation activities as an additional role, and some reported that they would need dedicated support, but that they currently do not have in place. We heard that additional staff support was required to:

- Provide administrative support;
- Facilitate awareness raising; and
- Coordinate activities such as the monitoring of revalidation dates.

Many organisation have developed materials to facilitate and communicate revalidation, including presentations, workshops, newsletters, e-mails, meetings, roadshows, and drop in Q&A sessions.

Resources produced by the NMC have also been used and circulated among registrants and managers of these registrants.

In addition, organisations have sent reminders to registrants of their revalidation dates and to register online with the NMC

[13] This section relates to 3.2 in the main report

3.3.2.2 IT Systems and Processes

A number of organisations explained that they already having e-portfolios in place as part of their current appraisal systems. These organisations intended to repurpose these existing systems for nursing and midwifery revalidation. Some stakeholders were concerned that registrants and employers may think an e-portfolio is required for revalidation. However, the NMC has made it clear it does not expect registrants to require e-portfolios.

We also heard that organisations had other electronic systems in place and that they planned to change existing templates to ensure they adequately reflect revalidation requirements. In more than one instance, organisations planned to use their existing systems for medical revalidation to support nursing and midwifery revalidation.

Some organisations have systems in place which identify when nurses and midwives are due to revalidate. Many organisations said that they do not have this information and need to gather this manually. Some felt they would need to look at changes to their systems to monitor revalidation and ensure compatibility with the NMC Online interface.

3.3.2.3 Practice hours

Several organisations intended to support their registrants through providing them job descriptions, time logs and copies of contracts to evidence their practice hours. Some organisations also said they would make their registrants aware of these various sources they could use them to meet the requirement.

3.3.2.4 Reflective practice, PDD and confirmation

At one non-pilot focus group, a nursing lead for one organisation explained how they were engaging a university to provide additional training and guidance to their registrant community on reflective practice over and above roadshows and general communications on revalidation. Another organisation shared how they were providing training for their registrants to better understand reflection.

A number of organisations reported that they planned to organise which individuals would hold PDDs and perform the confirmation role for each registrant, or set the principles that must be followed for these roles within their own organisations. For example, in one pilot organisation they set the confirmer role as a band 8 or higher. Another organisation suggested having a network of confirmers available in local areas, which would also allow information sharing.

We noted that most organisations were planning to support professional development discussions and confirmation through incorporating this within existing appraisal time. However, within smaller organisations it was reported that there are often no formal processes of appraisal in place. For example, we heard that appraisals are frequently not carried out by self-employed nurses or nurses within areas of non-clinical settings where nurses are not employed by an NHS body.

A number of organisations noted that some nurses and midwives may be required to seek support outside of a line management or appraisal structure. We heard comments that nurses working in self-employed roles, care homes and in GP settings may be required to hold PDDs and obtain confirmation from someone other than their line manager.

3.3.3 Organisation survey data relating to planning and implementation (resources: capacity and capability)

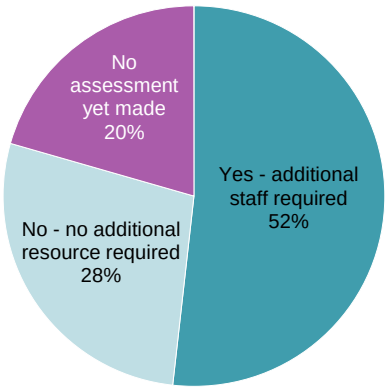
52% of organisation respondents told us they were planning to recruit staff to project manage the implementation of revalidation (Figure 13). However, of the 58 organisations planning to recruit additional staff, 40 were large organisations employing over 1,000 registrants.

The survey responses also highlighted that while nearly all organisation respondents were planning to undertake some form of action to prepare for revalidation (98%), only 20% had actually commenced preparatory work (Figure 14).

Of the 15 pilots who responded to the particular question in our survey, just 5 identified that they had completed any stages of their planned preparation. Of the remaining pilots, 9 were yet to complete planned actions to prepare for revalidation and one site identified that they had no plans for further action.

Figure 13

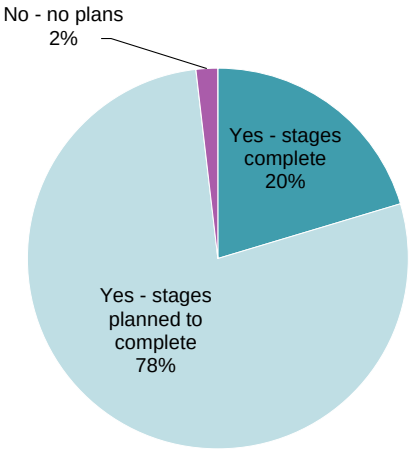
Q39. Do you consider that you need additional staff to take forward the project management aspect of implementing revalidation?



Number of respondents: 112

Figure 14

Q41. Have you taken, or do you plan to take, any action to prepare for the implementation of revalidation within your organisation?



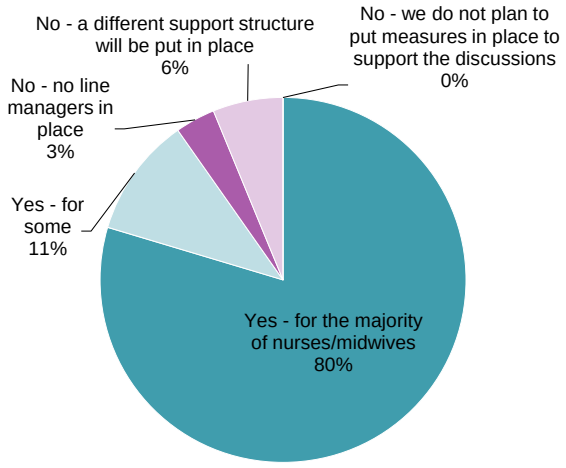
Number of respondents: 118

We asked organisations whether they were planning to use line managers to support professional development and confirmation discussions. 80% of organisation respondents told us line managers would conduct professional development discussions for the majority of their staff (Figure 15), and 85% would see line managers complete confirmation for the majority of staff (Figure 16).

We further noted that 70% of organisation respondents reported that confirmation discussion will happen entirely within working hours Figure 17).

Figure 15

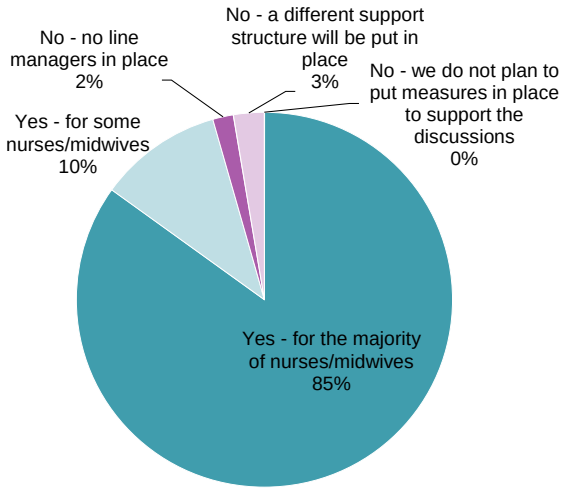
Q22. Do you plan to use line managers (where they are NMC registrants) to support professional development discussions?



Number of respondents: 113

Figure 16

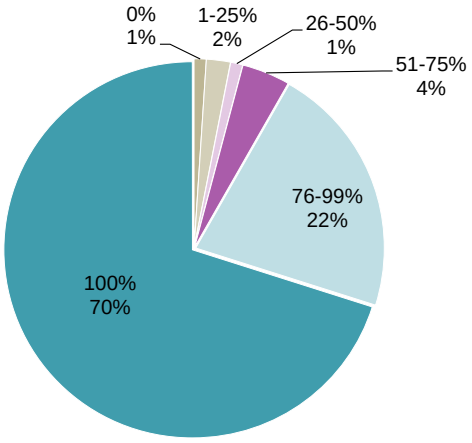
Q30. Do you plan to use line managers to support confirmation discussions?



Number of respondents: 113

Figure 17

Q29. On average, approximately what proportion [of time registered nurses and midwives will spend with confirmers in their confirmation discussion] do you expect will be conducted during contracted work hours?



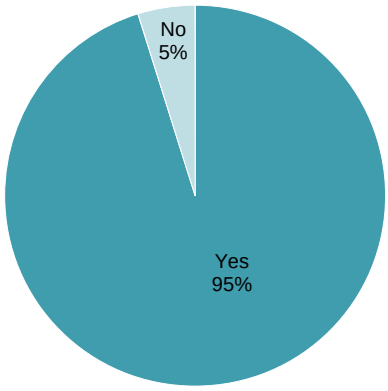
Number of respondents: 97

3.3.4 Organisation survey data relating to planning and implementation (systems and processes)

We found that 95% of organisations surveyed told us that they plan to monitor and report internally on the successful revalidation of their staff (Figure 18). However, 24% of organisation respondents reported that they do not currently know the renewal dates for all of their registered nurses and midwives and 26% only know renewal dates for some of their staff (Figure 19). At present 50% of organisation respondents are unaware of all of their registrants' renewal dates. We understand that currently NHS organisations in England and Wales can use Electronic Staff Records (ESR) to find out the renewal dates of their staff, but that from next year all employers will be able to find out staff renewal dates using the NMC Employer Confirmation Service[14].

Figure 18

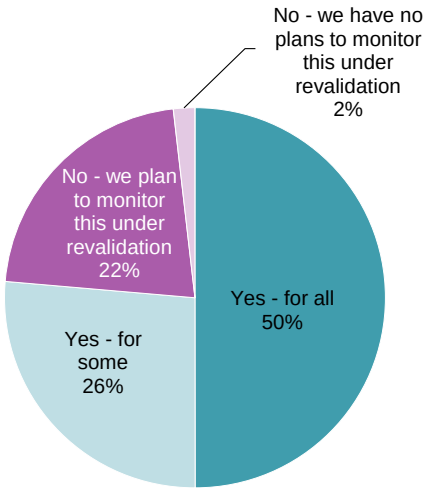
Q46. Do you plan to monitor and report internally the successful revalidation of registered nurses and/or midwives that work within your organisation?



Number of respondents: 103

Figure 19

Q43. Are you aware of the current three-yearly renewal dates for registered nurses and/or midwives that work within your organisation?



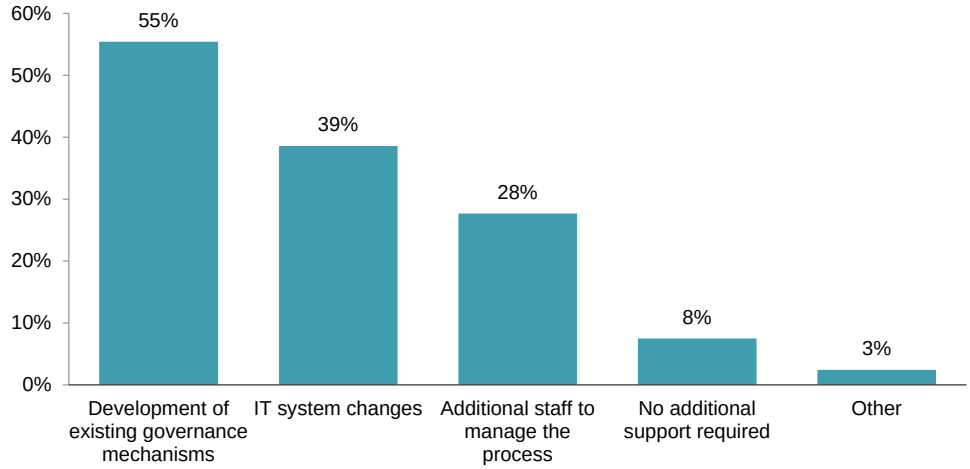
Number of respondents: 110

Many NHS organisations in England told us that they plan to capture revalidation data by making amendments to existing systems such as ESR. We also noted that organisations are planning to put in place a wide range of other methods to monitor revalidation (Figure 20).

[14] Available at https://www.nmc.org.uk/registration/employer-confirmations/?utm_source=Nursing+and+Midwifery+Council&utm_medium=email&utm_campaign=5885624_Revalidation+Round-up+June+2015&dm_i=129A,3I5DK,J7P4SN,CJXXL,1 (as at 05 August 2015)

Figure 20

Q47. Which, if any, of the following measures do you consider are required to support this [internal monitoring of the successful revalidation of nurses and midwives]?



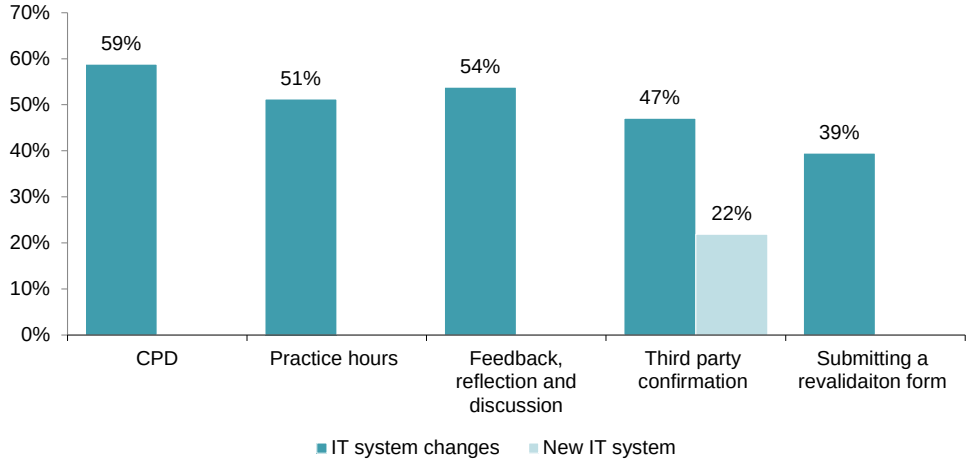
Averages calculated as proportion of total number of respondents (119)

39% of organisation respondents report that IT system changes would be required to support the monitoring and reporting of the successful revalidation of staff. Also IT system changes were often cited as being a requirement when organisation respondents considered the support they needed to provide in relation to the individual revalidation requirements (Figure 21).

Figure 21 - Percentage of organisations planning to implement IT changes for each activity

Data represented in this figure has been taken from separate questions in relation to each of the main changes required as part of revalidation: CPD, practice hours, feedback, reflection and discussion, third party confirmation and submitting a revalidation form.

Questions 12a, 16, 24, 31a and 34. Please indicate the types of support you expect to provide to your registered nurses and midwives in order to [comply with the required change] over and above support you already provide15.

