



Exploring the experiences of the revalidation pilots

FINAL | PUBLIC

Ipsos MORI research report

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Key findings

Approach

- The approach included an online survey of 1,120 registrants who had signed up to the pilot; 10 qualitative discussion groups and 28 in-depth interviews exploring the guidance in detail; and 127 in-depth interviews looking at the journey of the pilot, as experienced by registrants and confirmers.

The overall journey

- The majority of survey participants were able to achieve each requirement, with responses ranging from 88% for practice related feedback to almost 100% for practice hours (all but two participants reported this).
- Participants' experiences and perceptions were often positive, although there was a great deal of variability in the journeys experienced. Some of this indicated the need for further clarity in the requirements.

Familiarisation

- The majority of those taking part in the survey had heard of revalidation before the pilot (90%), although detailed awareness was low (4% said that they knew a great deal). This lack of detailed familiarity meant participants could initially feel daunted, but as they became more familiar with revalidation, concerns began to be alleviated.
- The majority had also used the Nursing and Midwifery Council (NMC) documents and guidance to familiarise themselves with the requirements (83%), and the 'How to revalidate with the NMC' guidance was generally perceived positively across the survey.

(Familiarisation continued)

- However, the guidance strand of the research indicated some key recommendations for change. For example, making it very clear what was involved early on in the documents through use of visual aids, such as flow-charts, and check lists. The research also found that tailoring the guidance for different types of confirmers will be important.
- Support from pilot organisations was welcomed by participants and often supported the tools provided by the NMC. At times participants indicated that organisational messages could become confused with the NMC guidance; greater clarity and tightening of the requirements could help with this in the future.

Collecting and recording evidence

- Evidence was strongly valued as part of the revalidation model; participants felt that this was one of the ways revalidation was different to the Prep standards. As a result, they had an expectation that their evidence would be checked.
- These perceptions impacted on the journey experienced. For example, while some understood the level of evidence could be minimal, others were worried about the type and depth required. This led to a notable variation in the volume of evidence participants told us they collected.

(Collecting and recording evidence continued)

- Where confirmers in the qualitative research were unsure of what was required of them or had misunderstood it, this could lead to over-compensation in what they expected of registrants. For example, some reported using the quality of written reflections as a basis to not confirm.
- As such, participants, both registrant and confirmer, wanted clear messages on the minimum requirements for evidence.

Reflection, discussion and confirmation

The model provided clear routes to confirmation for the majority in the survey:

- Confirmation through an NMC registered line manager was a common route to revalidation, with three quarters of those that received confirmation doing so through this route (74%).
- The flexibility in the model was also needed for others to achieve confirmation; 15% of those who had a PDD and received confirmation consulted separate people.

(Reflection, discussion and confirmation continued)

- However, the qualitative research revealed that there was a great deal of variability in how these elements were carried out regardless of the route taken:
 - The number and approach to written reflections varied greatly.
 - There was variation in how confirmers were selected, and as noted they sometimes struggled with how they were supposed to apply their judgement to the evidence provided.
 - There was variation in what was discussed as part of a PDD, for example the context in which the discussions took place and with whom influenced the experience.
- Nonetheless, across the strands of the research many were positive about these requirements; for example, three quarters thought that confirmation from a third-party would increase awareness of the Code (76%).
- Notably, the inclusion of reflection was valued, with many in the qualitative work seeing a logical link between seeking feedback on performance, reflection and self-improvement. The research suggested that there is a clear need to delineate the differences between PDD, confirmation and appraisal to not only create more standardisation, but also a stronger sense of ownership or professional identity among registrants.

Completing the process

- Very few in the survey said that they did not complete the online application (6%, which equated to 63 participants). Among those that did not, around half cited time as part of the pilot as a reason (perhaps unsurprising given the timeframe for the pilot, when compared with the three years the approach assumes registrants will have).
- Other responses indicated that additional reassurances and safeguards would be needed in the future on what registrants need to do in scenarios such as unexpected sick-leave or a last minute technical fault.
- Overall, the majority of survey participants were positive about being able to achieve each of the elements in the future. However, improvements and changes identified throughout the research would be needed to ensure these perceptions continue to improve.

Next steps

Four key next steps for the NMC were identified through the research:

- Clarify the requirements and the relationship between them;
- Make the rationale and purpose of revalidation as a whole feature strongly, and ensure ownership of revalidation sits with nurses and midwives;
- Make the evidence needed for each part clearer; and
- Revise structure of the guidance document and change some of the terminology.

Introduction and approach



- The Nursing and Midwifery Council (NMC), the regulator of nurses and midwives in the United Kingdom, commissioned Ipsos MORI to carry out research on their pilot of revalidation.
- Revalidation aims to improve public protection through additional requirements to the arrangements already in place for nurses and midwives. The research had two main aims:
 - To understand the journey of revalidation as experienced in the pilots by registrants and confirmers; and
 - To explore reactions to the NMC’s guidance materials and tools among those piloting the process and among other relevant professionals who were not part of the pilot.
- The document includes brief details of the methodology used before moving on to the summary of the findings. The findings section is structured thematically based on the analysis and interpretation of findings. The final chapter includes early thoughts on the next steps for the NMC. Greater detail on the methodology and notes on how to interpret the data are at the end of the report, and it is recommended that readers look at the notes on interpretation before reading the whole report in detail.

Summary of the methods

Main survey strand

- Online survey of 1,120 registrants who had signed up to the pilot

Guidance strand

- 10 discussion groups across pilot and non pilot organisations.
- 28 in-depth interviews, including non NMC-registered professionals

Journey mapping strand

- 127 in-depth interviews, including 60 registrants and 67 confirmers/peers

- The survey quantitatively measured the experiences of revalidation as well as attitudes and perceptions of revalidation.
- The guidance strand looked at how easy the guidance documents were to understand, how useful they were and what, if anything, needed to be added or improved.
- The journey mapping explored experiences of the different stages of the revalidation journey in depth.

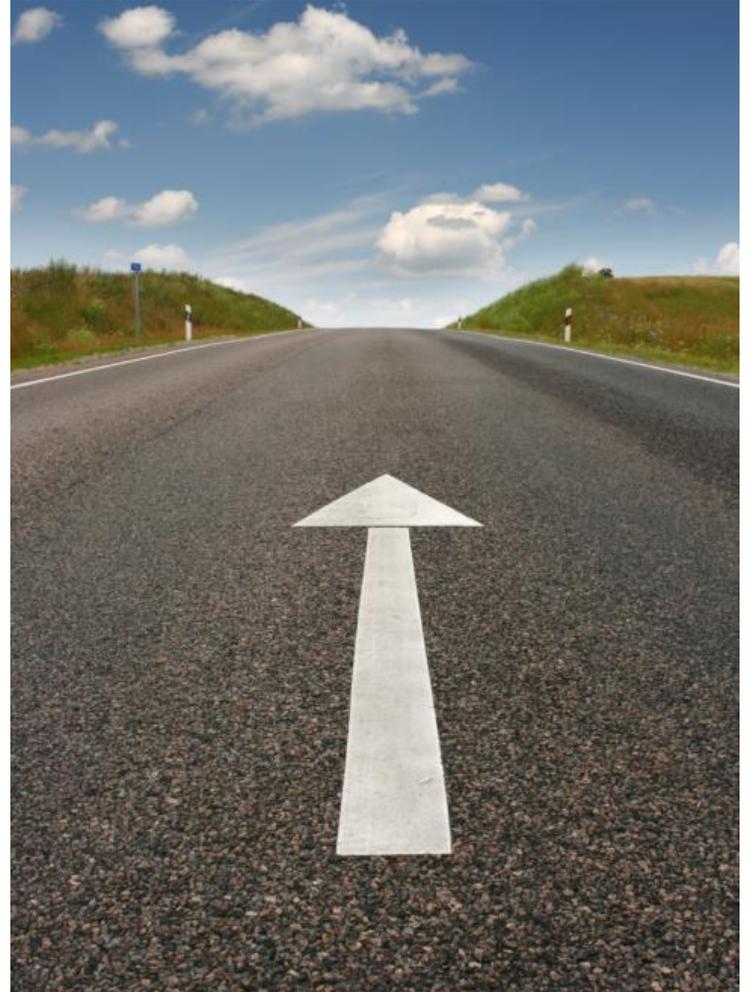
Detail on each is shown in the next slide.

The approaches in detail

As noted, the research comprised three strands: the main survey, the guidance strand and the journey-mapping strand.

- The **main survey** enabled feedback to be gathered from a wide cohort of participants across the pilot organisations, including registrants who completed the revalidation process and those who did not. All those who agreed to be approached were invited to complete a survey. The survey quantitatively measured the experiences of revalidation, alongside attitudes and perceptions of the requirements.
- The **guidance strand** was designed to collect in-depth qualitative views on the guidance documents and the templates among registrants and non-registrants alike (according to which guidance they may need to use in the future). It looked at how easy they were to understand, how useful they were and what, if anything, needed to be added or improved. Nurses and midwives from pilot and non-pilot organisations were included as well as other healthcare professionals, such as GPs, to understand how the guidance would be met by all audiences who may need it in the future and those that did not have access to other information sources in the pilot.
- The **journey mapping strand** was designed to explore the different stages of the revalidation journey in depth, including how registrants and confirmers/peers felt, what their information needs were and how, if at all, the journey could have been improved for them. Quotas were set to ensure a range of views and experiences could be gleaned.
- As noted previously, appended to this report is more information on the methodology and profile of participants. Notes on how to interpret the data are also included and **we suggest reading these before reading the report in full.**

Findings



1. The journey of revalidation in the pilot

Most participants taking part in the survey achieved each of the revalidation requirements

A key aim of the survey was to measure how achievable each of the elements had been for those taking part. Indeed, the majority of survey participants were able to achieve each requirement, with responses ranging from 88% for practice related feedback to nearly everybody for practice hours (one participant reported that they did not, and one was not sure).

Participants' experiences and perceptions were often positive, and different to early expectations, as is outlined in the findings below. However, there was a great deal of variability in the journeys experienced, with layers of factors or drivers influencing each individual's experience. An early hypothesis suggested that experiences of revalidation as part of the pilot would be clearly defined by the registrant's role, setting or type of work; but the multitude of factors influencing their experience meant that sometimes people working in similar roles or similar settings had very different journeys. Some of this variability indicated a need for further clarification or tightening of the requirements, as is discussed throughout.

The remainder of this chapter explores each of the stages of the journey in more detail including:

- The early stages of the process and how participants familiarised themselves with the requirements;
- The process of collecting evidence and what this meant to participants;
- The experiences of reflection, discussion and confirmation; and
- Completing the process in more detail.



