Ipsos MORI
Social Research Institute

July 2019

Evaluation of revalidation for nurses and midwives

Year three report

An independent evaluation undertaken by Ipsos MORI Social Research Institute on behalf of the Nursing and Midwifery Council

Contents

List of figures

List of tables

Acknowledgements

Ipsos MORI would like to thank all the participants who took the time to take part in the survey, interviews and case studies for this evaluation, including nurses, midwives, confirmers and stakeholders.

We would also like to thank: Professor Sir Cary L Cooper CBE, Professor of Organizational Psychology & Health at the University of Manchester; Beccy Baird, Senior Fellow at The King's Fund; and, Stephen Bevan, Director of Employer Research and Consultancy at the Institute for Employment Studies for their advice and guidance over the course of the evaluation.

Finally, we would like to thank Sara Kovach-Clark, Caroline Kenny, and Elizabeth Hancock at the Nursing and Midwifery Council for their feedback and support over the course of the evaluation.

List of abbreviations and acronyms

Acronym	Definition
CNO	Chief Nursing Officer
CPD	Continuing Professional Development
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
EEA	European Economic Area
ELS	Employer Link Service
EU	European Union
FFT	Friends and Family Test
FtP	Fitness to Practise
GMC	General Medical Council
GP	General Practitioner
HEE	Health Education England
HCSW	Healthcare Support Worker
NHS	National Health Service
NIPEC	Northern Ireland Practice and Education Council
NMC	Nursing and Midwifery Council
Prep	Post-registration education and practice
PSA	Professional Standards Authority
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RO	Responsible Officer
SCPHN	Specialist Community Public Health Nurse
UK	United Kingdom
WHO	World Health Organisation

Executive summary

In March 2016, Ipsos MORI was commissioned by the Nursing and Midwifery Council (NMC) to conduct an independent evaluation of revalidation for nurses and midwives. The evaluation ran alongside the first three years of revalidation, publishing reports on an annual basis. This is the final report for the evaluation, reporting on evidence of the progress revalidation has achieved against the process and outcomes evaluation framework.

Background to revalidation

As the independent regulator for the nursing, midwifery and nursing associate workforce in the UK, the NMC: maintains a register of all nurses and midwives who meet the requirements for registration; sets the standards for education, training, conduct, and performance; and processes proceedings to deal with instances in which a registrant's integrity or ability to provide safe care is questioned. There are currently over 698,000 individuals registered with the NMC.[1]

The introduction of revalidation in its current form (as a successor to the previous Post-registration education and practice standards– 'Prep'), was the culmination of a long-term discussion about how the NMC could use its role as a regulator to enhance public protection. The eventual catalyst for the introduction of revalidation was the findings and recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Sir Robert Francis QC.[2]

The current model is defined by the NMC as a continuous process that registrants will engage with throughout their career and that:

- allows registrants to maintain their registration with the NMC;

- demonstrates registrants continued ability to practise safely and effectively; and

- builds on existing renewal requirements.[3]

The revalidation process incorporates eight core elements (as detailed in Table 1.1). The requirements for practice-related feedback, reflection (accounts and discussion) and confirmation represent the key differences to the previous Prep system.

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[1] *The NMC register*, Nursing and Midwifery Council, 2019. Available online at:
https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/nmc-register-data-march-
[2]
http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf
[3] *How to revalidate with the NMC,* Nursing and Midwifery Council (2016)

Under revalidation, registered nurses and midwives must renew their registration every three years following their initial registration. All registrants who were on the NMC register on 1 April 2016 were required to revalidate to maintain their presence on the register by 1 April 2019.

Table 1.1: Revalidation requirements

Element	Details
Practice hours	Achieve minimum of 450 practice hours over three years[4].
Continuing Professional Development (CPD)	Undertake 35 hours of relevant CPD (20 hours participatory).
Practice-related feedback	Obtain five pieces of feedback.
Reflective accounts	Produce five written reflective accounts.
Reflective discussion	Discuss the reflective accounts with another NMC registrant.
Confirmation	Obtain confirmation from a suitable person that they have met the requirements of revalidation.
Health & Character Declaration	Declare whether any health and character issues exist that may impair fitness to practise.
Professional indemnity arrangement	Have (when practising), appropriate cover under an indemnity arrangement.

Revalidation of nurses and midwives was introduced in a challenging context. These challenges include financial constraints—with many NHS trusts running in financial deficit—major staffing and workforce retention issues, and the potential impact of the United Kingdom's (UK's) decision to leave the European Union (EU) on the nursing and midwifery workforce.

The General Medical Council (GMC) introduced revalidation for doctors in 2012, which was also subject to an independent evaluation. The findings of the GMC's evaluation have been important for the NMC to consider when seeking to understand the outcomes of revalidation for nurses and midwives. The GMC evaluation did not find substantial evidence that the process was leading to changes in practice but, in line with findings from this current evaluation, identified reflection as key to generating change.

The NMC has acted in response to the first two evaluation reports and are committed to improving the revalidation process further into the second cycle of revalidation and beyond. For example, over the course of revalidation, the NMC has maintained levels of communication with registrants, continually refreshed its guidance documents and updated its website to both reflect changes in the nursing sector and improve the clarity of these resources. The NMC has also begun collecting examples of best practice, developing and publishing example case studies with the intention to continue this work.

The NMC continues to monitor and reshape its strategies in order to ensure verification successfully deters registrants from non-compliance and detects non-compliant registrants.

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[4] Registrants practising as both a nurse and a midwife must undertake 450 practice hours in each of their areas of practice (900 hours total) over the three years prior to their revalidation.

About this evaluation

The evaluation used a theory-based approach to undertake an assessment of:

- the effectiveness of the process (Process Evaluation);

- the outcomes and impact of the revalidation process (Longitudinal Outcomes Evaluation); and,

- whether the benefits outweigh the burden of revalidation (Benefit/Burden Assessment).

A programme of evidence collection activities was carried out across the three-year evaluation, as outlined below.

- **Stakeholder consultations:** Interviews with representatives of patients and service users, as well as nurses and midwives in England, Scotland and Wales. In total, 27 interviews were carried out.

- **Analysis of monitoring information:** Independent analysis of the monitoring information collated by the NMC.

- **Literature & context review:** Exploration of sources of evidence to support the design of revalidation and review of the context within which revalidation is being implemented.

- **Registrant survey:** A longitudinal online survey exploring NMC registrants' experiences of revalidation processes, and attitudinal and behavioural outcomes of revalidation. The survey was repeated annually over three years with the same sample of registrants.

- **Case studies:** Qualitative, setting-based case studies with registrants, their line managers, confirmers, and reflective discussion partners. Seven case studies and a total of 13 in-depth interviews were conducted in Year One, and eight case studies and a total of 22 interviews were conducted in Year Two. A further 12 interviews were conducted with registrants in Year Three to explore their experiences of revalidation.

- **Benefit / burden registrant interviews:** In-depth interviews with 24 registrants specifically exploring the comparative perceived benefit and burden of revalidation.

- **Interviews with confirmers and reflective discussion partners**: In-depth qualitative interviews with those who had acted as confirmers or reflective discussion partners, focusing on understanding their experience of revalidation. In Year Two, 25 interviews were conducted and a further 8 were conducted in Year Three.

- **Interviews with lapsers**: Short, qualitative, telephone interviews in Year One with 24 former nurses and midwives who had lapsed from the NMC's register.

- **Interviews with employers of registrants:** In-depth interviews with seven employers of registrants in Year Three, to understand the employer perspective and experience of revalidation.

The simultaneous roll-out of revalidation across the UK meant it was not possible for the evaluation to attempt to attribute macro-level changes (such as improvement in patient outcomes) to revalidation. Therefore, the evaluation focussed on outcomes that, based on the Theory of Change, it was reasonable to measure during the three-year timeframe of the evaluation.

Data on these outcomes came from the survey of registrants which allowed for both non-experimental 'before vs after' regression analysis and a quasi-experimental 'pipeline' regression analysis, that utilised first three-year cycle. This analysis was used to explore behaviour change alongside any longer-term outcomes.

Both approaches allowed for the attribution of causality to revalidation with the latter approach providing more robust estimates. However, the use of both approaches allowed for an assessment of the validity of the findings, with similar effects observed in each case, giving confidence in the findings. These findings were also triangulated with the wider survey findings and the qualitative data to add depth and insight.

Additional regression analysis was conducted to control for scope and setting when looking at differences across ethnicity, age and gender in how easy registrants found each of the elements of revalidation.

Delivery of revalidation

The implementation of revalidation progressed as intended. As of March 2019, the first three-year revalidation cycle came to an end, and overall a total of 611,462 registrants had successfully revalidated out of a total of 658,100 due to undergo the process (93%).

This reflects that a high renewal rate was maintained over the three-year revalidation cycle. The rate of lapsing from the NMC's register under revalidation was not significantly different from rates of lapsing under the previous Prep system.

The experience of revalidation

Communication, guidance materials and support

Registrants across the evaluation were positive about the NMC's communications regarding revalidation. Most registrants felt that communication about the introduction of revalidation was clear, and a high proportion felt that the NMC provided enough information about how to prepare for revalidation, the volume of which increased as registrants approached revalidation.

Most registrants had used at least one of the information sources about revalidation available from the NMC. The most frequently used of these were the 'How to revalidate with the NMC' document, 'the Code', and the revalidation section of the NMC website. These three sources were viewed positively by registrants, with most registrants who used them finding them easy to read, helpful, and applicable to their place of work.

Not as many registrants as might be anticipated used the NMC's Code. However, usage did increase across the three-year period.

Almost all registrants used the NMC's templates when they were revalidating. Over nine in ten used the accounts log, and similar proportions used the CPD record log and the practice hours record log.

Because the NMC's revalidation materials were so well received, most registrants did not have to seek additional support from the NMC. Among those that did, the majority contacted the NMC by email. For those registrants who did contact the NMC, most said that their problem was resolved.

The extent to which registrants felt supported by their employer varied and was largely related to the setting in which they worked. Over half said that their employer had policies around who could act as registrants' confirmers or reflective discussion partners, and around half said employers held seminars or other sessions for their employees to learn about revalidation. This variety was reflected in the ways employers spoke about their policies and support mechanisms.

Larger organisations such as NHS trusts were able to provide more support to registrants whereas smaller organisations such as care homes, GP practices and voluntary settings tended to be less involved in providing support.

Completing the revalidation requirements

The revalidation process initially caused anxiety among registrants as it was new and more complex than the previous Prep system. This was particularly the case for older registrants. Overall, however, this initial anxiety abated as more registrants revalidated.

Registrants generally understood the revalidation requirements and found them easy to meet. Registrants and employers outlined that nurses and midwives were often already doing many aspects of revalidation as part of their practice before its introduction, making it easier to complete the requirements.

However, the extent to which it was easy or difficult for registrants to complete the revalidation requirements varied by setting. For example, those in more isolated roles could find it harder to collect enough practice-related feedback and to identify an appropriate person with which to have a reflective discussion or confirmation discussion.

Over half of registrants completed more than 60 hours of CPD in the three-year period before submitting their revalidation application; far more than the minimum 35 hours required. However, it could be more difficult for registrants to find CPD opportunities that were relevant to their scope of practice.

Registrants interviewed often used 'passively' collected feedback such as thank-you cards from patients, and, in the survey, many reported receiving no more feedback than they had done prior to revalidation. Nonetheless, registrants working in more isolated roles, those working with vulnerable patients, or who had little contact with patients could find it harder to ask for and receive feedback from patients.

Those working in organisations such as GP practices, where they were the only registrant employed, could find it more difficult to identify a suitable registrant to have their reflective discussion with.

The majority of registrants reported having their confirmation discussion at the same time as their reflective discussion, and often with their line manager.

Additional statistical analysis was carried out to understand whether there were differences in how easy registrants across demographic groups found each of the revalidation requirements, controlling for scope and setting differences. The findings showed that, while registrants overall found each of the requirements easy to meet, there were overall differences by ethnicity and gender.

Assessing burden in the process

Registrants' initial apprehension about revalidation was often driven by a belief that revalidation would be both complex and time consuming. This was particularly the case among registrants who worried about the collation of information, or registrants who had specific circumstances they thought would affect how

easy it was for them to revalidate, such as having moved roles. This meant in preparing for revalidation and in the earlier stages overall the burden of worry could outweigh the perceived benefits for registrants.

The time it took registrants to complete revalidation was explored in the benefit / burden interviews. The time taken to complete each requirement varied greatly across registrants. Most notably, registrants reported spending anywhere between 1.5 to 8 hours learning about and collecting evidence for revalidation, and between 15 minutes and 3 hours to write each reflective account. Overall, registrants said that they were likely to spend less time on their next revalidation as it had been easier than they expected.

Despite most registrants in the survey finding it easy to meet the minimum number of CPD hours in the three-years prior to their revalidation application, a sizable proportion reported that it was difficult to find the time to undertake CPD.

In addition, registrants in the interviews reported that it was necessary to complete at least some of the revalidation requirements in their personal time. This was necessitated, not by the complexity of the revalidation requirements, but by the nature of registrants' roles (for example working on a busy hospital ward), which meant it was not feasible to find time to spend on revalidation requirements.

There were also examples in the interviews of registrants incurring a financial burden from revalidation, such as taking a day of annual leave or placing a child in nursery for a day to complete the administrative aspects of revalidation.

Behaviour change among registrants and employers

Behaviour change among registrants

The practice-related feedback requirement of revalidation is intended to encourage nurses and midwives to actively seek feedback from patients and service users, which in turn should enable registrants to be more responsive to patient needs. Statistical analysis suggested that revalidation affected behaviours around practice-related feedback, with those who had revalidated being more likely to say that they actively sought practice-related feedback from patients and service users, than those who had not revalidated. However, this increase was not entirely sustained; two years after revalidation, the proportion reporting actively seeking feedback dropped, but not quite to pre-revalidation levels. In addition, the overall proportion – even at the point of revalidation – remained low and there were barriers identified, including challenges in approaching patients, which were felt keenly by registrants.

The CPD requirements are intended to encourage registrants to actively engage in CPD to develop new skills and respond to changes in nursing and midwifery. Statistical analysis found that revalidation led to an increase in registrants reporting that they proactively undertake CPD activities. The in-depth interviews with registrants suggested that the focus on recording CPD had led them to reflect more on the training they had undertaken, but also caused them to take a more mindful and proactive approach to training than they had prior to revalidation.

The requirements related to reflection (accounts and discussion) are intended to support registrants to identify ways to improve their practice and areas of good practice that they should continue. Statistical analysis suggested that revalidation impacted behaviours, leading to an increase in those who reported proactively reflecting on their practice. Overall, the evaluation found that registrants were aware of how to reflect, the importance of reflection, and the direct impact that reflection could have on their individual practice. While these attitudes were strongly held before nurses and midwives undertook revalidation, the evidence suggested that revalidation embedded these behaviours—or at least awareness of these behaviours—further.

The NMC encourages registrants to make use of the Code during the revalidation process. The evidence implied not only that revalidation led to more registrants viewing the Code as central to their everyday practice, but also that positive changes in attitudes relating to the Code have some longevity.

Behaviour change among employers

Revalidation intends for employers to take specific actions to support nurses and midwives through the process, which then also demonstrate employer engagement with revalidation. The evaluation mainly focussed on the survey of registrants to understand employer activities.

Statistical analysis found that registrants who had revalidated were more likely to agree their employer had helped them seek out opportunities for CPD than those who had not. Evidence suggested that these efforts were focused on registrants who were approaching their renewal date and declined to baseline levels once registrants had undertaken revalidation.

There was little evidence of employers providing additional internal training (beyond that for preparing registrants for revalidation), or funding for external training, as a result of revalidation.

Statistical analysis also showed that those who revalidated were also more likely to agree that their employer had encouraged them to seek feedback, than those who had not revalidated. As with CPD, these efforts were focused on registrants who were approaching their renewal date and appeared to decline to baseline levels once registrants undertook revalidation. There was also evidence of employers being aware of the barriers that registrants faced when collecting feedback from patients and service users.

The analysis of survey data also indicated that, as intended, revalidation was associated with an increased proportion of employers actively engaging with nurses and midwives regarding reflective practice. However, as was the case with measures relating to CPD and feedback, the increased engagement among employers was not maintained after the point of revalidation.

From behaviour change to outcomes

There are several cultural outcomes that revalidation seeks to affect, including: improved responsiveness to patient need; embedding standards across the sector; a culture of sharing, reflection and improvement; and early discussion of concerns being encouraged.

Looking at responsiveness to patient needs, the small increase in the proportion of registrants who reported actively seeking practice-related feedback was not sustained after revalidation. Coupled with this, barriers to collecting feedback from patients were recognised by both employers and registrants. These barriers led to many registrants using feedback from colleagues which, while potentially valuable, is

not how revalidation intends for registrants to be more responsive to patient need. Therefore, evidence that the feedback requirement contributed to improved responsiveness to patient needs was therefore limited.

Revalidation intends that the increased emphasis on the Code should embed common standards across the settings in which nurses and midwives operate. The in-depth interviews provided some evidence of the beginning of this form of cultural change. For example, some interviewees reported noticing registrants referring to the Code more regularly in order to guide their everyday practice. These insights suggested that the revalidation process may go on to contribute to increased embedding of standards among registrants in the future.

It is also anticipated that an increased culture of sharing, reflection and ongoing improvement will be fostered by engagement in reflective activities. The increased emphasis on reflection was welcomed by most registrants. Evidence suggested that in cases where formal reflection is already central to a registrant's practice, the additional focus placed on it by revalidation may help to reinforce these behaviours. In cases where registrants are less familiar with reflective practice as a concept, revalidation may encourage them to reflect in a more structured and regular manner.

Revalidation is intended to support the early identification and resolution of issues by creating a culture of reflection and by encouraging regular appraisals. Although there was evidence that revalidation has helped further embed reflective practice among registrants, there were some doubts among employers about the extent to which this will lead to early identification of issues. There was evidence, however, that although revalidation may not have prompted the introduction of regular appraisals, in some cases it had influenced the content of appraisals. This may lead to appraisals becoming more focused on identifying and addressing emerging issues in the future. However, some employers, confirmers and stakeholders thought that there could be potential barriers, as they questioned how appropriate any overlap between the role of reflective discussion partner or confirmer and employer is.

Public protection and regulatory effectiveness

Public protection

Through the continuous improvement in the quality of nursing and midwifery, revalidation seeks to both increase public confidence in the quality of care from nurses and midwives and ultimately enhance public health safety and wellbeing. The NMC designed revalidation as a process to facilitate safe and effective practice in order to achieve enhanced public protection.

Patient representatives and stakeholders appreciated this ambition and revalidation's role as a process to facilitate safe and effective care. Furthermore, the experience of revalidation also had a positive effect on registrants' perceptions of their individual ability to practise safely and effectively, as those who had revalidated were more likely to say their ability to practice safely and effectively had got better compared with those who had not. Where registrants thought their ability to practise safely and effectively had got better, most attributed this to revalidation to some extent.

Despite this, a higher proportion of registrants thought the new revalidation requirements would have a positive impact on nurses and midwives in general, than thought they would have a positive impact on them as individuals. This reflects a wider finding that registrants often had a belief in the value of

requirements in general, but this did not always translate to them fully experiencing the benefits of that requirement themselves.

Most audiences thought it was unlikely revalidation would have achieved the level of cultural change necessary for public protection to have been impacted following the first cycle of revalidation. However, stakeholders did recognise that revalidation could have a role in public protection, and that it complemented a wider shift towards openness and learning in health and social care. Nonetheless, participants thought the likelihood of revalidation ultimately having an impact on public protection depended on whether any limitations to the current approach are addressed in the subsequent stages of revalidation.

Regulatory effectiveness

The role of the NMC

Revalidation had a positive effect on perceptions of the role of the NMC in supporting and maintaining practice; registrants who had revalidated were more likely to agree that the NMC had this role. Stakeholders also held positive views of the role of the NMC in this respect.

Equality and diversity

There was no evidence of substantial equality and diversity issues. Most notably, statistical analysis of findings for the key attitudinal and behavioural outcomes for revalidation did not find any variation across demographic groups when scope of practice and setting were controlled for.

However, some small differences in renewal rates and differences in ease of completing the requirements were identified that the NMC may want to explore further.

Firstly, the evaluation found that renewal rates decreased slightly for those aged over 65 when compared with Prep. However, these registrants comprised only a small proportion of the total register. Many in this category may not have been practising prior to the introduction of revalidation; this was supported in the qualitative interviews across the evaluation, and particularly in the interviews with lapsers. Nonetheless, the NMC may want to continue to monitor renewal rates for this age group, and overall, particularly given the context of workforce challenges.

Secondly, controlling for scope and setting, White British registrants were more likely than registrants belonging to many other ethnic groups to say they found meeting the requirements easy. Similarly, female registrants were more likely than male registrants to report finding the requirements easy to meet. Despite these differences however, across groups a high proportion still found the requirements easy to meet. The reasons for any differences are likely to be wide ranging, with differences in workplace experiences identified in the NHS Interim People Plan perhaps offering some explanation for differences in revalidation experiences.

Finally, there were differences noted in lapsing rates for those living with a disability. However, analysis of active lapsers data suggested that disability differences in lapsing may be due to ill-health rather than aspects of revalidation.

Revalidation as a regulatory tool

Most registrants thought that confirmation would successfully ensure that all registrants have complied with revalidation requirements, and most agreed that confirmation would prevent nurses and midwives from making inaccurate declarations as part of revalidation. Equally, the majority thought that it was important that the NMC checks that registrants have complied with the revalidation requirements through verification.