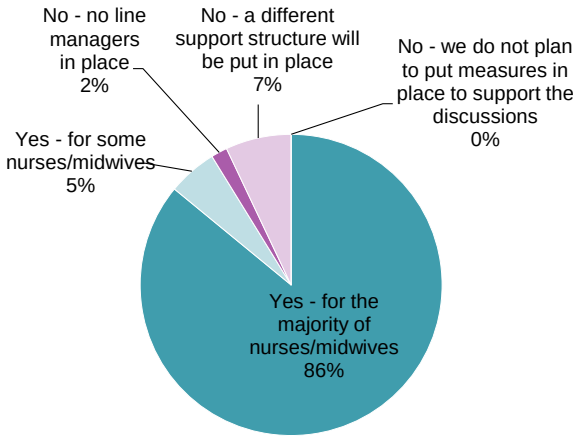


Averages calculated as proportion of total number of respondents (119)

85% of organisation respondents planned to use current appraisal programmes to support the professional development discussion for the majority of their registrants (Figure 23). Similarly 86% of organisation respondents planned to do this for the confirmation process (Figure 22) through their current appraisal process.

Figure 22

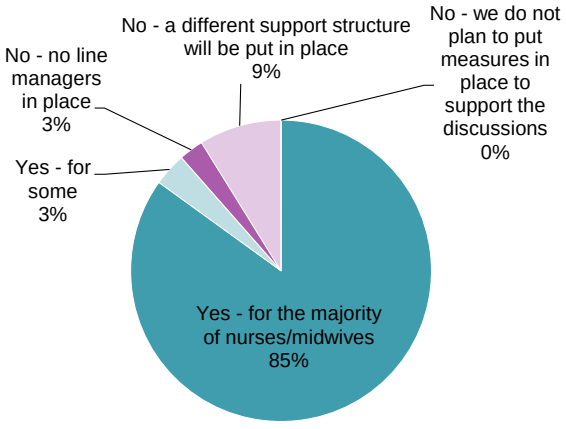
Q31. Do you plan to use your current appraisal programme (where in place) to support confirmation discussions?



Number of respondents: 113

Figure 23

Q23. Do you plan to use your current appraisal programme (where in place) to support professional development discussions?



Number of respondents: 113

[15] Note, only question 31a offered the option of 'New IT Systems' in addition to 'IT system changes'.

3.3.5 Organisation survey data relating to planning and implementation (guidance, tools and support)

We asked organisations whether they were planning to produce guidance or provide additional training to staff to support them in meeting the following requirements of revalidation:

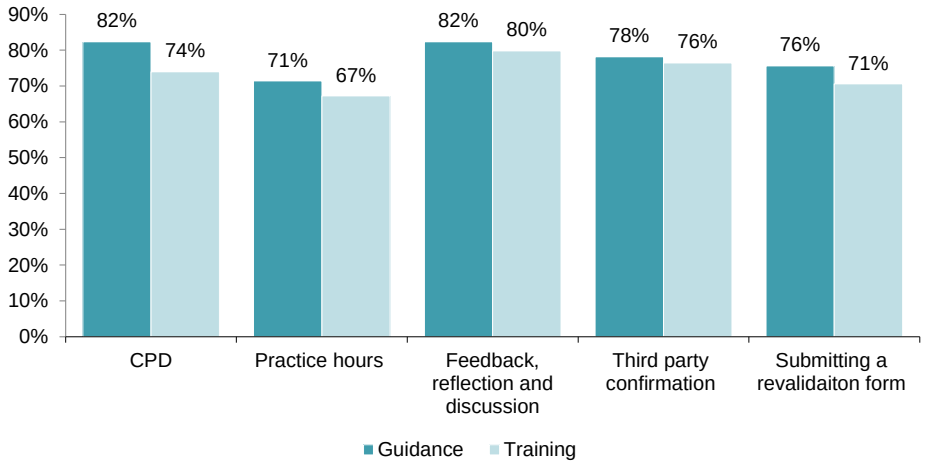
- CPD;
- Practice hours;
- Feedback, reflection and professional development discussion;
- Third party confirmation; and
- Submitting a revalidation form.

Taking an average across all areas, 78% of organisation respondents were planning on providing additional guidance to staff and 74% planned to provide training. Specific support planned is outlined below in Figure 24.

Figure 24 - Percentage of organisations planning to implement support for each activity

Data represented in this figure has been taken from separate questions in relation to each of the main changes required as part of revalidation: CPD, practice hours, feedback, reflection and discussion, third party confirmation and submitting a revalidation form.

Questions 12a, 16, 24, 31a and 34. Please indicate the types of support you expect to provide to your registered nurses and midwives in order to [comply with the required change] over and above support you already provide.



Averages calculated as proportion of total number of responses (119)

Responses received in the organisational survey demonstrate that a high proportion of organisation respondents have already put in place, or are planning to put in place, measures of support to assist nurses and midwives to submit their revalidation form online.

Appendix 4 Cost benefit analysis: supporting evidence

Appendix 4 Cost benefit analysis: supporting evidence

4.1 Introduction

This Appendix provides supplementary analysis and data in relation to the findings of our Cost Benefit Analysis as set out in Section 4 of our main report. This Appendix should be read in conjunction with that report.

The remainder of this Appendix is structured as follows:

- Section 4.2 - detailed findings of the benefits of revalidation for both organisation and registrants.
- Section 4.3 - detailed findings of the costs to organisations of revalidation.
- Section 4.4 - detailed findings of the costs to registrants of revalidation.

4.2 Detailed findings: Benefits of revalidation as reported by organisations and registrants

4.2.1 Overview

Across the interviews, focus groups and survey there was general consensus that revalidation will deliver benefits. It was suggested, however, that it is difficult to measure the potential scale of benefits or to know the timing of when they will be realised.

In the interviews and focus groups the benefits most frequently cited were those of giving nurses and midwives a greater sense of professionalism and improved patient safety. In particular, it was felt that the feedback, reflection and discussion elements of revalidation may deliver the greatest benefits given that these requirements should raise self-awareness amongst registrants, encourage an open and honest culture and allow nurses to learn from feedback via reflection. It was also noted that additional CPD may provide greater assurance of staffing quality, support development to more senior positions and increase recognition of skills and academic requirements.

An interviewee noted that the public generally think revalidation already exists and another stressed that revalidation was essential whatever the costs.

In spite of the general agreement that there would be benefits arising from revalidation, there was some disagreement about the potential scale of the benefits and the extent to which these would be realised depending 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, may mean that the full potential benefits of revalidation may not be realised.

Some interviewees believed that revalidation did not go far enough as it said nothing about fitness to practice and being a competent, compassionate nurse. A minority of those interviewed did not feel revalidation would bring any benefits. Some GP practices interviewed suggested that they saw revalidation as merely an additional administrative task and one midwifery organisation interviewed thought that revalidation may be "better than nothing for nurses" but could not understand why midwifery was not trying to improve on their current system of supervisions instead of introducing revalidation.

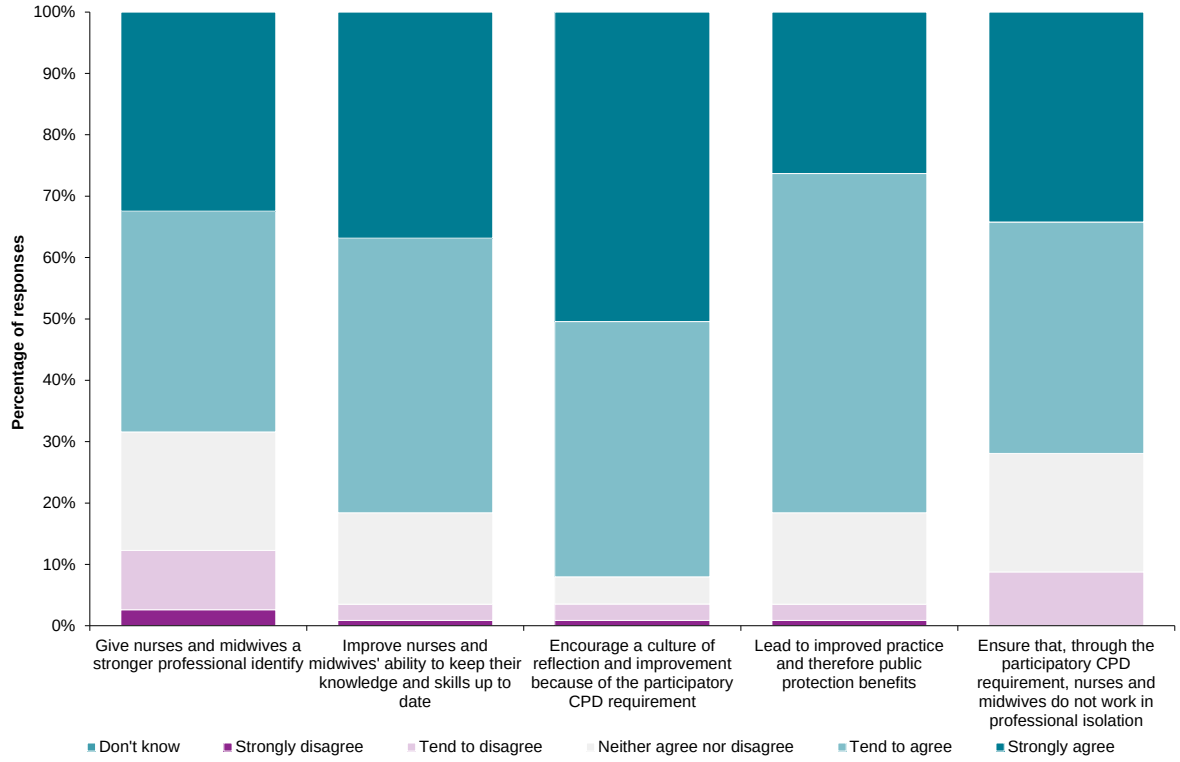
4.2.2 Benefits of revalidation by requirement

While the interviews and focus groups provided evidence of the overall benefits of revalidation the surveys provided evidence of the potential benefits associated with each area of the revalidation requirements. This survey evidence for organisations from our organisational survey, and from registrants at the pilot sites from the Ipsos MORI survey, is outlined below. We present the results from the organisation survey for pilot and non-pilot organisations collectively. There were no marked differences in the benefits findings between pilot and non-pilot organisations.

4.2.2.1 Continuous professional development

Results from the organisation survey show that, in general, organisation respondents agreed that the CPD requirements of revalidation will be beneficial in each of the five areas asked about in the survey.

Figure 25 – Organisation survey respondents' views on the benefits of the CPD requirements of revalidation[16]



In relation to all five areas of benefits over 65% of organisations surveyed either 'strongly agree' or 'tend to agree' with the stated benefits. Organisations most strongly agreed that participatory CPD would encourage a culture of reflection and improvement, with 92% of organisation respondents agreeing with this statement.

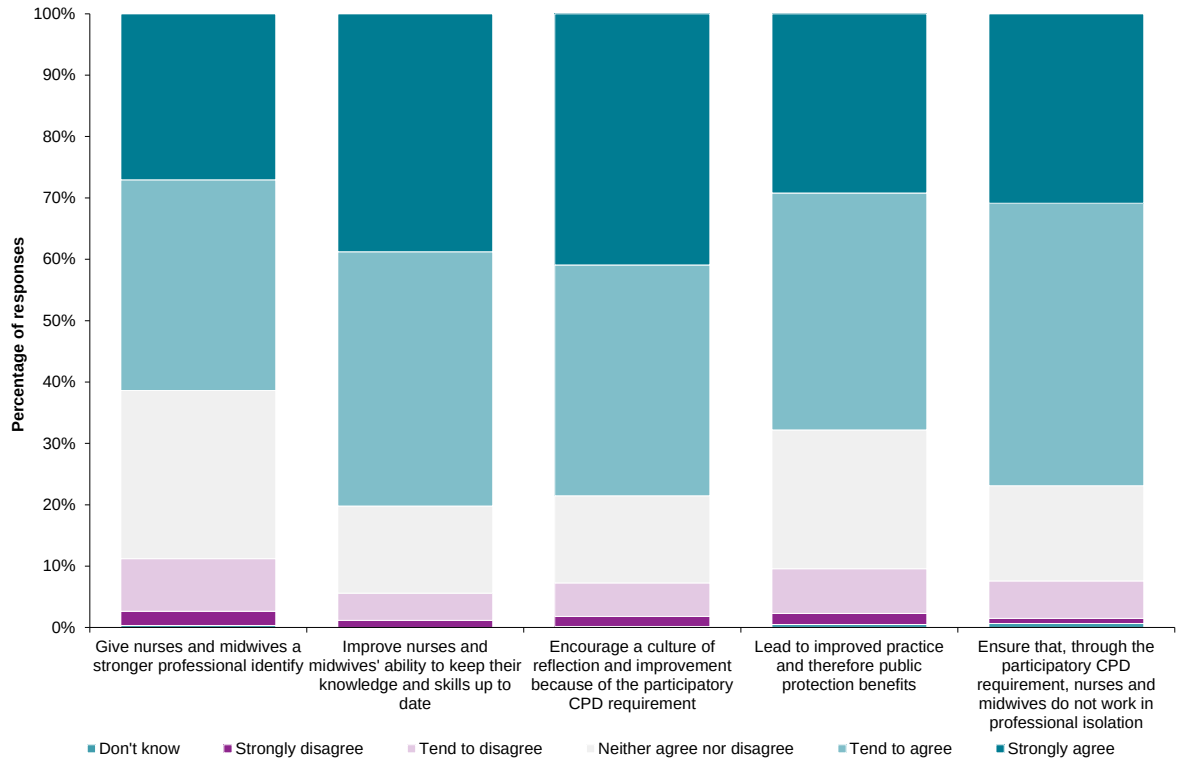
Only 1% or fewer organisation respondents strongly disagreed that the CPD requirements will result in the stated benefits. Organisations most strongly disagreed that the CPD

[16] Number of respondents for each question (left to right bar): 116, 116, 115, 116, 116.

requirements would give nurses and midwives a stronger professional identity (over 10% of organisation respondents strongly disagreed or tended to disagree with this benefit).

In terms of the registrant survey results on the benefits of CPD, the greatest proportion of registrant respondents agreed that CPD requirements would confer the benefits of improving their ability to keep knowledge and skills up to date and that it encourages a culture of reflection and improvement because of the participatory CPD requirement.