2. Familiarisation

2.1 Awareness and familiarity

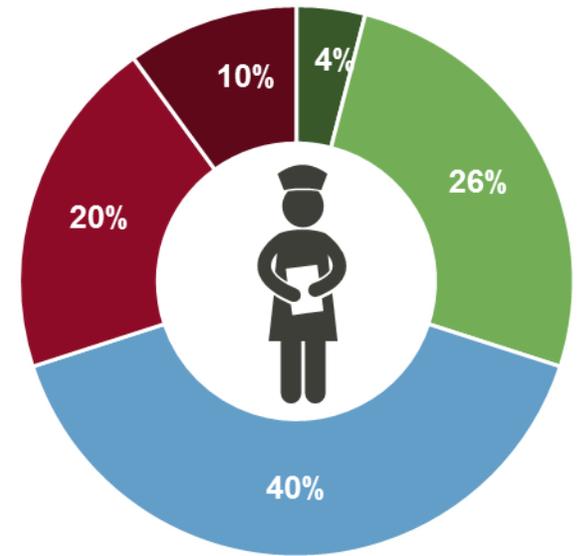
This section describes the starting point for participants taking part in the research, looking at how aware they were of revalidation before beginning the pilot and how they familiarised themselves with the requirements.

The majority had heard of revalidation before taking part in the survey

- Overall, 90% survey participants said that they had heard about revalidation before hearing about the pilot, and three in ten said that they knew a **great deal or fair amount** (30%). However, detailed knowledge was not common, with only 4% saying they knew a great deal.
- **There were also differences in awareness according to seniority.** Junior nurses were more likely than senior nurses to say they knew nothing about revalidation before the pilot, with 15% of those in band 5 – and also in band 6 – saying they knew nothing at all (compared with 4% and 3% for bands 7 and 8 respectively).

- **In the qualitative work,** non-registrants approached revalidation with particularly low levels of awareness. This was true not only about revalidation as a whole in some cases, but also with the terminology and concepts familiar to those in nursing and midwifery. For instance, participants mentioned not being aware of the Code or understanding ‘fitness to practise’.

Q: Before hearing about the revalidation pilot how much, if anything, would you say you knew about nurse and midwife revalidation?



- A great deal
- A fair amount
- Not very much
- I'd heard of it, but did not know anything else
- Nothing at all
- Don't know

Base: All participants (1,120)

Lack of detailed familiarity with the process meant participants could initially feel daunted

- Given that this was a pilot to test the new process of revalidation, it is perhaps not unexpected that initial awareness of the specifics of the model were low. However, these reactions do give an indication of how revalidation might be received among the wider population – who also may not be very familiar with the process.
- To illustrate, alongside low levels of awareness overall, participants expectations of revalidation were that it would involve a **lot of work and be time consuming**. Some reported that they assumed it would also involve a lot of paperwork, and felt a sense of demoralisation at the prospect of an additional layer of bureaucracy.
- In addition, at this stage, participants were **unsure about the support** that they would receive throughout the process, or the level of support their organisation would be able to give them.
- Overall, the lack of awareness of revalidation, combined with additional uncertainties about what lay ahead for participants, meant **feeling negative** early on was a common theme.

'I didn't realise how much work would be involved. It was a bit of a shock to the system!'
Nurse



As participants became more familiar with revalidation, concerns were alleviated

- Participants in the qualitative work were able to familiarise themselves with the requirements through several different routes, which contributed to them feeling reassured about the process and work they would need to do. Notably:
 - ✓ Support from organisations in some cases was greater than many expected and it addressed some of these initial concerns;
 - ✓ The guidance from the NMC also provided reassurance (although there were recommended changes as discussed throughout this report); and
 - ✓ The templates provided by the NMC and organisations themselves were also helpful in allaying concerns because they gave a sense of the scale of the task; participants felt the templates consolidated in a clear way exactly what they needed to do to achieve revalidation.
- Overall, more information tended to result in reduced anxiety about the workload and time demands of the process. As a result, many participants said that they **came to feel that revalidation built on a lot of the work that they were already carrying out**, and that this was reassuring

'...there was an initial panic of 'oh my goodness, what I am going to have to do!'...but actually it was quite a simple process of looking at the documentation you already had...and working your way through it'

Midwife

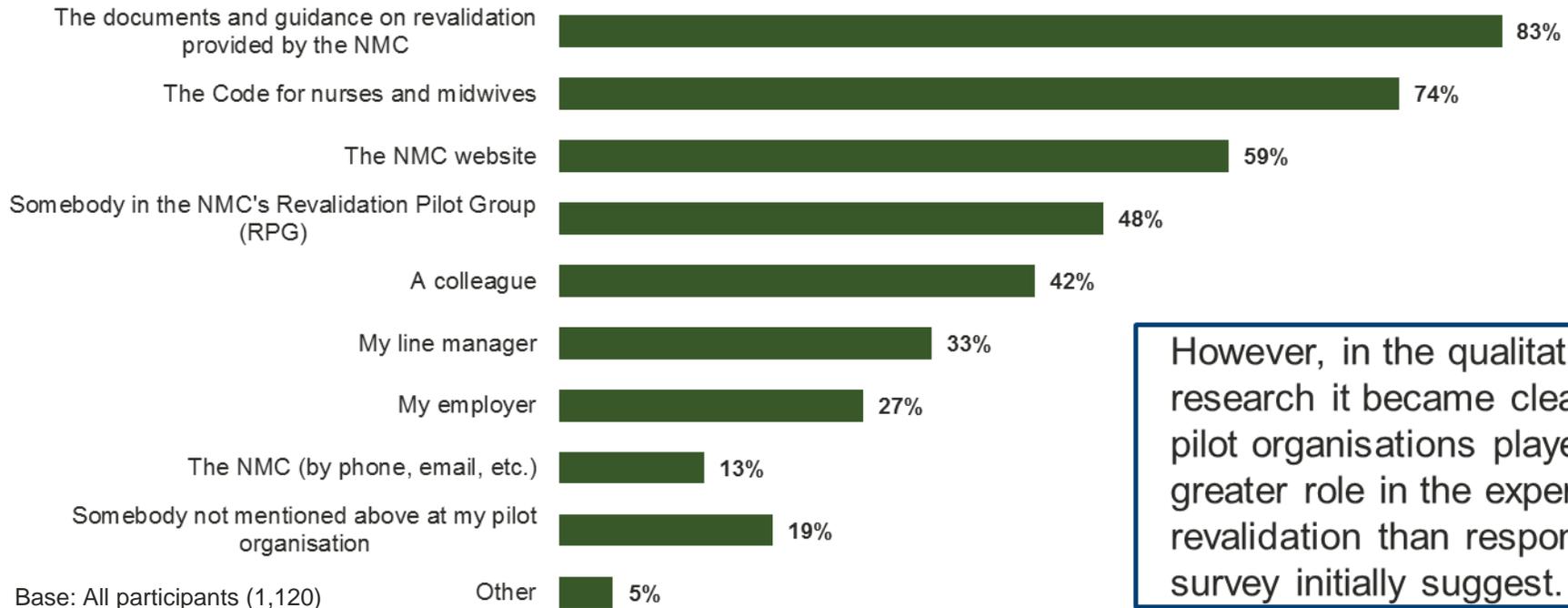
2.2 Sources of support

As mentioned previously, the support received from many organisations played a role in pilot in building awareness and familiarity with revalidation. The following section describes this support in more detail. It also provides insight into participants' reactions to the NMC guidance and templates provided as part of the pilot.

The majority used the NMC documents and guidance to familiarise themselves with revalidation

- The majority of survey participants used the documents and guidance on revalidation provided by the NMC to familiarise themselves with the requirements (83%). Other NMC sources were also commonly used; three quarters said they used the Code; and six in ten referred to the NMC website (74% and 59%). To a lesser extent, participants consulted colleagues and managers (42% and 33%).

Q: Throughout the pilot which, if any, of the following sources did you consult to familiarise yourself with the revalidation requirements?

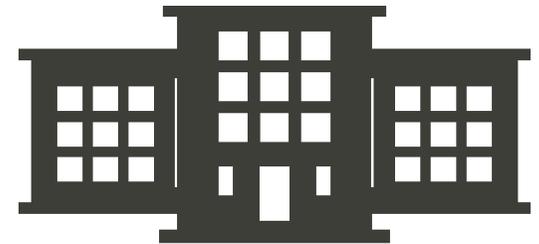


However, in the qualitative research it became clear that pilot organisations played a greater role in the experience of revalidation than responses to the survey initially suggest.

- **Some participants in the pilot organisations reported that the support they received from their organisation was valuable.** It is important to note that the NMC approach does not require organisations to provide additional support. However, participants told us that detailed documents were sometimes provided by organisations, and these sat alongside the NMC guidance, to further assist participants through the process.
- **Some of these documents were received well.** To illustrate, one organisation provided a day-by-day guidance document, which ensured that registrants broke down the task into smaller, manageable chunks – thus alleviating some of their worries about the time they had to revalidate during the pilot. Given the time-frame for the pilot was much shorter than real-life, this was well received by participants.
- Alongside document provision, other organisations organised seminars, study sessions and ‘revalidation champions’ to cascade information to nurses and midwives at the front line.

‘We were sent an email with links to different guidance documents, including this step-by-step process. When you look at it at first, it seems a lot but it’s not when it’s broken down... the small components made it more manageable.’

Nurse



Organisational messages could become confused with official NMC guidance

- Participants in the qualitative interviews reported that in some cases, **organisations added additional requirements to the revalidation process, meaning that it became more work intensive for nurses and midwives, and took up more of their time.** Examples of this included specifying which areas registrants needed to reflect on, and who should carry out confirmation.
- While organisations were an important source of support for nurses and midwives in the pilot, and key in alleviating concerns about revalidation, this nevertheless raises the question of what the right balance is for organisational support in the future.

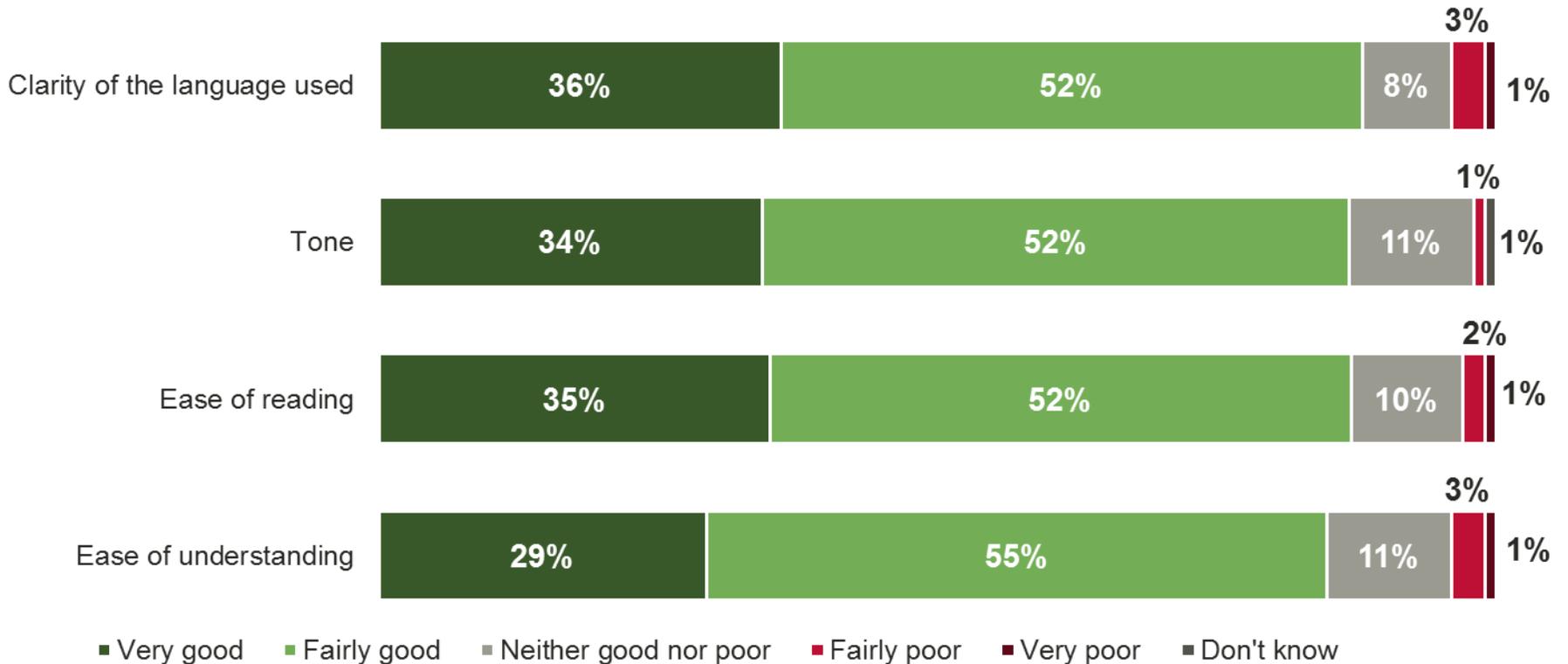
'Yes, I think the Trust said that we had to use their paperwork – I think they were doing that to make sure that we were all doing the same sort of thing, you know.'