While limitations were identified – such as being able ask a friend to act as confirmer – participants across audiences in the qualitative work highlighted that confirmation and verification are one example of how revalidation is more prescriptive and formalised than Prep. This was viewed as a key advantage of revalidation and made registrants and employers value it, even if they thought they or their employees were already meeting the requirements. Participants often simultaneously believed that individual registrants did not necessarily need to engage a great deal with revalidation, but that revalidation could still be an effective governance process and symbol of professionalisation.

However, in cases where registrants could not identify tangible benefits for themselves (mostly because they were meeting many of the requirements already), revalidation did not always feel proportionate. The burden of the paperwork felt greater than the benefits in these cases, particularly where registrants were using their own time to complete the administrative tasks associated with revalidation.

In this context, the limitations of the requirements became more apparent to participants across audiences, and in particular employers and stakeholders who have more of an oversight of registrants. This led to questions being raised about the evidence base behind specific requirements, including the definition 'practice' for practice hours, how the number of hours for CPD had been decided and whether the same value of the requirements would be felt in the next stages; the evidence indicated that as registrants continue to revalidate in the future, limitations and gaps could be exposed and the overall impact of revalidation affected.

Overall, therefore, revalidation was seen as a positive foundation, highlighting the achievement of its successful introduction, and the potential it has going forward. However, the evidence also suggested that the flexibility in the model, while important, needs to be balanced with ways to strengthen the model and maintain momentum.

Reflections and recommendations

Key reflections

The first cycle of revalidation progressed well and proved to be mainly successful against its objectives. There were no substantial issues with the process, and from the statistical analysis, positive effects were identified relating to nurses' and midwives' understanding of the Code and shifts in attitudes and behaviours. Revalidation was a contributing factor to these improvements, alongside other factors.

- Over the first three-year cycle, the revalidation process—including the improvements made by the NMC during the first cycle—has proven to be a success.

- As a model, revalidation has performed well against the desired outcomes. The statistical analysis demonstrated that, across the outcome evaluation measures, there was a positive effect among those who had revalidated compared with those who had not.

- The reflective elements of the revalidation model were particularly valued by registrants, employers and stakeholders.

- Revalidation also demonstrated success in placing increased emphasis on the Code. Statistical analysis implied not only that revalidation led to more registrants viewing the Code as central to their practice, but also that this impact had some longevity.

- Revalidation can be said to have improved responsiveness to patient and service user needs to a lesser extent. Although statistical analysis demonstrated a small increase in the proportion of registrants who reported actively seeking practice-related feedback, the proportion who reported this was low overall and the increase was not sustained post-revalidation.

- Registrants experienced barriers to actively collecting feedback from patients. The passively collected feedback which was often used was seen to be less likely to lead to meaningful change.

- There was limited evidence showing that revalidation met its objective of encouraging early discussion of concerns.

- The evaluation evidence indicated that employers provided support to registrants at the point of revalidation. However, the interviews with employers and registrants suggested that this was driven by a desire to minimise the perceived risks to registrants lapsing associated with revalidation, rather than a recognition of revalidation's benefits to the workforce necessarily.

- A key strength of revalidation evidenced across the evaluation was the structure it provided and that it legitimised certain pre-existing behaviours and attitudes among registrants.

- However, there was evidence across many measures that changes in behaviours and attitudes were focused on the point of revalidation, rather than being sustained.

- Therefore, while the successful implementation of the model on such a large scale, and the positive contribution to changes in outcomes provide a good foundation for the next cycle of revalidation, there remain questions around the sustainability of change, and the potential for revalidation to achieve its longer-term outcomes.

Considerations and recommendations

Approaching change

The evaluation found that much of the success of revalidation in the first cycle lay in the implementation of the model and embedding it across nursing and midwifery, as well as the contribution it was seen to make to positive shifts in attitudes and behaviours.

The evaluation also found that, to maximise the outcomes and potential for sustainability, the next stages for the NMC should be around strengthening and tightening the model. However, the challenge lies in making changes to the model that do not then risk the successful implementation seen in the first three-year cycle.

The approach the NMC takes to change also needs to bear in mind the parameters identified in the initial design of revalidation including:

- Ensuring the model is applicable to all the register, regardless of scope, role or setting, and bearing in mind the protected characteristics of registrants;

- Keeping in mind the principles of proportionate regulation, and not unnecessarily adding burden to the workforce; and

- The legislative framework the NMC works in.

Therefore, the recommendations outlined below have been shaped with this in mind, focusing on ways in which the NMC can:

- Strengthen the current model and maintain momentum, without risking the foundations established in the first three-years;

- Maximise the positive view of revalidation as a regulatory change and the role of the NMC in this; and

- Look to collect additional information that can then be fed back into the revalidation process and model.

Alongside the suggestions below, we recommend that the NMC focuses on carrying out additional work exploring the evidence base for the requirements. The review of evidence underpinning the design of revalidation and links behind the Theory of Change found that the evidence available, at that time, was limited. In addition, the evaluation found that registrants could not always see benefits of the requirements, and stakeholders and employers questioned the strength of the model. Therefore, in further evidencing the requirements, the NMC will not only verify the assumptions behind the Theory of Change, but also ground any changes made to the requirements or overall model in evidence, allowing for longer-term planning beyond the next cycle.

In the meantime, changes to the model following the first cycle do not necessarily need to involve adding new requirements or increasing the number of hours asked of participants; they can instead focus on improving the quality of how registrants revalidate.

Therefore, as the starting point for change, we recommend that the NMC presents the current model as the minimum expectation and reshapes aspects of the requirements to encourage wider learning and development, complementing this with additional communications and work with employers.

Build on the reflective elements

The reflective discussion has consistently shown to positively affect awareness, understanding, attitudes and behaviour; it is also one of the most valued elements of revalidation.

Over the course of the evaluation the NMC has made changes to documentation on reflection and has reviewed the guidance on who should and should not be a reflective discussion partner with an outlook of strengthening this requirement. We recommend that the NMC maintains this focus beyond the first cycle building on the positive findings for reflection.

For example, the NMC could look to:

- Build in ways to encourage registrants to reflect on their previous reflective discussion and any learning since they last revalidated, including any changes to their practice.

- Ground the guidance much more in an established model of reflection, which could be done while still retaining flexibility in how registrants approach it. This is another way in which building the evidence base around the requirement could strengthen it. Although the NMC recommends models that registrants could use, much more could be done to shape materials and guidance around the models and approaches. It may be useful to engage with academics who specialise in reflection to support changes.

- Ensure reflective discussion partners understand the value in constructively challenging other registrants and provide tools to do so. Employers could also be more directly encouraged to provide feedback to registrants, discussing it with them in a constructive way.

- Provide reflective discussion partners with guidance on how to review reflective accounts – for example with a checklist - as an inconsistent approach to assessing quality is evident from the evaluation (both whether quality is to be assessed, and if so against what criteria).

The NMC could also look for other ways to bring a narrative of ongoing learning and development into the process. For example, the online platform and application could be adapted so registrants are required to enter their top three learnings from revalidation. This would again also provide the NMC with a valuable source of data.

Focus on the type of CPD

We suggest that the NMC looks at evidence on the relationship between the type of CPD carried out and the intended outcomes for revalidation, rather than focusing on the number of hours.

The current requirement for the number of hours of CPD (and participatory CPD) could then remain, but the NMC could provide additional supporting material to help registrants decide the types of CPD they engage in. Examples of what 'good' looks like for specific roles or settings could be provided and grounded in the evidence.

Making the feedback requirement more meaningful

We continue to recommend that the NMC looks to adapt the feedback element seeking to make it more meaningful to registrants, and ensuring feedback is used in a constructive, critical and helpful way.

The current approach intends that getting feedback from patients and services users will in turn result in greater responsiveness to patient need and improvements in practice, ultimately impacting public protection. However, to make the feedback element more meaningful the NMC could reassess these assumptions and the evidence for the relationship between feedback and responsiveness to patient needs and improved practice. For example, it may be that constructive feedback from colleagues on clinical competence or working with patients is more valuable and meaningful for shaping responsiveness to patient need and ultimately more likely to better protect the public. The NMC could then encourage and support registrants to seek feedback from colleagues as well.

Other ways in which the NMC could reframe the feedback requirement to be more meaningful without adding burden include:

- Outlining the principles and value in constructive feedback in guidance documents, based on evidence where possible.

- Doing more to encourage reflection on the feedback overall, and potentially suggest at least one reflective account is focussed on feedback.

- Suggesting that registrants could use the feedback in discussions with their employer and during appraisals.

- Including a requirement for at least one piece of feedback to be discussed with the reflective discussion partner;

- Reducing the number of pieces of feedback but include a means for people to describe how they have used this feedback constructively.

The NMC is carrying out work with patients and service users on how they want to be asked for feedback to support registrants, and we agree this should be a focus.

Registrants were not always sure how to get feedback from patients and service users and the NMC could do more to support this. The NMC could work with other professional regulators to create common approaches for collecting and using feedback not just from patients but from other healthcare professionals.

Continue to review the verification process

Over the course of the evaluation, the NMC has carried out some work to assess the effectiveness of the current verification process, testing a random sample approach alongside the risk-based model.

We recommend that the NMC continues to review verification, ensuring a robust process is maintained that verification serves its purpose. One way that could be explored as part of this would be to take an employer-level or regional focused approach in addition to the current approach.

This could include selecting an employer or region with all, or some, of those due to revalidate in a timeframe being selected for verification in addition to those selected based on risk or at random. This could increase the visibility of the verification process, maintaining the effect it has in deterring non-compliance, and could be done with minimal impact on resources.

In addition, the NMC could explore ways to collect more in-depth or qualitative data for a proportion of those selected for verification in the future. This would add additional assurances – for example, if registrants were required to speak to somebody at the NMC – and also provide an additional source of data for the NMC to use.

We recommend that the NMC reviews the format in which registrants are required to input information at the point of verification to ensure consistency with how registrants are asked to, or advised to, record information during revalidation.

Focus on employers

The success of revalidation is reliant on employers' behaviours and attitudes. Ideally the NMC would make changes that shaped how employers had to engage with revalidation that would strengthen the model..

While this is not possible, the NMC should:

- Focus on ways to continually engage employers. We recommend this forms part of the communications strategy outlined below, but that additional strands of work are planned. This could include working with stakeholders who are able to influence employers across the multiple sectors and settings registrants work in.

- Encourage employers to make changes alongside any implemented for registrants. For example, supporting employers to implement structures to collect constructive feedback from patients and service users, and to work with registrants to reflect on feedback in a constructive way.

- Do much more to encourage similar behaviours that were shown to be beneficial in larger NHS Trusts among employers such as those in the voluntary sector and care homes. For example, more could be done to encourage these employers to help registrants identify a confirmer or reflective discussion partner.

- Work with employers in larger trusts to provide support mechanisms and structures for the wider local health economy.

Revisit the guidance and support

Over the first cycle of revalidation the NMC has made changes to the guidance and documentation.

In addition, the NMC is currently considering ways in which additional support or guidance targeted at non-NMC confirmers could enhance non-NMC confirmers' confidence in carrying out the role. We recommend the NMC continues to focus on this.

The recommendations outlined in this section are likely to necessitate further changes to the guidance and the NMC may want to release any updated guidance at the same time as planned communication activities around changes.

While there were no substantial equality and diversity issues evidenced, there may be additional targeted support the NMC could provide to groups who reported finding the process harder. In particular, we recommend the NMC revisits the guidance and support provided to registrants in settings with fewer other registrants, including those who are self-employed.

The NMC has work planned on the impact of all its processes on those with protected characteristics and the need for this additional support through revalidation could be explored as part of this.

Reshape the communication strategy

Over the first cycle of revalidation the NMC has maintained levels of communication with registrants as they approach revalidation, sending targeted emails and updating the website over the first cycle.

As revalidation continues the NMC should ensure those registrants who are newly qualified still receive sufficient communication to ensure their first experience of revalidation is positive.

However, communications with all nurses and midwives beyond the first cycle will be important to ensure the momentum behind revalidation continues and increase the likelihood of sustainable change.

We suggest the NMC develops a communication strategy and plan that avoids positioning revalidation as 'business as usual' for registrants who have already completed revalidation and instead positions revalidation more as an ongoing journey, communicating how the recommended changes form part of this.

Carry out additional data collection and monitoring

As noted, one of the intended outcomes for revalidation is for the NMC to utilise the large volume of data revalidation generates to continue to develop revalidation and improve overall regulatory effectiveness.

Alongside the NMC's own review of the monitoring information and work with audiences across the sector, the evaluation has provided the main source of information for the NMC on revalidation. It will therefore be important for the NMC to have a clear plan for continuing to monitor and learn from revalidation beyond the first cycle.

Some of the recommendations above could lead to the NMC holding much richer information, such as the collection of qualitative information through the verification process, or ways in which the online platform could be adapted.

Other ways in which the NMC could look to monitor and review revalidation include:

- Work with other regulators to look at the data and assess ways it could be used to support the workforce or shape regulatory processes as part of the shared aim of public protection.

- The NMC has work planned to follow the end of evaluation to review all NMC processes in terms of the impact on registrants with protected characteristics. We recommend that alongside this the NMC continues to monitor lapsing rates and work to diagnose the causes of issues or difficulties for particular groups should be continued. This will ensure any issues arising for registrants yet to undertake revalidation are detected and can be addressed.

- Look to repeat some of the survey questions to understand patterns in attitudes and behaviours, and whether the same pattern is seen in the second cycle, or if there is an increase or decrease at the point of revalidation.

- As new roles appear on the register – as has been the case with nursing associates – the NMC should monitor that revalidation is achievable and beneficial for these new roles across settings.

- Look to create key performance indicators (KPIs) around the next stages for revalidation. The evidence review could be used to develop some of these, while others could look to focus on collection of data around the longer-term outcomes.

- Alongside stakeholders, the NMC should look for ways to continually engage with employers around revalidation, particularly as models of employment shift and change with the sector. As noted, there are also limitations to the evidence the evaluation could collect from employers and the NMC may want to continue to explore the option of an additional survey of employers as part of its ongoing monitoring.

Ensure revalidation is 'future-proof'

Workforce challenges and changes to the register mean the NMC should look to periodically carry out future-proofing assessments of revalidation. For example, changes to the sector, such as the move to

integrated care systems (ICSs) and examples of general practice federations, mean roles are likely to move away from more traditional models and settings, requiring much closer work with other teams and healthcare professionals.

These changes may mean the skills and experiences needed are likely to also change and revalidation should adapt to allow for that and reflect it. Workforce issues also mean the sector may adapt further to allow for more flexible working and it will also be important that revalidation is approached with the same mindset to account for different ways of working.

1   The background to revalidation

Revalidation for nurses and midwives was formally announced in October 2015 and launched as a process in April 2016, with those registrants due to renew their registration during April 2016 the first to go through the process.

The first cycle of revalidation completed in April 2019, with all registrants who had the three-year anniversary of their most recent renewal, or the third anniversary of joining the register, being required to revalidate. After revalidating for the first time, registrants will be required to revalidate once every three years.

This chapter describes the rationale for revalidation and any changes to the implementation of revalidation over the first cycle. The wider context around revalidation is also outlined.

1.1 Background and rationale for revalidation

The Nursing and Midwifery Council (NMC) is the independent regulator for the nursing, midwifery and nursing associate workforce in the UK, which account for a large portion of the UK healthcare workforce. As the regulator, the NMC maintains a register of all nurses and midwives that meet the requirements for registration; sets the standards for education, training, conduct, and performance; and processes proceedings to deal with instances in which a registrant's integrity or ability to provide safe care is questioned. As of the 31st March 2019 there were more than 698,000 nurses and midwives on the NMC register, an increase of 1.2% from the same time the previous year.[5]

As part of their responsibilities, the NMC developed a system of revalidation that was launched in April 2016. The rationale for the development, piloting, and implementation of a system of revalidation for those practising as nurses and midwives in the UK stemmed from an increased awareness across the health and social care sector of the need for a heightened focus on ensuring quality of care, and in turn enhancing public protection. The NMC is not the only professional regulator to introduce such a system, with the GMC having introduced a system of revalidation for licensed doctors from December 2012.[6]

Beyond this long-term trend of increasing focus on quality of care and public protection, a number of high-profile reviews of, and inquiries into, the quality of care in the health and social care sector in the UK were conducted in the early 2010s, which further highlighted a need for regulators to respond to the challenges identified. Most notable among these was the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Sir Robert Francis QC, and published in February 2013. This report into the failings at Mid Staffordshire NHS Foundation Trust served to provide renewed impetus in activity designed to improve public protection, of which revalidation was considered a key part. While the design

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[5] *The NMC register*, Nursing and Midwifery Council, 2019. Available online at:
https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/nmc-register-data-march-19.pdf
[6] Further information about GMC revalidation is available online at: http://www.gmc-uk.org/doctors/revalidation/9627.asp

of nursing and midwifery revalidation was already well underway, the output from this inquiry acted as the catalyst for the timing of the introduction of revalidation for nurses and midwives.

1.2 Revalidation for nurses and midwives

The NMC[7] defines revalidation as a continuous process that registrants will engage with throughout their career and that:

- allows registrants to maintain their registration with the NMC;

- demonstrates registrants continued ability to practise safely and effectively; and

- builds on existing renewal requirements.

The introduction of the revalidation process ultimately aims to enhance public protection through the additional requirements implemented that build on those enshrined within the existing Post-registration education and practice (Prep)[8] system for nurses and midwives. In order to successfully revalidate, registrants must:

- collect five pieces of **practice related feedback**;

- write up five **reflective accounts**;

- **discuss** these five reflective accounts with another NMC registrant; and

- obtain **confirmation** from a suitable person (as defined by the revalidation guidance).

Two requirements of the Prep framework remain: achieving 450 practice hours[9] and achieving 35 hours of relevant Continuing Professional Development (CPD), of which 20 hours must now be classed as participatory learning[10].

Finally, the NMC selects a sample of submitted applications to be subject to the **verification** process. This process seeks to identify non-compliance with the requirements of revalidation. Registrants are selected for verification based on risk-based categorisation or through random selection and must provide the NMC with additional evidence to support their application. Their confirmer is also contacted by the NMC for assurance as to their involvement.

As fixed in current legislation[11], registered nurses and midwives must renew their registration every three years, with the renewal date set based upon the anniversary of their initial registration. By 1 April 2019 all

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[7] *How to revalidate with the NMC,* Nursing and Midwifery Council (2019)

[8] *The Prep Handbook*, Nursing and Midwifery Council (2011)

[9] Registrants practising as both a nurse and a midwife must undertake 450 practice hours in each of their areas of practice (900 hours total) across the three years leading up to their revalidation.

[10] *How to revalidate with the NMC,* Nursing and Midwifery Council (2019)

[11] *The Nursing and Midwifery Order 2001 (SI 2002/253)*, Article 10.

NMC registrants at the time revalidation was introduced—approximately 698,000 registrants[12]— had to revalidate to maintain their presence on the register.

Evidence base for revalidation

The NMC conducted a series of evidence reviews during the design and development of the revalidation process. In addition, once consulted on and designed, the approach was piloted with 19 organisations between January and June 2015, and research was conducted to understand experiences of revalidation[13].

The evidence base around revalidation was reviewed in Year One of the evaluation. At this time, the review identified a lack of robust evidence on the causal process, linking the individual elements of revalidation and overall model to the ultimate outcomes that revalidation seeks to propagate. The full evidence review from Year One is included as part of the annexes to this report, provided under separate cover.

1.3 Changes to revalidation during the first cycle

Changes to the revalidation model

Options for revalidation were explored in the appraisal conducted by the NMC in 2015. These options include amendments to underlying regulations allowing the number of practice hours to be changed, limiting of revalidation to certain settings or scope of practices and changing the period of renewal in addition to options that include the introduction of a responsible officer role (more akin to the GMC revalidation model).

During the first cycle of revalidation, no changes have been made to the model, but this evaluation makes suggestions for decisions on the model following the first three-year cycle.

Changes to the supporting processes for revalidation

While there have been no changes to the revalidation model, the NMC has sought to improve the revalidation process by taking into account some of the considerations raised across the evaluation. Table 1.1 provides a summary of the changes that have already been implemented, and those that are planned or currently in progress.

Table 1.1: Summary of changes to revalidation

Consideration	Change
Maintain levels of communication activity	- The NMC has maintained the same level of communication with nurses and midwives about their revalidation. - Some of the NMC's formal communications have been updated following feedback from applicants and internal review.

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[12] *The NMC register*, Nursing and Midwifery Council, 2019. Available online at:
https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/nmc-register-data-march-19.pdf
[13] *Exploring the experiences of the revalidation pilots,* Ipsos MORI (2015)
https://www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council-2015/nmc-pilot-research_ipsos-mori_final-report-for-publication.pdf

	• The NMC has continued to attend workshops and seminars providing advice on how to revalidate and tips on how to make the most of the process.
	• The website has been regularly refreshed and updated.
Refresh guidance and supporting materials, including a focus on settings where registrants are likely to work with very few, or no other registrants as well as more unusual practice settings.	• The NMC has refreshed the 'How to revalidate with the NMC' and 'Guidance for employers' documents, along with guidance for registrants who might have difficulty revalidating.
	• The NMC has developed a new guidance sheet on reflective practice. This document more clearly outlines the criteria for assessing the quality of reflective discussion. The definition of conflict of interest has also been strengthened.
	• The NMC has begun a rolling programme of developing and publishing new revalidation case studies focusing on those in more unusual practice settings.
	• During 2019 and 2020 the NMC will also be collecting examples of good practice across employers. They will use this to develop shared learnings across different practice settings with the intention to develop a suite of best practice examples and to facilitate joint meetings between different cohorts.
	• Guidance documents have also been updated to reflect a number of other changes such as the introduction of the nursing associate role, updated health and character guidance, and the removal of transitional arrangements.
Communications with stakeholders	• The NMC has developed a protocol with the RCN to ensure timely communication of any issues with revalidation (e.g. technical issues with the online process or with payments).
	• The NMC has developed a joint communication with the RCN and other stakeholder groups about the importance of maintaining registration and how registrants can avoid inadvertent lapsing.
	• The NMC has engaged with stakeholders over the past year on key changes to revalidation. They have also used existing newsletters to employers and registrants to provide updates.
Patient/service-user feedback	• The NMC has commissioned a project to explore patient and service-user wishes regarding provision of feedback. Findings will be used to inform updates to guidance for collecting feedback.
Guidance on reflective accounts and reflective discussion	• NMC is currently exploring whether to update employer guidance regarding reflective practice.
	• NMC is considering how, in the next cycle of revalidation (April 2019 onwards), registrants working with few other registrants could be better supported to find an appropriate reflective discussion partner.
Monitoring lapsing rates	• NMC is looking to carry out organisation-wide research to begin in 2019 looking at the impact of all their processes on nurses, midwives, and nursing associates who share protected characteristics.
Verification	• Over the course of the evaluation the NMC has tested a risk-based approach to verification and implemented a random selection approach as well.