Figure 26 - Registrant survey respondents' views on the benefits of the CPD requirements of revalidation[17]



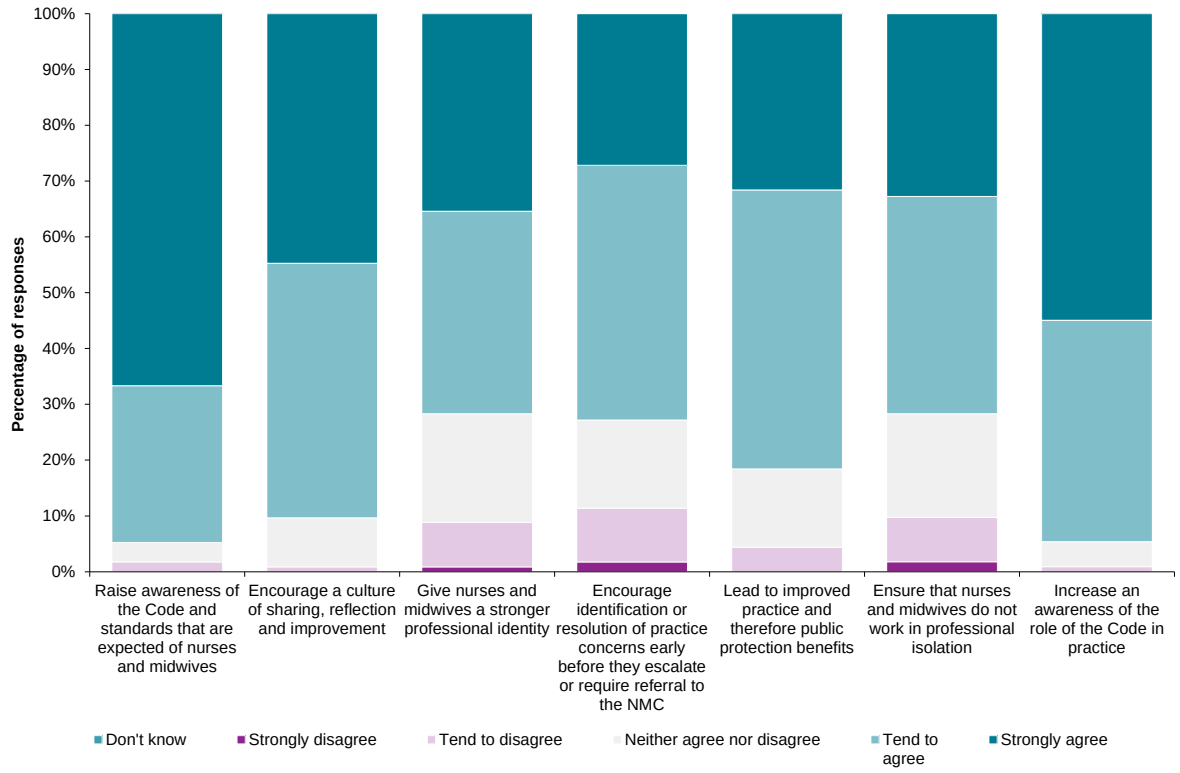
4.2.2.2 Feedback, reflection and professional development discussions

In the case of feedback, from the organisation survey responses the level of organisations' agreement with all benefits was strong with over 70% of respondents indicating that they strongly agreed or tended to agree that the benefits would be realised. There was the greatest level of agreement among organisation respondents that the feedback requirements would raise awareness of the Code and standards expected of nurses and midwives and that it would increase awareness of the role of the Code in practice.

Despite 'professionalism' being a benefit of revalidation frequently cited in the focus groups and interviews, similar to the CPD survey responses, fewer organisation respondents agreed that the feedback would give nurses and midwives a stronger professional identity than some of the other potential benefits.

[17] Number of respondents was 1,120 for each question

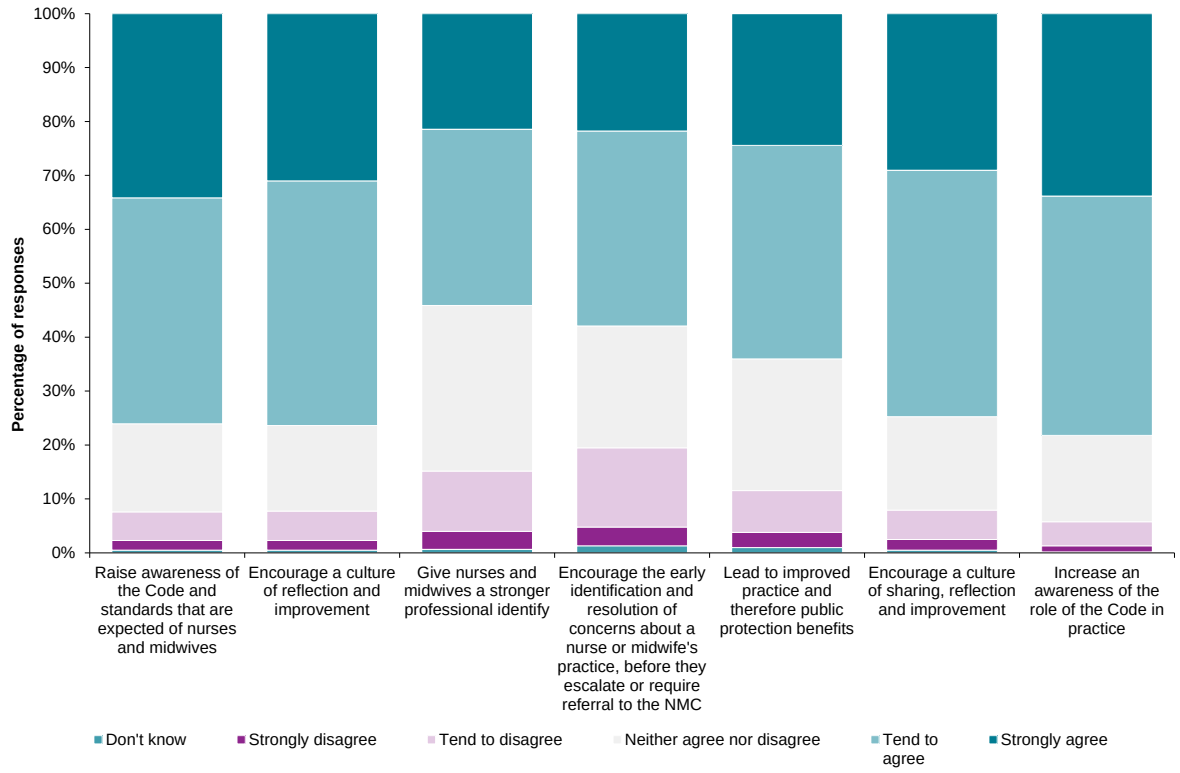
Figure 27 - Organisation survey respondents' views on the benefits of the feedback, reflection and PDD requirements of revalidation[18]



Overall, registrant survey respondents reported that they generally agreed with the seven benefits asked about in the survey, consistent with the responses from organisations. However, there was generally a lower level of agreement from registrant respondents that the benefits would be realised. Equally, more registrant respondents than organisation respondents stated that they 'neither agree nor disagree' with the stated benefits they were asked about. Registrant respondents were also more likely to disagree that the benefits of feedback, reflection and discussion would be realised.

[18] Number of respondents for each question (left to right bar): 116, 116, 115, 116, 116, 115, 113.

Figure 28 - Registrant survey respondents' views on the benefits of the feedback requirements of revalidation[19]

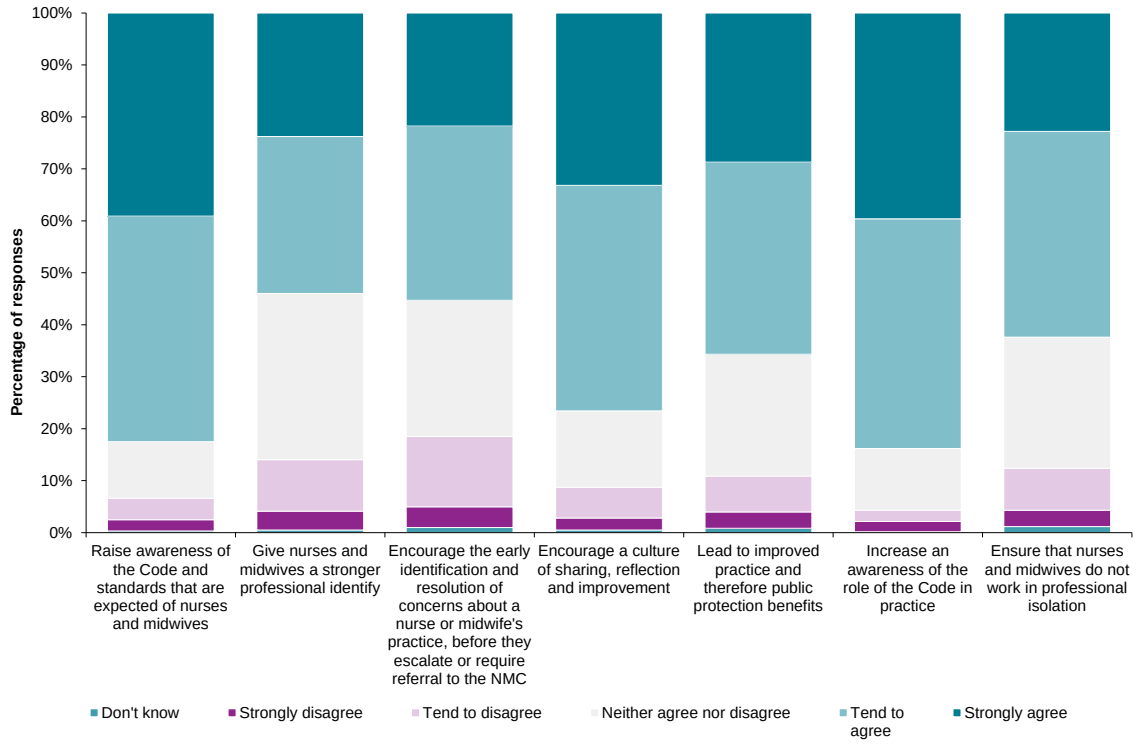


In terms of the requirements on registrants to write written reflections, registrant respondents most strongly agreed that this would confer the benefit of raising awareness of the Code and expected standards. The agreement that these benefits would be realised is likely to be because under revalidation, each registrant must consider how their reflective account relates to the Code. Therefore, registrants are likely to gain a better awareness and understanding of the Code, in order to properly reflect on their performance. This echoes the views of those interviewed.

Registrant survey respondents were also asked about the benefits associated with the written reflective accounts requirements of revalidations. They were also asked separately about the benefits of professional development discussions. Similar to the responses in relation to the feedback and reflection requirements, there was the greatest level of agreement that these requirements would raise awareness of the Code.

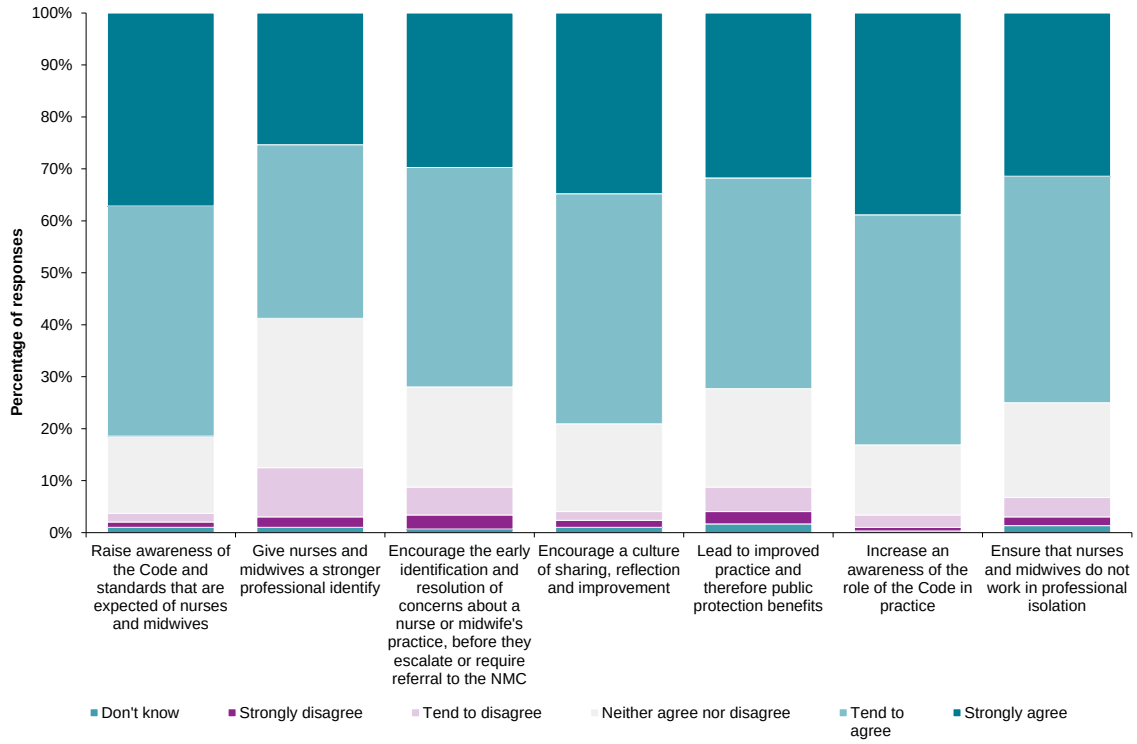
[19] Number of respondents was 1,120 for each question

Figure 29 - Registrant survey respondents' views on the benefits of the written reflective accounts requirements of revalidation[20]



[20] Number of respondents was 1,120 for each question

Figure 30 - Registrant survey respondents' views on the benefits of the professional development discussion requirements of revalidation[21]



In all but one area of potential benefits associated with the professional development discussion requirements of revalidation, over 70% of registrants surveyed said they either "strongly agree" or "tend to agree" that they would be realised. In the interviews and focus groups the professional development discussion was generally highlighted as a requirement that would deliver benefits. A number of pilot organisations particularly noted that there had been positive feedback from their registrants on the value of these discussions.