Midwife

The NMC guidance was generally perceived positively in the survey

- As shown by the chart below, the NMC 'How to Revalidate' guidance was rated highly among those that had read it across a number of key measures. As can be seen, the majority rated the guidance as good (either fairly or very) across the measures.

Q: How would you rate the "How to revalidate with the NMC" guidance document as a whole on each of the following?

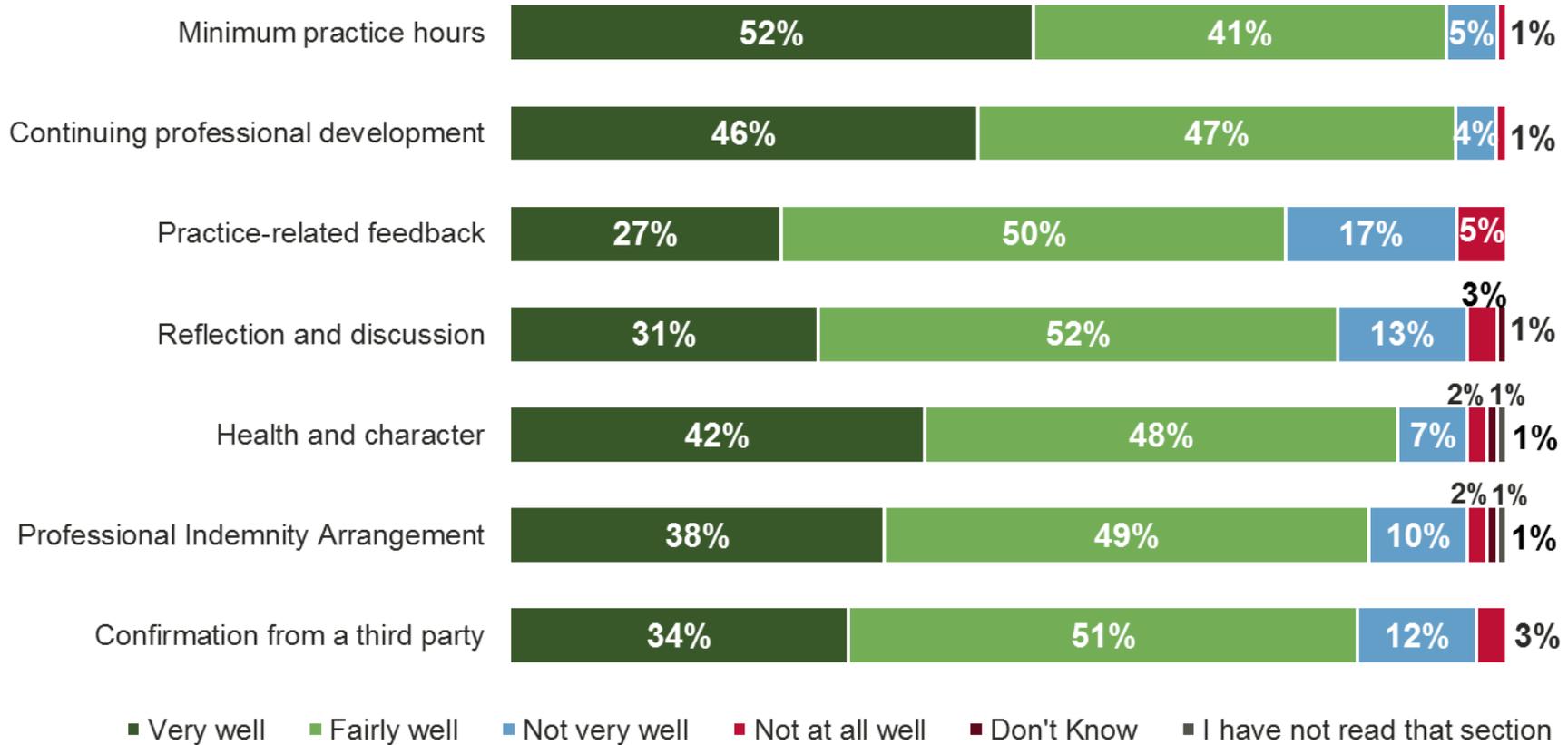


Base: All those who read at least some of the guidance (1,103)

Source: Ipsos MORI

The majority in the survey thought the guidance outlined each of the requirements well

Q: How well, if at all, would you say the “How to revalidate with the NMC” guidance outlines the requirements for the following parts of revalidation



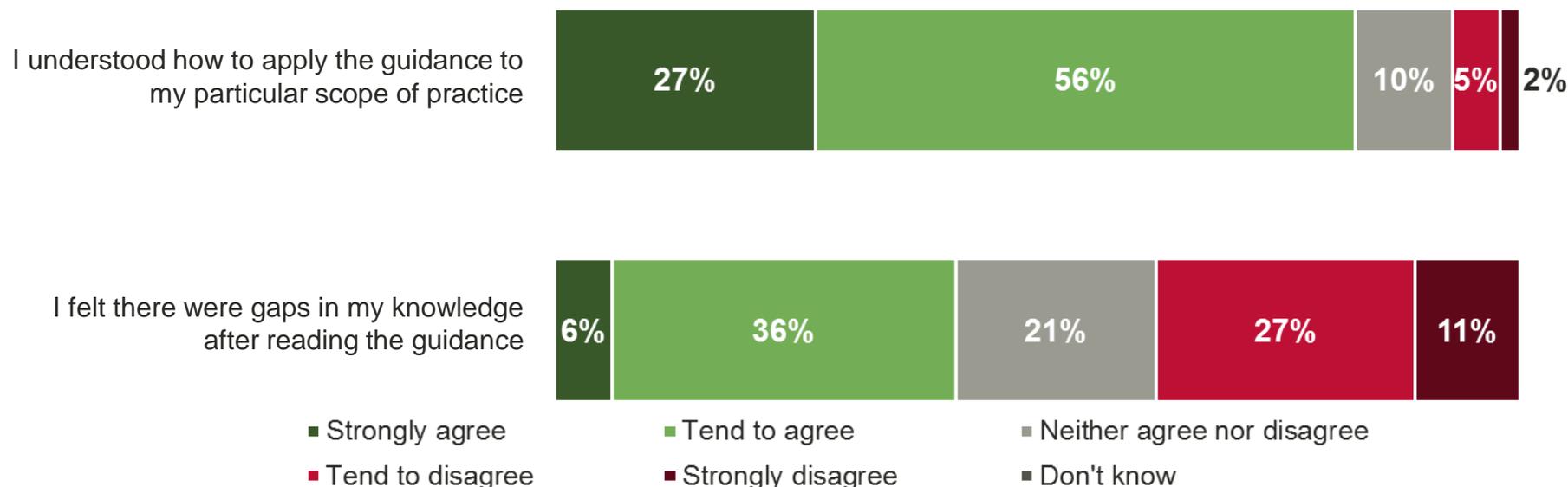
Base: All those who read at least some of the guidance (1,103)

Source: Ipsos MORI

Most understood how to apply the guidance to their scope of practice, but there were some gaps in knowledge

- The majority of survey participants who had read the guidance agreed that they understood how to apply the guidance to their scope of practice, despite four out of ten agreeing that there were still gaps in their knowledge about how to revalidate (83% and 42%). These knowledge gaps may reflect that revalidation is not currently embedded into nursing and midwifery, and they may reduce over time. However, the qualitative work also revealed some of the changes and improvements that may also help to reduce the gaps.

Q: To what extent do you agree or disagree with the following statements about the “How to revalidate with the NMC guidance document?”



Base: All those who read all of the guidance (873)

Source: Ipsos MORI

There were clear recommendations for changes to the guidance from the qualitative work

- In the qualitative guidance strand of the research, participants were asked to explore the guidance in detail. Looking at the 'How to Revalidate' guidance, the findings revealed that, while top level responses were positive and in line with the quantitative findings, participants had clear recommendations for changes that included:
 1. **Making it clear what is required of people from the start.** Participants wanted to clearly know what they had to do to be able to revalidate. To make it immediately clear what the process would involve, participants wanted summarised information early on. Suggestions included a flow chart of the stages or requirements, including check-lists at the start, as well as key dates and timings to be made aware of.
 2. **Make it clear what is required throughout the document.** In line with the above, participants wanted the descriptions to be tightened at points, with the use of the phrase 'may wish to' feeling ambiguous to people. Where something is not mandatory, additional rationale as to why it could be beneficial was required. Further, some terms were unclear to people throughout the guidance. For example, 'third-party confirmation' was interpreted to mean a third person needed to be present. Similarly, the term PDD was often mistaken for PDR.

Confirmers had their own suggestions for changes

- **Suggestions for how to improve the ‘Guidance for Confirmers’ document often reflected the key points made by registrants.** For example, summaries and visual aids were desired, with the inclusion of templates to assist people in understanding what they were going to be completing.
- **Other questions raised were more specific to the role of the confirmer,** and the further detail that people wanted from the guidance about what this involves, for instance:
 - As will be discussed in the next section, there were queries about what constituted ‘sufficient evidence’ for them to confirm a registrant, as well as how they would know whether a registrant had already been declined for confirmation by another confirmer.
 - There were also questions around how appraisals fitted into confirmation and whether confirmers needed to see evidence of these.
 - The time that should be spent on the PDD and confirmation discussion also needed clarification.
 - There was confusion about whether any healthcare professionals were exempt from being able to provide confirmation and whether there were any restrictions in terms of levels of seniority or relationships with the registrants.
 - And finally, details on exactly what the confirmer needs to do if they are uncomfortable confirming a registrant were also requested.