1.4 The context in which revalidation operates

The current environment for nurses and midwives is affected by many of the issues facing the health and social care sector in general. Of priority for many in the sector is the fact that the NHS is understaffed and

facing severe shortage of professional qualified clinical staff. This is widely documented by policy specialists and think tanks and is an important political issue. Rising demand and shortage of new joiners, as well as issues retaining current staff in many roles, has created both an immediate and medium-term lack of supply of healthcare professionals. In addition, the NHS continues to grapple with tight financial constraints alongside this rising demand. These pressures are made starkly visible to the public each year during the winter months. Indeed, particularly severe winters can lead to emotive sights of patients held within corridors and is often a rallying point around which more financial resource for the service is demanded by actors from across the system. This section charts some of these pressures.

Staff shortages in the NHS

Ensuring adequate supply of staff arguably remains the most significant challenge for the health service.[14] While there are many individual aspects of this challenge faced by the UK, this is a global issue as demand for health services rises across the world. The World Health Organisation (WHO) estimates that by 2030 there will be shortfall of nearly two million professional clinical staff across its member states.[15] Nonetheless, in comparison with similar countries, the UK has a much lower ratio of doctors, nurses and midwives per capita. In 2017 the UK had 7.9 nurses per 1,000 inhabitants, putting it in the bottom 50% of OECD countries. This was less than half than the average of 16.5 nurses per 1,000 inhabitants for the top three countries in the OECD based on latest data for each country.[16]

In a report on the issue, three health think tanks highlighted several factors behind the shortage of staff. Among others, this includes inadequate funding for training places, restrictive immigration policies, low pay incentives, and high numbers leaving their jobs before retirement.[17] While many of these issues remain outside of the control of the NMC and revalidation they remain key factors in the likelihood that revalidation will achieve its stated outcomes.

In response to the challenge of maintaining a sufficient workforce NHS England announced the creation of a new national workforce group. This group will be led by NHS Improvement (the regulator of NHS trusts) alongside experts from Health Education England (HEE) and NHS England. One of the group's first tasks will be the publication of a workforce implementation plan later in 2019 which will outline how the NHS intends to meet these workforce issues. An Interim NHS People Plan[18] was published in early June 2019 setting out a vision for staff working in the NHS to ensure the NHS Long Term plan can be delivered. The plan sets out the challenges facing many of those working in the NHS, including '...growing pressure, frustration with not having enough time with patients, and rising levels of bullying and harassment.' A key focus of the plan is to improve experiences for staff, to improve retention and recruitment across the NHS.

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[14] *The health care workforce in England,* The King's Fund, The Health Foundation & Nuffield Trust, November 2018. Available online at: https://www.kingsfund.org.uk/publications/health-care-workforce-england

[15] World Health Organisation, 2016. "Global strategy on human resources for health: Workforce 2030". Available online at: https://www.who.int/hrh/resources/global_strategy_workforce2030_14_print.pdf

[16] Using data from the OECD's website. The most recent data available has been used for each country. Available online at: https://data.oecd.org/healthres/nurses.htm. For doctors the UK has 2.8 per 1,000 inhabitants, putting it in the lowest ten of the OECD countries. This compares with an average of 4.8 per 1,000 inhabitants for the highest three countries in the OECD.

[17] *The health care workforce in England,* The King's Fund, The Health Foundation & Nuffield Trust, November 2018. Available online at: https://www.kingsfund.org.uk/publications/health-care-workforce-england

[18] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

Nursing and midwifery staff shortages in the NHS

The Interim NHS People Plan recognises the urgency of the shortage of nurses. Indeed, as the largest single group of healthcare professionals and making up over 50% of the clinically trained NHS workforce, the challenge is clearly significant within nursing. The People Plan report outlines a focus on improving retention rates among nursing, including supporting trusts to carry out work to retain staff, such as provision of flexible working and career opportunities.

According to the Health Foundation, over 1 in 10 nursing roles remain unfilled.[19] Furthermore, the demographic structure of the nursing workforce – with nearly a third of nurses due to retire in the next 10 years[20] – means the challenge could increase. The People Plan also notes significant shortages in mental health, learning disability, primary and community nursing.

Latest data from the NMC's register shows that the number of registrants in March 2019 was 1.2% higher than at the same point the previous year, at approximately 698,000[21]. As the numbers of nurses and midwives on the NMC's register fell in March 2017 for the first time since 2007, the reversal this year is an encouraging sign.

However, the past 12 months saw a continued decrease in the number of European Economic Area (EEA) nurses registered with the NMC. The figures for 2018/19 (published in March 2019) show a drop of 5.9% in the number of EEA nationals on the register overall compared with the same period in the year before.

Looking at rates of EEA nationals joining the register, there was a considerable drop of 87% in the number of EEA nationals joining the register between March 2017 and March 2018. Over the same time there was an increase in EEA nationals leaving the register. While slightly more joined the register between March 2018 and March 2019, there still remains a net reduction in the number of EEA nurses on the register compared with March 2018.

In order to understand more about the reasons why some nurses and midwives lapse their registration, the NMC conducted a survey of those lapsing their registration with findings published as part of the March 2019 register report. Their findings provide some insight into the underlying factors for leaving across different groups. For each, the top three most frequently cited reasons were:

▪ **UK nurses and midwives[22]:** retirement (54%), too much pressure (31%), and a change to their personal circumstances (27%).

▪ **EEA nurses and midwives:** leaving the UK (66%), Brexit (51%), and too much pressure or personal circumstances (both 22%).

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[19] The Health Foundation, "A Critical Moment: NHS staffing trends, retention and attrition". Available online at: http://reader.health.org.uk/a-critical-moment

[20] Marangozov et al, 2016. "The labour market for nurses in the UK and its relationship to the demand for, and supply of, international nurses in the NHS". Institute for Employment Studies, p.19.

[21] *The NMC register*, Nursing and Midwifery Council, 2019. Available online at: https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/nmc-register-data-march-19.pdf

[22] 3,201 UK nurses and midwives completed the survey, 180 EEA nurses and midwives completed the survey and 114 nurses and midwives from outside the EEA.

- **Non-EEA nurses and midwives:** leaving the UK (46%), poor pay and benefits (25%), and being concerned about not being able to meet revalidation requirements (22%).

Analysis from the Department for Health and Social Care (DHSC) reported in the Health Service Journal (HSJ) also highlights the potential implication of Brexit on nursing staff numbers, with the worst-case scenario estimating a shortage of between 26,000 and 42,000 nurses once the UK has exited the EU.[23]

The impact of the removal of the bursary scheme for nursing undergraduates on the recruitment of nurses is yet to be seen. However, there is considerable debate around this policy which suggests it could have an influence on recruitment.

Overall, an inability to secure sufficient volumes of nurses and midwives in the NHS is likely to endanger the ability of services to deliver safe and effective care. This is exacerbated by similar, if not as acute, staffing issues across other healthcare professions. Indeed, research suggests that there is a clear link between staffing levels and patient safety. The Francis report, published in the wake of significant and widespread failings in care at Mid-Staffordshire NHS Foundation Trust, recommended a series of measures designed to prevent such a crisis of care from ever occurring again.[24] This included a recommendation that appropriate tools should be developed to ensure that evidence is used to determine optimum staffing levels on wards. These tools were then developed by the National Institute for Health and Care Excellence (NICE).

Reliance on agency staff

Workforce pressures have cost implications too. As the vast majority of acute trusts face supply issues, many turn towards agencies to fill the void. In 2014/15 NHS providers spent £3.3 billion on temporary staff. It is estimated that this was £700 million more than would have been spent were the staff employed directly by the provider.[25] Indeed, the data suggested that nearly 10% of total employment costs are spent on temporary workers.[26]

But there are also other implications of this reliance on agency staff. Most seriously, the use of agency staff has been linked with negative patient experience.[27] Use of agency staff has also been linked with worse staff experience.[28]

Efforts to reduce spending on agency staff, driven by NHS Improvement, were reported to have reduced spending by £1bn between October 2015 and February 2017. Nonetheless, there remain a large number of agency nurses and midwives working within the NHS.

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[23] https://www.hsj.co.uk/topics/workforce/exclusive-leak-reveals-worst-case-scenario-for-nursing-after-brexit/7017082.article
[24] Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Available online at: http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf
[25] Marangozov et al, 2016. "The labour market for nurses in the UK and its relationship to the demand for, and supply of, international nurses in the NHS". Institute for Employment Studies, p.14.
[26] *The health care workforce in England,* The King's Fund, The Health Foundation & Nuffield Trust, November 2018. Available online at: https://www.kingsfund.org.uk/publications/health-care-workforce-england
[27] The King's Fund & The Picker Institute, 2018. "The risk to care quality and staff wellbeing of an NHS system under pressure".
[28] Ibid, pp. 3.

Other local and national contexts

While the NMC, as the regulator for the nursing and midwifery professions, operates across the UK, responsibility for health and social care policy is devolved to the four nations. As such, policies within the four countries could also impact upon revalidation and have been considered as part of this context review.

Since the first report from this evaluation was published in July 2017, there has been only one change to the context of note.[29] The Nurse Staffing Levels (Wales) Act was implemented by the Welsh Government from April 2018 onwards. In the context of the links between staffing and care outlined earlier in this section, this represents a significant event.

The Act places a duty on health boards and NHS Trusts to take steps to calculate and maintain nurse staffing levels in adult acute medical and surgical inpatient wards, as well as a broader duty to consider how many nurses are necessary to provide care for patients sensitively in all settings.
It also ensures that the NHS more widely recognises the professional judgement of nurses in identifying the needs of their patients, and supports nurses from ward to board to have the necessary and sometimes difficult conversations about the resource needs of their patients based on those needs.
Welsh Government, April 2018[30]

Changes to Fitness to Practise

In July 2017 changes to the Fitness to Practise legislation came into effect. The key changes are outlined below.[31]

- Case examiners have additional powers to give advice, issue warnings or recommend undertakings. These changes allow less serious cases to be resolved outside of a full hearing.

- The NMC has expanded their power to review case examiner decisions.

- A single Fitness to Practise Committee has been formed to streamline the process.

- Substantive order reviews are now at the discretion of practice committee panels.

In addition, the NMC has developed a revised strategy for Fitness to Practise, which, following consultation, was launched in 2018.[32] The strategy focusses on delivering a consistent and proportionate approach to Fitness to Practise and puts people at the heart of Fitness to Practise; redefines the purpose of hearings; emphasises the need to give nurses, midwives and nursing associates the change to remedy

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[29] This is based on consultations with three CNOs or their representatives (Wales, Scotland and Northern Ireland). At the time of writing, it had not been possible to secure a consultation with the CNO for England.

[30] https://gov.wales/newsroom/health-and-social-services/2018/staffing-levels/?lang=en

[31] Further detail can be found on the NMC website at: https://www.nmc.org.uk/concerns-nurses-midwives/changes-ftp-legislation/

[32] The strategy can be found on the NMC website at: https://www.nmc.org.uk/concerns-nurses-midwives/fitness-to-practise-a-new-approach/

and address the concern; looks at ways employers can deal with complaints at a local level; underlines the importance of considering the context of a case.

Medical revalidation

The General Medical Council (GMC) introduced revalidation for doctors ('medical revalidation') in December 2012. As with nursing and midwifery revalidation, this represented a significant departure from previous practice. Medical revalidation has also been subject to an independent evaluation between 2015 and 2017. The final evaluation report was published in February 2018.[33] This final report provided important context for this evaluation and the relevant findings from this evaluation can be summarised as follows:

- Experiences of revalidation differ across groups. Female, younger and BAME doctors are more likely to defer their revalidation than other doctors.

- Doctors working within existing governance structures find revalidation to be more straightforward, especially when it comes to collecting the necessary Supporting Information.

- As a result of medical revalidation, there has been an increase in participation in annual appraisals among UK doctors. This has been harder for some groups (especially locums).

- Reflection has been identified as key for generating change, but as yet the reflection undertaken as part of appraisal is not yet translating into ongoing reflective practice.

- Revalidation is shown to lead to a documentation of practice, but not necessarily an improvement in professional practice. The ability of revalidation to influence practice comes mainly through the appraisal mechanism. Appraisal is a mechanism for raising some concerns about doctors, and successfully addressing concerns.

- There is inconsistent and sometimes problematic engagement with patient feedback (by doctors and patients).

Nursing associate role

Following a report by HEE in 2015, the government announced the creation of a new role: the nursing associate. Nursing associates contribute to some of the core aspects of nursing and it is intended they bridge a skills gap between health care assistants and registered nurses. It is hoped that this will free up time for nurses to work on more complex aspects of clinical care. It is also intended as a route into graduate level nursing to help contribute towards meeting the demand for nurses outlined above.

The nursing associate is a two-year apprenticeship scheme, with nursing associates learning during their employment. Unlike registered nurses, nursing associates will not initially specialise within a scope of practice (such as adult, learning disabilities, mental health, and children's nursing). Instead they will gain multi-disciplinary experience, with the expectation that they will have the opportunity to work in a variety of settings. The NMC is the regulator for nursing associates and like registered nurses and midwives,

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[33] *Evaluating the regulatory impact of medical revalidation*, UMbRELLA (February 2018). Available online at: https://www.gmc-uk.org/-/media/documents/umbrella-report-final_pdf-74454378.pdf

nursing associates will have to undertake revalidation every three years. The first nursing associates will revalidate in the second cycle of revalidation.

2 About this evaluation

2.1 Evaluation scope and objectives

The overarching objectives of this evaluation are to:

- Understand and measure the impact that revalidation has on public protection through the promotion of specific attitudes and behaviours among the nursing and midwifery workforce; and

- Inform future improvement of the activities and processes involved with revalidation, with the intention of further increasing the ability of revalidation to deliver its stated goals.

The evaluation adopted a theory-based approach. To facilitate this approach, a Theory of Change (see Figure 2.1) was produced and agreed with the NMC and stakeholders as part of the evaluation scoping exercise. The Theory of Change is a model of the causal process which demonstrates how a programme or project—in this case revalidation—is expected to achieve its aims. It links the inputs of revalidation for nurses and midwives to the outcomes and impacts anticipated. It demonstrates the causal links through the activities and outputs, to the promotion of specific attitudes and behaviours that it is anticipated revalidation will lead to, and the ultimate outcomes and impacts that it is anticipated will result from this change.

Based on the Theory of Change, a series of evaluation frameworks were designed, the detailed versions of which are included in the annexes to the report provided under separate cover. These outline the specific research questions the evaluation sought to answer, and the data collection methodologies that contributed towards the assessment of each of these. The evaluation questions within the evaluation frameworks pertained to each of the three primary objectives of the evaluation.

1. An assessment of the effectiveness of the process **(Process Evaluation).**

2. An assessment of the outcomes and impact of the revalidation process **(Longitudinal Outcomes Evaluation)**.

3. An assessment of whether the benefits outweigh the burden of revalidation **(Benefit/Burden assessment)**.

In fulfilling the above, the evaluation sought to identify whether improvements can be made to the processes, or changes required to the current revalidation policy.

Figure 2.1: Theory of Change diagram

Opportunities and challenges for revalidation

The NMC exists to **protect the public** through **regulating nurses and midwives** in England, Wales, Scotland and Northern Ireland. The Department of Health **(*Enabling Excellence,* 2011)** suggested that additional regulatory effort on revalidation would generate significant added value in terms of increased safety or quality of care for users of health care services. Development of the NMC revalidation model began in response to this. Subsequent reviews of the health and social care sector, for example the Francis Inquiry (2013), provided the renewed impetus for implementing revalidation within the current timeframe.

Revalidation design: An appropriate approach to ensure nurses and midwives are reflecting on the role of the Code in their practice, 'living' the standards set out within it, and ultimately leads to enhanced public protection. An approach that works for a diverse range of registrants in a wide range of professional settings.

Revised Code of professional standards and behaviour for nurses and midwives: Prioritise people; practice effectively; preserve safety; promote professionalism and trust

Revalidation activities: NMC
- Communications
- Guidance
- Forms
- NMC Online
- Microsite
- Application support
- Risk-based selection and verification of sample of applications by the NMC

Revalidation activities: Nurses and midwives
- Practice hours (450 hours)
- Declarations of **health, character** and **professional indemnity**
- **Continuing Professional Development:** engaging with others (including 20 participatory hours) and developing skills
- Written **reflective accounts** to identify improvements to practice
- **Feedback** on practice from patients, service users and colleagues
- **Reflective discussion** with another nurse or midwife
- Completion of requirements
- Submission of application
- Confirmation before submission to demonstrate requirements met

Revalidation activities: Employers*
- Raising awareness
- Signposting to guidance
- Supporting employees through process of revalidation

Continuous feedback and improvement

Promotion of specific behaviours and attitudes

	REGISTRANTS	EMPLOYERS
Awareness	Registrants have increased <u>awareness</u> of: possible sources of feedback (from patients, service users and colleagues); the availability of CPD; the availability of professional networks; and of the Code.	Employers have increased <u>awareness</u> of: the Code; of revalidation; and of when their employees need to revalidate.
Understanding	Registrants have increased <u>understanding</u> of: the need to seek feedback from patients, service users and colleagues; the need to stay up to date with professional practice and the role of CPD in this; the benefits of involvement in professional networks; and of the links between the Code and their practice.	Employers have increased <u>understanding</u> of: regulatory standards; how registrants meet them; the role of revalidation; and implications for their work.
Attitudes	Registrants demonstrate <u>attitudinal</u> change, they: believe the value of feedback from patients, service users and colleagues; believe the value of CPD in maintaining professional practice; believe the benefits of involvement in professional networks; and believe that the principles of the Code are central to good practice.	Employers demonstrate <u>attitudinal</u> change, they: believe in the importance of regulatory standards; and believe that better/more comprehensive appraisal processes are needed.
Behaviours	Registrants demonstrate <u>behavioural</u> change, they: proactively seek feedback from patients, service users and colleagues; proactively seek to stay up to date in professional practice through CPD; proactively engage in professional networks; and 'live' the principles of the Code through their practice.	Employers demonstrate <u>behavioural</u> change, they: seek to actively engage with nurses and midwives regarding practice and regulation; and undertake regular appraisals.

Outcomes
- NMC have access to, and use, more extensive data on performance to continually improve revalidation
- Improved responsiveness to patient needs
- Embedding standards across the sector
- Culture of sharing, reflection and improvement
- Early discussion of concerns encouraged

Impacts
- Improved regulatory effectiveness
- Increased public confidence in quality of care from nurses and midwives
- Continuous improvement in quality of nursing and midwifery
- Problems are detected and resolved quickly
- **Enhanced protection of public health, safety and wellbeing**

* Employer activities are not always carried out e.g. Registrants operating in the independent sector may not have an employer, and confirmers/reflective partners may not be from the registrant's employer.

2.2 Evaluation methodology

This report is based on evidence collected during the full three years since revalidation was implemented, using data collected in Year One, Year Two and Year Three of the evaluation.

Table 2.1 provides an outline of each source of evidence used across the whole of the three-year evaluation.[34] Any limitations of the evidence collected to date are considered in this section. Further technical detail of the methodology, copy of the questionnaire and example discussion guides can be found in the annexes to this report, provided under separate cover.

Table 2.1: Evaluation evidence collection over the three years

Evaluation activity	Detail
Stakeholder consultations	Consultations with stakeholders to gather views on the context for revalidation, perceptions of revalidation processes and information on any factors that may have an influence on the outcomes of revalidation.
	Year One:
	Eight interviews conducted in early 2017 with the Chief Nursing Officer (CNOs) or a delegated representative of the CNO office for each of the four UK nations and representatives of the four largest nursing and midwifery unions.
	Year Two:
	Three interviews conducted in April 2018 with the Chief Nursing Officer (CNOs) or a delegated representative of the CNO office for each of Wales, Scotland and Northern Ireland.
	Five interviews conducted in March – June 2018 with patient and public representative groups (e.g. charities and regulators).
	Year Three:
	At the start of year three of the evaluation (April 2018), five interviews were conducted with patient and public representative organisations, such as charities and regulators.
	Eleven interviews additional interviews were also conducted between February and March 2019 with representatives from government, including the four CNO offices, the Royal Colleges and trade unions.
Analysis of monitoring information	Independent analysis of monitoring information collected by the NMC in relation to revalidation. This data has been used to assess patterns of revalidation and understand whether revalidation is being experienced differently by registrants with different characteristics (e.g. scope of practice, work setting, demographics).
	Sources include:
	• Quarterly and annual revalidation reports; and

[34] For further detail on the sources of evidence used during Year One and Year Two, please refer to the reports from Year One and Year Two.