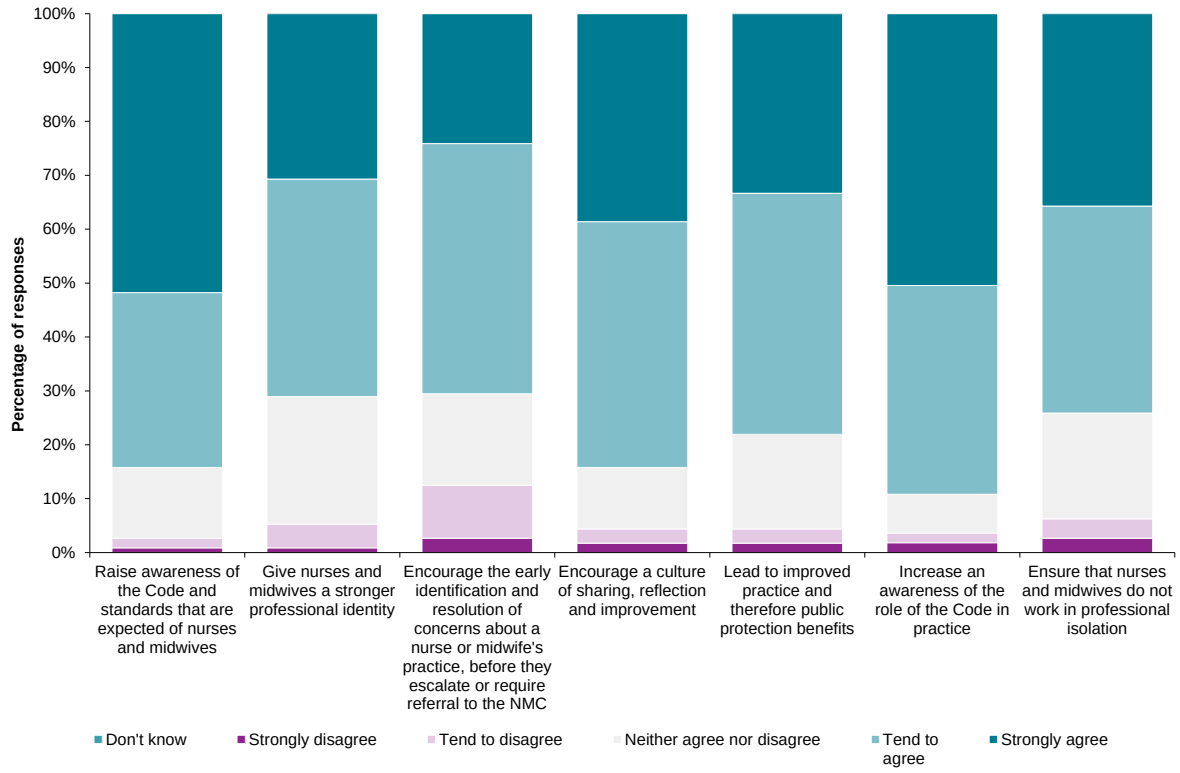
4.2.2.3 Third party confirmation

In the interviews and focus groups a number of stakeholders raised concerns that third party confirmation may become "a tick box exercise" if not properly supported and if there were not sufficient checks in place at the organisation level, and particularly from the NMC in terms of the requests for further information. However, like all other areas of the revalidation requirements, the large majority of survey respondents, both organisations and registrants, agreed that the third party confirmation requirements would deliver benefits.

The lowest proportion of both registrant and organisation survey respondents agreed that it would contribute to giving nurses and midwives a stronger professional identity. And the majority of organisation and registrant respondents agreed that the benefits would be linked to increasing awareness of the Code.

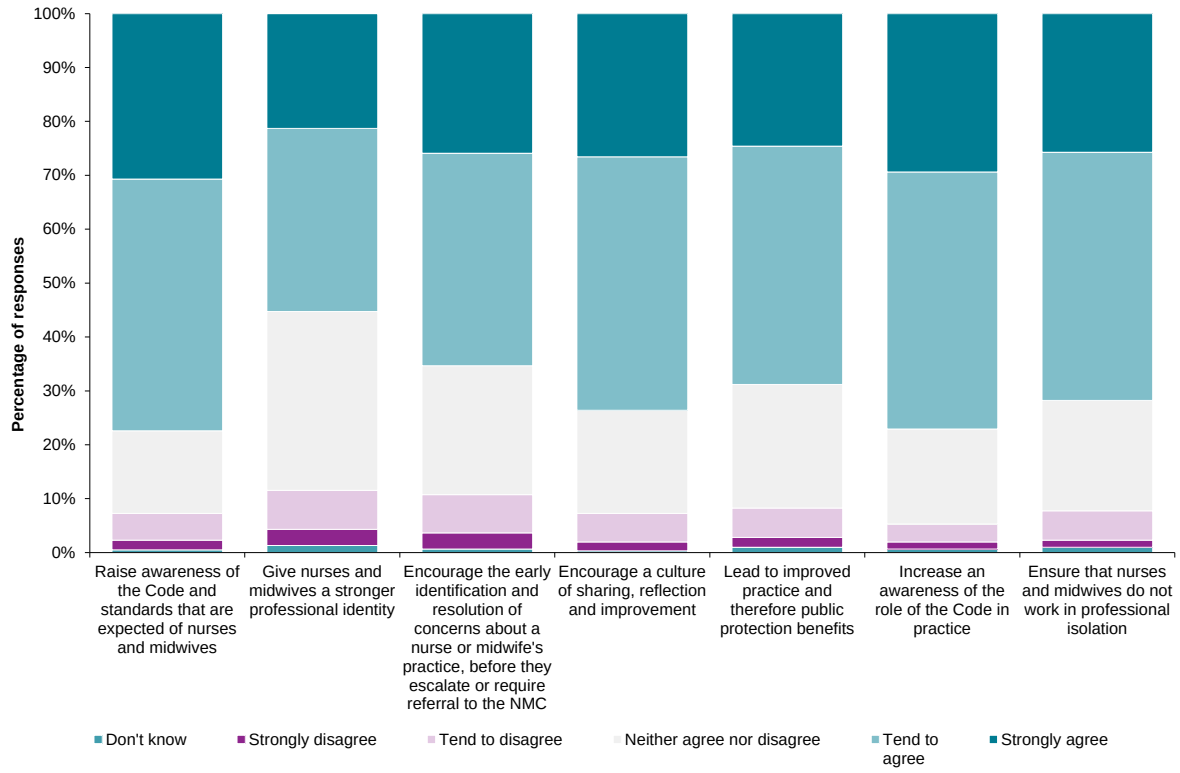
[21] Number of respondents was 1,120 for each question

Figure 31 – Organisation survey respondents' views on the benefits of the third-party confirmation requirements of revalidation[22]



[22] Number of respondents for each question (left to right bar): 116, 116, 114, 116, 116, 113, 114.

Figure 32 – Registrant survey respondents' views on the benefits of the third-party confirmation requirements of revalidation[23]



4.3 Detailed findings: Cost to organisations of revalidation

In the organisation survey, respondents were asked to provide estimates in relation to the costs of the support that they plan to put in place for each of the areas of revalidation requirements. Organisations were asked to estimate the one-off upfront costs of revalidation and the annual ongoing costs of revalidation (through the first cycle of revalidation and cycles thereafter).

Detailed summaries of the costs reported by organisations for each of the revalidation requirements are set out below.

4.3.1 Variation in organisations' estimates of costs: distribution analysis

As is discussed in Section 4 of our main report, organisation survey responses show significant variation in the estimated cost of revalidation across organisations on a per registrant basis.

There was significant variation in the cost estimates provided by both pilot and non-pilot organisation respondents for the one-off upfront costs and the ongoing costs of revalidation. In order to assess in more detail this variation in cost estimates provided by organisation respondents we conducted distribution analysis. This allows us to see the range in the estimated costs and their distribution. The distribution of estimated total costs on a per

[23] Number of respondents was 1,120 for each question

registrant basis[24] from pilot and non-pilot organisation respondents is shown in Figure 33, Figure 34 and Figure 35.

Figure 33 – Organisation survey respondents' estimates of the total one-off per registrant cost of revalidation

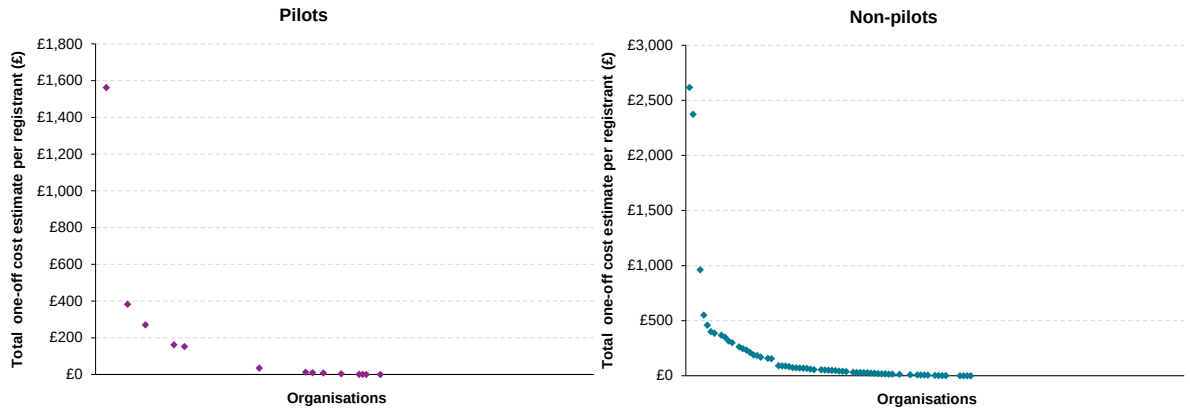
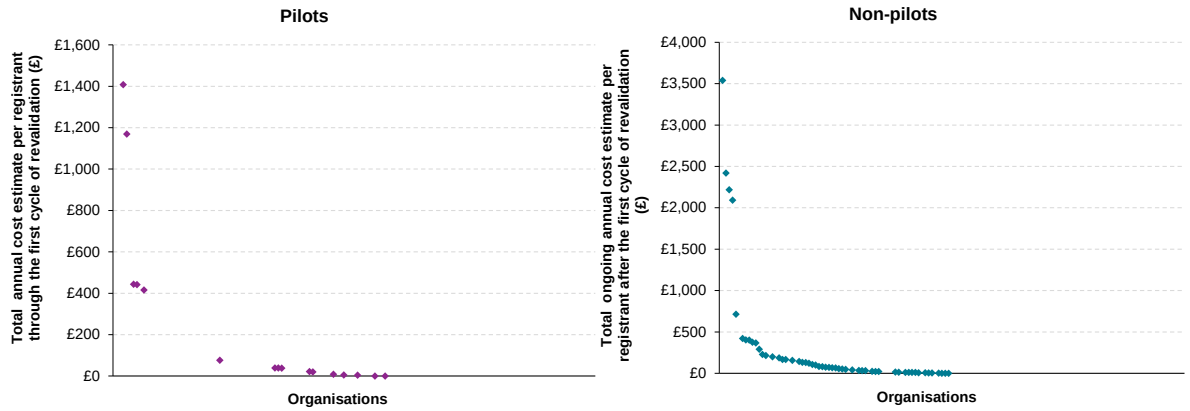
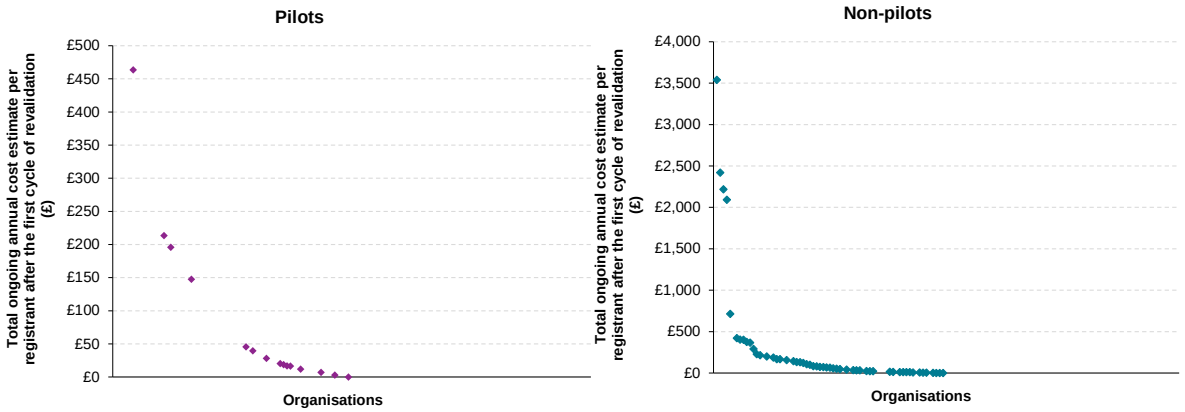


Figure 34 – Organisation survey respondents' estimates of the total annual per registrant cost through the first cycle of revalidation



[24] Organisations were not asked to provide an estimate of the total cost of revalidation to their organisation. They were asked to provide estimates of the costs associated with each of the requirements of revalidation individually. These have been aggregated to provide total organisation costs for the purposes of our analysis.

Figure 35 - Organisation survey respondents' estimates of the total ongoing annual per registrant cost after the first cycle of revalidation



As shown in the Figures above, even though there is a broadly similar distribution pattern of cost estimates from the pilot and non-pilot organisation respondents, the scale of costs estimated by pilot respondents, in general, is lower than that reported by non-pilot organisations.

Furthermore, although the majority of organisation respondents' (both pilots and non-pilots) overall cost estimates are clustered towards the lower end of the range of costs, a small number of both pilot and non-pilot organisation respondents estimated the overall costs of revalidation, on a one-off and ongoing basis, to be considerably higher than the majority of other organisation respondents. However, the cost estimates of these organisations were not consistently higher across all areas of revalidation requirements than other organisations. For example, while one pilot organisation had the highest estimated cost on a per registrant basis overall and in relation to supporting CPD, their cost estimates for supporting other revalidation requirements (such as feedback, reflection and discussion) were at or below the average (mean) costs reported by all pilot organisations.

The Figures above also highlight the difference in scale of costs estimated by pilot and non-pilot organisation respondents. In general, pilot organisations estimated lower per registrant costs of revalidation than non-pilots.