Tailoring the confirmer guidance to meet the needs of a wider pool of individuals will be important

- For those who were acting as a peer only, neither source addressed the expectations of their role. This audience in particular wanted greater clarity on what their role was – and was not – and the distinction between their role and that of the confirmer.
- **Moreover, those approaching the guidance from a non-nursing or midwifery perspective needed greater reassurance and clarity overall.** To illustrate:
 - Even after reading the guidance, medics consulted in this research still used their own medical revalidation process as a frame of reference.
 - For others outside of the NMC or General Medical Council (GMC) registers, the guidance did not take into account their even more reduced understanding. For example, ‘the Code of Conduct’ did not have any meaning to some.

‘The professional development discussion...do you mean the discussion of continuing professional development evidence? I’m not immediately remembering what you are referring to there’

General Practitioner

- **However, while the guidance can be changed to provide the further clarity and assurances needed, some fundamental misunderstandings about revalidation also need to be addressed, as discussed in the following chapters of this report.**

3. Collecting and recording evidence

3.1 Views of collecting and recording evidence

The increased focus on evidence as part of revalidation was welcomed by many of those taking part in the research. This section outlines participants' expectations of collecting and recording evidence and use of a portfolio.

- Many participants placed great **value on recording and collecting evidence** that proved they had met the requirements of revalidation.
- Indeed, for some, evidence was one of the only aspects of revalidation that had a clear rationale, as well as **distinguishing it from the Prep standards**. Here, evidencing not only added value to the process, but also formalised some of what participants already did, such as having conversations with peers about practice development.
- **To some extent, the value placed on evidence was attributable to the culture of the professions.** Participants insinuated that evidence and documentation are of chief importance in nursing and midwifery, and a way to be reassured that high quality and consistent care is being given. For instance, the example of check-lists was given, as they are often used in nursing and midwifery documentation and these could help registrants be reassured they have completed the task fully.



Participants had an expectation that their evidence would be checked

If I'm collecting evidence then surely it will be reviewed?

- Either through confirmation, or through the NMC audit process, many **participants believed that all of their evidence would be evaluated** at some point. This has implications for the lengths some participants went to in order to be thorough, as discussed in the following section of this chapter.

If its going to be seen, then I don't want to get it wrong

- **This also led to a focus on collecting the 'right' material.** As is explored later in this report, participants were not always clear on the revalidation model or what was required of them. As such, some worried about making a mistake in the evidence they collected. Even some who began qualitative discussions confident that they had completed the process correctly, started to question this as they talked through their experiences; concerns around what evidence to collect and how to collect it were central to their reflective concerns. As a result, participants in the qualitative research often requested worked examples to reassure them that they were collecting the most appropriate evidence for the task.

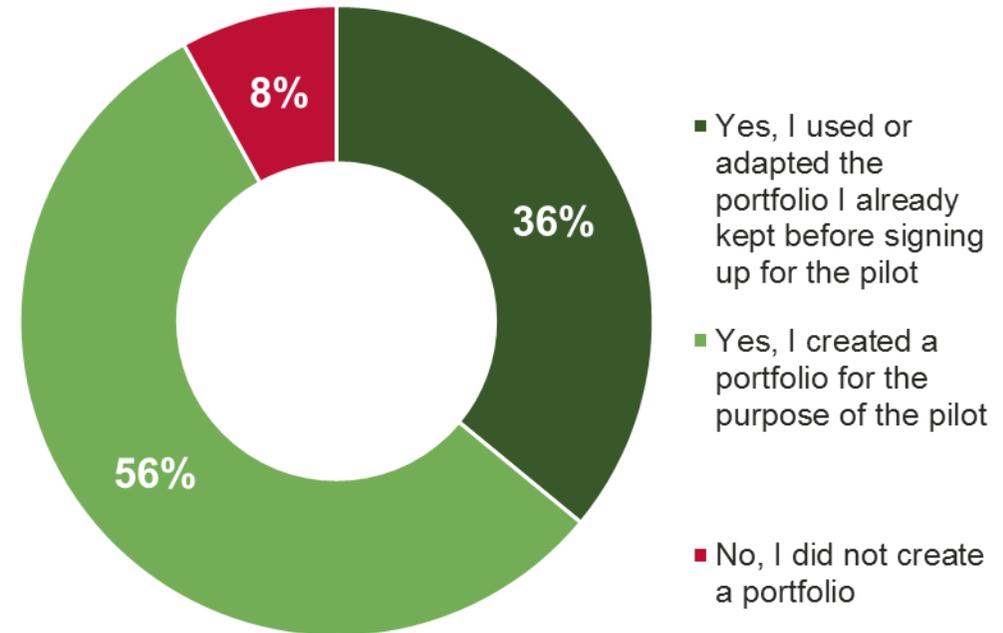
'...it would have helped to have seen examples of completed revalidations from 'Joe Nurse', - what feedback do I include, you know? So I know I'm doing it right'

Nurse

The majority kept a portfolio of some kind

- **Keeping paper or mixed paper and electronic format portfolios was common** among those participating in the survey, while solely electronic portfolios were less so (46%, 46% and 8% respectively). Indeed, fewer than one in ten did not keep a portfolio at all (8%). And, just over half created a portfolio for the purposes of the pilot (56%).
- **An overwhelming majority said they would be fairly or very likely, in the future, to keep a portfolio (96%).**

Q: At any point in the pilot, did you create a portfolio (either in paper or electronic format) to collate your evidence on some or all of the revalidation requirements?



Base: All participants (1,120)

Source: Ipsos MORI

3.2 The impact of evidence on the revalidation journey

The following section explores how the value placed on evidence by participants impacted their interpretation of revalidation, and affected elements of their journey, such as confirmation.

Some understood the level of evidence could be minimal, others were worried about the type and depth required

- The qualitative work revealed that some of those taking part in the pilot did realise that the level of evidence required can be minimal:

'I thought, they're not after complications, they just want you to reference what you're doing and validate what you're doing. So I thought, I'm not going to get het up about it. All I had to do was transfer what I already had onto their templates.' Nurse

- For others, however, the fact that evidence needed to be provided raised questions, even where the requirements were not new. In some cases, this led participants to provide additional evidence above and beyond the requirement as a precaution. Questions asked included the following:

Practice hours: Do I need to include all of my hours or just enough to show I have met the requirement? What happens if I am audited and have incorrectly recorded annual leave? Should I evidence more hours than required in order to be safe? Wouldn't it be easier if Human Resources provided documentation to the NMC?

CPD: Why am I being asked to use a log when I am providing certificates anyway? Do certificates need to explicitly state whether or not CPD is participatory? Does CPD need to be formal courses? If so, does this need to be evidenced in a special way?

There could be notable variation in the volume of evidence provided within portfolios

- **The contrasting cases below demonstrate how the process of gathering evidence could vary greatly.** It shows how 'Nurse A' – a registrant who was not very worried about providing evidence, had a quite different experience to 'Nurse B' who worked in a dual role, and wanted to make sure her evidence reflected the scope of the CPD that had been undertaken.

Case study: Variation in the provision of portfolio evidence for CPD

'Nurse A' worked for a large NHS Trust and was able to revalidate in the pilot. She did not create a portfolio for the purposes of the pilot. In fact, in order to check that she had met the CPD requirements, 'Nurse A' made a mental note of what courses she had done and mentioned these to her confirmer during their meeting.

'Nurse B' worked in two roles and was also able to revalidate in the pilot. 'Nurse B' collected details for every piece of CPD undertaken over the last three years and logged them in the NMC template. She then linked each piece to the Code, and scanned copies of her evidence and certificates to keep in an electronic portfolio. Nurse B created two logs; one for each of her roles.

'...You could be competent in one role but a total loon in other...and you could be proving clear evidence in one role and not the other, so I think it should be universal across the board... [to provide evidence for] both' Nurse

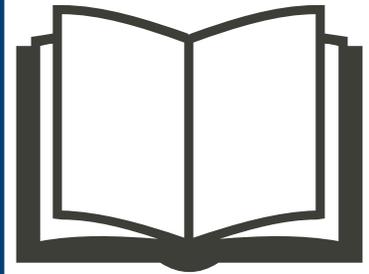
Confirmers' views of evidence impacted on the experience for both parties

- **Confirmers, too, often had concerns about the level of evidence required.** Two common queries were mentioned:
 1. **How thorough should the evidence be in order to be reassured that a registrant is fit to be revalidated? and**
 2. **How, if at all, should they judge the quality of the evidence being provided?**
- Indeed, even after reading the 'How to be a Confirmer' guidance, some thought that they were being asked to **make a judgement on the quality of the evidence** being provided, and this could be daunting.
- **And, as with registrants, confirmers in the research could over-compensate because of a lack of understanding by requesting additional evidence.** For instance, one confirmer refused to provide confirmation as the registrant in question had not provided postcodes alongside diary entries that had been collated to evidence her having met the practice hours requirements. Another registrant felt comfortable with the evidence they had supplied – in the form of completed NMC templates – but their confirmer disagreed and refused to sign their form until it was amended.
- Despite this, the opposite could also be true; one or two said that their **confirmer let them get away without providing evidence because they 'trusted them'**.

Where evidence was not asked for, the value of the requirement could be questioned

- The scope of feedback participants told us that they collected varied from verbal to more formalised sources – with some doing bespoke questionnaires.
- However, there was confusion over whether or not evidence of practice-related feedback needed to be provided and, if so, what that evidence should look like. The NMC guidance on this point was felt to be unclear: some **struggled with the notion of needing to gather feedback, but not needing to include the actual instances** of feedback in the portfolio. Some found this contradictory and were unsure whether or not they were being asked to provide evidence of feedback as well.
- **For those who understood that evidence of practice-related feedback did not need to be provided, this raised additional questions.** Indeed, without a need to evidence their feedback, participants began to question the rationale for its inclusion at all.
- **Nonetheless, the majority of survey participants said that they obtained at least five pieces of practice-related feedback in the three years up to and including the pilot (88%).**
- For those whose understanding was that evidence should be provided, concerns were raised about how exactly verbal feedback could be recorded or proved.

- **Clearly, guidance about evidence sufficiency will be important to communicate to registrants and confirmers in detail.** To illustrate further, while the majority of survey participants thought that meeting the practice hours requirement would be achievable in the future, fewer thought that providing evidence of having met this requirement would be achievable (97% and 87%). Indeed, the second-most common reason for not completing the final stage of the revalidation pilot was not having all the necessary evidence (27 of the 63 participants that did not complete this stage cited this).
- **As identified in the qualitative research, what constitutes ‘necessary evidence’ was very open to interpretation.** The research suggests that, among those who did not complete the online application because they thought they did not have the necessary evidence, one reason may well have been because it was their confirmer who deemed it to be lacking.
- **As part of this, a way of standardising how people interpret their own evidence provision may also be valuable.** For example, one nurse mentioned that she and a colleague filled out the template for practice hours, but their interpretation of the same course meant that they logged different hours on the form.



4. Reflection, discussion and confirmation

4.1 The different routes to confirmation

The research shows that, while many participants took a similar route to achieve confirmation and a PDD, flexibility in the model is needed to allow those in different scopes of practice to revalidate; particularly those without a registrant line manager.