	• Historical data on lapsing.
Evidence review	A review of the sources of evidence relating to revalidation.
Context review	A context review, continually updated based on stakeholder consultations, to monitor any external factors impacting upon the outcomes of interest to revalidation.
Process and outcomes survey with registrants	A longitudinal, quantitative online survey of NMC registrants was conducted for each year of the evaluation. In Year One, the first wave of the survey was conducted between November 2016 and March 2017; the second wave (Year Two) was conducted between November 2017 and March 2018; and the third and final wave (Year Three) was conducted between November 2018 and March 2019. Each year, registrants in three groups were invited to take part; the first group were registrants who completed revalidation in October, November, December 2016 & January 2017, the second those with renewal dates in October, November, December and January 2017/18 and the final group covered renewals the same months in 2018/19. Throughout this report, for ease of reference and clarity, these cohorts are referred to as revalidating in 2016/17, 2017/18 and 2018/19 respectively. The survey was used both to gather information on experience of the revalidation processes, to measure attitudes of registrants towards the key elements of revalidation and obtain reported change in behaviour and practice. The longitudinal approach with three cohorts allowed construction of a comparison group. In the production of the final report statistical analysis[35] has been conducted to facilitate analysis of differences in reported behaviour change, and to estimate the extent to revalidation contributed to changes. In Year One, a total of 35,981 registrants completed the survey across the three groups, representing a response rate of 21[36]%. Those who took part in the first survey and consented to being re-contacted were invited to take part in the second survey. In Year Two, a total of 11,242 registrants completed the survey across the three groups, representing a response rate of 44%. Those who took part in the second survey and consented to being re-contacted were then invited to take part in the third and final survey. In Year Three, a total of 5,298 registrants completed the survey across the three groups, representing a response rate of 53%[37.] Data for each year were weighted to the known population profile for all registrants within each of the three cohorts, and therefore results are not used to make claims about the views or experiences of registrants overall.

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[35] Regression analysis was used to understand the differences in reported outcomes between groups.

[36] 2016/17 registrants: 15,438 completes (21% response rate); 2017/18 registrants: 10,349 completes (18% response rate); 2018/19 registrants: 10,193 completes (17% response rate).

[37] 2016/2017 registrants: 2,014 completes (51% response rate); 2017/2018 registrants: 1,701 completes (29% response rate); 2018/2019 registrants: 1,583 (60% response rate);

	The profile of registrants in each cohort is comparable, and therefore allows analysis of difference between the cohorts.
	Unlike previous years, which have compared the three different cohorts within that individual wave of the survey[38,] data collected from all three waves of the survey have been used for the analysis in this final report. See 'Interpretation of survey findings' for details on how the survey findings from all three waves have been used in this report.
	Differences between groups of registrants are only reported where statistically significant, and where base sizes exceed 50.
	Statistical analysis of survey responses was conducted for several outcomes included in the survey in Year Three, using both a non-experimental and quasi-experimental design. This is outlined in the section on the analysis of outcomes below.
Case studies (Year One and Year Two) and additional interviews (Year Three)	Longitudinal, qualitative, setting-based case studies, with fieldwork phased throughout the three years of the evaluation. **Year One:** Seven case studies were commenced during Year One, with a total of 13 interviews conducted, both with registrants who had completed revalidation during Year One, and those who acted as their line manager, their confirmer and their reflective discussion partner. Interviews conducted during this phase, and feeding into the Year One report, took place between March and May 2017. **Year Two:** In Year Two, a further eight case study interviews were conducted. A total of 22 in-depth telephone interviews were conducted with registrants who had completed revalidation during Year Two, and those who had acted as their line manager, their confirmer and their reflective discussion partner. Case studies were conducted in a range of settings, and included nurses working in prisons, community triage, residential homes, as health visitors, and in mental health teams. Interviews conducted during this phase, and feeding into the Year Two report, took place between January and March 2018. **Year Three:** In Year Three, 12 additional in-depth interviews were completed with registrants to explore their experiences of revalidation, conducted between January and March 2019. These were stand-alone interviews, not part of a case study, but the discussions covered the same topics.
Interviews with confirmers and reflective	The aim of this strand of work was to focus on the experience of confirmers and reflective discussion partners of the revalidation process.

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[38] For further details on the data analysis used in previous years of the evaluation, please refer to the reports from Year One and Year Two.

discussion partners (Year Two and Year Three)	**Year Two:** A total of 25 in-depth telephone interviews were completed with a selection of confirmers and reflective discussion partners, between October and December 2017. **Year Three:** A total of 8 additional in-depth telephone interviews were conducted with confirmers and reflective discussion partners, between January and March 2019.
Interviews with lapsers (Year One)	The aim of these interviews was to understand whether revalidation resulted in an increased rate of lapsing and the reasons for lapsing whether related to revalidation or not. A total of 24 short, qualitative interviews with former nurses and midwives who had lapsed from the NMC's register were conducted by telephone between April and June 2017.
Employers (Year Three)	In Year Three, in-depth interviews were conducted with registrant's employers, to understand the employer experience of, and perspective on, revalidation. Some employers also offered a wider stakeholder perspective. A total of seven interviews were conducted with employers of registrants between January and March 2019, in addition to those completed as part of the case studies in Year One and Year Two.
Benefit / Burden interviews (Year Three)	In Year Three, in-depth interviews were conducted with registrants exploring views of the benefits and burden of revalidation. A total of 24 in-depth interviews were completed with registrants, specifically exploring the comparative benefit and burden of revalidation, including exploring barriers to revalidation for those with protected characteristics and the perceived proportionality of the process. These were conducted between January and March 2019.

Interpretation of survey findings

It should be noted that a sample and not the entire population of NMC registrants in the three sample groups responded to each wave of the survey. Consequently, all results are subject to potential margins of error. For example, for a question where 50% of the people in a weighted sample of 15,441 respond with a particular answer, the chances are 95 times out of 100 that this result would not vary more than plus or minus 0.7 percentage points from the result obtained if all eligible registrants had responded to the survey.

However, only significant differences are reported in this report. In addition, the volume of registrants completing the survey in each of the three waves, coupled with the similarity of the respondent profile to the overall profile of the NMC register, mean that even small changes between groups were often

statistically significant. Further guidance on interpreting the survey findings can be found in the methodological annex.[39]

Table 2.2 sets out the number of registrants from each group who completed each wave of the survey. Table 2.3 sets out the number of registrants at each point of the full revalidation cycle.

Table 2.2: Volume of registrants completing surveys by year of revalidation

Year of revalidation	Survey wave			Total
	Wave 1	Wave 2	Wave 3	
2016/17	15,439	4,345	2,014	21,798
2017/18	10,349	3,942	1,701	15,992
2018/19	10,193	2,955	1,583	14,731
Total	35,981	11,242	5,298	52,521

Table 2.3: Volume of registrants completing surveys by stage

Point of revalidation	Survey wave			Total
	Wave 1	Wave 2	Wave 3	
Two years before revalidation	10,193	-	-	10,193
One year before revalidation	10,349	2,955	-	13,304
At point of revalidation	15,438	3,942	1,517	20,897
One year after revalidation	-	4,345	1,788	6,113
Two years after revalidation	-	-	2,003	2,003

The data were combined and compared in different ways, based on the different stages of the revalidation process:

One year prior to revalidation: Findings from registrants who revalidated in 2017/2018 one year before they revalidated (Wave 1) and those who revalidated in 2018/2019 one year before they revalidated (Wave 2). These datasets were combined in order to obtain an overall picture of the experiences of registrants one year before revalidating, and they were compared in order to measure differences in experiences of registrants one year prior to their revalidation, in the first year since revalidation was implemented compared with the second year.

At point of revalidation: Findings from registrants who revalidated in 2016/17 at their point of revalidation (Wave 1) with those who revalidated in 2017/18 at their point of revalidation (Wave 2), and those who revalidated in 2018/2019 (Wave 3). Datasets were combined in order to obtain an overall picture of the experiences of registrants revalidating, and findings across them were compared in order to measure differences in experiences of registrants at the point of revalidation, in the first, second and third year since revalidation was implemented.

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[39] Annexes are available upon request from the NMC.

One year after revalidation: Findings from registrants who revalidated in 2016/2017 one year after they revalidated (Wave 2) with those who revalidated in 2017/2018 one year after they revalidated (Wave 3). Datasets were combined in order to obtain an overall picture of the experiences of registrants one year after revalidating, and findings across them were compared in order to measure differences in experiences of registrants one year after they revalidate, in the first, second and third year since revalidation was implemented.

The findings from registrants two years before they revalidated, and two years after they revalidated, were also analysed:

- **Two years prior to revalidation:** The findings for registrants who completed the survey two years prior to revalidating (registrants who revalidated in 2018/2019, Wave One).

- **Two years after revalidation:** The results for registrants who completed the survey two years after they revalidated (registrants who revalidated in 2016/2017, Wave Three).

Statistical analysis

The simultaneous roll-out of revalidation across the UK meant it was not possible for the evaluation to attempt to attribute macro-level changes (such as improvement in patient outcomes) to revalidation. The challenges of isolating the impact of revalidation from other changes in the healthcare environment also make it difficult to attribute macro-level changes to revalidation. Therefore, the evaluation focussed on outcomes that, based on the Theory of Change, it was reasonable to measure during the three-year timeframe of the evaluation.

Data on these outcomes came from the survey of registrants which allowed for both non-experimental 'before vs after' regression analysis in addition to a quasi-experimental 'pipeline' regression analysis, that utilised the three-year cycle of revalidation:

- **Before vs after**: In this approach to regression analysis, the year that a registrant completed revalidation was considered to be the treatment period and outcomes were compared to the year before revalidation. This required at least one year of data for the year before revalidation, therefore limiting the analysis to those who revalidated in 2017/18 and those who revalidated in 2018/19. However, it was also possible to adapt this approach to analyse experience and outcomes over time for each year group revalidating separately in order to establish how experiences and outcomes evolved from before to after revalidation.

  While this approach allowed the analysis to control for potential individual characteristics and work setting and scope factors that may have affected experiences and outcomes, it is less robust than quasi-experimental approaches, such as the pipeline approach below. The main reason for this is the existence possible alternative explanations for the changes observed in experiences and outcomes, such as through changes to working methods or organisational changes.

- **Pipeline approach:** Making use of the staggered nature of revalidation, this regression analysis compared outcomes for registrants that had completed revalidation with outcomes for those who were yet to complete the process in each year. This meant that in Wave One only those who revalidated in 2016/17 were considered treated for the purpose of the analysis, with the control

group comprised of both those who revalidated in 2017/18 and those who revalidated in 2018/19. In Wave Two, those who revalidated in 2016/17 and 2017/18 were both be considered treated and compared with those who revalidated in 2018/19, while in Wave 3 all registrants were considered treated. Such an approach also controlled for individual and work setting and scope factors and is more robust than the before and after approach above (provided any wider changes that may impact the outcomes affect both the treatment and control groups equally).

Both forms of analysis allowed for the attribution of causality to revalidation with the latter approach providing more robust estimates. However, the use of both approaches allowed for an assessment of the validity of the findings with similar effects observed in each case giving confidence in the findings. Both are therefore presented in this report and are included in Chapters 5 and 6.

Additional regression analysis was carried to control for scope and setting when looking at differences across ethnicity, age and gender in how easy registrants found each of the elements of revalidation. In this analysis differences for each registrant demographic were estimated relative to a reference group within that demographic. In the case of ethnicity, White British registrants comprised the reference group, for gender, male registrants were the reference, and for age, the 18 to 24 year old age group formed the reference group. All other groups within that demographic were compared with that reference group. There were some limitations in the analysis given the sample size for some registrants, such as Gypsy or Irish Traveller, Bangladeshi and Arab participants. The findings from this analysis are outlined in Chapters 4 and 6.

Throughout this report, where reference is made to 'statistical analysis' this refers to one or more of the approaches described above.

Limitations of the evidence

This report represents the total analytical output of a three-year evaluation running alongside the phased three-year initial introduction of revalidation. The following considerations apply to this report.

- **Qualitative work should be treated as indicative only:** A wide range of qualitative work was carried out across the evaluation. In each strand of qualitative research, quotas were used to ensure that registrants represented broad spread by scope, setting, geographic location and demographics. However, qualitative research does not aim to be generalisable, but rather provide in depth insight. As such, the qualitative evidence should be treated as indicative only. It provides further detail and information to help explain the quantitative findings. Where verbatim quotes are included these are used to illustrate general themes and should not be taken to represent the views of all participants.

- **Challenges incorporating the employer perspective:** In Year One and Year Two, there were difficulties in identifying and speaking to employers as part of the case studies, and a lower number of employers than anticipated took part. This year, to account for this, a revised approach was used to incorporate the employer perspective. An additional eight interviews with employers were conducted in Year Three.

- **Challenges measuring outcomes**: Revalidation ultimately aims to deliver increased public protection. As set out in the Theory of Change[40], this relies first on achieving attitudinal and behavioural change across NMC registrants. It has not been possible to identify objective measures through which to measure the impact or outcomes of revalidation. The initial assessment of these changes included in this report is based on self-reported data collected from registrants and other colleagues. While evidence is triangulated across strands to inform an assessment of early evidence that the outcomes that are being realised, linking changes to the 'ultimate goal' of revalidation has not been possible.

2.3 Structure of the report

The remainder of this report is structured as follows:

- **Chapter Three – The delivery of revalidation to date:** This chapter provides an overview of the delivery of revalidation since April 2016. This draws heavily on the annual and quarterly revalidation reports produced by the NMC.

- **Chapter Four – Experiences of the revalidation process:** This chapter presents the process evaluation findings, including evidence on the experiences of registrants revalidating across the first three years of revalidation (and others involved), and the effectiveness of the revalidation processes.

- **Chapter Five - Behaviour change among registrants and employers:** This chapter presents evidence on the extent to which revalidation has led to an increase in the desired behaviours among registrants and employers. It also discusses any evidence to infer the extent to which behaviour changes have led to, or are likely to lead to, the desired cultural outcomes (as described in the Theory of Change).

- **Chapter Six - Public protection and regulatory effectiveness:** This chapter outlines any additional evidence on the overall aim of revalidation to enhance public protection, as well as evidence on revalidation as a regulatory change. In doing so, it also begins to focus on the future of revalidation.

- **Chapter Seven - Reflections and recommendations:** This final chapter brings together learning from across the first cycle of revalidation, considering how well revalidation has performed against its objectives, the contribution of revalidation to outcomes to date and what this means for the next stages of revalidation.

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[40] Please refer to the 'Evaluation scope and objectives' section of this report for the Theory of Change.

3 The delivery of revalidation to date

3.1 Calls made to the contact centre

Data on the number of calls made to the NMC contact centre was provided by the NMC. This data included records of all calls which were coded by the NMC; it omitted any other calls received but not coded over the three years.

Across the three years the data showed a decline in the overall number of calls made to the NMC contact centre; from 253,841 calls in Year One to 121,168 calls during Year Three. This decline was also evident for calls specifically regarding revalidation with just 14,195 made in the period between April 2018 and March 2019. This compared with a total of 18,242 in the preceding 12 months and 34,946 in the first year of revalidation (14 percent of total calls in Year One). In Year Three, calls relating to revalidation accounted for 11.7 percent of total calls.

The continued decline in calls made to the NMC contact centre may be in part due to the continued development of the online platform, as was noted in Year Two of the evaluation, and the decline in calls related to revalidation would suggest few problems issues driving registrants to contact the NMC.

3.2 Volume of registrants revalidating

Overall volumes revalidating and lapsing

In the third year of the evaluation (April 2018 to March 2019) a total of 219,516 registrants were due to undertake revalidation for their first time. Of these:

- 204,545 (93.2%) registrants successfully completed the process; and

- 13,520 (6.2%) lapsed from the register.[41]

As of the end of March 2019, a total of 611,462[42] registrants had successfully revalidated in the first three years of revalidation out of a total of 658,100 due to undergo the process, representing 93% of the total number of nurses and midwives.

Similar patterns in renewal date and revalidation were evident across all years, with quarter 2 seeing the largest proportion of registrants due to undertake revalidation and consequently the largest number of registrants lapsing.

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[41] The remaining 0.6% were being 'held effective' at the end of the period in which they were due to revalidate. This may be because their application was undergoing verification, the registrant declared a caution or conviction or because they were subject to Fitness to Practice proceedings.

[42] Note that this does not include registrants who were held effective at the end of their revalidation month and therefore will underestimate the total number.

Figure 3.1: Registrants due to revalidate and revalidated (Apr 2018 – Mar 2019)
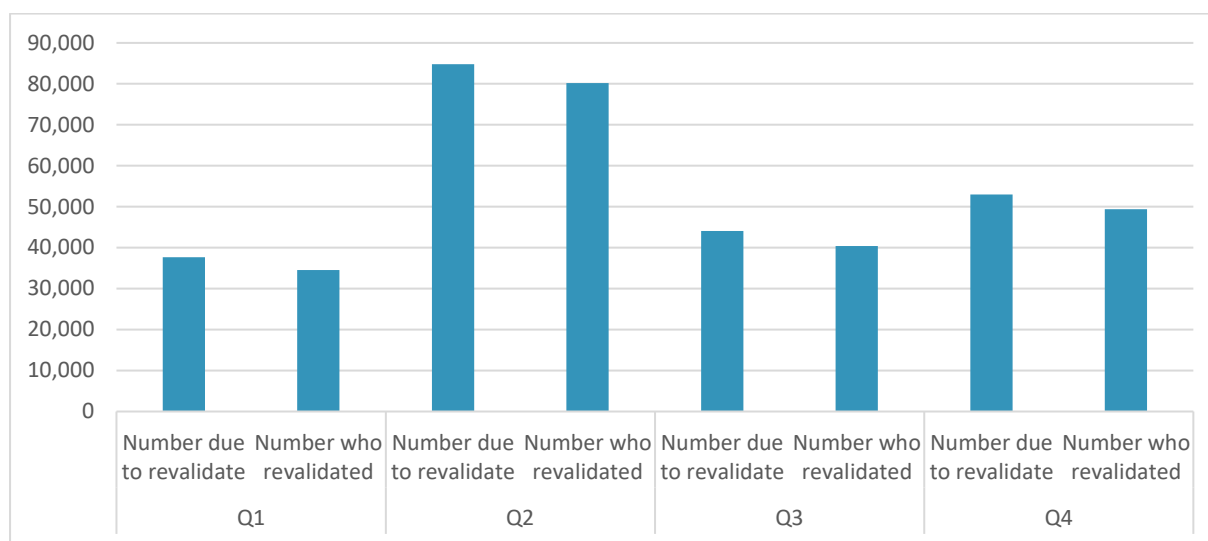
Source: Ipsos MORI analysis of NMC data

The overall number of registrants lapsing over the first three years of revalidation was 42,167[43] (6.4%). The lapsing rate of 6.2% in Year 3 is identical to the lapsing rate in Year Two of revalidation and similar to that from Year One at 6.9%. It did not represent a notable departure from the historic lapsing rate observed prior to the introduction of revalidation (see table 3.1 below). The pattern of lapsing was stable throughout the first 3 years of revalidation.

Use of exceptional circumstances

The proportion of registrants revalidating through the exceptional circumstances[44] process was once again small and fell to 0.3% in Year Three compared to 0.4% in Year Two and 1.1% in Year One.

Renewal rates over time

Figure 3.2 sets out the historical renewal rates for registrants on the NMC register since 2010/11. Comparison of the renewal rates achieved through revalidation to those under the previous Prep mechanism has been undertaken to understand the impact of revalidation. This suggested that the rate of renewal has plateaued since the introduction of revalidation, indicating a lack of an adverse effect on renewal rates.

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[43] ibid

[44] The process whereby the NMC allows registrants with mitigating circumstances who would be unable to meet the requirements of revalidation, to renew their registration in line with the previous Prep regime

Figure 3.2: Historical revalidation[45]/Prep renewal rate
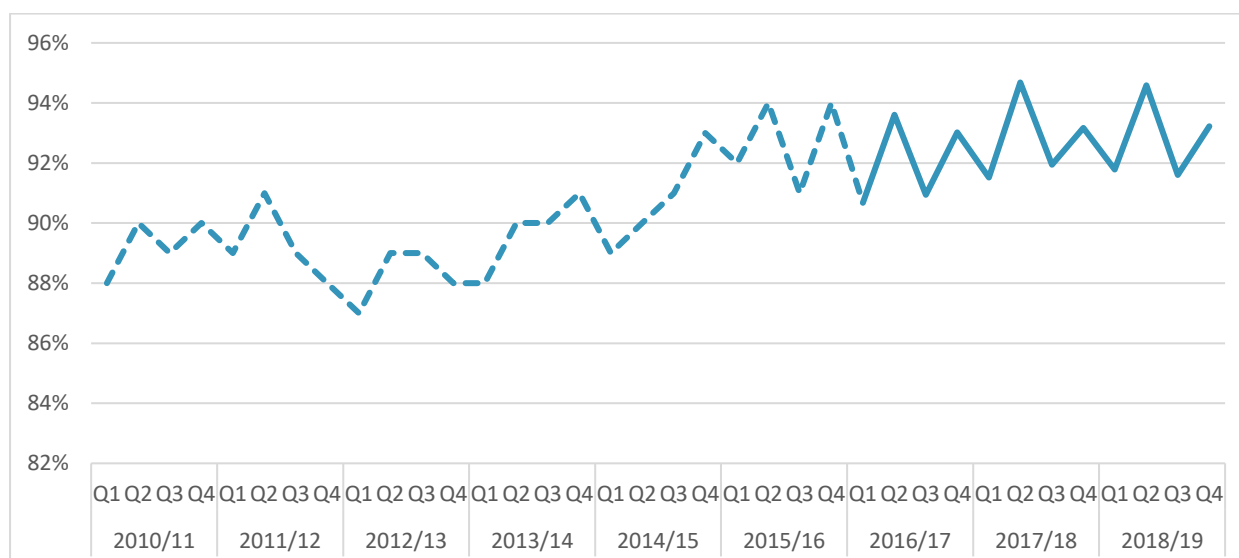
Source: Ipsos MORI analysis of NMC data

Variation by country

The largest proportion of registrants due to revalidate over the first three years of revalidation were practising in England with 79.2% of all registrants. The second largest proportion of registrants due to revalidate across the same period were practising in Scotland with 9.9% of the register with the remaining registrants practising in Wales (5.0%), Northern Ireland (3.6%) and outside of the UK (2.3%).