4.3.2 Cost to organisations of continuing professional development (CPD)

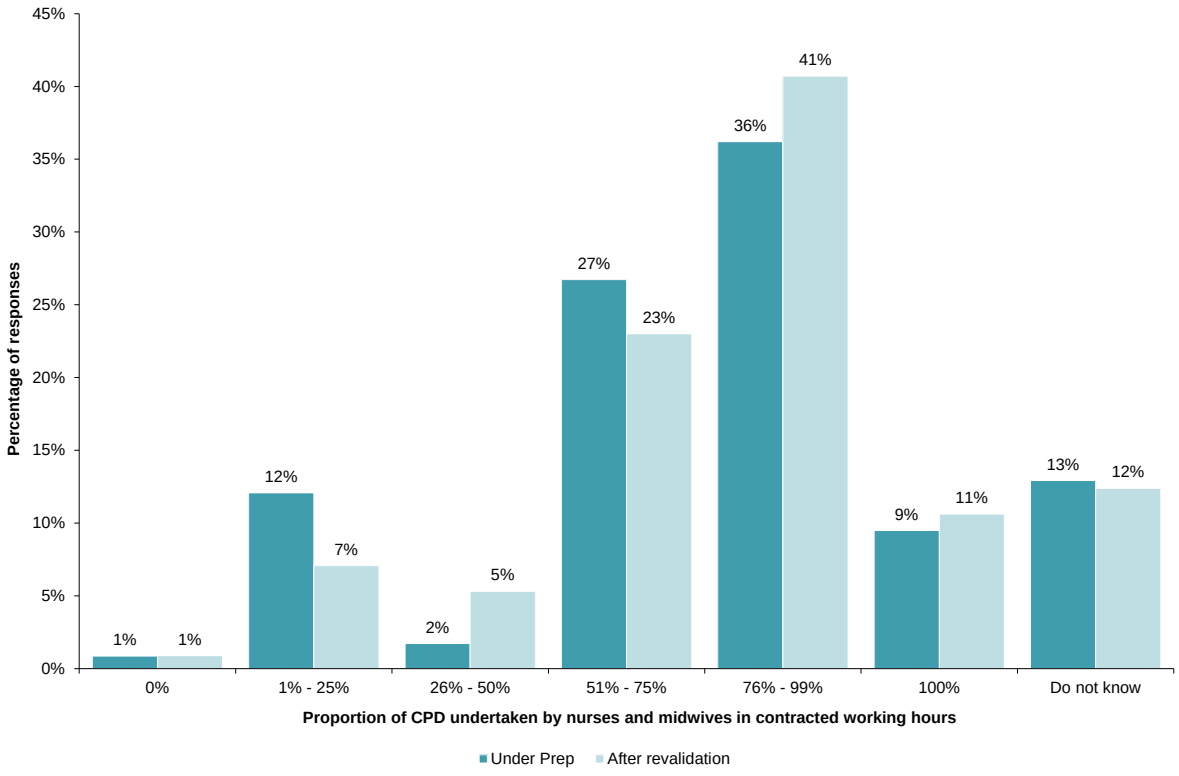
Under revalidation registered nurses and midwives will be required to undertake five extra hours of CPD to take total CPD hours to 40 hours over three years (from the current requirement of 35 hours). Of these 40 hours, 20 hours must be for participatory learning. Registrants will also be required to maintain a CPD record in their portfolio.

The majority of organisations involved our interviews and focus groups indicated that they considered that the main costs associated with the CPD requirements would relate to their efforts to highlight to registrants what activities could be considered as CPD. It was also suggested that costs would be associated with the additional time their registrants would need to spend recording their CPD which may divert them away from clinical practice. Some interviewees and focus group participants raised concerns that if their organisations gave their registrants extra time to undertake and to record CPD during work hours there

would be pressure on resources if nurses and midwives needed to spend extra time away from clinical practice.

Reponses to our organisation survey suggest that the majority of CPD is conducted in contracted work hours and that this is not expected to change under revalidation. Around 75% of organisation respondents indicated that at present their registrants undertake over half of their CPD activity during work hours. 10% of organisation respondents reported that all their registrants' CPD is undertaken in work hours. If this is the case, there are likely to be cost implications for organisations associated with the opportunity cost of their registrants' additional time spent meeting the CPD revalidation requirements in work time. However, it should be noted that the organisation assessment of the proportion of CPD undertaken in work hours contrasts significantly with the view of respondents to the registrants survey at the pilot organisations. Analysis of the registrant survey responses indicates that approximately 11% of CPD hours are undertaken during contracted work hours.

Figure 36 – Organisation survey respondents' views of the degree of CPD conducted during contracted work hours under Prep and post-revalidation introduction



In the interviews and focus groups some concerns were raised in relation to registrants working in small independent organisations, bank staff and for those working in non-clinical roles. For example, NHS organisations in England and Scotland suggested that they were concerned that they might have to take on the responsibility of offering additional CPD to bank staff and thus incur the costs associated with this. Some interviewees also indicated that they thought that additional CPD may be required for nurses in managerial roles which organisations may be expected to pay for.

Although, overall, in the interviews and focus groups it was suggested that the costs associated with the CPD requirements may be relatively limited, the estimates provided by

respondents to the organisation survey suggests that organisations consider that the CPD requirements could result in significant costs.

Figure 37, Figure 38 and Figure 39, below show the types of support that organisation respondents indicated that they plan to put in place to support their registrants to meet the CPD requirements and their associated estimated one-off and ongoing costs. Although many organisation respondents suggested that they would incur costs associated with different types of support for the CPD requirements, 16% of organisations providing cost estimates for the new CPD requirements stated that they did not expect to incur any costs at all.

Figure 37 - Response to organisation survey: Impact of CPD on one-off upfront costs. *Number of respondents: 16 pilots and 88 non-pilots*

	One-off upfront costs before revalidation is introduced (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
IT system changes	0	7	1	0	118	8
Use of NMC published guidance	0	3	0	0	9	1
Preparation of additional material and guidance	0	14	3	0	39	5
Website development	0	4	1	0	17	1
Training staff to provide support	0	26	6	0	367	25
HR/other team support	0	15	3	0	67	10
Development and provision of E-portfolio	0	66	10	0	100	12
Other	0	15	6	0	7	2
Participatory learning	0	1,316	183	0	1,000	49
Total[25]	**0**	**1,479**	**93**	**0**	**1,154**	**54**

[25] The total is the average of the total cost of revalidation reported by each organisation – it is not equal to the sum of the rows above.

Figure 38 - Response to organisation survey: Impact of CPD on annual costs through first 3 year cycle of revalidation. *Number of respondents: 15 pilots and 82 non-pilots*

	Annual costs through first 3 year cycle of revalidation (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
IT system changes	0	3	1	0	73	6
Use of NMC published guidance	0	2	0	0	5	0
Preparation of additional material and guidance	0	6	1	0	39	2
Website development	0	3	1	0	8	0
Training staff to provide support	0	585	61	0	70	9
HR/other team support	0	585	51	0	30	5
Development and provision of E-portfolio	0	21	5	0	71	12
Other	0	15	7	0	7	1
Participatory learning	0	1,316	184	0	923	62
Total[26]	**0**	**1,354**	**167**	**0**	**931**	**43**

Figure 39 - Response to organisation survey: Impact of CPD on ongoing annual costs after the first 3 year cycle of revalidation. *Number of respondents: 14 pilots and 77 non-pilots*

	Ongoing annual costs after the first 3 year cycle of revalidation (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
IT system changes	0	3	1	0	82	5
Use of NMC published guidance	0	2	0	0	5	0
Preparation of additional material and guidance	0	2	1	0	39	3
Website development	0	3	0	0	5	0
Training staff to provide support	0	13	3	0	70	8
HR/other team support	0	13	2	0	30	4
Development and provision of E-portfolio	0	21	5	0	71	9
Other	0	15	6	0	7	1
Participatory learning	0	144	38	0	923	62
Total[27]	**0**	**170**	**28**	**0**	**931**	**35**

[26] See Footnote 25.

[27] See Footnote 25.

As discussed in Section 4.4.2 some of the above costs estimated by organisation respondents are linked to highly supportive measures that are not necessarily required from organisations to support the requirements of revalidation. These measures include:

- IT system changes which, on average, account for 1% of the ongoing cost estimates for pilots and 6% for non-pilots;
- Website development which, on average, accounts for 1% of the ongoing cost estimates for pilots and 0.3% for non-pilots;
- Training staff to provide support which, on average, accounts for 5% of the ongoing cost estimates for pilots and 8% for non-pilots; and
- Development and provision of E-portfolios which, on average, accounts for 10% of the ongoing cost estimates for pilots and 10% for non-pilots.

If these highly supportive measures were not put in place by organisations it would result in a 17% reduction in costs for pilots and 24% for non-pilots. This is equivalent to a reduction in cost of approximately £5 per registrant for pilots and £9 per registrant for non-pilots on average.

4.3.3 Costs to organisations of practice hour requirements

Under revalidation, the number of hours that nurses and midwives must practice are largely unchanged compared to Prep. However, there are some changes to the recording of practice hours, for example, evidence must be collated by nurses and midwives on their scope of practice as this may be required by the NMC as part of the request for further information to support the revalidation application.

It was generally considered by those individuals we interviewed and who participated in our focus groups that the practice hour requirements would entail very limited costs as it was considered that most registrants would already be working hours exceeding the minimum requirement for revalidation. It was suggested, however, that there may be costs incurred to collect evidence and record practice hours but that this could generally be acquired through electronic systems at the organisation, using timesheets or printing off electronic diaries. We were told that some private hospitals had planning sheets which stated where nurses were to be at different times which they considered could be used to evidence meeting the practice hour requirements.

In our interviews and focus groups across the UK, it was suggested that the practice hours requirements may pose some difficulties for those in managerial roles who could need extra support to reach the hours required.[28] Interviewees suggested that this could place costs on organisations in terms of administration support required and the loss of worktime for those registrants affected. There were mixed opinions about whether this cost should be borne by organisations and that "those in non-nursing roles where registration is not required are not an organisation's responsibility". Several other interviewees from across the UK stressed the importance of their registrants not in clinical practice being able to revalidate and already offered support to assist them in this.

[28] It is important to note however that, as is outlined above, Scotland and Northern Ireland are not as well represented in the survey responses as England and Wales.

Organisations responding to our survey, on average (mean), estimated that the costs associated with the practice hour requirements would be lower than those for most other areas of the revalidation requirements on a one-off and ongoing basis.

Figure 40 - Response to organisation survey: Impact of practice hours on one-off upfront costs. *Number of respondents: 12 pilots and 68 non-pilots*

	One-off upfront costs before revalidation is introduced (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
IT system changes	0	4	1	0	49	4
Preparation of additional material and guidance	0	12	3	0	245	9
Website development	0	3	1	0	49	2
Development and provision of e-portfolio	0	15	5	0	42	7
Training staff to provide support	0	12	3	0	245	19
HR/other team support	0	5	1	0	49	6
Access to job descriptions	0	1	0	0	10	0
Provision of attendance records	0	4	1	0	10	1
Other	0	4	2	0	10	2
Total[29]	**0**	**40**	**7**	**0**	**706**	**25**

[29] See Footnote 25.

Figure 41 - Response to organisation survey: Impact of practice hours on annual costs through the first 3 year cycle of revalidation. *Number of respondents: 12 pilots and 61 non-pilots*

	Annual costs through first 3 year cycle of revalidation (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
IT system changes	0	3	1	0	73	5
Preparation of additional material and guidance	0	6	2	0	245	9
Website development	0	3	0	0	10	1
Development and provision of e-portfolio	0	8	3	0	66	7
Training staff to provide support	0	3	1	0	147	13
HR/other team support	0	4	1	0	49	6
Access to job descriptions	0	2	0	0	5	0
Provision of attendance records	0	2	0	0	10	0
Other	0	4	2	0	10	2
Total[30]	**0**	**23**	**4**	**0**	**554**	**23**

[30] See Footnote 25.

Figure 42 - Response to organisation survey: Impact of practice hours on ongoing annual costs after the first 3 year cycle of revalidation. *Number of respondents: 12 pilots and 57 non-pilots*

	Ongoing annual costs after the first 3 year cycle of revalidation (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
IT system changes	0	3	1	0	82	3
Preparation of additional material and guidance	0	2	0	0	14	1
Website development	0	3	0	0	5	0
Development and provision of e-portfolio	0	8	2	0	22	4
Training staff to provide support	0	2	0	0	147	14
HR/other team support	0	4	1	0	93	7
Access to job descriptions	0	2	0	0	5	0
Provision of attendance records	0	2	0	0	10	0
Other	0	3	2	0	10	2
Total[31]	**0**	**20**	**3**	**0**	**332**	**17**

As shown in the Figures above, the main drivers of the costs estimated by organisation respondents to support the practice hour requirements differ in terms of one-off and ongoing costs, as well as across pilot and non-pilot organisation respondents.

Some of the costs estimated by organisation respondents, however, are linked to highly supportive measures that are not necessarily required from organisations to support the requirements of revalidation. These measures include:

- IT system changes which, on average, account for 10% of the ongoing cost estimates for pilots and 10% for non-pilots;
- Website development which, on average, accounts for 6% of the ongoing cost estimates for pilots and 1% for non-pilots;
- Development and provision of e-portfolios which, on average, accounts for 31% of the ongoing cost estimates for pilots and 14% for non-pilots; and
- Training staff to provide support which, on average, accounts for 7% of the ongoing cost estimates for pilots and 43% for non-pilots.

If these highly supportive measures were not put in place by organisations it would result in a 54% reduction in costs for pilots and 68% for non-pilots. This is equivalent to a reduction in cost of approximately £1 per registrant for pilots and £12 per registrant for non-pilots on average.

[31] See Footnote 25.

4.3.4 Costs to organisations of practice related feedback, reflection and professional development discussion (PDD)

In relation to practice related feedback, reflection and discussion, revalidation will require registered nurses and midwives to:

- Obtain at least five pieces of practice-related feedback over the three years prior to the renewal of their registration. There will be flexibility around the sources of feedback;
- Record a minimum of five written reflections on the Code, CPD, and practice-related feedback over the three years prior to the renewal of their registration;
- Have a Professional development discussion (PDD) with another NMC registrant, covering their reflections on the Code, their CPD, and practice-related feedback.

In the interviews and focus groups, it was suggested that the greatest costs of the feedback, reflection and discussion requirements would be associated with the extra time required for nurses and midwives to fulfil the requirements and for the organisations to support them in doing so. It was considered by interviewees that extra time would be required for registrants to develop these aspects of their portfolios and for organisations to put processes in place to incorporate revalidation into existing appraisal processes. It was also suggested that there would also be ongoing time costs associated with longer appraisal discussions that incorporated the PDD. The extent of these costs would depend on what systems organisations already had in place and how much organisations expected registrants to do in their own time.

Interviewees and focus group participants suggested that organisations with good performance management and appraisals procedures were likely to incur less additional time costs as their appraisals were more likely to already incorporate elements of the reflection and development discussions required for revalidation. For instance, it was noted that many agencies already have a robust system of appraisals as it is a requirement for their staff. Also, midwives already have statutory supervisions. However, it was suggested that for nurses in the NHS appraisals were "not as strong as they should be". It was also mentioned that registrants working in some practice settings, such as in the community and in GP practices, may find it more challenging to identify someone within their organisation to hold the PDD with and so may incur additional time costs.