Confirmation through an NMC registered line manager was a common route to revalidation

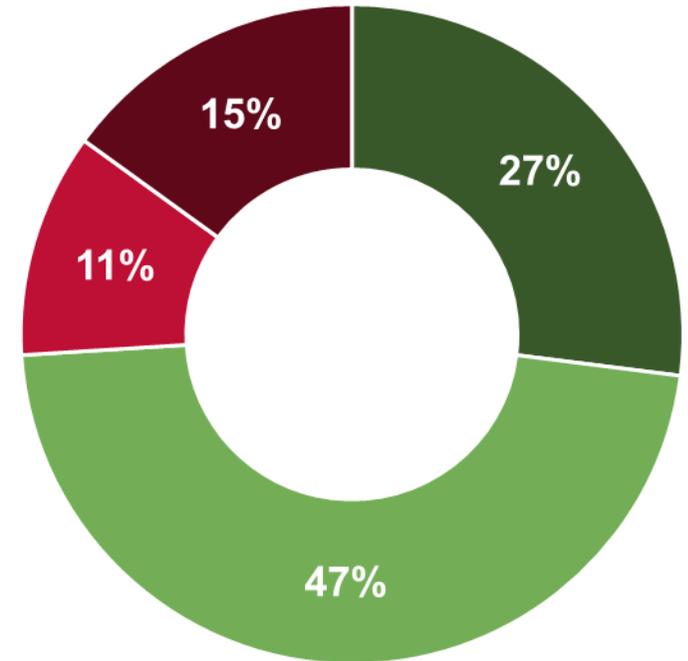
- As is discussed throughout this report, the majority of survey participants reported having met the requirements and completing the online application.
- One of the hypotheses tested in this research was that the majority of participants would be able to call on another NMC registrant, typically their line manager, to help them fulfil the requirements of both confirmation and the PDD.
- This finding was generally borne out in the research; indeed, in terms of confirmation, most survey participants that received confirmation were confirmed by another registered nurse or midwife (94%):
 - three quarters of those that received confirmation did so from their line manager who was also an NMC registrant (74%); and
 - a fifth of those that received confirmation did so from an NMC registrant who was not their line manager (20%).
- In order to complete their PDD, seven out of ten survey participants who had a PDD undertook a discussion with their line manager (70%).
- Among those who had a PDD and confirmation, typically they took place at the same time (74%).

'I chose my boss to do the confirmation and the discussion – I guess, well, she's a nurse too and just the most obvious person'

Nurse

Flexibility in the model was also needed

- The revalidation model was designed to ensure that all registrants would be able to find someone to carry out a PDD and confirmation. Flexibility was built in to the design, to ensure those, such as the self-employed, would be able to do this.
- **The research suggests that achievability of revalidation in the pilot did indeed rely upon this flexibility.** For instance, of those who had PDD and received confirmation, 15% needed to consult separate people. While these figures are not representative of all nurses and midwives, it does indicate a need to continue this flexibility as part of the model.
- Further, the model was also designed to allow alignment between organisational structures and revalidation; a quarter of those who had a PDD and confirmation did so at the same time in an appraisal or annual review setting (27%).



- PDD and confirmation at same, time during appraisal/annual review
- PDD and confirmation at the same time, outside appraisal/annual review
- PDD and confirmation at separate times but with same person
- PDD and confirmation with different people
- Not stated

Base: All those who had a PDD and obtained third party confirmation (974)

Q: Did you receive third-party confirmation for the purposes of the pilot? This includes completing the 'Confirmation from a third party form'; Was this the same person you had the professional development discussion with?; Which of the following best describes the person who provided third party confirmation?; Did you have a professional development discussion for the purposes of the pilot? This includes completing a 'Professional development discussion (PDD) form'.

Confirmation and PDD were also generally achievable for those without a line manager

- **Across the survey sample, a small proportion of participants did not have a line manager** (8% or 86 participants).
- **The majority of these were able to achieve confirmation and complete a PDD.** To fulfil the requirement, those without a line manager approached relevant individuals that worked with them, or in the local area. To illustrate, one registrant asked a nurse that she employs to confirm her; another contacted a registrant in her area. One nurse said that a colleague contacted him saying she had already confirmed other people and would he like her to do it for him over Skype – which he agreed to.
- **However, a very small minority of those without a line manager said they were unable to achieve confirmation and complete a PDD** (7 respondents). Only two people in the survey without a line manager said that they could not identify an appropriate person to receive confirmation from. Similarly, only one participant without a line manager said that not being able to find an appropriate person to have a PDD with was the reason they could not complete the process.
- This highlights that identifying an appropriate person was not a substantial factor preventing confirmation among those who self-managed.

*'... I knew of a few other nurses who practice ...in the same town as me – about 6 of us – I could have asked any of them – the one I did ask had to look it up as they hadn't heard of revalidation. We arranged a time to meet face to face'.
Nurse*

4.2 The variability in meeting the requirements

Irrespective of what route to confirmation was taken, there was some misunderstanding of how to meet the reflection and discussion requirements of revalidation. Participants' experiences in relation to reflection, confirmation and PDD will be discussed in more in this section.

- Whereas **some participants told us they wrote short accounts, others wrote many pages.** Again, comparing approaches with colleagues could also lead some to question whether they were ‘doing it right’, with participants across the qualitative strands wanting more examples to reassure themselves.
- **While most claimed to understand the requirement for written reflections, it became clear that a full understanding could be lacking.** To illustrate, the qualitative research showed that some registrants were unclear how many accounts should be provided: some completed 15 in total (five on the Code, five on CPD and five on practice-related feedback); others completed fewer than five because, for example, they were unable to collate patient feedback; one participant who was registered as both a nurse and a midwife, thought she would have to do ten – five for each of her registrations.

‘I only completed 5 pieces which was a mixture of CPD, practice learning and feedback. However, I know colleagues who thought this meant 10 pieces altogether.’
Nurse

The majority were able to receive confirmation, although the role of the confirmer was not always clear

- **Again, the majority of those participating in the survey were able to meet the requirement for confirmation (89%).**
- **However, there was also some variation in how confirmation was interpreted and therefore carried out.** For instance, confirmers were unclear whether they needed to go through reflections with the registrant, or whether they were just 'signing off' that reflections have taken place. In addition, and as mentioned earlier in the report, some confirmers struggled with how they were supposed to apply their judgement to the evidence provided, and as a result, misinterpreted their role. For example, one confirmer asked a registrant to re-work her reflections because they were not of the standard she would have expected.
- **How the confirmer was selected was also undertaken differently in the pilot.** While in some organisations this was the registrant's decision, in others, the organisation appointed a confirmer. Half of those who received confirmation said that their organisation helped them a lot in selecting a confirmer (50%). Participants told us that in some cases during the pilot this created a 'bottle-neck' of registrants to be confirmed by a small number of confirmers, creating additional workload for those in this role.

'The nurse I did [confirmation for] is quite a senior, experienced nurse, but her reflections were really like two or three sentences; so actually, they weren't very comprehensive, and what we discussed was far greater than what she initially produced. So actually I sent her back to redo them'
Nurse

Most had a PDD, but there was variation in how it was undertaken

- **Most registrants also managed to meet the requirement to participate in a PDD;** 92% of those taking part in the survey said they had a PDD (and a further 2% had the discussion but did not complete the form).
- **As with reflection and confirmation, there was also some variation in how PDDs were implemented by those taking part in the pilot.** For example, while some registrants did discuss their written reflections, others broadened the discussions to talk about the CPD they had carried out, and, in some cases, their experiences of revalidation more generally.
- **This variation had implications for the registrant experience of revalidation as a whole,** for example:
 - Those that adapted the PDD to allow them to have a longer and more general discussion with a peer, felt this offered a valued opportunity to reflect more on all aspects of revalidation and what this meant for them in the future.
 - However, others who had their PDD with a line manager as part of their appraisal could still be positive, but often pointed out they were influenced by the context, and were hesitant to expose anything they had done in their practice for which they received negative feedback.

“Reflections are supposed to be a personal thing. What worries me is that... you have to show them to your confirmer. Because reflections are personal and what you put in them sometimes can be a very personal thing, which someone else might not understand.”

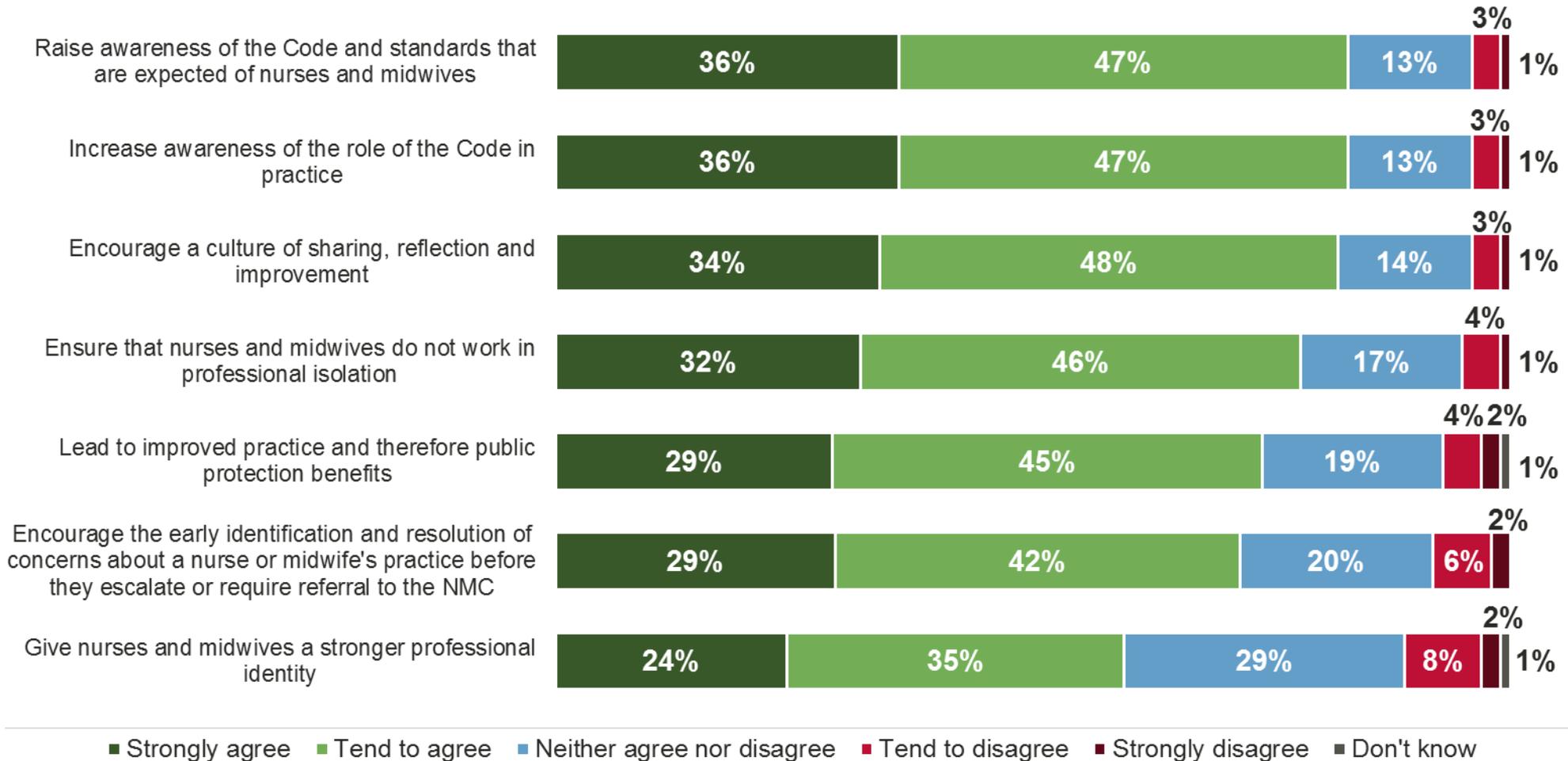
Midwife

4.3 Maximising the value of reflection and confirmation

The variability in experiences had both positive and negative implications. This section looks at the benefits participants identified and potential ways to maximise these.