Table 3.1 outlines both the number due to revalidate in each year by country and the proportion lapsing by country illustrating only slight variation across UK countries. However, registrants practising outside of the UK were significantly more likely to lapse across all years.

Table 3.1: Registrants due to revalidate and proportion lapsing by country (Apr 2017-Mar 2018)

	Year One	Year Two	Year Three				
	Total	Total	Q1	Q2	Q3	Q4	Total
England	173,587	174,130	29,877	66,363	35,248	42,230	173,718
Scotland	21,975	21,616	3,277	9,331	4,006	4,864	21,478
Wales	10,992	11,237	2,021	4,009	1,918	3,031	10,979
Northern Ireland	7,941	7,634	1,462	3,232	1,648	1,499	7,841
Non-UK (overseas and EU)	4,946	4,526	1,021	1,859	1,250	1,370	5,500
Total	219,441	219,143	37,658	84,794	44,070	52,994	219,516
Registrants lapsed (%)							

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[45] The revalidation rate from Q1 2016/17 excludes those held effective at months end and therefore represents a slight underestimate of the 'true' rate.

	Year One	Year Two	Year Three				
	Total	Total	Q1	Q2	Q3	Q4	Total
England	6.2%	5.5%	6.2%	4.3%	6.9%	5.4%	5.4%
Scotland	6.4%	5.6%	8.0%	4.1%	8.3%	5.9%	5.9%
Wales	5.9%	5.1%	7.5%	4.1%	8.0%	5.2%	5.7%
Northern Ireland	5.3%	5.3%	6.0%	3.2%	5.0%	5.9%	4.6%
Non-UK (overseas and EU)	39.8%	37.2%	44.4%	28.5%	34.9%	32.0%	33.8%
Total	6.9%	6.2 %	7.4%	4.8%	7.8%	6.1%	6.2%

Source: Ipsos MORI analysis of NMC data

Variation by registration type

In Year Three of revalidation there was no clear trend in the rates of revalidation across registrant types, consistent with both Year One and Year Two. Additional data from Year Two did, however, allow for the exploration of the extent to which registrants acquire or drop registrations during revalidation. This highlighted that only 0.6% of registrants revalidating in Year Two dropped one or more registration types around the point of revalidation; and the most common change is for registrants previously holding a dual Nurse/Midwife registration to drop one of these.

Variation by employment type, setting and scope of practice

The analysis contained here relates to 'periods of practice'. This means that jobs, rather than individual registrants, are the unit of measurement—if a registrant has more than one job, each job will be counted separately. In Year Three, the majority of periods of practice were once again via direct employment accounting for 93.6 percent of the total, 5% were through an agency, 1.3% through self-employment and less than 1% through volunteering.

In addition, most registrants were once again employed in direct clinical care or management of some kind with these categories accounting for 94.2% of the total in Year Three. Adult and general nursing care was the most common category in all years. The majority of registrants (56%) revalidating in Year Three were also working within a hospital or other secondary care work setting consistent with both Years One and Two.

Table 3.2: Breakdown by current scope of practice by year since the introduction of revalidation[46]

Scope of practice	Total current periods of practice					
	Year One		Year Two		Year Three	
	N	%	N	%	N	%
Direct clinical care or management - adult and general care nursing	133,025	62.8%	134,549	63.3%	134,740	63.5%
Direct clinical care or management - mental health nursing	22,462	10.6%	22,424	10.6%	22,161	10.4%

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[46] In tables 3.2 and 3.3 jobs, rather than individual registrants, are the unit of measurement. Therefore, if a registrant has more than one job, each job will be counted separately.

Direct clinical care or management - <u>children's and neo-natal nursing</u>	12,275	5.8%	12,623	5.9%	12,874	6.1%
Direct clinical care or management - <u>midwifery</u>	11,202	5.3%	10,989	5.2%	11,182	5.3%
Direct clinical care or management - <u>health visiting</u>	5,984	2.8%	5,767	2.7%	5,435	2.6%
Direct clinical care or management - <u>other</u>	5,314	2.5%	4,987	2.3%	4,654	2.2%
Education	4,148	2.0%	4,151	2.0%	4,179	2.0%
Direct clinical care or management - <u>learning disabilities nursing</u>	3,400	1.6%	3,206	1.5%	3,205	1.5%
Direct clinical care or management - <u>school nursing</u>	2,319	1.1%	2,294	1.1%	2,220	1.0%
Direct clinical care or management - <u>occupational health</u>	1,854	0.9%	1,833	0.9%	1,818	0.9%
Research	1,566	0.7%	1,593	0.7%	1,644	0.8%
Direct clinical care or management - <u>public health</u>	1,365	0.6%	1,392	0.7%	1,392	0.7%
Commissioning	1,064	0.5%	1,107	0.5%	1,143	0.5%
Quality assurance or inspection	1,067	0.5%	1,032	0.5%	1,055	0.5%
Policy	191	0.1%	178	0.1%	192	0.1%
Other	4,613	2.2%	4,376	2.1%	4,329	2.0%
Total current periods of practice	211,849	100%	212,501	100%	212,223	100%

Source: Ipsos MORI analysis of NMC data

Table 3.3: Breakdown by current work setting by year since the introduction of revalidation[47]

Work setting	Year One		Year Two		Year Three	
	N	%	N	%	N	%
Hospital or other secondary care	118,983	56.2%	118,640	55.8%	118,767	56.0%
Community setting, including district nursing and community psychiatric nursing	37,581	17.7%	38,123	17.9%	37,358	17.6%
Care home sector	16,629	7.8%	16,946	8.0%	17,497	8.2%
GP practice or other primary care	11,817	5.6%	12,121	5.7%	11,818	5.6%
Maternity unit or birth centre	6,003	2.8%	5,821	2.7%	5,932	2.8%
Specialist or other tertiary care including hospice	2,733	1.3%	2,605	1.2%	2,670	1.3%
University or other research facility	2,439	1.2%	2,415	1.1%	2,436	1.2%
Occupational health	1,719	0.8%	1,689	0.8%	1,697	0.8%
Public health organisation	1,617	0.8%	1,707	0.8%	1,790	0.8%
Voluntary or charity sector	1,245	0.6%	1,278	0.6%	1,232	0.6%
School	1,238	0.6%	1,274	0.6%	1,177	0.6%
Prison	1,051	0.5%	1,022	0.5%	951	0.5%
Other	8,794	4.2%	8,860	4.3%	8,898	4.2%
Total current periods of practice	211,849	100%	212,501	100%	212,223	100%

Source: Ipsos MORI analysis of NMC data

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[47] ibid

Variation by registrant characteristics

In Year Three, the revalidation rate for registrants aged 71 and above was lowest at 58.5% with the rate for registrants aged between 61 and 70 second lowest at 76%. These figures are comparable to both Year One and Year Two and was expected as many registrants in these categories may be approaching retirement and less in need of their registration.

The second evaluation report, however, highlighted the decrease in the renewal rate for registrants aged 65 and over when compared to the Prep process. However, these registrants make up only a small proportion of the total register though and many of those lapsing in this category may not have been practising but maintaining a registration under Prep. In the qualitative interviews with recent lapsers, while the introduction of revalidation had prompted them to allow their registration to lapse, not being able to meet the practice hours requirement was typically cited as the reason, suggesting they were not practising or were practising very little. Therefore, there is unlikely to be a direct impact on staffing levels or the ability to fill vacant nursing and midwifery posts as a result of this.

Male registrants were slightly less likely to successfully revalidate in Year Three with 91.1% of such registrants due to complete the process successfully completing it compared with 93.4% for female registrants.

As was also the case in Year Two, the revalidation rate was below 90% for the 'Asian/Asian British Chinese' or 'Other black' ethnic groups. However, several categories of ethnicity contain relatively small numbers and in general, differences are small.

Finally, registrants reporting a disability exhibited a lower rate of revalidation at 89.5% compared with 94.7% for registrants without. This mirrors the finding looking at 'active lapsers' (registrants informing the NMC of their intention to lapse directly) in Year Two: in this analysis registrants with a self-declared disability were shown to be more likely to lapse due to ill health than those without a disability. People with a disability were no more likely to lapse due to not being able to meet the revalidation requirements than people without a disability. However, further research may be necessary to fully understand the impact on registrants with a self-declared disability.

Differences in experiences and outcomes across registrant characteristics are explored throughout this report. A summary of the findings related to equality and diversity is outlined in Chapter 6.

3.3 Verification

Verification is the assurance mechanism through which the NMC seeks to monitor compliance with the requirements of revalidation for a proportion of those registrants who have submitted an application to revalidate. As such, verification has a key role in ensuring that revalidation is seen as more robust than the previous Prep regime. The NMC's approach to verification was reviewed by the evaluation team during Year One, and following this, recommendations were made to the NMC to allow further interrogation of the robustness of the verification approach.

The approach taken to verification incorporates a risk categorisation of every application with a representative sample selected for review. The categorisation identifies two main types of risks, namely

the practice environment the registrant works in and the organisation context. In practice, the environment is tested through whether or not an individual has an NMC registered line manager or not while the organisational context is assessed through whether or not a registrant has an annual appraisal.

The NMC annual report on revalidation for Year 3 contains further details of the verification process.

4 Experiences of the revalidation process

4.1 Effectiveness of the NMC's communication activities and guidance materials

The evaluation found that the NMC's communications about the introduction of revalidation, and the revalidation requirements were clear to registrants. The guidance materials produced by the NMC were helpful, and NMC registrants had not usually needed to contact the NMC for additional support. Those who had contacted the NMC for support by phone, email or post typically had their problem resolved. There were however some groups of registrants—particularly those working for agencies or the voluntary sector—who found the guidance materials less relevant to their roles.

Did the NMC's communication activities make registrants aware of the introduction of revalidation?

At the point of revalidation, most registrants (90%) agreed that the NMC had provided enough advance notice about the introduction of revalidation. This proportion did increase slightly across the first revalidation cycle (89% of those revalidating in 2016-17 compared with 92% of those revalidating in 2018-19), which reflects the additional notice that those with later renewal dates benefitted from. Overall however, the high proportion of registrants agreeing with this suggests that the timings of communications about the introduction of revalidation did not cause widespread issues.

Opinions on the clarity of the NMC's communications were more mixed, however. In the years before they undertook revalidation, a notable minority of registrants (9%) felt that the NMC had not communicated clearly about the introduction of revalidation. Some registrants suggested that the language used in the NMC's communications was sometimes overly complex and did not provide a clear sense of how much work would be involved in the revalidation process.

"Initially I thought it was a huge amount of work and panicked. Throughout, the language was over-complicated. I didn't really know how much work would be involved, especially with the reflective pieces. It didn't sound clear or easy." Nurse, secondary care

As registrants started to experience revalidation, these concerns often subsided. At the point of revalidation, the proportion of registrants who reported that the NMC's communications had lacked clarity dropped to 4%. Registrants reported that their initial anxiety about revalidation was reduced by speaking to colleagues who had already completed the revalidation process or by engaging in the process as a reflective discussion partner or confirmer.

"I felt it was quite anxiety provoking at the start. But then I spoke to colleagues who had gone through it, and they said—and actually I agree now—once you've started doing it, it's actually quite straightforward and not too stressful or demanding." Nurse, community setting

Attitudes towards the NMC's communications about the introduction of revalidation were relatively similar across demographic groups and by role and setting, suggesting that the NMC's communications about the introduction of revalidation served all registrants well.

Did the NMC's communication activities make registrants aware of the revalidation requirements?

In the years before their renewal date, though most felt informed, this was lower than anticipated as a notable proportion did not say they felt informed. Two in three registrants (67%) felt the NMC provided enough information about how to prepare for revalidation two years before their renewal date, and seven in ten (70%) felt they had enough information one year before their renewal date. By the point of revalidation however, a higher proportion of registrants (86%) agreed that the NMC had provided them with enough information about how to prepare for revalidation.

This gap in feeling informed may have been influenced by several factors. There was evidence, for example, that some registrants did not fully engage with information provided by the NMC until the year they were due to revalidate. Nonetheless, now that the first revalidation cycle is complete, registrants who have successfully revalidated are more informed about the requirements.

"I thought, I haven't got to revalidate for a couple of years, so I have a bit of breathing space. I didn't think too much about it, but it filled me with a bit of apprehension." Nurse, community setting

A subset of registrants also commented that there was a lot of unvalidated information circulating prior to the introduction of revalidation, which provoked anxiety among registrants. Detailed information from the NMC at an earlier date—providing practical information about the revalidation requirements—would have been welcomed.

"They spent so long reassuring nurses that it was nothing to worry about that it made you think they were lying. If they'd have just told us about it—said this is what you'll have to do and all the information is on the website—I'd have been happy with that." Nurse, community setting

Those who engaged with the information provided by the NMC were positive about how informative it was. Registrants generally felt as though the NMC had provided clear expectations and information about the revalidation requirements and had communicated this well.

How effective were the NMC's guidance materials, and how could they be improved?

High proportions of registrants reported using the NMC's guidance materials when preparing for revalidation. The most frequently used sources were the 'How to revalidate with the NMC' document (84%), 'the Code' for nurses and midwives (63%), and the revalidation section of the NMC website (79%). While the guidance materials received a very positive reception from the vast majority of registrants, there are groups of registrants for whom specific materials are less applicable or accessible.

The 'How to revalidate with the NMC' document

The vast majority of registrants agreed that the 'How to revalidate with the NMC' document was helpful (95%), easy to read (95%), easy to understand (94%), and that it gave them all the information they needed (94%). These high proportions suggest that this document was very effective.

"When I had a hard copy sitting in front of me, I was able to logically work my way through it. It's not an intimidating document, it's a very useful guide to say 'okay, this is where I need to be with my own personal development'" Nurse, independent sector

However, although a high proportion of registrants overall (92%) said that the document was applicable to their place of work, the data suggested that there is more that can be done to make it relevant for self-employed and voluntary workers. While just 2% of registrants overall disagreed that the guidance was applicable to their place of work, 7% of those who are self-employed and 8% of voluntary workers disagreed that it was.

The Code for nurses and midwives

Although the majority (63%) of registrants reported having used the Code at the point of revalidation, this is somewhat lower than might have been expected given the document's centrality to the revalidation process. Nonetheless, there was a substantial increase in the proportion of registrants who reported using the Code between 2016-2017 and 2018-2019 (61% compared with 74%) indicating that, as revalidation became more embedded, the Code became more embedded.

Registrants who had used the Code were extremely positive about it, with high proportions saying it was helpful (95%), easy to read (95%), easy to understand (95%), gave them all the information they needed (90%) and was applicable to their place of work (94%).

Notably, registrants working for agencies were less likely to report having used the Code than registrants with any other employment status (only 55% of agency workers compared with 63% of registrants overall). However, those agency workers who had used the Code were more positive about it than registrants overall. This suggests that their lower uptake is not a result of any difficulty applying the document to their role, but instead suggests that agencies could do more to stress the importance of integrating the Code into registrants' preparation for revalidation.

The revalidation section of the NMC website

The vast majority of those who used the revalidation section of the NMC website reported that it was helpful (95%), easy to read (95%), easy to understand (94%), gave them all the information they needed (93%) and was applicable to their place of work (91%). This suggests that the website was an effective way of communicating about revalidation to registrants.

"I found the website straightforward, I found the templates helpful. It was quite straightforward." Nurse, secondary care

A lower proportion of registrants aged 65 or over (70%) had used the website, which is likely reflective of wider trends of internet use by this age group.[48] A higher proportion of this age group compared with registrants overall went to a revalidation conference organised by the NMC (15% compared with 10% of registrants overall) or had a face-to-face conversation to learn about the requirements with another NMC registrant (7% compared with 4% overall). This suggests that older registrants rely more on face-to-face guidance to prepare themselves for revalidation.

As was the case with the 'How to Revalidate with the NMC' document, a higher proportion of self-employed and voluntary workers (both 7%) disagreed that it was applicable to their place of work, indicating that the website would benefit from being tailored to these groups.

What were registrants' experiences of seeking revalidation support from the NMC?

Most registrants did not have to seek revalidation direct support from the NMC. At the point of revalidation, just under one fifth had contacted the NMC by email (17%). Even fewer has contacted the NMC by phone (3%) or by post (3%).

Those that did seek support by phone, email or post usually had a positive experience of doing so. The majority agreed that the NMC had solved their problem (82%), had provided adequate guidance (83%), that the response was clear (83%) and that the response was prompt (84%). This suggests that generally, registrants who have sought support from the NMC has had positive experiences of doing so.

However, there may still be room for improvement; over one in ten registrants who contacted the NMC by phone, email or post (12%) disagreed that the NMC had solved their problem. Registrants with an 'other' scope of practice were particularly likely to disagree (22%), suggesting that those working in less common roles were particularly affected.

What were registrants' experiences of seeking alternative support arrangements from the NMC?

Very few registrants (1%) reported contacting the NMC for alternative support arrangements. The requested alternative support arrangements included: exceptional circumstances (requested by 1% of registrants), reasonable adjustments for using NMC online (1%), and an extension to their revalidation deadline which was marginally more common (2%).

Among those who did contact the NMC for these alternative support arrangements, over half (53%) felt that the NMC supported them to successfully revalidate. Nonetheless, a sizable minority (24%) felt that the NMC had helped them successfully revalidate 'just a little' or 'not at all'. The NMC has recently withdrawn the exceptional circumstances for the second cycle onwards but might want to consider whether there are any further ways they could support those who would have requested this previously.

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[48] Latest results from Ipsos MORI's Tech Tracker (2019 Q1) shows that internet connectivity drops amongst people over 65 compared with the rest of the population. Available online at: https://www.ipsos.com/sites/default/files/ct/publication/documents/2019-04/techtracker_report_q12019_final.pdf.

4.2 Registrants' experiences of the support provided by employers

What support for revalidation have registrants received from their employer?

Support preparing for revalidation

At the point of revalidation, most registrants (93%) reported that their employer had provided some form of support to help them successfully revalidate.

The most common type of support that registrants (61%) received from their employer was information and guidance about who could act as their confirmer. Interviews with registrants and employers demonstrated great variation in employer guidance on who could act as registrants' confirmer. Some employers—often large NHS Trusts—had policies specifying who should act as registrants' confirmers (often their line manager, as suggested in NMC guidance). In other cases—often smaller organisations—registrants had a greater role in determining who their confirmer would be. Interviews with stakeholders suggested that this clarification had a positive effect on supporting staff to prepare for revalidation. In addition, stakeholders were asked about national policies that had been put in place around revalidation, while there were few at a national level, the Scottish government had reiterated the NMC's suggestion that confirmers should be the line managers of registrants.

The second most common type of support received by registrants (55%) was information and guidance about who could act as registrants' reflective discussion partners. This type of support also varied by setting, with lower proportions of those working in a general practice setting (41%) or isolated clinical settings (43%) reporting receipt of this type of support at the point of revalidation.

At the point of revalidation, just over half of registrants (52%) reported that their employer had provided seminars or other sessions for them to learn about revalidation. Registrants in our in-depth interviews often mentioned employee support sessions when talking about how they prepared for revalidation. For many, these were an important resource for preparation. However, as with other forms of support, their provision varied by role; those working in the voluntary sector (28%), occupational health (33%), or the care home sector (33%) were less likely to receive this support than others (52%). Conversely, registrants working within organisations employing large numbers of registrants—such as maternity units (58%) or hospitals (55%)—were among the most likely to receive this type of support.

"We ran workshops, probably once a month for around 8 or 9 months. That was for registrants going through revalidation who wanted a bit more information to find out how it would work, because it can be a bit different for nurses who work for an agency." Employer, agency

Although most registrants reported receiving some support from their employer, the data reveals that employers' support primarily focused on the point at which registrants undertook revalidation. For example, the proportion of registrants who report that their employer provided seminars one year (44%) or two years (45%) before they revalidated is relatively low. This pattern of a lack of early engagement from employers may have limited registrants 'ability to engage with the revalidation requirements, and start preparations, early in the cycle. It also indicates that employers' focus may lie on ensuring registrants

are technically able to meet the revalidation requirements, rather than on encouraging the behaviours that revalidation seeks to embed over the longer-term.

Support completing the CPD requirement

At the point of revalidation, most (74%) agreed that their employer provided CPD opportunities, while one in ten (10%) disagreed that their employer provided CPD. While most registrants said that their employer provided CPD, a lower proportion (60%) at the point of revalidation agreed that their employer helps them to seek out opportunities for CPD. However, 15% of registrants disagreed that their employer helped them seek out opportunities.

How has the support received from employers differed by setting?

At the point of revalidation, over two thirds of registrants (68%) agreed that their employer gave them all the support that they needed to revalidate. However, a significant minority of registrants (11%) disagreed that their employer gave them all the support that they needed.

The data does suggest that there are some settings in which more could be done to support registrants throughout the revalidation process; particularly those settings which employ few registrants. For example, registrants who work in occupational health felt considerably less supported, with nearly 19% disagreeing that their organisation had provided enough support. Likewise, those who worked within GP practices (15%) or in a public health organisation (15%) were more likely to lack support. It may be the case that, in situations where registrants are less able to turn to other registrants for advice, they require more guidance from their employer.