Some stakeholders indicated that for the revalidation pilot they had offered additional support to registrants in some settings. For example, one Health Board in Wales expected its staff to hold appraisals and professional discussions with nurses working in community settings and GP surgeries, despite the time costs this would place on the organisation.

Figure 43, Figure 44 and Figure 45 below show the types of support that organisation respondents to our survey indicated that they plan to put in place to support their registrants to meet the feedback, reflection and discussion requirements and their associated estimated one-off and ongoing costs.

Figure 43 - Response to organisation survey: Impact of practice related feedback and reflection and discussion on one-off upfront costs. *Number of respondents: 12 pilots and 65 non-pilots*

	One-off upfront costs before revalidation is introduced (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Identify people for the discussion to be held with	0	5	0	0	43	4
Use of line managers	0	5	0	0	462	19
Use of appraisal programme	0	15	2	0	385	13
Development of guidance documents	0	12	2	0	49	5
Additional training	0	23	6	0	147	18
IT system changes	0	5	1	0	400	18
Website development	0	5	1	0	29	2
Additional staff to manage the process	0	38	6	0	216	16
Other	4	4	4	0	7	1
Total[32]	**0**	**100**	**11**	**0**	**885**	**55**

[32] See Footnote 25.

Figure 44 - Response to organisation survey: Impact of practice related feedback and reflection and discussion on annual costs through the first 3 year cycle. *Number of respondents: 11 pilots and 64 non-pilots*

	Annual costs through first 3 year cycle of revalidation (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Identify people for the discussion to be held with	0	12	2	0	21	2
Use of line managers	0	5	0	0	462	18
Use of appraisal programme	0	385	1	0	385	11
Development of guidance documents	0	6	1	0	49	3
Additional training	0	30	7	0	98	10
IT system changes	0	3	1	0	73	5
Website development	0	2	0	0	29	2
Additional staff to manage the process	0	38	7	0	216	20
Other	4	4	4	0	0	0
Total[33]	**0**	**98**	**10**	**0**	**846**	**39**

[33] See Footnote 25.

Figure 45 - Response to organisation survey: Impact of practice related feedback and reflection and discussion on ongoing annual costs after the first 3 year cycle. *Number of respondents: 11 pilots and 60 non-pilots*

	Ongoing annual costs after the first 3 year cycle of revalidation (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Identify people for the discussion to be held with	0	6	1	0	50	3
Use of line managers	0	5	0	0	462	23
Use of appraisal programme	0	8	1	0	385	12
Development of guidance documents	0	2	0	0	20	2
Additional training	0	15	4	0	150	14
IT system changes	0	3	1	0	17	2
Website development	0	2	0	0	10	1
Additional staff to manage the process	0	38	7	0	216	17
Other	4	4	4	0	0	0
Total[34]	**0**	**81**	**7**	**0**	**846**	**42**

As shown in the Figures above, for pilot organisation respondents, the main driver of both the one-off and ongoing costs are associated with the use of additional staff to manage the process and additional training. For non-pilot organisation respondents, the use of additional staff to manage the process was also a key driver of the expected cost of this requirement as well as the use of line managers.

Additionally, organisation respondents indicated that they expect to incur costs in training. Stakeholders interviewed also suggested that there would be a need to train staff performing the PDDs to ensure that they were properly conducted, added value and so allowed the benefits of these requirements to be realised.

However, some of the above costs estimated by organisation respondents are linked to highly supportive measures that are not necessarily required from organisations to support the requirements of revalidation. These measures include:

- Identifying people for discussions to be held with which, on average, account for 3% of the ongoing cost estimates for pilots and 4% for non-pilots;
- Additional training which, on average, accounts for 25% of the ongoing cost estimates for pilots and 19% for non-pilots;
- IT system changes which, on average, account for 4% of the ongoing cost estimates for pilots and 3% for non-pilots; and

[34] See Footnote 25.

- Website development which, on average, accounts for 1% of the ongoing cost estimates for pilots and 2% for non-pilots.

If these highly supportive measures were not put in place by organisations it would result in a 33% reduction in estimated costs for pilots and 26% for non-pilots. This is equivalent to a reduction in cost of approximately £2 per registrant for pilots and £11 per registrant for non-pilots on average.

4.3.5 Cost to organisations of third party confirmation

Third party confirmation requirements of revalidation require registered nurses and midwives to:

- Declare that they have demonstrated to an appropriate third party that they have complied with the revalidation requirements; and
- Hold this confirmation discussion face-to-face conversation or via teleconference; provide the name, NMC PIN or other professional identification number (where relevant), email, professional address and postcode of the third party confirmer.

Those interviewed suggested that there would be time costs to all organisations associated with third party confirmation discussions. Due to some uncertainty over the confirmation requirements, some organisations participating in our interviews and focus groups thought they may occur additional costs from extra clarification, guidance and possible training for confirmers. Stakeholders interviewed, particularly those in Scotland, considered that confirmers would need to be NMC registrants (so as to understand the requirements they were confirming) and that confirmers would need training to effectively fulfil this role.

Several organisations interviewed also indicated that they would need to put systems/processes in place to monitor who was acting as confirmer for each registrant. This would be facilitate checking that the confirmation had taken place and to ensure that 'friends just didn't sign each other off'. It was suggested that this could either be added to the NMC's online system or incorporated into organisations' current systems for a small set-up cost.

Figure 46, Figure 47 and Figure 48 below show the types of support that organisation respondents to our survey indicated that they plan to put in place to support their registrants with third party confirmation and their associated estimated one-off and ongoing costs. While the average costs for this requirement estimated by organisation respondents are not as high as other areas of the requirements, they are still substantial and the maximum costs reported are very large in some cases.

Figure 46 - Response to organisation survey: Impact of Third Party Confirmation on one-off upfront costs. *Number of respondents: 14 pilots and 68 non-pilots*

	One-off upfront costs before revalidation is introduced (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Identifying confirmers	0	12	1	0	49	2
Use of line managers	0	8	1	0	154	8
Assigning registered nurses and midwives to confirmers	0	8	2	0	20	2
Use of appraisal process	0	66	8	0	77	3
Development of guidance documents	0	12	2	0	49	4
Training for confirmers	0	0	6	0	98	13
Development of existing IT systems	0	0	1	0	35	4
New IT systems	0	0	3	0	34	4
Website development	0	5	1	0	25	1
Additional staff to manage confirmation process	0	45	12	0	490	25
Other	0	8	4	0	7	1
Total[35]	**0**	**109**	**16**	**0**	**868**	**32**

[35] See Footnote 25.

Figure 47 - Response to organisation survey: Impact of Third Party Confirmation on annual costs through the first 3 year cycle. *Number of respondents: 13 pilots and 65 non-pilots*

	Annual costs through first 3 year cycle of revalidation (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Identifying confirmers	0	87	8	0	9	1
Use of line managers	0	6	1	0	154	7
Assigning registered nurses and midwives to confirmers	0	4	1	0	20	1
Use of appraisal process	0	13	2	0	77	3
Development of guidance documents	0	6	2	0	38	4
Training for confirmers	0	11	3	0	49	7
Development of existing IT systems	0	8	2	0	10	1
New IT systems	0	8	1	0	73	6
Website development	0	3	1	0	25	1
Additional staff to manage confirmation process	0	45	12	0	490	25
Other	0	8	4	0	0	0
Total[36]	**0**	**125**	**15**	**0**	**706**	**24**

[36] See Footnote25.

Figure 48 - Response to organisation survey: Impact of Third Party Confirmation on ongoing annual costs after the first 3 year cycle. *Number of respondents: 13 pilots and 61 non-pilots*

	Ongoing annual costs after the first 3 year cycle of revalidation (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Identifying confirmers	0	6	1	0	9	0
Use of line managers	0	6	1	0	154	6
Assigning registered nurses and midwives to confirmers	0	4	1	0	20	1
Use of appraisal process	0	13	2	0	77	3
Development of guidance documents	0	2	1	0	38	2
Training for confirmers	0	5	2	0	49	5
Development of existing IT systems	0	3	1	0	10	1
New IT systems	0	8	1	0	73	6
Website development	0	3	1	0	5	1
Additional staff to manage confirmation process	0	47	13	0	490	26
Other	0	8	4	0	0	0
Total[37]	**0**	**88**	**8**	**0**	**613**	**22**

The main drivers of costs for third party confirmation, for both pilot and non-pilot organisation respondents, are reported to be those associated with additional staff to manage the confirmation process. The other main areas where organisation respondents expect to incur costs are associated with the use of line managers, use of the appraisal process and training for confirmers. These costs are expected to be incurred on a one-off and ongoing basis.

Feedback from interviews and focus groups indicated that the confirmation requirement caused the most confusion amongst organisations about what was required. This uncertainty may be why organisations estimates of additional staff costs show a wide spread.

Some of the above costs estimated by organisation respondents are linked to highly supportive measures that are not necessarily required from organisations to support the requirements of revalidation. These measures include:

- Identifying confirmers which, on average, accounts for 3% of the ongoing cost estimates for pilots and 1% for non-pilots;
- Training for confirmers which, on average, accounts for 7% of the ongoing cost estimates for pilots and 9% for non-pilots;

[37] See Footnote 25.

- Development of existing IT systems which, on average, accounts for 2% of the ongoing cost estimates for pilots and 2% for non-pilots;
- New IT systems which, on average, account for 6% of the ongoing cost estimates for pilots and 13% for non-pilots; and
- Website development which, on average, accounts for 2% of the ongoing cost estimates for pilots and 1% for non-pilots.

If these highly supportive measures were not put in place by organisations it would result in a 20% reduction in estimated costs for pilot and 26% for non-pilot organisation respondents. This is equivalent to a reduction in cost of approximately £2 per registrant for pilot and £6 per registrant for non-pilot respondents on average.

4.3.6 Costs to organisations of the online submission

Under revalidation, registered nurses and midwives will be required to:

- Register with NMC Online and submit online their revalidation form for maintaining their ongoing registration; and
- Comply with the NMC if they request further information to verify/support the declarations made as part of the revalidation process. This will also be submitted through NMC Online.

It was suggested by some stakeholders interviewed that a small minority of registrants may struggle with an online approach to revalidation. It was suggested that for those registrants working in Boards, Trusts and community settings there may be a lack of available computers and many of these organisations participating in our interviews and focus groups emphasised that registrants may need to upload documentation at home. Where this is not possible, it was suggested that organisations may need to provide additional equipment, support and guidance to those with no access to a computer or scanner.

Figure 49, Figure 50 and Figure 51 below show the types of support that organisation respondents to our survey indicated that they plan to put in place to support their registrants with their online revalidation submission and the associated estimated one-off and ongoing costs. Organisation respondents estimated the costs of supporting registrants with the online revalidation submission to be relatively low compared to the other areas of requirements. This is consistent with evidence from the interviews and focus groups where many organisations indicated that they expected staff to complete much of the process from home without organisation support.

Figure 49 - Response to organisation survey: Impact of online submissions on one-off upfront costs. *Number of respondents: 10 pilots and 54 non-pilots*

	One-off upfront costs before revalidation is introduced (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Development of guidance documents	0	12	3	0	49	3
Additional training	0	23	5	0	60	12
IT system changes	0	5	1	0	34	5
Website development	0	5	1	0	29	2
Additional staff to manage process	0	45	9	0	85	9
Other	0	4	1	0	0	0
Total[38]	**0**	**85**	**13**	**0**	**196**	**17**

Figure 50 - Response to organisation survey: Impact of online submissions on annual costs through the first 3 year cycle. *Number of respondents: 10 pilots and 48 non-pilots*

	Annual costs through first 3 year cycle of revalidation (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Development of guidance documents	0	8	2	0	49	3
Additional training	0	30	5	0	49	6
IT system changes	0	3	1	0	18	3
Website development	0	3	1	0	10	1
Additional staff to manage process	0	45	8	0	43	7
Other	0	4	1	0	0	0
Total[39]	**0**	**91**	**11**	**0**	**118**	**10**

[38] See Footnote 25.

[39] See Footnote 25.

Figure 51 - Response to organisation survey: Impact of online submissions on ongoing annual costs after the first 3 year cycle. *Number of respondents: 8 pilots and 46 non-pilots*

	Ongoing annual costs after the first 3 year cycle of revalidation (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Development of guidance documents	0	5	1	0	14	1
Additional training	0	23	4	0	49	5
IT system changes	0	3	1	0	18	3
Website development	0	3	1	0	5	1
Additional staff to manage process	0	45	8	0	43	7
Other	0	4	1	0	0	0
Total[40]	**0**	**80**	**10**	**0**	**78**	**9**

The estimated organisation respondent costs associated with online submission are driven by different factors dependent on the stage in the implementation cycle of revalidation. For pilot organisation respondents, the one-off upfront costs are largely driven by additional staff to manage the process, additional training and the development of guidance. For non-pilot organisation respondents, additional staff to manage the process and training are the key drivers of the upfront one-off cost. When revalidation is introduced, additional staff to manage the process and additional training these organisations estimated these support measures to remain key drivers of costs.

As noted in relation to the other revalidation requirements, some of the above costs estimated by organisation respondents are linked to highly supportive measures that are not necessarily required to support the requirements of revalidation. These measures include:

- Additional training which, on average, accounts for 27% of the ongoing cost estimates for pilots and 29% for non-pilots;
- IT system changes which, on average, account for 4% of the ongoing cost estimates for pilots and 18% for non-pilots; and
- Website development which, on average, accounts for 4% of the ongoing cost estimates for pilots and 5% for non-pilots.

If these highly supportive measures were not put in place by organisations it would result in a 35% reduction in costs estimated by pilot organisation respondents and 51% for non-pilot organisation respondents. This is equivalent to a reduction in cost of approximately £4 per registrant for pilots and £5 per registrant for non-pilots on average.

4.3.7 Costs to organisations of preparation for revalidation and the overall management of revalidation

In addition to supporting each of the revalidation requirements, organisations are likely to incur costs in preparing for revalidation and project managing the process. Evidence from

[40] See Footnote 25.

our interviews and focus groups suggests that most of the pilot sites employed additional resources to help their registrants with the introduction of revalidation, especially those pilot organisations with a large number of registrants. Depending on the size of the organisation we were told that time from a senior nurse was needed to oversee the process and then an additional full or part time position was required to organise all aspects of revalidation including awareness raising.

As shown in Figure 52 below, in terms of preparing for revalidation, organisations reported costs associated with reviewing and familiarising themselves with the requirements, organising workshops and other sessions, and preparing their own guidance and support material.