Many in the survey were positive about the benefits of a PDD

Q: To what extent do you agree or disagree that the requirement for a professional development discussion under revalidation will...?



Reflection as part of the model was viewed very positively across the research

- When asked to think about the potential benefits of revalidation for individuals and the profession as a whole, participants generally welcomed feedback and reflection. Many saw a logical link between seeking feedback on performance, reflection and self-improvement.

'It's really important as it helps you see yourself from others' experience of you'
Nurse

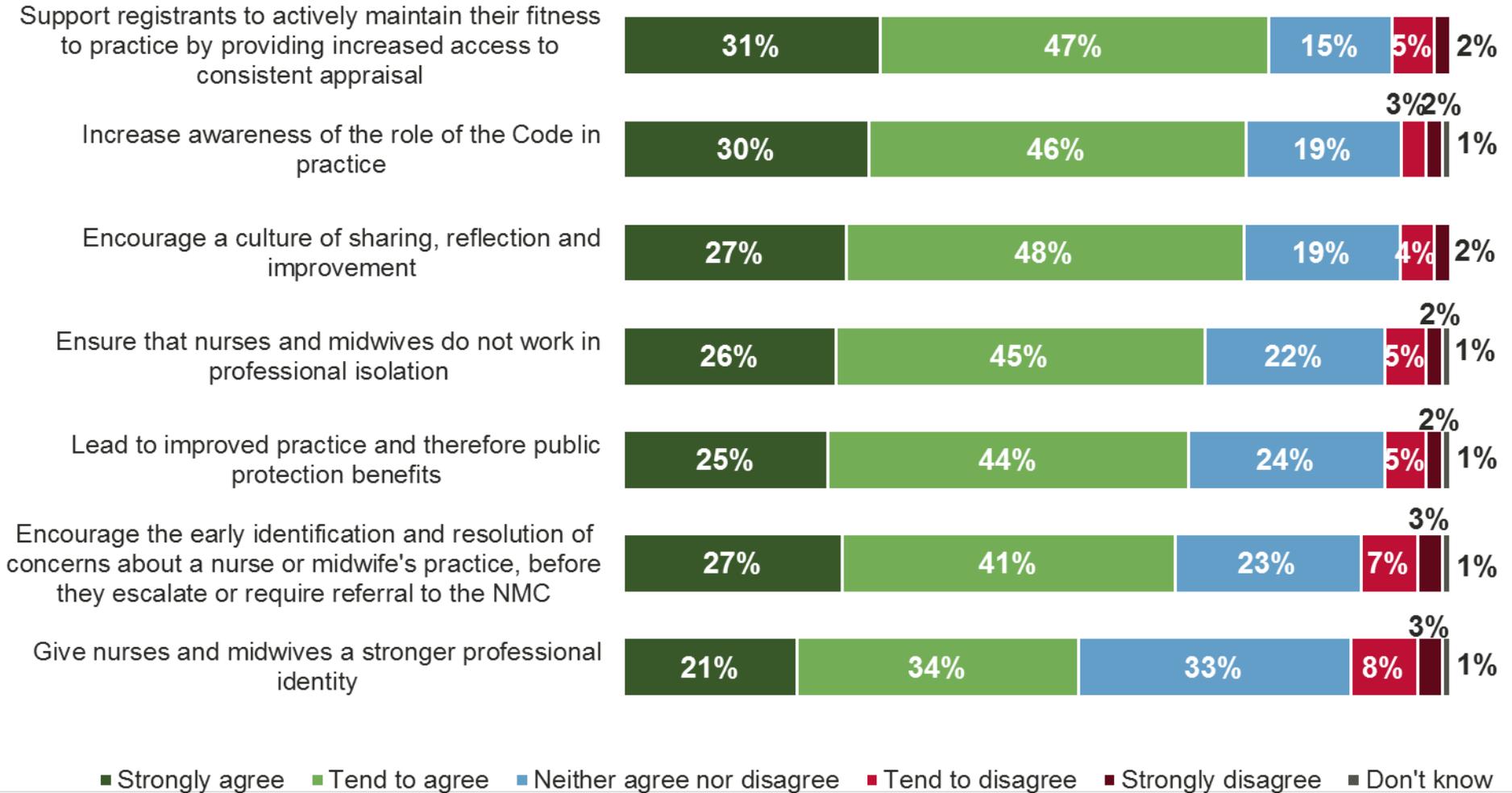
'I would think very carefully now whenever I'm doing CPD...is it participatory? How can I record it in my portfolio? What impact did it have, with regard to the code?...Whereas in the past I wouldn't have thought like that...it will encourage me to think of the impact it'll have on patients' Nurse

- However, people were only able to reach this point when they understood, and believed in, the rationale for the model and its benefits (either the intended ones, or those they derived for themselves). This quotation from a nurse highlights the journey of that attitude:

'I had a discussion with my friends about it and their initial thoughts were [that] the NMC is handing across lots of things for us to do when we're already busy. And my argument was, we should be doing this anyway... so for me it's a good thing...it's a tool for development and discussion.' Nurse

The majority of survey participants viewed confirmation positively

Q: To what extent do you agree or disagree that having to receive confirmation from a third-party as part of revalidation will...?



Base: All participants (1,120)

Source: Ipsos MORI

Strengthening professional identity was a less obvious benefit

- **Across the research, one of the less obvious benefits identified was the professional identity revalidation could bring.** Indeed, throughout the journey mapping interviews it was clear that participants did not necessarily feel a sense of ownership of revalidation.
- The qualitative research found that many could articulate the distinction between revalidation and fitness to practise procedures, but then did not naturally see an alternative rationale. This meant that at times it was still assumed that revalidation was about fitness to practise for both registrants and confirmers taking part.
- As such, it will be important to clearly outline the rationale and purpose of revalidation and the individual components. This should also lead on to articulating what the precise roles of all of those involved should, and should not entail.

The relationship between the PDD, confirmation and appraisal also requires clarity to maximise the benefits

- **A key factor underpinning participants' varied experiences, was that reflection, confirmation and the professional discussion lacked distinction from one another.** For example, when discussion and confirmation were happening with two separate individuals, sometimes the PDD was repeated within the confirmation meeting, or, there was confusion about the point at which the portfolio should be checked.
- **It was also unclear to many how the PDD, confirmation and appraisal linked together.** For just over a quarter of those surveyed who had a PDD and received confirmation, PDD and confirmation formed part of an appraisal (27%). However where this was the case, and as alluded to above, the ownership for revalidation could sit in the hands of the line manager conducting the appraisal rather than the individual. This led people to question not only the rationale for each of the individual elements, but for the process as a whole: why are they doing it, and who are they doing it for? That is not to say that the link to appraisal as suggested in the model was the cause. However, the research suggests that the context in which these meetings take place can influence their content, and potentially the outcome, particularly when the rationale and framework for each is not clear.



There is a need, therefore, to delineate the differences between appraisal, PDD and confirmation in order to ensure that these elements can be undertaken more precisely and, therefore, as effectively as possible. Indeed, without clarity in the model, it is difficult to know if views of the perceived benefits relate more to how revalidation has been interpreted than to how it was intended.

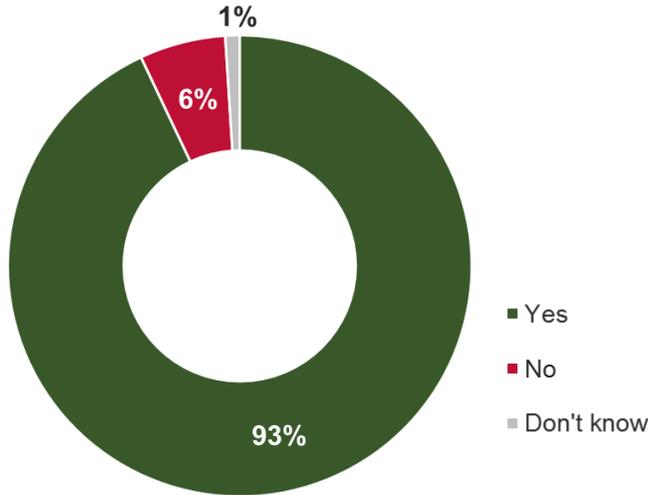
5. Completing the process

5.1 Completing the online application

Most taking part in the survey were able to complete the online application, but there are clear learning points among those that were not.

Most taking part in the survey completed the online application

Q: Did you complete the online revalidation application as part of the pilot?



Submission complete

Thank you for submitting your information.

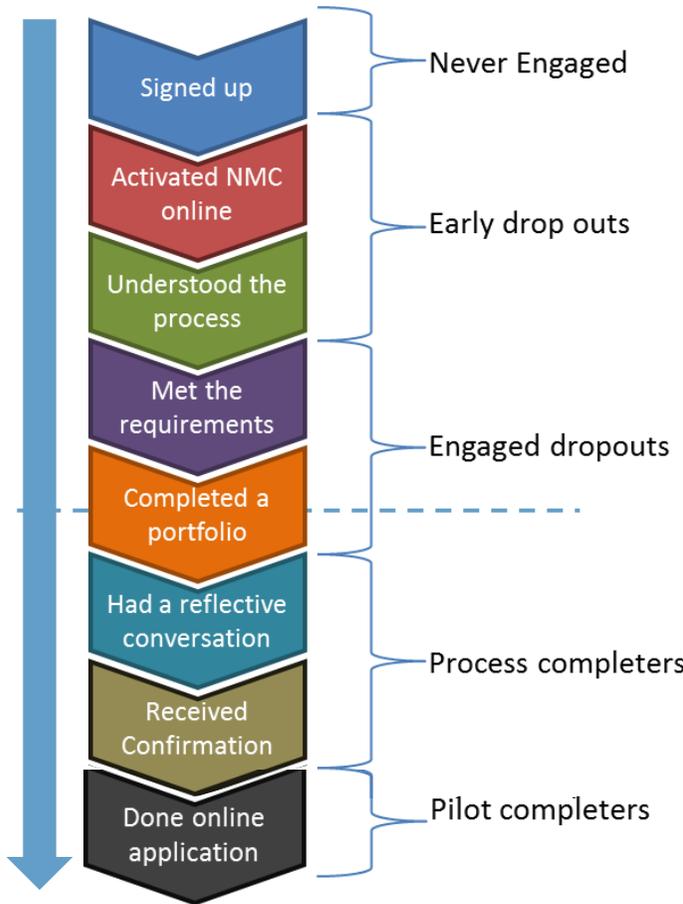
- In total, **93% of those that took part in the survey completed the application** and 6% reported that they did not. This equated to 63 participants (an additional 12 people were not sure if they had completed the online application).
- Due to the small base sizes of non-completers, figures in this section are reported as the number of participants responding, rather than as percentages.