"In GP practices they tend to not to engage with revalidation, they just let you get on with it. You're a bit on a limb sometimes with GP practice." Nurse, primary care setting

The challenge faced by registrants who worked in relative isolation from other registrants was also reflected in the in-depth interviews. For example, a stakeholder indicated that there has been some misunderstanding among employers about whether health visitors are required to revalidate, leading to lower levels of support provided. The NMC may need to provide employers within these settings with additional guidance on how they can support registrants through revalidation.

How could the support provided by employers be improved?

It was evident from both the survey data and in-depth interviews that formal policies about revalidation were associated with registrants feeling more supported by their employer. For example, registrants who did not receive information or guidance from their organisation about who should act as their confirmer were considerably more likely to feel under supported by their organisation (23% compared with 11% overall). Similarly, where employers allocated reflective discussion partners (as was often the case in large secondary care trusts)—thereby removing the need for registrants to identify their own—registrants reported finding the process less burdensome.

"It was easy, as the reflective discussion partner was a set person. She told us when it was happening. You didn't have to waste time thinking – oh, who am I going to get to go through this?" Midwife, secondary care

However, employers also reinforced that it remains important to remain flexible on this and ensure employees can chose others if they would like to. The importance of this was highlighted in the interviews with lapsers; one former registrant reported that they were forced to lapse their registration as they found it unfeasible to find a confirmer who met the requirements set by their employer.

These findings suggest clear communications and guidance from employers about who should act as confirmers and reflective discussion partners would help to support registrants through the revalidation process. However, they also highlight that it is important that requirements remain flexible to accommodate registrants where appropriate.

Furthermore, to overcome the challenges faced by nurses and midwives working with few other registrants, employers could partner with organisations that employ more registrants (such as local NHS trusts) in the local health economy to help identify reflective discussion partners for registrants. If such partnerships were feasible, registrants working with few other registrants may also be able to benefit from seminars about revalidation that were provided by the larger organisation (as previously mentioned, registrants working in organisations that employed more registrants, tended to provide more formalised, structured training).

Another area of concern is the risk that employer support for revalidation would reduce after the first revalidation cycle. It is important for employers and the NMC to maintain momentum by continually providing support and training for new members of staff, as well as refresher support for those who have already undertaken revalidation.

Registrants seeking support elsewhere

Data from the survey supports in-depth interview findings, showing that registrants often sought support from their peers and colleagues in preparing for revalidation. At the point of revalidation, over three quarters (77%) of registrants went to other nurses and midwives that they work with for support. These proportions increased over the revalidation cycle, from 76% for registrants revalidating in 2016/2017 to 81% for those revalidating in 2018/2019.

The data also shows that 14% of registrants sought support from a membership body/trade union (such as the Royal College of Nursing or the Royal College of Midwives) for support in preparing for revalidation, meaning that registrants looked for support outside of their employer, the NMC and their peers. This finding was supported by the in-depth interviews with registrants.

"Well I went on the RCN website and used that as my source of reference to learn about it. I didn't feel that I needed to go on a study day about it or a conference about it. I read it online, I downloaded the necessary forms that I needed and collectively put my folder together." Senior practice nurse, primary care

Agency workers were more likely to use a membership body or trade union for support than other registrants (27% compared with 14% overall).

These findings suggest that support is available from a range of sources. The NMC could potentially further engage stakeholders that are currently providing this support and, where appropriate, do more to sign-post registrants to these sources. Some registrants may benefit from further support from their employer or from the NMC, reducing the need for registrants to look elsewhere for support or information.

4.3 Registrants' experiences of completing revalidation activities

What have been registrants' experiences of completing the practice hours requirement?

Understanding of the practice hours requirement

One year before revalidation, almost all registrants (93%) understood what was required of them to fulfil the minimum number of practice hours. The proportion who understood slightly increased over the first revalidation cycle from 92% for those revalidating in 2016-2017 to 94% for 2018-2019, however this shows that awareness of the practice hours requirement was high from early in the revalidation cycle.

Registrants we spoke to as part of the in-depth interviews demonstrated a good understanding of what the requirement involved and the purpose of it. There was recognition that, for most registrants, it was necessary to meet a certain number of practice hours in order to practise effectively.

"We need to know someone is consistently practising. It's a profession, it's a responsibility. We need to know that someone's not just dipping in and out of it. It's not a job you can do properly unless everything's in place and it's not a job you can do really unless you've well – practised." Nurse, secondary care

Experiences of completing the practice hours requirement

At the point of revalidation, most registrants (90%) reported that it was easy to meet the practice hours requirement. The proportion who found it easy remained the same over the three-year revalidation cycle, suggesting that the practice hours requirement had felt achievable for most registrants since revalidation was first implemented. This was also reflected in the in-depth interviews, as most registrants—including those working part-time—were already meeting the minimum number of practice hours and therefore did not need to increase in the number of hours they worked.

"If you divide that over 3 years, it actually really isn't that much. If you're working full-time in one month you do like 150 hours, so it actually isn't a huge amount of practice hours." Midwife, secondary care

In interviews with former registrants who had lapsed from the register, the practice hours requirement was the most frequently given reason for not revalidating. The main reasons for this challenge were two-fold; some had reduced their hours substantially as they approached retirement while others had retired or taken a career-break before deciding that they wished to return to work. As noted earlier, this was reflected in the NMC data on renewal rates among older registrants.

Some registrants in the interviews worried more about how to record their practice hours than others, for example where they had taken a period of leave or swapped between full-time and part-time roles. While they were confident that they had carried out the hours of practice required, they did not want to miscalculate or record this wrongly.

What have been registrants' experiences of completing the continuing professional development requirement?

Understanding of the CPD requirement

One year before revalidation, most registrants (89%) understood what was required of them to meet the CPD requirement. The proportion who understood this increased slightly over the first revalidation cycle, from 89% of those who revalidated in 2016-2017 to 92% of those who revalidated in 2018-2019. Again, this suggests that, although understanding among registrants was high when revalidation was introduced, it increased slightly over the first revalidation cycle. Registrants who participated in the in-depth interviews were aware of why the NMC required registrants to complete CPD, and what they needed to do in order to fulfil the requirement.

"It's about making sure that you are continuing to update your practice. It's important to keep the focus on that. So not using outdated skills". Nurse, secondary care

The most frequent types of CPD that registrants undertook during the year they revalidated were course attendance (94%), online learning (84%), and reading journal articles and books (77%). Registrants also often attended meetings as part of their CPD (67%).

Differences in the types of CPD conducted, were apparent based on the age and role of registrants. Older registrants aged 65 and over were less likely than average to participate in online courses as part of their CPD (74% of registrants aged 65 and over completed online courses compared with 84% of all registrants). Older registrants were, however, more likely to read journals and books than younger registrants aged under 25 (83% compared with 44% respectively). Registrants working in occupational health were less likely to attend courses (87% compared with 94% overall) and take part in online courses (76% compared with 84% overall).

Experiences completing the CPD requirement

At the point of revalidation, most registrants (83%) said that they had found it easy to undertake the minimum number of CPD hours required and that they had also found it easy to undertake the minimum number of *participatory* CPD hours (79%). The ease of undertaking the minimum number of CPD hours was reflected in the in-depth interviews. Registrants typically reported that they were already completing many hours of CPD before revalidation was put into place and that revalidation itself, while it may have given them additional focus on the need to undertake CPD, did not place much additional burden on them.

"They set the bar quite low really with the numbers of hours." Nurse, secondary care

Reflecting the ease with which most registrants met the CPD requirements, half of registrants (52%) completed more than 60 hours of CPD in the three-year period before submitting their revalidation application. Just 13% completed the minimum amount of CPD (between 35-40 hours). Furthermore, half

(52%) of registrants reported that they spent over 35 hours undertaking *participatory* CPD alone, with just 15% reporting completing the minimum hours of participatory CPD (between 20-25 hours).

Despite most registrants reporting that it was easy to meet the minimum number of CPD hours required, a significant proportion of registrants did experience difficulties finding time to undertake CPD leading up to their revalidation application. At the point of revalidation, 44% of registrants agreed that it was difficult to find the time to undertake CPD. This challenge was particularly likely to be experienced by registrants working in secondary care (47%), public health organisations (46%) and community settings (45%). These findings indicate that although meeting the minimum numbers of hours over the three-year period is generally easy for registrants, it can be difficult for them to find time to undertake as much CPD as they would like. The in-depth interviews reflected these findings. For example, staffing issues, levels of support from the employer, and needing to fit CPD around working hours all provided barriers.

"Each practice that I've been with has been very supportive of training. I know not all practices are, and that's where nurses struggle, to do these courses at their cost." Nurse, primary care

Although the registrants who participated in the in-depth interviews generally found meeting the requirements of CPD relatively easy, the interviews did highlight specific factors which had acted as barriers to accessing CPD. For example, one registrant expressed difficulties accessing mandatory training due to working in a rural area and expressed the need for more support.

In the interviews conducted with former registrants who had lapsed from the NMC register, a relatively small number reported difficulties fulfilling the CPD requirement. Those who were still in employment found that CPD opportunities were readily available via their employer, however those who had been out of work reported more difficulties. While courses were available to these participants, finding time to attend (given caring or childcare responsibilities for example), and the cost of the courses, were seen as barriers.

How have experiences of the CPD requirements differed?

Overall, the evaluation evidence suggests that the requirement for registrants to undertake at least 35 hours of CPD in the three years prior to revalidation was not been particularly difficult for registrants to meet.

Bank workers were least likely to do over 60 hours (40%) and more likely to do the minimum 35-40 hours (20%), which may reflect lower levels of support around CPD opportunities for registrants in bank roles (a higher proportion of bank workers disagreed that their employer helps them to seek out opportunities for CPD; 20% compared with 15% of registrants overall at the point of revalidation).

Difficulties in finding the time to undertake CPD differed by age group. Younger registrants were more likely to agree that it was difficult (52% of 25 to 34-year olds said it was difficult compared with 35% of registrants over 65+). Younger people may struggle to find the time to undertake CPD if, for example, they have responsibilities caring for young children or are studying for a qualification that does not count towards this requirement.

Difficulties in finding time for CPD also varied by role, with those employed directly by an organisation (for example an NHS Trust) finding it the most difficult (45%) and those self-employed find it least difficult

(41%). It may be that self-employed registrants have more control over their own time and therefore are able to dedicate time to CPD more easily.

What have been registrants' experiences of gathering feedback from patients, service users and colleagues?

Understanding of the practice-related feedback requirement

One year before revalidation, 82% said they understood the requirement to collect practice-related feedback. There was an increase in the proportion of registrants who understood this requirement over the revalidation cycle (81% of those who revalidated in 2016-2017, compared with 86% of those who revalidated in 2018-2019). This may be because over time, registrants could speak to others who had already revalidated in order to understand this requirement, or they might have experienced being asked to provide feedback for a colleague who was revalidating.

Experience of completing the practice-related feedback requirement

At the point of revalidation, most registrants collected feedback from colleagues (95%) and patients (73%). Smaller proportions of registrants collected feedback from students (55%), service users (52%) and carers (31%).

Most registrants (72%) reported finding it easy to meet the practice-related feedback requirement, while 10% found it difficult. Registrants working in isolated clinical roles were least likely to report that collecting feedback was easy (66%), which is to be expected as these registrants are less likely to be in patient facing roles or may have fewer colleagues to ask for feedback. Former registrants who had recently lapsed from the register did not report that the feedback requirement was a contributing factor in their lapsing. Even those who had taken a career break, or reduced their hours, reported no difficulty meeting the feedback requirement.

However, a higher proportion of registrants (29%) found it difficult to obtain practice-related feedback *from patients and service users*. The in-depth interviews shed further light on this challenge. Registrants working in clinical roles with frequent patient interaction spoke of receiving feedback naturally or passively from patients without having to actively seek it, for example in the form of thank-you cards received from patients and their families.

"It was quite easy to get five pieces of feedback from patients and from colleagues. I got some emails from my colleagues, they just said how good I am. And patients give thank-you cards" Nurse, community setting

However, registrants working in roles such as health visitors, midwives and those working with vulnerable groups—who were less likely to receive passive feedback—often felt that it was not always appropriate for them to ask for feedback. For example, a registrant working in a hospice felt it was inappropriate to ask for feedback from patients or their carers. Challenges were also faced by those who did not work in patient facing roles.

"I find that is more challenging now, because my role is not patient facing. I don't have any feedback yet. I'm fairly certain that other people in similar roles also think that." Midwife, secondary care

This perceived barrier limited the volume of feedback that was actively sought by registrants. Furthermore, the reliance on passively collected feedback—such as thank-you cards—may decrease the likelihood of registrants having access to constructive feedback or use feedback constructively which will enable them to improve their practice.

"It's very easy just to get the good feedback and ignore the negative feedback. It's easy for someone who isn't good to get that good feedback from patients. It would be useful to be more directive about what type of feedback they should be getting." Nurse, community setting

What have been registrants' experiences of completing the reflective accounts?

One year before revalidation, most registrants (85%) said they understood the requirement to produce five written reflections well. Positively, most registrants (60%) focused their reflective accounts on a range of areas, including the Code, CPD activities they had undertaken, and practice-related feedback. Only a minority of registrants (17%) focused exclusively on one of these areas across their five reflective accounts.

Over three quarters (77%) reported that it was easy to produce the reflective accounts. As with other requirements, the proportion of registrants who found the requirement easy to meet, increased over the first revalidation cycle. This may be because as revalidation progressed, registrants heard about others' experiences and were able to look at examples of others' reflective accounts to guide their own. For example, some interviewees mentioned finding it useful to refer to the reflective accounts of other registrants when preparing their own, as well as using the examples of reflective accounts from the NMC's website. Over time, line managers may have also been able to provide more advice to registrants about writing the reflective accounts.

"The first one was quite difficult, but it was easier after writing the first one, reading examples on the NMC website, and realising there was no right or wrong way of putting it across." Midwife and nurse, secondary care

The in-depth interviews reflected these findings. Many registrants expressed familiarity with the process of reflection, having already incorporated it into their everyday practice prior to revalidation. As such, the main difficulty posed by revalidation was the process of writing the formal accounts of reflection, rather than the reflection itself. However, for some registrants the main difficulty was actually writing the reflections in a formal way rather than reflecting in their head or discussing it with another colleague.

"Reflecting wasn't a problem. I did it more formally this time than previously. This time I wrote it down for someone I didn't know, who wasn't a midwife, so they could understand what I was trying to say." Midwife, bank worker

Interviews with former registrants who had recently lapsed from the register highlighted that, for some, the discussion of reflective accounts was a major barrier to revalidation. Perhaps due to the type of work that many of these registrants were undertaking – which was often irregular, voluntary or infrequent – a significant minority reported that they would have had difficulty identifying a suitable registrant to act as their discussion partner.

Perhaps linked to this finding, in-depth interviews highlighted perceptions that some registrants found keeping reflective accounts harder than others, namely older registrants in the latter stages of their careers. The primary reason for this was the suggestion that younger nurses were likely to have received training in formal reflective practice as part of their Nursing degrees. The survey findings show that younger nurses and midwives (aged 18 to 34) were more likely to say that this requirement is difficult to meet (19% for those aged 18 to 34, compared with an average of 13% for those aged 35+). This may not be as at odds with the qualitative findings as it seems, since it may indicate different expectations for what a written account should look like and the amount of time and detail needed.

"I think at the moment the reflection relies on individuals. You don't have a consistent approach." Nurse, secondary care

Indeed, some registrants expressed a lack of clarity about the exact form that the reflective accounts should take. Feedback from confirmers and reflective discussion partners suggested high levels of variability in the length and content of the accounts. In some cases, reflective discussion partners and confirmers said they would welcome further guidance from the NMC before they felt confident accepting registrants' accounts.

This was reflected in the variation in time registrants said it took them to complete the written accounts.

What have been registrants' experiences of undertaking the reflective discussion?

One year before revalidating, eight in ten registrants (81%) understood the reflective discussion requirement well. Evidence from across the evaluation, suggests that the reflective discussion is considered one of the most beneficial aspects of revalidation. At the point of revalidation, 86% of registrants found it useful to take the time to reflect on their practice. In addition, the reflective discussion partners included in the qualitative work said that they particularly valued the reflective aspect and having dedicated time to reflect on their practice.

"This was the most challenging but the most enjoyable part. She went into everything that I'd reflected on and what I'd learned from it, what I would do different next time, and how would it effect my practice." Nurse, secondary care

Furthermore, at point of revalidation, most registrants (82%) found it easy to identify an appropriate reflective discussion partner. Around half of registrants (54%) had their discussion with their line manager; for one in five registrants (18%) this was compulsory. Among the 45% of registrants who did not have the reflective discussion with their line manager, 8% had the reflective discussion with someone who they did not work with regularly.

Questions of who was most appropriate to fulfil the role of reflective discussion partner arose frequently in the in-depth interviews. Some registrants felt that it was beneficial for the reflective discussion partner to have a thorough understanding of the registrants' strengths, weaknesses, and working environment. On the other hand, some felt that the reflective discussions benefitted when there was a degree of distance between the partners.

"Unless someone understands what you do, it's quite difficult for them to get their head around what you're describing. How on earth are you going to improve your practice if they don't understand what your current practice is? For me that's very important." Nurse, community setting

The in-depth interviews with reflective discussion partners highlighted that a degree of distance between the partner and the registrant did not necessarily hinder the discussion. Partners expressed that their main role as the discussion partner was to enable the registrant to reflect with the intention of developing and improving their practice, rather than being to tell them how they should or shouldn't have acted in a particular circumstance.

"I don't really think that to be a reflective discussion partner you need to be at the same nurse level or doing the same job. Because they're only showing that they can reflect and discuss – you're not showing if they've done anything wrong on their reflection...I don't think it has to be someone of the same grade, as long as it's a registrant." Nurse, primary care

The qualitative work suggested that some registrants were having to conduct the reflective discussion outside of normal working hours. This was either because this was the only time that both they and their reflective discussion partner were free, or because their employer did not give them the opportunity to do it within normal working hours. Nonetheless, this was not spoken about in a particularly negative way during the interviews, as many considered it merely to be a formalisation of what they were already doing.

"I'm part of a very supportive team and there's a lot of informal supervision anyway. So most issues have been discussed and we support each other within the role anyway." Nurse, community setting

Despite registrants' positive experiences of reflective discussions overall, there was some variation by setting. A high proportion of voluntary workers reported that it was difficult to have a reflective discussion (17% compared with 6% overall). Similarly, registrants working in settings with few other registrants were more likely than others to find it difficult to have this discussion (8% compared with 6% overall).

In addition to the registrants themselves benefiting from this aspect of the revalidation process, reflective discussion partners expressed in the in-depth interviews that they also found the experience useful for reflecting on their own practice.

"We both learnt from the reflections, it was like a two-way learning. So, I thought it was useful." Nurse, Primary care

What have been registrants' experiences of having the confirmation discussion?

One year before revalidation, over three quarters of registrants (78%) understood the confirmation requirements and, at the point of revalidation, the majority of registrants (85%) said it was easy to obtain confirmation for their application from an appropriate confirmer. The necessity of the confirmation process was recognised in the in-depth interviews, where registrants reflected on the need for oversight of the revalidation process.

"I can see from a legal, professional point of view, that there is benefit in someone in a role higher than me having sat and gone through the requirements to say I'm safe to practice." Midwife, secondary care

The majority (88%) of registrants at the point of revalidation said that it was easy to identify an appropriate person for the confirmation conversation. Most registrants had their confirmation discussion with their line manager (72%), while a quarter of registrants (25%) had their confirmation discussion with another NMC registrant who was not their line manager.

Over one third of registrants (36%) said it was compulsory that their line manager acted as their confirmer. This compared with a lower proportion (18%) who said it was compulsory for their *reflective discussion partner* to be their line manager. This was reflected in the in-depth interviews; employers more commonly mentioned having formal policies around who could act as a confirmer than who could act as a reflective discussion partner.

Some registrants expressed surprise that it was not necessary for the confirmer to be of greater seniority than the registrant. This led to concerns among registrants that the confirmation process could be manipulated, for example by friends acting as confirmers (although the NMC guidance discourages this).

"You're very dependent on the person who acts as confirmer. Some people might not spend so long completing all the forms, and just get a friend to confirm them. I actually have heard that before. Nurses who are not so professional could have done that." Nurse, secondary care

For the majority of registrants (61%), confirmation took place at the same time as the reflective discussion and was with the same person.

Just one quarter of registrants (28%) had their confirmation discussion as part of a regular appraisal.

The in-depth interviews with confirmers reflected that they found the confirmation experience relatively straight-forward. Confirmers expressed that they were usually the registrant's line manager or that they were working at a more senior level than the registrant, so they found it was logical for them to act as the confirmer, and that the process was in line with what they would expect to do in a manager role.

What have been registrants' experiences of completing the health and character and professional indemnity requirements?

The vast majority of registrants (89%) found it easy to meet the requirements of the health and character declaration. Just two per cent said they had found it difficult. Those working as agency workers (4%) or voluntary workers (5%) were more likely than average to report that it was difficult.

Four in five registrants (80%) understood the professional indemnity requirement one year before they revalidated. However, nearly one in five registrants (19%) did not understand what was required of them one year before revalidation.

Despite this requirement being less understood than most other revalidation requirements, the majority (83%) said it was easy to meet the requirement to have an appropriate professional indemnity arrangement.

Did experiences of how easy registrants found the requirements differ across demographic groups?

Overall, as noted above across the requirements registrants found the revalidation process easy to complete, although there were some differences by setting.

Additional statistical analysis was carried out to understand whether there were differences in how easy registrants across demographic groups found each of the revalidation requirements, controlling for scope and setting differences.