Figure 52 - Response to organisation survey: Impact of actions organisation plan to undertake/have undertaken to prepare for revalidation. *Number of responses: 9 pilots and 46 non-pilots.*

	One-off upfront costs before revalidation is introduced (£)					
	Pilot sites			Non-pilot sites		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Review and familiarisation with the revalidation requirements	0	13	4	0	98	7
Organising workshops/training/information sharing sessions	2	26	10	0	245	17
Preparation and dissemination of any additional guidance/support materials	1	10	4	0	98	7
Other	0	5	3	0	98	16

In addition, organisation respondents indicated that they considered they would require additional staff to take forward the project management of revalidation, with high associated costs.

Figure 53 - Response to organisation survey: Impact of additional staff needed to take forward the project management of revalidation. *Number of responses: 8 pilots and 33 non-pilots*

	Annual cost of additional staff (£)					
	Pilot sites			**Non-pilot sites**		
	Min	**Max**	**Average (mean)**	**Min**	**Max**	**Average (mean)**
Professional clinical staff	0	69	21	0	1,846	179
Professional non-clinical staff	0	17	6	0	806	128
Admin staff	0	35	18	0	294	54
HR staff	0	31	11	0	308	72
Other	0	0	0	0	367	88

And when revalidation is introduced, organisation respondents indicated that they expect to incur costs in monitoring renewal dates for revalidation and monitoring the successful revalidation of registered nurses and midwives:

- Average annual costs through the first cycle of revalidation associated with monitoring renewal dates were reported to be equivalent to £4 per registrant for pilot and £8 for non-pilot organisation respondents (£3 and £7 respectively after the first cycle of revalidation). These costs were largely driven by estimated costs associated with IT system changes and the need to speak to each nurse/midwife individually to obtain information;
- Average annual costs through the first cycle of revalidation associated with monitoring the successful revalidation of registered nurses and midwives were reported to be equivalent to £6 per registrant for pilot and £19 for non-pilot organisation respondents (£6 and £18 respectively after the first cycle of revalidation). These costs were largely driven by estimated costs associated with IT system changes and additional staff to manage the process.

However, renewal itself is already a requirement of registration with the NMC, but the renewal date will also be used as the date of revalidation for registrants. As registrants are already required to renew, the NMC considers that monitoring renewal dates is a highly supportive measure that organisations may choose to put in place, but that it is not necessarily required for revalidation.

4.4 Detailed findings: Cost to registrants of revalidation

4.4.1 Costs to registrants of Continuing Professional Development

The general consensus from the interviews and focus groups we conducted across the UK was that there would be minimal or no additional costs arising from the new CPD requirements for most registrants. While many organisations wanted clarity on what registrants could include in recording their hours, they expected that their staff were already meeting or exceeding the requirements.

This view is reinforced by the results from the Ipsos MORI survey of registrants at the pilot sites. The registrant survey results indicate that the majority of registrant respondents are currently meeting or exceeding the 40 hours minimum CPD requirement and that the majority of registrant respondents are also currently meeting the participatory CPD requirements:

- When asked how much time they have spent undertaking CPD in the past three years, up and including the pilot, the estimates from registrant respondents ranged from 3 hours to 2,000 hours. The average mean time spent undertaking CPD was 101 hours and 19 minutes and the median was 65 hours;[41]
- In relation to the number of hours spent undertaking participatory learning as part of CPD in the past three years, the estimates from registrant respondents ranged from 5 hours to 2,000 hours. The average mean time spent undertaking participatory learning was 66 hours and 23 minutes and the median was 40 hours;
- 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;

[41] The true maximum hours of CPD reported was 17,250 hours. However, we have deemed this as an outlier and thus have removed it from our analysis.

- Of those registrant respondents not currently meeting the CPD revalidation requirements, on average (mean) 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 (mean), an additional 5 hours and 48 minutes of CPD. The equivalent time and costs of this spread across all registrants is 12 minutes and £4 per registrant.

The suggestion from the registrant survey that the vast majority of registrants are already undertaking enough participatory CPD to meet the requirements suggests that the CPD costs estimated by organisation survey respondents may be an overestimate. In the survey, many organisations suggested they would incur costs in providing CPD learning opportunities), whereas the current levels of participatory CPD activity among registrant respondents at the pilot sites suggest this may not be needed.

While in general registrant respondents indicated that they already meet or exceed the CPD hours requirements, evidence suggests that additional time would be required to meet the revalidation requirements in relation to recording CPD activity.

Figure 54 below shows the proportion of registrant survey respondents currently recording the CPD information required under revalidation. While only 5% of the registrants surveyed reported that they did not currently record any of the information/evidence that would be required of them under revalidation, the large majority did not typically collate or record everything required.

Figure 54 - CPD information currently collated or recorded by registrants in a typical three year period. *Number of respondents: 1,109 registrants.*

Type of information/evidence	Number of responses	Percentage of registrants
A description of the topic of each activity and how it related to my practice	563	50%
The method of each activity	352	31%
The dates each activity was carried out	845	75%
The number of hours carried out	608	54%
The number of hours spent carrying out participatory CPD	388	35%
Which part of the Code each activity related to	136	12%
Evidence of CPD activities, such as certificates or signed letters	887	79%
None of the above	59	5%
Don't know	32	3%
Blank response	11	1%

On average, registrants surveyed at the pilot sites reported that it took them a mean time of 9 hours and 21 minutes to record the required CPD information, of which an average of 3 hours and 51 minutes of this was additional time taken to meet revalidation requirements.

In monetary terms, the additional cost of recording CPD hours to meet revalidation requirements is, on average, £65 per registrant.

The median time taken to record CPD information was 3 hours and 10 minutes, of which 2 hours was additional time taken to meet the revalidation requirements. In monetary terms, the additional cost of recording CPD to meet revalidation requirements is £34 per registrant.

4.4.2 Cost to registrants of practice hour requirements

Similar to the CPD requirements, evidence from respondents to the registrants' survey suggests that the majority of registrant respondents are not currently collating or recording the information on practice hours that will be required under revalidation. Therefore, costs will be associated with this. To the extent to which the current recording requirements are not being met, the additional costs associated with revalidation are likely to be overestimated in our analysis.

The registrants surveyed were asked what information they would typically record in a three year period that would contribute to the practice hour requirements. The responses of the registrants are set out in Figure 55 below.

Figure 55 - Which would you normally collate or record in a typical three year period? *Number of respondents: 1,113 registrants.*

Type of information/evidence	Number of responses	Percentage of registrants
Dates of practice	523	47%
The number of hours undertook	452	40%
Name, address and postcode of organisations	442	39%
Scope of practice	409	37%
Work setting	397	35%
A description of the work you undertook	472	42%
Evidence of those practice hours, such as timesheets, job specifications and role profiles	471	42%
None of the above	259	23%
Don't know	58	5%
Blank response	7	1%

Almost a quarter of registrant respondents currently do not record any of the information that would be required under revalidation. However, 47% of registrant respondents do record one or more of the types of information.

On average, the registrants surveyed reported that it took them a mean time of 9 hours and 38 minutes to record practice information, of which an average of four hours was additional time spent to meet revalidation requirements.[42] This is over a third of the average total time taken to record practice information, and suggests that a substantial amount of additional

[42] 16% of registrants stated that meeting the revalidation requirements for practice hours required no additional time.

time will be required by registrants to meet the revalidation requirements. The cost equivalent of these additional hours is £67 per registrant over the three year period.

The median time spent by registrant respondents in recording practice information was 3 hours. Of which 1 hour was additional time required to meet revalidation requirements. The cost equivalent of this additional hour is £17 over the three year period.

4.4.3 Costs to registrants of feedback, reflection and professional development discussion requirements

Only 19% of the registrants surveyed reported that they normally seek five or more pieces of feedback in a typical three year period. This suggests that 81% of registrant respondents will need to increase the number of pieces of feedback they seek to receive in order to meet the revalidation requirements.

- Registrants surveyed reported spending, on average (mean), 8 hours and 14 minutes actively seeking practice-related feedback in the three years up to and including the pilot. The time spent actively seeking feedback varied considerably between registrants, ranging from zero hours to 300 hours; and[43]
- Of that time, a mean of 2 hours and 21 minutes was additional time spent by registrant respondents to meet the revalidation requirements. The equivalent cost of this time is £40 per registrant over a three year period. If the median registrant survey responses as used, a median time of an additional 30 minutes was spent to meet the revalidation requirements, with an equivalent cost per registrant of £8.

Under revalidation nurses and midwives must record a minimum of five written reflections on the Code, CPD and practice-related feedback, over a three year period.[44] However, responses provided to the registrant survey at present this requirement is generally not being met. Therefore, revalidation will involve additional time and costs:

- In the three years before the pilot, registrant respondents reported writing, on average (mean), two reflective accounts. The lowest reported number of reflective accounts written was zero and the highest was 90;
- Registrant respondents reported that, on average (mean), it took 1 hour and 38 minutes (median: 1 hour) to write one reflective account. The lowest time reported was 5 minutes and the maximum reported was 40 hours;
- The results of the registrant survey suggest that, on average (mean), a registrant will need to write an additional three reflective accounts over a three year period to meet the revalidation requirement of five;
- Using the assumption that it took 1 hour and 38 minutes to write one reflective account, based on the average (mean) reported time in the registrant survey, we could expect a registrant to spend a minimum of 8 additional hours and 8 minutes writing reflective accounts over three years in order to meet the revalidation requirements. The equivalent cost of this time is £137 per registrant over a three year period, or an annual cost of £46 per registrant; and

[43] We have removed one outlier from the data as it significantly skewed the results of the analysis.

[44] Actively 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.

- Using the median time reported by registrant respondents of 1 hour to write one reflective account, and the median response from registrant respondents in terms of the number of additional reflective accounts that they would be required to write (5 additional accounts), registrants would need to spend a minimum of 5 additional hours writing reflective accounts over three years in order to meet the revalidation requirements. The equivalent cost of this time is £84 per registrant over a three year period, or an annual cost of £28 per registrant.

Under revalidation, registrants will be required to hold a Professional Development Discussion (PDD) where they discuss their feedback and written reflections with another NMC-registered nurse or midwife. This would be a new requirement for registrants therefore all the time associated with this will be additional:

- Registrant survey respondents reported taking, on average (mean), 1 hour and 16 minutes to complete the PDD. The median reported time was 1 hour. The lowest reported time taken to complete the PDD was 1 minute, and the highest was 30 hours;[45]
- The equivalent cost of the time spent completing the PDD is, on average (mean), £21 per registrant respondent (median: £17). This does not include the time cost for the person the PDD is held with. Given that they should be another NMC registrant (and so have equivalent average salary costs) the cost would be double; and
- 50% of registrant respondents reported that their PDD occurred during work hours, which would impose an organisational cost in terms of the registrant and registrant the PDD was held with being diverted away from other work duties during that time.

As shown in Figure 43 above, organisation survey respondents estimated relatively low costs associated with identifying who registrants should have their PDD with. While it may be the case that if this support is provided the costs are relatively low, evidence from the registrants' survey suggests that over two-thirds of respondents reported receiving some level of help (46% of respondents reported that they received a lot of help).

Figure 56 - To what extent did the organisation help you identify the registrant you had your PDD with? *Number of responses: 1,035*

Extent of help	Number of responses	Percentage of registrants
They helped me a lot	514	46%
They helped me a little	269	24%
They did not help me at all	236	21%
Don't know	16	1%
Blank response	85	8%
Total responses	1120	100%

[45] One registrant reported taking zero hours and minutes to complete the PDD. We have eliminated this as an outlier as it is not possible to complete the PDD in zero hours or minutes.

4.4.4 Costs to registrants of third party confirmation

To complete revalidation, registrants must have a third party confirm that they have met the revalidation requirements. This is a new requirement so all time spent on this and the associated costs are additional:

- The majority of registrant respondents reported that they were confirmed by their line manager. Figure 57 below sets out the registrants' responses when asked who provided their third-party confirmation. Only 5% of registrants reported obtaining confirmation from an individual who was not an NMC registrant. Whilst over two-thirds of registrant respondents reported obtaining confirmation from their line manager.

Figure 57 - What best describes the person who provided third-party confirmation? *Number of responses: 999 registrants.*

What best describes the person who provided third-party confirmation?	Number of responses	Percentage of responses
My line manager, who is an NMC registrant	741	66%
My line manager, who is not an NMC registrant	38	3%
An NMC registrant who is not my line manager	197	18%
Another UK registered healthcare professional	12	1%
A healthcare professional registered outside of the UK	0	0%
Other	11	1%
Blank response	121	11%
Total responses	1120	100%

- Registrants surveyed reported that, on average (mean), it took 1 hour to obtain confirmation. The median time reported was 30 minutes. The lowest time reported to obtain confirmation was 1 minute and the highest 120 hours;
- The equivalent (mean) cost of receiving confirmation is £16 per registrant (median: £8);
- 65% of registrant respondents reported that they received confirmation from the same person as they had their PDD with and at the same time. A further 10% of registrant respondents indicated that they obtain confirmation from the same person as they had their PDD with but it took place at a separate time. 14% of registrant respondents obtained confirmation from a different person to whom they had their PDD with. There is no clear evidence from the survey of time (and cost) savings associated with the third party confirmation and PDD being conducted by the same person;
- Of the 1,120 registrants surveyed only 216 provided third-party confirmation for another registrant. The average (mean) time reported by a third-party to confirm one registrant, including the conversation and potentially also the preparation for this, was 1 hour and 58 minutes. This is equivalent to the cost of £33 per registrant. The median time spent being a confirmer was 1 hour, with an equivalent cost of £17 per registrant;
- Therefore, on the basis of the registrant survey responses, the total time cost of third-party confirmation is £49 per registrant (median: £25); and
- Just over one-fifth of registrant respondents reported that their confirmation took place during work hours. However, 76% of registrants surveyed did not answer this question.

4.4.5 Costs to registrants of online submission and NMC requests for further information

On average (mean), registrants surveyed reported that it took them 1 hour and 22 minutes to complete the online application form. With agreement from the NMC, for the purposes of our analysis we assume that this is all additional time, given that the registration process currently in place is minimal and could be assumed to take virtually no time to complete. The median time reported by registrant respondents was 30 minutes. The lowest reported time was three minutes and the highest was 72 hours. The equivalent cost of this time is £23, on average (mean), per registrant. The equivalent median cost is £8 per registrant.

During the revalidation pilot the NMC surveyed the registrants who were required to submit further evidence to the NMC. The NMC received 57 responses to this survey.

When revalidation is introduced only a small proportion of registrants will be required to provide further information to the NMC to support their application. Therefore, the time and costs noted below will only apply to a subset of registrants.