While we cannot assume from the pilots or the survey that the proportion completing the online application would be the same in a real-life scenario, the data on these non-completers does provide **an indication of the barriers** participants faced and key learning points for the next steps for the NMC. The findings do allow us to explore:

- Why did people not reach the end of the process?
- Which requirements were least straightforward to achieve, and why?
- What are the implications for the future?

Base: All participants (1,120)

Lack of time in the pilot and gaps in evidence were the most common reasons for not submitting the application



- Some non-completer participants in the qualitative work said that the fact that it was a pilot made it less 'real' for them, and therefore they did not take part. These people did not collect any evidence and are unlikely to have taken part in the online survey. Of the 63 people who did complete the survey:
 - Around half said that they simply ran out of time to reach this point as part of the pilot, which is perhaps unsurprising given the timeframe for the pilot when compared with the three years the approach assumes registrants will have (30).
 - As discussed previously, a similar number realised they did not have all the evidence required to revalidate (27).
 - 13 people had some sort of technical difficulty related either to the online portal or the form itself.
 - 10 people were unable to complete the pilot for circumstantial reasons rather than fundamental issues relating to the achievability of the requirements (such as annual leave and sick leave).



Reassurances and safeguards would be welcomed

- Given lack of time was the main reason people could not complete the online application, it is feasible that this would not apply in the future as registrants would have three years to revalidate. Indeed, in the qualitative work, those who did not complete the process often said that they **still valued the experience and felt reassured** about being able to revalidate in real life.
- However, the findings do indicate that the NMC guidance would benefit from **making safeguards clearer** to registrants – for example, what would happen if a registrant did leave their application to the last day and was unexpectedly taken sick?
- When reflecting on their experiences participants in the qualitative work said that the key learning point for those at the beginning of revalidation would be to **start preparing early to mitigate against barriers** such as lack of time or unexpected circumstances.
- In addition, for this crucial stage of the journey, there is a clear **reliance on technology** and again the research suggests additional reassurances and safeguards would be beneficial (particularly for those who have restricted access to IT or are less IT literate).

'I had all the information gathered but had not completed the relevant templates and reflections in time due to busy period at work. I felt it useful to have taken part in the pilot as it has given me insight into the whole process. I don't think I will have any problem meeting the requirements in future (...).'

Nurse

'For nurses working in the remotest settings with primitive IT facilities and poor transport links, these requirements are arduous.'

Nurse

5.2 Completing all of the requirements

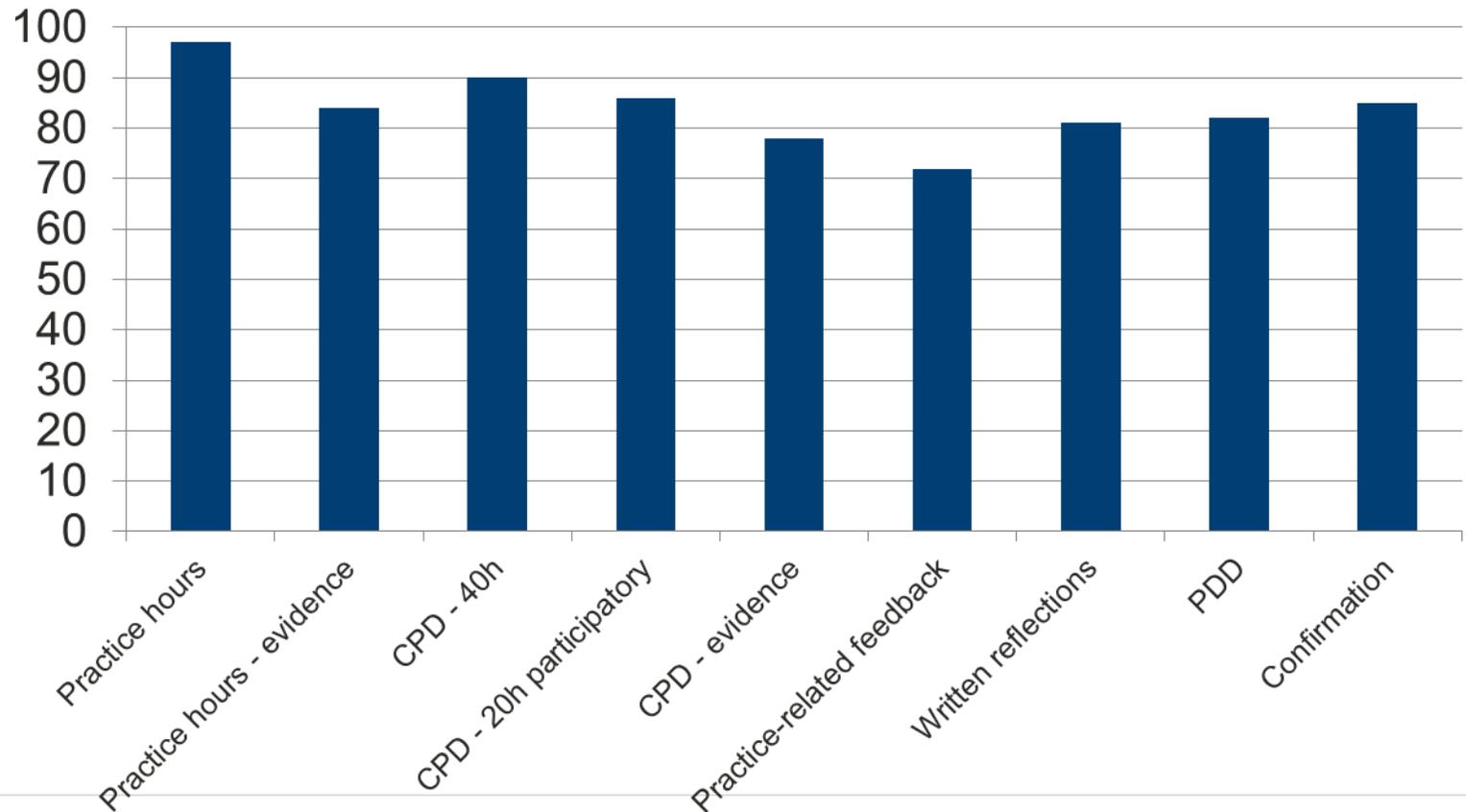
The experience of the other elements of revalidation among those who did not complete the online application reinforces the findings throughout this report, but also highlights some additional areas for improvement to minimise any barriers in the future.

- All 63 participants who did not complete the online application **met the practice hours requirement**, and most met the revised CPD requirement.
- However, only **around half completed the feedback and reflections requirements** (27 and 25 people respectively). This is consistent with our findings from across the research where these two requirements appear to be particularly confusing to participants. Equally, writing reflections requires extra effort and time in the pilot which we know was a major constraint.
- **Fewer non-completers went on to have their PDD and obtain confirmation**, which is at least partly explained by the model itself since other requirements must be met before these can take place (13 and 11 participants respectively).

The majority in the survey were, on the whole, positive about how easy each requirement would be in the future

Q: Thinking about when you are required to revalidate in the future, in general, how easy or difficult do you think it will be to [achieve]..?

% Very/Fairly easy



Optimism about practice-related feedback and written reflections was lower, and again, the findings throughout – such as the need to get evidence right – offer some explanation as to why people may still have had concerns and around these elements.

Base: All participants (1,120)

Source: Ipsos MORI

For those who were unable to achieve a requirement, changes to the guidance may improve the ease with which it can be done in the future

- **Those who did not complete the final stage of revalidation tended to be less optimistic about being able to complete the new requirements in the future.** As outlined at the start of this report, actually going through the process alleviated concerns to some extent. However, the research also suggests that confusion around the model could also cause concerns about the future ease of the process.
- **12% of survey participants reported that they completed the online application, but did not complete one of more of the elements.** There are some possible explanations for this based on the findings from the research, for example:
 1. **People are able to complete the online application without necessarily having completed a requirement.** It could be that, given this was a pilot, people may not have been comfortable with leaving gaps. Nonetheless, it would be beneficial to revisit the application form to ensure this is not likely to happen in future.
 2. **The misinterpretation of the model or the requirements.** We know from the research that how each element is explained changes how people interpret what is required (e.g. some participants thought third-party confirmation needed to involve a third person). This could therefore mean that people may well have completed the requirement but did not understand the explanation of that requirement in the survey. As such, as the model and the guidance are clarified, and the constraints of the pilot are removed, the process may potentially be more achievable for this group.

Next stages

Next steps for the NMC

The research has found that many aspects of revalidation were experienced positively, with the majority in the survey completing the process and seeing the value in the requirements. However, the findings also indicate some clear next steps for the NMC to clarify the approach and maximise benefits.

Clarifying the requirements and outlining the rationale will be important

Clarify the requirements and the relationship between them:

- There is a clear need to **delineate the differences between appraisal, PDD and confirmation**. Underpinning this is a need to establish the purpose of each element to ensure the benefits participants felt are fully realised. For example, it could be useful to consider renaming the PDD and changing the focus to be reflection on all elements of revalidation, rather than just the written reflections. In addition, allowing registrants to choose who they have that discussion with may give them greater ownership, and additional guidance on topics of conversation or questions for the peer to ask could again maximise the benefits.

Make the rationale and purpose of revalidation as a whole feature strongly, and ensure ownership of revalidation sits with nurses and midwives:

- In revisiting the model and the guidance, it will be important to **establish the rationale for each element** to ensure buy-in among registrants in the future. For example, if the main purpose of confirmation is to add another layer to the declaration nurses and midwives make on renewing their registration, this could be made clearer by a more declaration like process.
- Similarly, in making the principles for revalidation as a whole clearer, **a greater sense of ownership** could be taken by nurses and midwives in the future. This would rebalance the relationships among those involved in revalidation – for example, where participants looked to organisations or confirmers to lead their revalidation process. In establishing the principles, revalidation could become more about a relationship between the registrant and the regulator, with the organisational role being one of support (from which they could also benefit).

Making the evidence expectations clearer, and revising the documents will also be beneficial

Make the evidence needed for each part clearer:

- A distinguishing feature of revalidation for participants across the research was the need to provide greater evidence and as such, they were keen to get this right. The next steps for the NMC will be finding the balance between the demand for more examples and encouraging registrants to take ownership and be resourceful. One way to do this would be to **clearly outline the minimum expectations** for evidence by providing examples of where people have taken different approaches, clearly highlighting the benefits.