The findings showed that, while registrants overall found each of the requirements easy to meet, there were overall differences across ethnicity and gender, when controlling for scope of practice and setting.

For example, looking at ethnicity: broadly, White British registrants were more likely to say each of the requirements were easy to meet than registrants from across other ethnic groups, including BAME registrants and registrants from any other White background. As an example, looking at practice hours, White British registrants were 8 percentage points more likely to say that it was easy to meet this requirement than Asian/Asian British Indian registrants when controlling for scope and setting.

For gender, broadly speaking, female registrants were more likely to say that they found the requirements easy than male registrants.

Again, the proportions stating that the requirements were easy were high across audiences and there may be several explanations or reasons shaping differences. For example, the recent Interim NHS People Plan[49] outlines the pressures faced by staff and notes the findings from the NHS Staff Survey highlighting that BAME staff "...report some of the poorest workplace experiences." This may go some way to explaining differences in experience and ease of completion across the different revalidation requirements.

Any differences across the outcome revalidation seeks to achieve are covered in Chapter 5, and a summary of equality and diversity in relation to revalidation is outlined in Chapter 6.

What have been registrants' experiences of completing the revalidation forms?

Registrants' experience of completing the revalidation forms were largely positive. The vast majority of registrants reported that they have used the reflective accounts log (94%), the CPD record log (94%) and the practice hours record log (92%). Nearly all registrants also reported that the record logs were easy to use (95%, 94% and 94% respectively).

Nine out of ten registrants (91%) said that the online application process was straightforward. Only a very small number of registrants disagreed. Only 3% disagreed that the instructions were clear and easy to follow, and 2% disagreed that the online screens were user friendly, that it was easy to fill in all the information required (2%) and that the application was easy to complete (2%). These findings imply that there is no urgent need for these processes to be changed or improved.

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[49] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

What burden did registrants associate with revalidation?

A key concern relating to the performance of revalidation was that the additional burden—whether actual or perceived—of complying with revalidation would outweigh the perceived benefits to be gained from compliance. We summarise below the additional findings on burden, with benefits covered in Chapter 5 and the proportionality of revalidation covered in Chapter 6.

For registrants, their assessment of burden of revalidation was not only measured in terms of the time spent (including whether this was in or out of work hours) and any costs associated with it, but also the mental load or worry associated with it.

As noted earlier, registrants were often anxious about revalidation in the early stages, and for many this was driven by a belief that revalidation would be both complex and time consuming. This was particularly so for those who were concerned that they would not be able collate the information in an organised way, or those who had specific circumstances they thought would affect how easy it was for them to revalidate (such as having moved roles).

Because of this, the preparation for revalidation and the worry around this could leave registrants feeling as though the burden outweighed the benefits of revalidating at this stage. However, as noted earlier going through the process reduced this apprehension, as registrants began to recognise how the revalidation requirements related to their current practice.

Beyond this point, most registrants thought meeting the requirements was relatively easy as noted earlier. Despite this, the process still required time and effort from registrants, and this how time consuming it was for registrants to complete each requirement varied greatly by registrant.

Preparation: The amount of time registrants spent preparing for revalidation varied between 1.5 hours to 7 hours, depending on how worried they were and the level of employer support they received among other factors. Some registrants reported spending a notable proportion of their own time preparing. Overall the time spent was typically used to look at the NMC's website and their guidance materials, and, for some, attending seminars or other events held by their employer to learn about revalidation.

Now that the first revalidation cycle is over and revalidation is well-embedded, registrants said that they expect to spend less time understanding the requirements the next time they revalidate.

CPD: As previously discussed, the survey data suggested that many registrants were undertaking hours of CPD that were far beyond the minimum number of 35 hours required to revalidate. In the in-depth interviews, the number of CPD hours undertaken varied greatly depending on role and level of employer support, with one registrant estimating they undertook 200 hours of CPD in the three-year period leading up to revalidation.

Many registrants reported that they were doing a similar number of CPD hours prior to revalidation as they were after its introduction, however additional time was now required to keep a record of this. While the CPD itself was highly valued by registrants, the administrative task of recording the number of hours could be burdensome.

Despite most registrants finding it easy to meet the minimum number of CPD hours in the three-years leading up to their revalidation, a sizable proportion reported that it was difficult to find the time to undertake CPD (44% at the point of revalidation said this), and this was reflected in the in-depth interview. Many registrants reported that they spent some of their own time doing their own study or online training, as well as work time attending courses that their employer hosted.

"I find that my work days are so busy...so there tends to be not much opportunity to do training...I will sit at home on my days off and do that." Nurse, primary care

Practice-related feedback: As with other requirements, the additional burden for registrants was collating practice-related feedback as they were using feedback they were already receiving, such as thank-you cards or appraisal feedback. This typically did not take very long, with several saying it took around one hour. This requirement was most burdensome for registrants who were not naturally receiving feedback, such as those not in patient-facing roles or roles in which patients or service users would or could not typically provide feedback. In these cases, registrants had to proactively seek feedback, which could be more time consuming and make registrants feel awkward.

"From speaking to colleagues, I think this is something that people have found more difficult. I used emails I'd received giving me feedback. And some cards from clients."
Nurse, community setting

Written accounts: The amount of time and effort registrants needed to write their five reflective accounts was particularly variable, depending the depth of reflection. Some reflective accounts could be more difficult for registrants to write than others, for example if they were writing a reflection on a difficult clinical incident. There was also a recognition that the style of reflection was also highly personal to the registrant and that the NMC was flexible about the length and style of each written account – this was viewed positively by registrants. The time that registrants in the interviews told us it took to write each reflective account varied from 15 minutes to 3 hours, which may have been spread across several days to complete all five.

"People say that they flung it together in a couple of days, but I have no idea what they were doing or how they did that." Nurse, primary care

While reflection overall was viewed positively, the task of writing this down was viewed as burdensome by some registrants, and was seen as the most time consuming aspect of revalidation.

> **Case study insight - Burden associated with reflective accounts and discussions**
>
> One registrant discussed how the process of writing reflective accounts and taking part in a reflective discussion as part of the revalidation process felt *'excessive'* and *'repetitive'*.
>
> *"I think the number of reflective discussions, I think it is five in total, is a little bit excessive. I think it's strange to have five because it then puts pressure on the individual to kind of come up with five different scenarios."* **Registrant**

The registrant explained that there was already daily peer supervision and support which enabled them to regularly reflect on and discuss their practice. They therefore felt that spending an hour and a half to discuss this with a reflective discussion partner seems unnecessary and repetitive.

However, it may not be the case that all registrants are able to reflect and discuss their practice during their everyday role. The registrant's line manager (who also acted as this registrant's confirmer, and has acted as a reflective discussion partner for other registrants she works with) reported seeing an increase in reflection among registrants since revalidation was implemented. The line manager felt that registrants had benefited from having a reflective discussion as part of the revalidation process, as it enabled registrants to take the time out to reflect and focus on good things that have happened in their practice. She felt that registrants may not have otherwise been able to do this due to their busy workload.

"You're so busy on a day-to-day basis you don't get time to draw breath and think about things so it is good to reflect on things. A lot of practitioners have been in post for a long, long time so we didn't do reflective practice when we trained so it's a new thing and a new way of thinking which is quite good and people have enjoyed it." **Line manager**

Reflective discussion: Having the reflective discussion was often seen as the most beneficial element for registrants and took comparatively less time. These discussions typically lasted around one hour, although some were said to be done in around 15 minutes and were deemed as less helpful because of this. More time was spent identifying who to have the discussion with, which was a burden reduced in cases where the employer suggested this or there was somebody employed in that role. Some registrants were able to incorporate the reflective discussion into their working day, while others had to find a suitable time in their lunch hour or at home.

"It was easy for me because the manager where I work took responsibility for that." Midwife, secondary care

Confirmation: Where the confirmation took place at the same time as the reflective discussion, this made the process easier. Registrants said this this typically took up to an hour, although one registrant said that it took half a day to go through their folder. Because registrants had already done the work required for the other revalidation requirements as a prerequisite for confirmation, it was not considered particularly burdensome.

Overall, registrants often reported that it was necessary to complete at least some of the revalidation requirements in their personal time. This was necessitated, not by the complexity of the revalidation requirements, but by the nature of registrants' roles (for example working on a busy hospital ward), which meant it was not feasible to find time to spend on revalidation requirements.

"When I work nights it's very difficult to do things during the day, so that's why I do things in my own time." Nurse, community setting

There were also examples of registrants incurring a financial burden from revalidation, such as taking a day of annual leave or placing a child in nursery for a day to complete the administrative aspects of

revalidation. While most registrants found that their employer funded their CPD, there are cases where registrants paid for external courses.

Overall, registrants did not view the revalidation requirements themselves as being difficult to meet, but it did place some burden on them as would have been expected. The evidence on the benefits of revalidation are covered in the next chapter, with how proportional it was seen overall being discussed in chapter 6.

5 Behaviour change among registrants and employers

The Theory of Change outlines that the anticipated outcomes and impacts of revalidation will be brought about by the entrenchment of specific behaviours among both registrants and employers.

Among registrants, it is theorised that undertaking the activities required by the revalidation process, coupled with the NMC's revalidation activities (which include communications, application support and verification), will lead to increased demonstration of the following four behaviours:

1. Proactively seeking feedback from patients, service users and colleagues

2. Staying up to date with professional practice through CPD

3. Proactively engaging in ongoing reflective practice

4. 'Living' the principles of the Code through practice

Although the revalidation process places no direct requirements on employers, it is theorised that the introduction of revalidation and the NMC's revalidation activities aimed at employers, will result in increased demonstration of the following two behaviours by employers:

1. Actively engaging with registrants about their practice

2. Undertaking regular appraisals

This chapter presents evidence of the extent to which, if at all, revalidation to date has led to an increase in the desired behaviours among registrants and employers. In common with many major theories of behaviour change, the evaluation considers behaviour change as a process. Within this process, the desired behaviour results from the interaction of three major aspects of change; awareness, understanding, and attitudes. This recognises that behaviour is part of an interacting system involving all these components.

The following sections describe the specific interpretation of these components in relation to registrants and to employers in turn. This is followed by an assessment of the extent to which, for each desired behaviour change, each component of the behaviour change mechanism is evidenced. Finally, chapter looks at the extent to which these behaviour changes have led to, or are likely to lead to, the desired cultural outcomes described in the Theory of Change.

5.1 Behaviour change among registrants

In assessing the extent to which revalidation has led to the desired behaviours among registrants, we consider awareness, understanding, attitudinal changes and behaviour changes according to the following definitions.

Awareness encompasses the degree to which registrants are aware of the Code, how to reflect, how to obtain feedback and available CPD. As a result of completing revalidation it is expected that registrants should have a better awareness of each of these than they did previously and have increased levels of exposure to them.

Understanding centres on the extent to which registrants can grasp the meaning and importance of the desired behaviours. This includes understanding the need to remain updated in terms of CPD, the need to seek feedback, the need to engage in reflective practice and the understanding of the links between the Code and good practice.

Attitudinal changes result from an increased level of understanding, and an increased demonstration of the beliefs that the activities undertaken during revalidation and described in the Code are beneficial, and more than merely tick-box exercises required in order to maintain a presence on the register. In the case where the desired attitudes already exist, then reaffirmation of these is anticipated.

Lastly, increased awareness, increased understanding, and specific attitudinal changes relate to increased demonstration of the desired *behaviours*. Specifically, that registrants actively seek feedback, engage in CPD, engage in reflective practice, and 'live the Code'. While registrants are only required to demonstrate that they have undertaken the required activities during the three years prior to their renewal date, it is anticipated that, if successful, revalidation will lead to registrants undertaking these behaviours on an ongoing basis. Again, it is possible that some registrants will already be demonstrating the targeted behaviours, and in these cases it is anticipated that the activities involved in revalidation will serve to reaffirm and increase these behaviours.

Proactively seeking feedback from patients and service users

As outlined in the Theory of Change, the practice-related feedback requirement is intended to encourage nurses and midwives to actively seek feedback from patients and service users. Flexibility was built into the guidance for registrants on this element, to account for the fact that not all registrants have patient facing roles, and as such they could chose to collect feedback from colleagues, although the focus is placed on patient and service user feedback.
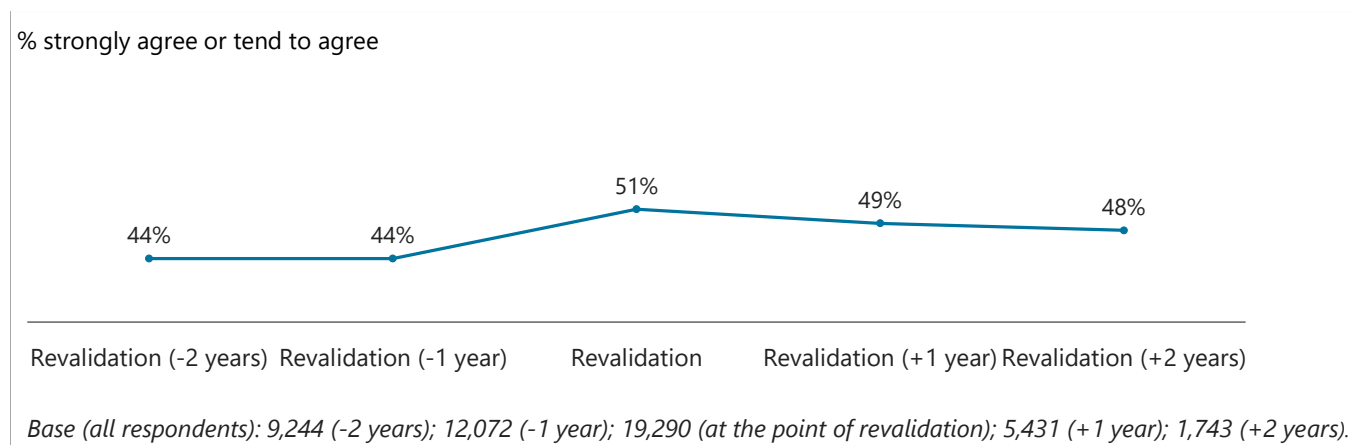
The Theory of Change outlines that ultimately collecting feedback from patients and service users should enable nurses and midwives to be more responsive to patients' and service users' needs. For the requirement to have sustained impact however, feedback should be collected on a regular basis, not just when registrants are approaching their renewal date.

Statistical analysis of survey responses suggested that undertaking revalidation impacted reported behaviour, leading to an increase the proportion of registrants who reported actively seeking feedback from patients and service users. Across the statistical models, registrants were estimated between 5.1. and 9.4 percentage points more likely to agree that they actively seek regular feedback from patients and

service users when they had revalidated (against the comparison group who had not revalidated). However, this increase was not completely sustained; two years after revalidation, the proportion reporting actively seeking feedback had dropped, but was not quite baseline level (48% against a baseline of 44%).

This finding could imply that the act of revalidation led to an increase in the frequency with which registrants sought feedback or, alternatively, that it led to increased awareness among registrants of their pre-existing behaviours.

Figure 5.1: 'I actively seek feedback from patients and service users on a regular basis'

% strongly agree or tend to agree

| Revalidation (-2 years) | Revalidation (-1 year) | Revalidation | Revalidation (+1 year) | Revalidation (+2 years) |
| 44% | 44% | 51% | 49% | 48% |

Base (all respondents): 9,244 (-2 years); 12,072 (-1 year); 19,290 (at the point of revalidation); 5,431 (+1 year); 1,743 (+2 years).

However, although revalidation led to an increase in registrants actively seeking feedback, this proportion remained low. Even at the point of revalidation – when registrants were most likely to report seeking feedback – only half (51%) reported actively doing so.

This low proportion is particularly striking as the data suggested that registrants understood the importance of seeking feedback and held positive attitudes towards how it could improve their practice. For example, at the point of revalidation, 88% of registrants agreed that feedback provides insight that helps improve their practice and 81% agreed that seeking feedback helped them to be responsive to patients' needs.

One explanation for the small proportion of registrants who actively sought feedback may have been registrants' low awareness of how to do so. Just 58% of registrants felt able to approach patients for feedback in each of the two years prior to revalidation. Midwives found approaching patients for feedback particularly challenging, with just 45% saying they felt able to do so. At the point of revalidation however, this proportion rose to 65% (57% among midwives), suggesting that undertaking revalidation led to increased confidence among registrants. This effect was not sustained though; two years after completing revalidation, the proportion of registrants who felt able to approach patients for feedback had returned to the baseline level of 58%.

In-depth interviews with registrants reflected these findings, demonstrating that registrants often felt it was inappropriate or awkward to approach patients for feedback.

"It's slightly awkward for nurses to find that sort of feedback. I was able to use cards that patients had given me, but I did find that awkward." Nurse, primary care

This was exacerbated for midwives, who often felt it was particularly inappropriate to burden new mothers with requests for feedback.
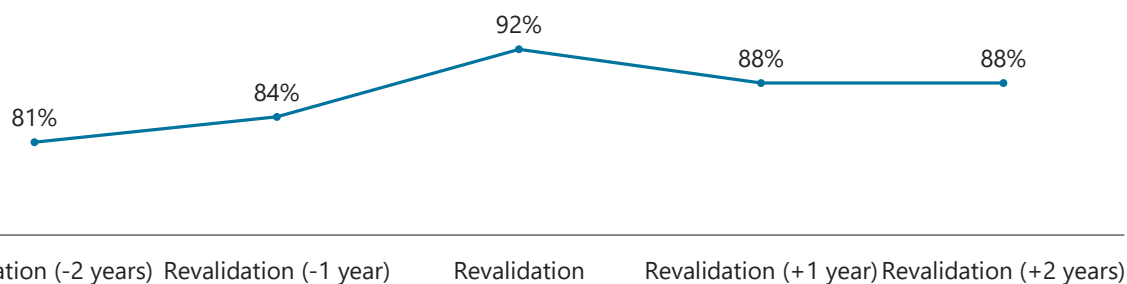
Staying up to date with professional practice

The revalidation requirements relating to CPD are intended to encourage registrants to actively engage with CPD activity in order to develop new skills and to respond to changes and advances in nursing and midwifery. This was deemed particularly important in the design of revalidation in light of the events investigated as part of the Mid Staffordshire NHS Foundation Trust Inquiry in 2010[50] or the Morecombe Bay NHS Foundation Trust review in 2015[51] and the possible contribution of a lack of CPD.

In line with these ambitions, statistical analysis of survey responses relating to CPD suggested that the revalidation process had an impact on reported behaviour; across the statistical models, registrants who had revalidated were estimated to be between 5.0 and 8.3 percentage points more likely to agree that they actively undertake CPD to keep up to date with developments in professional practice than registrants who had not revalidated. While this probability declined slightly in the two years following revalidation, it remained higher than in the two years preceding revalidation.

Figure 5.2: 'I actively undertake CPD to keep up to date with developments in professional practice'

% strongly agree or tend to agree

| Revalidation (-2 years) | Revalidation (-1 year) | Revalidation | Revalidation (+1 year) | Revalidation (+2 years) |

81%　84%　92%　88%　88%

Base (all respondents): 10,193 (-2 years); 13,304 (-1 year); 20,897 (at the point of revalidation); 6,133 (+1 year); 2,003 (+2 years).

As was the case for the feedback requirement, these findings could imply either that revalidation led to a more proactive approach to CPD or, alternatively, an increased awareness of pre-existing behaviours. The in-depth interviews with registrants suggested that a combination of both these effects was taking place. Registrants reported that the focus on recording CPD led them to reflect more on the CPD they had undertaken, but also caused them to take a more mindful and proactive approach to CPD than they had prior to revalidation.

"I've been quite mindful about making sure I do plenty of training. Now that I've got the folder, I've been keeping it up to date and adding to it, which I'd never done before." Nurse, community setting

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50 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Francis, R. (2013)
51 The Report of the Morecambe Bay Investigation, Kirkup, B. (2015)

The increased propensity of registrants to report actively undertaking CPD was bolstered by registrants' increased understanding of CPD's importance. In the year of revalidation, 93% of registrants agreed that keeping their skills up to date through CPD enabled them to improve their practice. While this proportion was slightly lower in the two years following revalidation (92% one year after revalidation and 90% two years after), it remained higher than the two years preceding revalidation (86% two years prior to revalidation and 88% one year prior). The importance of CPD was also reflected in the in-depth interviews with registrants, many of whom articulated the practical importance of CPD in their day-to-day practice.

"From my perspective, without participating in CPD I wouldn't feel confident in providing the service that I do to my clients. Good practice is evidence based so, unless you have the knowledge to provide that, it's not possible." Nurse, community setting

Positively, most registrants could find CPD opportunities that were relevant to their scope of practice. The proportion that reported finding this difficult decreased at the point of revalidation (to 23% compared with 27% one year prior to revalidation) indicating that, for the majority, relevant CPD opportunities were available. However, the proportion of registrants reporting difficulty finding relevant CPD opportunities was significantly higher than average among nurses working in occupational health (30%), learning disabilities nursing (29%) and adult and general care (24%).

Together, these findings indicate that revalidation had a positive impact on perceptions of the importance of CPD, the perceived availability of relevant CPD, and the proactiveness with which registrants undertake CPD (or their awareness of existing behaviours).

## Proactively engaging in ongoing reflective practice

The reflective account and reflective discussion requirements are intended to support nurses and midwives to identify ways to improve their practice, and areas of good practice that should continue. They require nurses and midwives to discuss their professional development and improvement, thereby ensuring that nurses and midwives do not practise in professional isolation. Ultimately, the requirements aim to instil an ongoing culture of sharing, reflection and improvement.