Registrants taking part in the NMC's request for further information survey reported that, on average (mean), it took them an additional 8 hours to prepare further information to support their revalidation submission. This is equivalent to a cost of £136 per registrant. The median reported time spent preparing further information was 5 hours, which is equivalent to a cost of £84.

Following preparation of further information, registrants reported spending an average (mean) of 4 hours and 11 minutes submitting the information to support their submission. This is at a cost of £71 per registrant. The median reported time spent submitting the information was 3 hours. This is equivalent to a cost of £51.

Of this total time, on average (mean), 3 hours and 27 minutes (median: 1 hour) was reportedly undertaken during contracted work hours. Therefore, the will be a cost to the organisation of this time.

Annex to Appendix 4: Cost benefit analysis technical notes and assumptions

In order to conduct our cost benefit analysis, we had to clean the survey data and to make a number of assumptions, as set out in this Appendix.

4.5 Organisation survey

The data cleaning of the organisation survey responses, and assumptions made for our analysis, included:

- Many of the monetary values reported by organisation had to be converted into numerical format so that they could be analysed. Examples include changing a "£30k" to "£30,000" and "c1200" to "£1,200";
- A small number of text responses had to be edited. This involved correcting typographical errors in answers, such as those in the organisation name text field;
- There were also a number of instances in which organisations indicated that there would be 'no / negligible cost' associated with part of a requirement but in the subsequent question did not provide a cost estimate of £0, or a small cost estimate. Where this was the case, we assumed the cost was £0 and factored this in to our analysis; and
- In a cost estimate question if an organisation respondent provided an estimate for one type of support for a specific requirement (such as for costs relating to IT systems for CPD) and did not provide a cost estimate for other types of support for that same specific requirement (i.e. left the box blank), we have assumed a cost equal to £0 for the blanks.

4.6 Registrant survey

The data cleaning of the registrant survey responses, and assumptions made for our analysis, included:

- Some edits were made to the registrant responses to ensure the consistency of organisation name. No data cleaning was required for the numerical data, with the exception of the treatment of outliers (see below);
- There were some responses which were significantly higher than the average. In the cases where we identified these extreme outliers we removed them from the data set (all outliers removed were at least 40 times larger than the average). This was done to ensure that the data averages and thus the conclusions are not skewed.

Three questions in the survey (D7, H9 and H12) asked registrants to estimate how much time, in addition to the time they usually spent undertaking an activity under Prep, they spent in meeting the requirements of revalidation. When asked this type of question registrants had the choice of three answers:

a) …. hours … minutes

b) No additional time

c) Don't know

If a registrant selected option b), this was treated as a time of zero hours and zero minutes and included in our calculation of average times.

- We asked registrants how long it took for them to complete their professional development discussion and third-party confirmation. One survey respondent reported it

took them zero hours and zero minutes to complete the professional development discussion and five respondents reported zero hours and zero minutes for the third-party confirmation. As these are discussions/meetings we have assumed that it is not possible for the requirement to be met in zero hours and zero minutes. Therefore we have removed these responses from the data set used for our analysis; and

- In our analysis of the registrant survey responses we include all registrants responding to the survey in our base. This includes blank responses which may arise where registrant survey respondents chose not to answer a particular question or where the routing of the survey meant that they were not asked certain questions. This approaches differs to that followed by Ipsos MORI in its analysis of the registrants' survey and may account for any differences between our reported results.

Appendix 5 Stakeholders engaged in our analysis

Appendix 5 Stakeholders engaged

Figure 58 – Focus groups

Name	Organisation	Country
Lisa Cheek	Kingston Hospital NHS Foundation Trust	England (London, Non-pilot Group)
George Chidyausiku	London Healthcare Agency	
Irena Chojnacka	University of Greenwich	
Elizabeth Webster	Birmingham Community Healthcare NHS Trust	England (Birmingham, Non-pilot Group)
Christopher Wagstaff	University of Birmingham	
Jane Beach	Unite the Union [Pilot]	
Karen Moore	University Hospital of South Manchester NHS Foundation Trust	England (Manchester, Non-pilot Group)
Trish Mattinson	Liverpool Community Health NHS Trust	
Paul Tubbs	Manchester Metropolitan University	
Jacqueline Gladwin	Manchester Metropolitan University	
Joanna Dunn	Manchester Metropolitan University	
Helen Kirk	Public Health England [Pilot]	
Victoria Heilbron	Bridgewater Community Healthcare NHS Foundation Trust	
Andrea Boland	Central Manchester University Hospitals NHS Foundation Trust	England (Manchester, Pilot Group)
Susan Hooton	Mersey Care NHS Trust	
Cheryl Barton	Private Independent Aesthetic Practices Association (PIAPA)	
Amy Senior	PIAPA	
Helen Mackenzie	Berkshire Healthcare NHS Foundation Trust	England (Reading, Non-pilot Group)
Nancy Barber	Berkshire Healthcare NHS Foundation Trust	
Julia Fairhall	Sussex Community NHS Trust	
Anita Underwood	Gloucestershire Care Services NHS Trust	
Ann Bailieff	University of Southampton	
Julia Atherton	Barchester Healthcare	
Kate Mansfield Loynes	Barchester Healthcare	
Donna Stuart	Sanctuary Care	
Jan Glaze	NHS Bracknell and Ascot CCG	England (Reading, Pilot Group)
Sarah Bellars	NHS Bracknell and Ascot CCG	
Major Sara Hawkins	Defence Primary Healthcare South West Region	
Sharron Brown	British Association of Cosmetic Nurses (BACN)	
Ellen Hudson	Royal College of Nursing	Scotland (Pilot Group)
Angus Kidd	BMI Healthcare	
John Lee	University of Dundee	

Fiona Paton	Four Seasons Health Centre	
Swaran Rakhra	Scottish Care Ltd	
Janice Torbet	NHS Tayside	
Kim Donaldson	St Columba's Hospice	Scotland (Non-pilot Group)
Abigail Mullings	Healthcare Associated Infection Policy Unit, Scottish Government	
Anne Moffat	Educator	
Anna Buckby	Educator	
Calum Thomson	NHS National Services Scotland	
Judith Hill	Cardiff and Vale University Health Board	Wales (Non-Pilot Group)
Vicky Rees	MPS Healthcare	
Anna Mogie	Cardiff and Vale University Health Board	
Natalie Williams	Cardiff and Vale University Health Board	
Vinny Ness	Powys Teaching Health Board	
Lyn Middleton	Aneurin Bevan University Health Board	Wales (Pilot Group)
Louise Taylor	Aneurin Bevan University Health Board	
Alison Powell	Aneurin Bevan University Health Board	
Sheila Richards	Aneurin Bevan University Health Board	
Penny Gordon	Aneurin Bevan University Health Board	
Jackie Shacklady	Aneurin Bevan University Health Board	
John Carroll	Aneurin Bevan University Health Board	
Anita Davies	Aneurin Bevan University Health Board	
Gail Powell	Aneurin Bevan University Health Board	
June Manley	Aneurin Bevan University Health Board	
Lena Evans	Aneurin Bevan University Health Board	
Vivien Coughlin	Aneurin Bevan University Health Board	
Bev Jenkins	Aneurin Bevan University Health Board	
Lesley Constance	Aneurin Bevan University Health Board	
Tanya Strange	Aneurin Bevan University Health Board	
Oriel Brown	Public Health Agency for Northern Ireland	Northern Ireland (Non-pilot Group)
Polly Adegy	Kennedy Healthcare	
Professor Owen Bar	University of Ulster	
Elaine McShane	Four Seasons Health Care	
Melanie Bowden	Four Seasons Health Care	
Moira Mannion	Belfast Health and Social Care Trust	
Lorna Hamilton	Western Health and Social Care Trust	Northern Ireland (Pilot Group)
Gillian McCorkell	Western Health and Social Care Trust	

Mary McKenna	Western Health and Social Care Trust	
Claire Brown	Western Health and Social Care Trust	
Lyn Middleton	Aneurin Bevan University Health Board	RPG
Nicola Ryley	Aneurin Bevan University Health Board	
Sharron Brown	BACN	
Lou Sommereux	BACN	
Graham Johnson	BUPA	
Helen Kirk	Public Health England	
Frances Cannon	NIPEC	
Jane Beach	Unite the Union	
Cheryl Barton	PIAPA	
Amy Senior	PIAP	
Dawn Pike	Central Manchester University Hospitals	
Andrea Boland	Central Manchester University Hospitals	
Donna O'Boyle	Scottish Government	
Julie Hamilton	Guy's and St Thomas' NHS Foundation Trust	
Sara Hawkins	Defence Primary Healthcare South West Region	
Jon Lee	Dundee University	
Roger Cobley	Birmingham City University	
Eddie Alder	Nottinghamshire Healthcare NHS Trust	
Gillian Costello	NHS Tayside	
Anne Witherow	Western Health and Social Care Trust	
Sue Hooton	Mersey Care NHS Trust	
Jan Glaze	NHS Bracknell and Ascot CCG	
Louise Scull	NMC	RSAG
Carol Shillabeer	NMC	
Angela McLernon	NIPEC	
Ann Holmes	Scottish Government	
Clare Barton	General Medical Council	
Sue Covill	NHS Employers	
David Foster	Department of Health	
Lindsey Proctor	Department of Health	
Eileen Sills	Guy's & St Thomas' NHS Foundation Trust	
Fiona Dagge-Bell	Healthcare Improvement Scotland	
Gail Adams	Unison	
Helen Whyley	Welsh Assembly Government	

Howard Catton	Royal College of Nursing	
Juliet Beal	NHS England	
Lisa Bayliss-Pratt	Health Education England	
Louise Silverton	Royal College of Midwives	
Margaret Rowe	Northumbria University	
Obi Amadi	Unite	
Ray Walker	Mersey Care NHS Trust	
Rona McCandlish	Care Quality Commission	
Sally Taber	Association of Independent Healthcare Organisations	
Colonel Karen Irvine	Armed Forces	
Manjit Darby	NHS England	
Rachel Bell	Department of Health	

Figure 59 – Interviews

Name	Organisation	Country
Jane Cummings	CNO, England	England (System Interview)
Viv Bennett	Public Health England	
David Foster	Department of Health	
Nick Clarke	Department of Health	
Jacqueline McKenna and Peter Blythin	NHS Trust Development Authority	
Ruth May	Monitor	
Lisa Bayliss-Pratt	Health Education England	
Sharon Blackburn	National Care Forum	
Deborah Sturdy	Care England	
Ian Turner	Registered Care Home Managers' Association	
Sheree Axon	National HR Representative, NHS England	
Ursula Gallagher	CQC	
Jessica Read	LSAMO, London	
Alison Kedward	HIW	
Helen Kirk	Public Health England	
Eileen Sills	Guy's and St Thomas's Hospital (GSTT)	England (Organisation Interview)
Jan Glaze and Sarah Bellars	NHS Bracknell and Ascot CCG	
Deberah Robertson	Sussex Community NHS Trust	
Eddie Alder	Nottingham NHS Foundation Trust	
Cheryl Barton	PIAPA	
Christine Whitney Cooper	De Montfort University	

Myo Swe	Cuckoo Lane Surgery	
Jonathan Love	Melbourne Grove Medical Practice	
Christina Butterworth	Association of Occupational Health Nurse Practitioners	
Fiona McQueen	CNO, Scotland	Scotland (System Interview)
Yvonne Bronsky	LSAMO, Scotland	
Colette Ferguson	NHS Education for Scotland	
David McLeod	Health Workforce Directorate, Scottish Government	
Brian Webster	Council of Deans and Edinburgh Napier University	
Suzie Flower	Spire Healthcare	Scotland (Organisation Interview)
Margaret McGuire	NHS Tayside	
Stephen Griffiths	Workforce, Education and Development Services	Wales (System Interview)
Alison Kedward	Health Inspectorate Wales	
Gerry Evans	Care Council for Wales	
Fiona Giraud	Chair, All Wales Heads of Midwifery Board	
Jean White	CNO, Wales	
Denise Llewellyn	Aneurin Bevan University Health Board	Wales (Organisation Interview)
Alan Corry-Finn	Western Health and Social Care Trust	Northern Ireland (Organisation Interview)
Charlotte McArdle	CNO, NI	Northern Ireland (System Interview)
Verena Wallace	LSAMO, NI	
Glynis Henry	HSC Clinical Education Centre	
Kathy Fodey	Regulation and Quality Improvement Authority	
Maeve Hully	Patient and Client Council	
Caroline Lee	Deputy CNO, NI	
Janet Davies	Royal College of Nursing	UK (System Interview)
Cathy Warwick	Royal College of Midwives	
Clare Barton	General Medical Council	
Christine Braithwaite	Professional Standards Agency	
Karen Barraclough	NHS Professionals	
Danny Mortimer and Sue Covill	NHS Employers	

Figure 60 – Workshops and other meetings

Name	Organisation	Workshop
Manjit Darby	NHS England	KPMG Workshop A
Susan Aitkenhead	NHS England	

Sylvia Kwan	NHS England	
Angela McLernon	NIPEC	
Frances Cannon	NIPEC	
Donna O'Boyle	Scottish Government	
Angela Heathcote	NHS England	
Susan Aitkenhead	NHS England	KPMG Workshop B
Deborah Wheeler	NHS England	
Manjit Darby	NHS England	
Helen Whyley	Department for Health, Wales	
Angela McLernon	NIPEC	
Donna O'Boyle	Scottish Government	
Angela McLernon	NIPEC	4 Country Programme Board Representatives meeting
Frances Cannon	NIPEC	
Donna O'Boyle	Scottish Government	
Maureen Kirwan	NHS England	
Juliet Beal	NHS England	England Programme Board
David Foster	Department of Health	
Nick Clarke	Department of Health	
Janet Davies	Royal College of Nursing	
Louise Silverton	Royal College of Midwives	
Helen Kirk	Public Health England	
Caroline Alexander	NHS England London	
Deborah Wheeler	South of England	
Obi Amadi	Unite	
Siobhan Heathfield	Trust Development Authority	
Julie Hamilton	Guy's & St Thomas	
Rona McCandlish	Care Quality Commission	
Manjit Darby	NHS England	
Maureen Kirwan	NHS England	
Rachel Souter	NHS England	
Sue Hooton	Mersey Care	
Sally Taber	Association of Independent Healthcare Organisations	
Sue Covill	NHS Employers	

Appendix 6
Glossary

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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 Authority
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	NHS Trust Development Authority
UK	United Kingdom
WHSCT	Western Health and Social Care Trust