Revise structure of the guidance document and change some of the terminology:

- The guidance (and communications around revalidation) will be key in facilitating all of the next steps already outlined. Participants were quite positive about the guidance, but clearly felt that their experience would have benefitted from summarised information early on in the document. However, the next steps for the NMC will not only be addressing some of the top level recommendations for changes to the guidance (such as terminology amendments or tightening descriptions) but also **ensuring the documents provide the reassurances needed for each audience** that may use them. One way to do this would be through additional support materials, such as training videos.

Appendix: methodology and interpretation of the data



The quantitative data

The main survey approach

- The main survey enabled feedback to be gathered from a wide cohort of participants across the pilot organisations, including registrants who completed the revalidation process and those who did not. All those who agreed to be approached were invited to complete a survey. The survey quantitatively measured the experiences of revalidation, alongside attitudes and perceptions of the requirements.
- Registrants were asked upon signing up to the pilot if they would be happy to be invited to take part in the research at a later date; all of those who had agreed were then invited to take part in the survey once they had completed revalidation or at the end of the pilot.
- In total, 2,305 of those who signed up to take part in the pilot agreed to be contacted about the survey. Of these, 1,120 completed the survey; giving a total response rate of 49%.
- The main survey was then carried out by Ipsos MORI between 21st May and 21st June 2015 among registrants who had agreed to take part in the pilot across the 19 pilot organisations.
- The overall profile of the survey respondents by key demographic variables is shown on the next page. The profile reflected the overall pilot population on key demographics.

The main survey sample profile

Sample demographic information		Percentage
<i>Base size = 1,120</i>		
Gender	Male	8%
	Female	92%
Age	18 - 24	1%
	25 - 34	11%
	35 - 44	24%
	45 - 54	46%
	55 - 64	16%
	65 or over	1%
Role	UK-registered nurse	97%
	UK-registered midwife	6%
	Specialist Community Public Health Nurse (SCPHN)	8%
Time since qualification (nurse)	One year or less	0%
	Over one year, and up to and including two years	1%
	Over two years, and up to and including five years	6%
	Over five years, and up to and including ten years	12%
	Over ten years	80%
Time since qualification (midwife)	One year or less	0%
	Over one year, and up to and including two years	1%
	Over two years, and up to and including five years	4%
	Over five years, and up to and including ten years	14%
	Over ten years	78%
	Not stated	1%
Seniority	Band 5 (or equivalent)	26%
	Band 6 (or equivalent)	28%
	Band 7 (or equivalent)	27%
	Band 8 (or equivalent) or higher	13%
	Don't know	2%
	Not applicable	5%

Interpretation of the quantitative data

- Due to the nature of the pilot, the selection of pilot organisations by the NMC was purposive and not designed to be representative of the entire population of registrants across the UK .
- Not all the people who signed up to the pilot agreed to take part in research and not all of those who did completed the survey. As a consequence, the survey sample cannot be treated as representative of nurses and midwives in the UK or across the pilot organisations, but only of the people who took part in the survey (referred to in the report as ‘participants in the survey’). However, as noted, the profile reflected the overall pilot.
- The survey was not designed to predict the outcome of ‘real-life’ revalidation. Rather, it provides insight into people’s journeys, allowing for measurement of attitudes and experiences.
- Where an asterisk (*) appears it indicates a percentage of less than half, but greater than zero.

- Alongside this research, the NMC commissioned KPMG to explore readiness for revalidation and to carry out a cost benefit analysis of the revalidation model. For the KPMG cost benefit analysis, questions were asked as part of the Ipsos MORI survey to provide data on the activities that participants had to undertake to meet the revalidation requirements, the total and additional time they spent and the perceived benefits.
- KPMG was provided with a data set by the NMC that included the raw Ipsos MORI survey data for the questions needed for their cost benefit analysis.
- Some questions are used in both pieces of research. However, data processing and analysis were carried out by KPMG and Ipsos MORI separately. This means the approach to analysing the data may differ. In this report:
 - Only whole figures are reported, and where percentages do not add up to 100% this is due to a variety of factors (such as the exclusion of ‘Don’t know’ or ‘Other’ responses, the allowance of multiple responses at a question or computer rounding).
 - The base is indicated throughout. Responses are always based on those who were given the chance to answer a question (following the questionnaire routing).

- Because a sample, rather than the entire population, was interviewed the percentage results are subject to sampling tolerances – which vary with the size of the sample and the percentage figure concerned. For example, for a question where 30% of the people in a sample of 1,120 respond with a particular answer, the chances are 95 in 100 that this result would not vary by more than 2 percentage points, plus or minus, from the result that would have been obtained had the entire population taking part in the pilot completed a survey. Theoretically, every separate estimate has its own sampling tolerance, but, as a guide, approximate sampling tolerances that apply in this survey to percentages at or near the levels shown below (at the 95% confidence level) are provided.

Approximate sampling tolerances applicable to percentages at or near these levels (at the 95% confidence level)			
Size of sample or sub-group on which survey result is based	10% or 90% ±	30% or 70% ±	50% ±
1,120 (NMC pilot survey participants)	1.3	2.0	2.2

- Tolerances are also involved in the comparison of results between different elements of the sample. A difference must be of at least a certain size to be statistically significant. The following table is a guide to the sampling tolerances applicable to comparisons between sub-groups.

Example sub-group sizes	Differences in % required for significance at the 95% confidence level at or near these percentages		
	10% or 90%	30% or 70%	50% or 50%
50 and 50	15.0	19.0	19.0
200 and 200	7.0	10.0	10.0
Males in this survey (87) vs. Females in this survey (1030)	6.6	10.1	11.0

The qualitative data

The guidance strand sample

- The guidance strand of research comprised 10 group discussions with NMC registrants, 18 tele-depth interviews with nurses and midwives and 10 tele-depth interviews with other healthcare professionals. Each group discussion was carried out face-to-face and lasted around two hours. Each tele-depth lasted approximately 45 minutes to an hour.

Guidance document explored	Tele-depths or discussion group	Pilot or non-pilot organisation	Number	Audience
How to revalidate	Tele-depths	Pilot	9 participants	2 midwives, 7 nurses
	Discussion groups	Pilot	3 groups	9 midwives, 18 nurses
	Discussion groups	Non-pilot	3 groups	10 midwives, 19 nurses
Information for confirmers guidance	Tele-depths	Pilot	9 participants	5 midwives, 4 nurses
	Discussion groups	Pilot	3 groups	7 midwives, 15 nurses
	Discussion groups	Non-pilot	1 group	9 midwives
	Tele-depths	Non-pilot	10 other healthcare professionals	See next table

- The interviews with other healthcare professionals included a range of professions. Each tele-depth lasted approximately 45 minutes and the information for confirmers guidance was explored in each.

Participant type	Number
GPs	3
Occupational Therapists	2
Anaesthetist	1
Senior Theatre Practitioner	1
Physiotherapist	1
Senior dietician	1
Paramedic	1

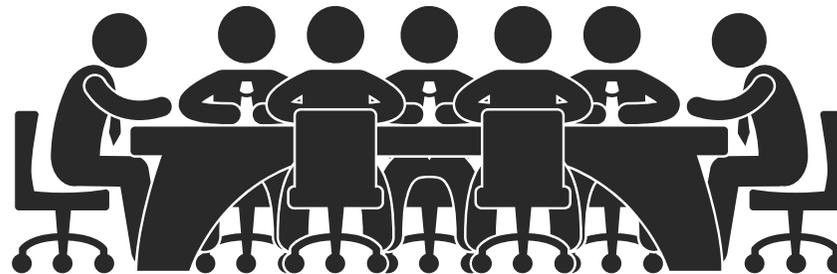
The journey-mapping strand sample

- The journey mapping strand comprised 127 depth interviews, each lasting approximately 45 minutes to an hour and carried out over the phone. Quotas were set to ensure a range of experiences could be captured. For example, peers who carried out a Professional Development Discussion (PDD) were included alongside confirmers who carried out the PDD and provided confirmation.
- Additional quotas were set to ensure registrants from all pilot organisations were included and across nursing and midwifery.

Participant type	Number
Registrant: did not complete revalidation	16
Registrant: completed revalidation	44
Confirmer: carried out PDD and confirmation	52
Confirmer: only carried out confirmation	7
Peer: carried out a PDD only	8

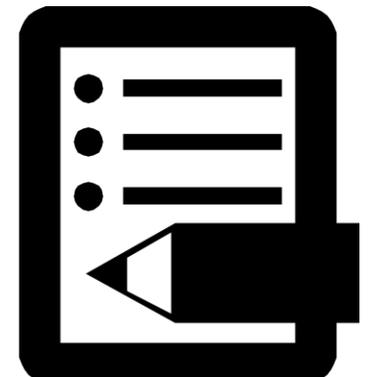
Interpreting the qualitative data

- The qualitative aspects of the research were designed to be exploratory and to provide an insight into the perceptions, feelings and behaviours of people. It is important to note that these qualitative findings are not statistically representative of the views of the audiences included.
- As all discussions were qualitative in nature, verbatim comments from the interviews have been included within this report. These should not be interpreted as defining the views of all participants, but have been selected to provide insight into a particular issue or topic.
- Indeed, the perceptions of participants make up a considerable proportion of the evidence in this study, and it is important to remember that, although such perceptions may not always be factually accurate, they represent the truth to those who relay them.



Quotas for the qualitative work

- Primary and secondary recruitment quotas were set for both strands of qualitative research – the discussion groups and interviews looking at the guidance, as well as the journey-mapping interviews undertaken among those piloting the process, and other healthcare professionals.
- These were set to ensure a range of views and experiences were explored.
- The following slides provide an overview of how quotas were set for each of these elements.



Guidance strand research among nurses and midwives

- Primary quotas were set as follows:
 - Pilot organisation: 6 discussion groups were made up of those from pilot organisations, and 4 discussion groups were conducted among a range of registrants at non-pilot organisations.
 - Level of seniority: a mix of band 5-8 registrants were captured.
 - Scope of practise: a range of different scopes of practise as dictated by pilot organisation were also covered including those working for the NHS in hospitals and the community; those working for private providers; and those employed in commercial settings.

Guidance research among non-NMC registered professionals.

- Our sampling allowed for a mix of professionals that work with nurses and midwives who might be asked to act as a confirmer (including, for example, General Practitioners, Occupational Therapists and Physiotherapists).
- All participants had not seen the NMC's guidance or carried out confirmation / acted as a peer for a nurse or midwife revalidating.
- Quotas were also set to ensure that no more than two participants were from the same specialism.

Journey-mapping (registrants)

- Primary quotas were set to ensure at least one nurse or midwife at each of the pilot organisations was consulted.
- Secondary sampling variables included: length of time in practice (greater than / less than 10 years); those with a line manager (including those that had an NMC registrant, another UK regulated health professional or another non-healthcare professional as their line manager); those without a line manager (including self-employed); those that work with other registrants in their work setting; those that had / had not had an appraisal in the last 12 months; some that had more than one role / registration; and some that did not complete revalidation as part of the pilot.

Journey-mapping (confirmers)

- Primary quotas were set to ensure at least one confirmer at each of the pilot organisations was consulted.
- Secondary quotas were set to capture three dynamics:
 - those who acted as confirmer only;
 - those who acted as peer only; and
 - those who carried out both roles.

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