Statistical analysis of survey responses suggested that undertaking revalidation impacted reported behaviour; leading to an increase the proportion of registrants who reported proactively reflecting on their practice. Registrants who had gone through revalidation were estimated to be 3.5 to 5.4 percentage points more likely across the statistical models to agree that they proactively take time to think about their practice and how it can be improved than those who had not. While this probability declined very slightly in the two years following revalidation, it remained higher than the two years preceding revalidation, indicating that revalidation had a lasting effect on this measure.

It is again important to note that these findings could imply either that revalidation led to an increase in the proportion of registrants who reflect on their practice or, alternatively, that it led to increased awareness among registrants of their pre-existing behaviours.

Figure 5.3: 'I proactively take time to think about my practice and how it can be improved'

% strongly agree or tend to agree
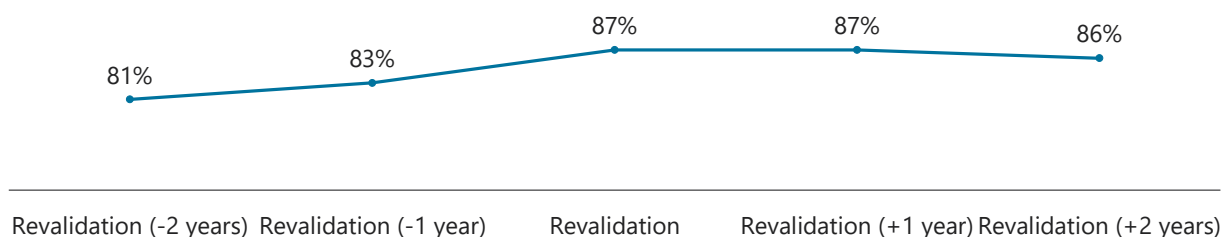
| Revalidation (-2 years) | Revalidation (-1 year) | Revalidation | Revalidation (+1 year) | Revalidation (+2 years) |

Base (all respondents): 10,193 (-2 years); 13,304 (-1 year); 20,897 (at the point of revalidation); 6,133 (+1 year); 2,003 (+2 years).

In contrast to the feedback requirement, registrants demonstrated a high level of awareness of what reflection entails, and relative ease in undertaking the reflective practice requirements. For example, only one-in-ten (10%) registrants reported finding it difficult to identify an appropriate person to act as their reflective discussion partner.

The in-depth interviews with registrants also revealed that, prior to the introduction of revalidation, many nurses felt they already incorporated reflection into their day-to-day practice; for example, by having informal reflective conversations with their colleagues. This was particularly the case for more recently qualified nurses, who tended to be knowledgeable about reflection – both in terms of the academic models of reflection and how to apply these models to practice. This was due, at least in part, to the emphasis placed on reflective practice by nursing and midwifery degrees.

"All the things that they ask us to do now, are things that we should have been doing all along. While you are in university you are always being told that you have to keep a portfolio that includes evidence of reflection." Nurse, community setting

As well as understanding the practicalities of reflective practice, there was evidence that registrants understood why reflection is an important way of improving practice. Again, this understanding was apparent before registrants revalidated; in each of the two years prior to revalidation, 91% of registrants agreed that reflecting on their practice was an important way of improving. The proportion of registrants who recognised the importance of reflection peaked at the point of revalidation and one year after (94%), before declining to pre-revalidation levels two years after revalidation (91%). These high levels of understanding were reflected in the in-depth interviews; registrants often thought that the reflective account and reflective discussion requirements were the most important of the revalidation requirements.

"I've always been quite committed to reflection and reflective practice because I feel like it's a really good way of learning." Nurse, community setting

As well as understanding the importance of reflection, many registrants reported that they benefited personally from reflecting on their practice. At the point of revalidation, 86% of registrants agreed with the statement *'I found it useful to take the time to reflect on my practice'*. A higher proportion of older registrants recognised the personal benefits of reflection than younger registrants (at the point of revalidation 93% of those aged 65+reported finding this useful compared with 86% of all registrants).

Demonstrating the effects of reflection, in the in-depth interviews, some registrants gave examples of how reflection had changed their own practice, or wider practice within their place of work. For example, one registrant used their reflective account as evidence to persuade their employer to change policies about drug administration to end-of-life care patients.

"It took me a month to write this particular reflection and I used it to present my case to the Heads of Department. They are actually changing the policy now, because they knew I was right according to the Code." Nurse, community setting

Together these findings indicate that registrants were aware of how to reflect, the importance of reflection, and the direct impact that reflection can have on their individual practice. These attitudes were strongly held before nurses and midwives undertook revalidation, however the data suggests that revalidation embedded these behaviours – or at least awareness of these behaviours – further. This was particularly the case among registrants who had been qualified for longer, and who may not have received formal instruction in reflection.

## 'Living' the principles of the Code through practice

The NMC encourages registrants to make use of the Code during the revalidation process, particularly when completing the reflective elements of revalidation. An intended measure of the success of revalidation is the extent to which registrants are 'living' these principles – i.e. they are practising with them in mind. Ultimately, the increased centrality of the Code is intended to embed common standards across the multitude of settings in which nurses and midwives operate.

Survey data indicated that the Code was fundamental to many registrants' practice. Even two years prior to revalidation, 84% reported that their understanding of the Code was central to their everyday practice. However, statistical analysis found that those who had revalidated were more likely that the comparison group to believe this. Across the statistical models, registrants who went through revalidation were estimated to be 1.5 to 2.6 percentage points more likely to agree that the Code was central to their everyday practice than registrants who had not revalidated. The proportion remained high one year after revalidation (90%) before declining to similar levels to prior to revalidation (86%).

The revalidation process had a greater impact on nurses and midwives who were open to change. Those scoring highest on the 'openness to change' index were 4.6 percentage points more likely to strongly agree that their understanding of the Code was central to their practice in the year of revalidation then one year before.

Figure 5.4: 'My understanding of the Code, and how it applies to my place of work, is central to my everyday practice'

% strongly agree or tend to agree
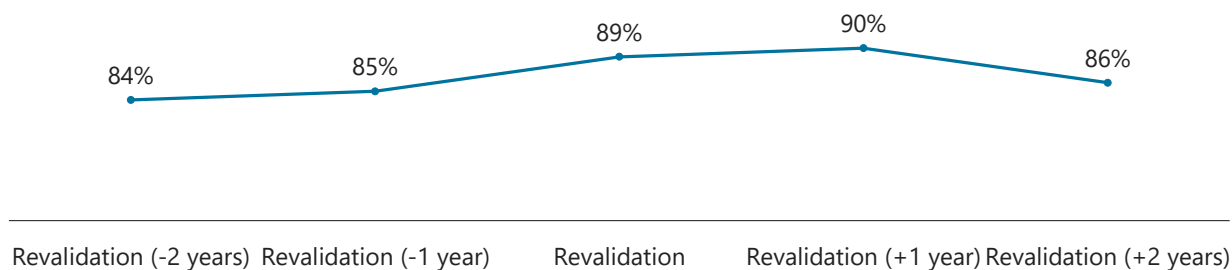
| Revalidation (-2 years) | Revalidation (-1 year) | Revalidation | Revalidation (+1 year) | Revalidation (+2 years) |

Base (all respondents): 10,193 (-2 years); 13,304 (-1 year); 20,897 (at the point of revalidation); 6,133 (+1 year); 2,003 (+2 years).

This increased application of the Code was enabled by registrants' increased understanding of the Code's content. At the point of revalidation, 88% of registrants agreed with the statement '*I have a thorough knowledge of the standards outlined in the Code*' compared with just 79% two years prior to revalidation. After revalidation, this increase was largely maintained; 88% of registrants agreed they had a thorough understanding of the Code one year after revalidation, and 85% of registrants agreed two years afterwards. Insight from the in-depth interviews also demonstrated an increased understanding of the Code, with registrants describing how the revalidation activities – particularly writing reflective accounts – had increased their knowledge of the Code.

"I referred to the Code all the time when writing the accounts and, without a doubt, it helped increase my familiarity with the Code." Nurse, community setting

Furthermore, application of the Code was enabled by a widespread awareness among registrants of how the Code applies to their practice. At the point of revalidation, almost all registrants (96%) agreed that '*I understand how the Code applies to the role in which I practise*', an increase from 91% in the two years prior to revalidation. Again, this increase was maintained, with 96% registrants agreeing they understood how the Code applied to their role one year after revalidation, and 95% agreeing two years afterwards.

"The bit on the form where it gets you to link to the Code, and think about how the Code applies, is quite good because, for me, that's not something that would automatically happen." Midwife, maternity services

Building on the existing widespread knowledge of the Code and understanding of how it applies to practice, revalidation has further embedded the attitude that knowledge of the Code helps improve the quality of registrants' practice. At the point of revalidation, 87% of registrants agreed that '*my knowledge of the Code helps to improve the quality of my practice*', an increase from 83% one year prior to revalidation. This increase was maintained one year after revalidation (87%) before declining slightly at two years post revalidation (84%).

5.2 Behaviour change among employers

The Theory of Change identifies specific actions for employers to take to support nurses and midwives through the revalidation process, which also demonstrate employer engagement with revalidation. For example, employers should help registrants identify opportunities for CPD, encourage registrants to seek advice or feedback, and encourage registrants to reflect on their practice. It is worth noting that, unlike registrants, the NMC cannot impose any changes on employers.

It is also important to acknowledge the limitations of the evaluation evidence concerning employers. The evaluation methodology included relatively few direct in-depth interviews with employers (although many other line managers, confirmers and registrants interviewed were employers and could provide the employer perspective). However, while selected to reflect different settings, those interviewed as employers were likely to be particularly engaged with the revalidation process, while other employers may have been less actively engaged. The survey data was also exclusively from the point of view of registrants, which provides useful insight but the NMC may want to continue to explore the option of an additional survey of employers as part of its ongoing monitoring.
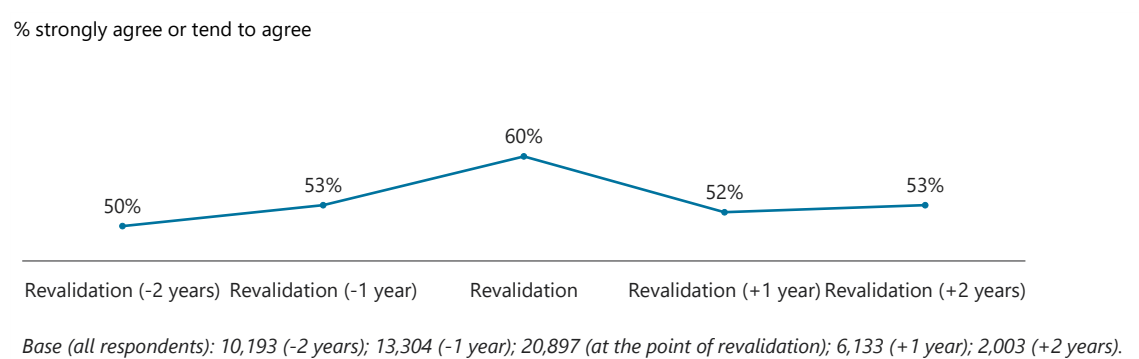
Nonetheless, the evaluation evidence suggests that, in each of these domains, employers provided more to registrants at the point they undertook revalidation than they provided before, or after.

Supporting the identification of CPD opportunities

It is anticipated that revalidation will lead to an increase in the proportion of employers that encourage registrants to participate in CPD, provide CPD opportunities, and support registrants to identify appropriate CPD opportunities.

Data from the survey of registrants indicated that revalidation had a positive impact on at least some of these domains. At the point of revalidation, 60% of registrants said their employer helped them seek opportunities for CPD; an increase from 50% two years before they undertook revalidation. Statistical analysis showed that, across the models, registrants were 6.4 to 8.5 percentage points more likely to agree that their employer helped them to seek out opportunities for CPD when they revalidated compared with the group who had not revalidated. Despite earlier findings on the differences in employer support by setting, there was no relationship between the extent to which the employer supported registrants seeking CPD and registrants' setting.

Figure 5.5: 'My employer helps me to seek out opportunities for CPD'

% strongly agree or tend to agree

| Revalidation (-2 years) | Revalidation (-1 year) | Revalidation | Revalidation (+1 year) | Revalidation (+2 years) |

Base (all respondents): 10,193 (-2 years); 13,304 (-1 year); 20,897 (at the point of revalidation); 6,133 (+1 year); 2,003 (+2 years).

Nonetheless, in-depth interviews with employers offered evidence of the additional focus that some employers were placing on CPD as a result of the introduction of revalidation. For example, several employers spoke about actions they had taken to raise awareness of the range of CPD opportunities that were available to registrants. Others went further, by encouraging registrants to carefully consider the type of CPD that would be most useful to improve their practice – in some cases as part of their annual appraisal.

"I worry that staff are leaving in droves because they don't feel supported, they don't feel they're given time. I'm really keen that we encourage appropriate CPD. But staff have to identify appropriate CPD, not just going on a jolly." Employer, independent sector

It was notable that relatively few employers mentioned that as a result of revalidation, they had either provided additional internal training, or had provided funding for registrants to attend external training. This indicates that, where employers did provide additional support for registrants, it was often limited to awareness raising and monitoring. Given the relative ease with which most registrants fulfilled the CPD requirement however, this does not appear to have caused widespread issues.

This increased support does not appear to have been sustained by employers in the years following revalidation, however; the proportion of registrants reporting that their employer supports them declined significantly one year after revalidation. This suggests that employers primarily provided support for registrants in the year they undertook revalidation, but not throughout the revalidation cycle.

In summary, employers appeared to have responded to the introduction of revalidation by acting to raise registrants' awareness of the types of CPD that are available to them. These efforts were highly focused on registrants who were approaching their renewal date and appear to decline to baseline levels once registrants have undertaken revalidation. There was little evidence of employers providing additional internal training, or funding for external training, as a result of revalidation.

Encouragement to seek feedback

The revalidation requirements are intended to lead to an increase in the proportion of employers that actively encourage registrants to collect feedback from patients and service users.

Statistical analysis of the survey data showed that those who revalidated were more likely to agree that their employer encouraged them to seek advice or feedback, than those in the comparison group who had not revalidated; this ranged from 6.0 to 9.5 percentage points, across the statistical models.

At the point of revalidation, 58% of registrants said their employer encouraged them to seek advice or feedback on how they could improve their practice; an increase from 50% two years before they undertook revalidation. There were no meaningful differences in employers' behaviour across settings.

Figure 5.6: 'My employer encourages me to seek advice or feedback on how I can improve my practice'
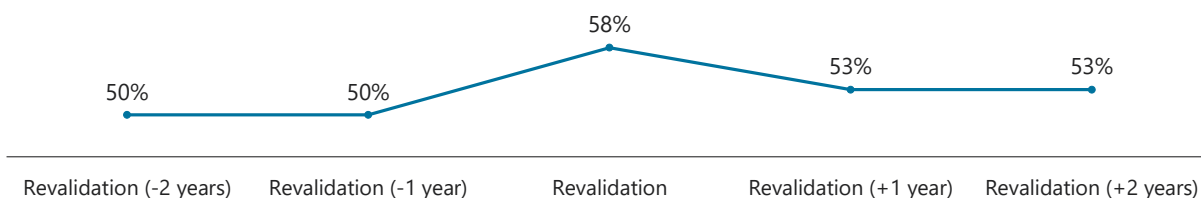
% strongly agree or tend to agree

Base (all respondents): 10,193 (-2 years); 13,304 (-1 year); 20,897 (at the point of revalidation); 6,133 (+1 year); 2,003 (+2 years).

The in-depth interviews with employers offered very little evidence of the ways in which employers encouraged registrants to seek feedback. However, there were one or two examples of employers who reminded registrants to use the comments book on their ward or collect relevant Friends and Family Test (FFT) feedback.

There was, however, a strong awareness among employers interviewed that – as detailed earlier in this chapter – many registrants found the process of collecting feedback challenging.

"The patient feedback is more of a challenge for us because obviously we have a lot of patients who are very, very ill." Employer, hospice

There was also an awareness among employers that the feedback used by registrants for the purposes of revalidation was often positive, with little constructive content or assessment. Some employers recognised their role in encouraging registrants to overcome this barrier by giving further guidance on how to give feedback. It was also suggested that the NMC could do more to support registrants with feedback.

"I think we could help people structure their feedback. It's easy to give good feedback, but we should be facing up to issues and talking about issues that need development. So, any support the NMC can give practitioners to do that would be good." Stakeholder

As was the case with support for CPD, the proportion of registrants reporting that their employer encourages them to collect feedback declined significantly one year after revalidation. This suggests that employers primarily encouraged registrants to collect feedback in the year they undertook revalidation, but not throughout the revalidation cycle. Alternatively, it may be the case that registrants had a heightened awareness of their employers' behaviours in the year that they undertook revalidation.

In summary, employers appeared to have responded to the introduction of revalidation by encouraging registrants to seek feedback at the point of revalidation. As with CPD, these efforts are highly focused on registrants who are approaching their renewal date and appear to decline to baseline levels once registrants have undertaken revalidation. There did, however, seem to be awareness among employers about the barriers that registrants face when collecting feedback, and potential weaknesses in the feedback that registrants do collect.

## Encouragement to reflect on practice

It is intended that, as a result of revalidation, more employers will actively engage with nurses and midwives regarding reflective practice.

The survey data indicated that this has been the case. At the point of revalidation, a higher proportion of registrants (67%) reported that their employer encouraged them to reflect on their practice than had done in the two years prior to revalidation (58% two years before and 59% one year before revalidation). Statistical analysis indicated that across the models showed that, registrants who had revalidated were between 6.3 to 8.6 percentage points more likely to agree their employer encouraged them to reflect.

However, as was the case with measures relating to CPD and feedback, the increased engagement among employers was not maintained. Two years after revalidation, the proportion of registrants who agreed that their employer encouraged them to reflect had declined to 61%.

Figure 5.7: 'My employer encourages me to reflect on my practice.'

% strongly agree or tend to agree
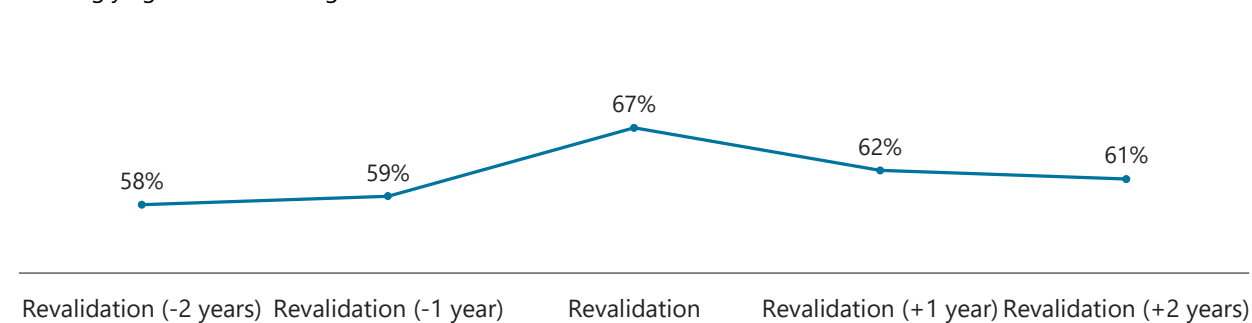
| Revalidation (-2 years) | Revalidation (-1 year) | Revalidation | Revalidation (+1 year) | Revalidation (+2 years) |

Base (all respondents): 10,193 (-2 years); 13,304 (-1 year); 20,897 (at the point of revalidation); 6,133 (+1 year); 2,003 (+2 years).

The in-depth interviews provided examples of the ways in which employers had encouraged nurses and midwives to engage in reflective practice. For example, the focus on reflection in the revalidation process had prompted one employer to introduce 'reflection sessions' with their team, which were a chance for NMC registrants and non-registrants to consider ways in which they could improve their everyday practise. Similarly, another employer discussed the wider support networks that had formed as a result of revalidation, and how those networks were being used to share, reflect and learn.

"I suppose it's just having that support network in place so if staff are having any difficulties, they can talk to us." Employer, agency

5.3 From behaviour change to cultural outcomes

As described in the Theory of Change, the following four cultural outcomes are desired effects of the revalidation process on employers and the workforce:

1. Improved responsiveness to patient needs

2. Embedding standards across the sector

3. Culture of sharing, reflection and improvement

4. Early discussion of concerns encouraged

It is anticipated that these outcomes will result from the behaviour changes described earlier in this chapter. However, for the behaviour changes to be translated to cultural change, they must be consistent across the workforce or employers (as relevant) and sustained over time.

Given that revalidation has only completed the first three-year cycle, it has not been possible to provide an empirically grounded assessment against these longer-term outcomes. Instead, the evaluation summarises the evidence towards these longer-term outcomes to understand likely direction of travel.

Improved responsiveness to patient and service user needs

The Theory of Change suggests that the collection of practice-related feedback will support registrants to become more responsive to patient and service user needs.

As outlined earlier in this chapter, revalidation led to a small increase in the proportion of registrants who report actively seeking practice-related feedback. However, this increase was not sustained; two years after revalidation, the proportion reporting actively seeking feedback had returned to its, relatively low, pre-revalidation level.

Additionally, both the survey responses and in-depth interviews revealed that registrants faced barriers to approaching patients and services users for feedback. As discussed in Chapter 4.3, these barriers often led registrants to collect feedback passively. For example, many registrants reported using thank-you cards from patients to fulfil the requirement for practice-related feedback. Although the NMC's guidance permits its use, there is recognition among registrants, employers and stakeholders that this form of feedback – which is often positive – can have limited value.

"My experience is that most nurses are using examples of positive feedback, and just talk about how good they are. I would like to see that as a change; you have to have at least three of them that are constructive." Employer, independent

These limitations indicate that the extent to which the feedback requirement has contributed to the anticipated outcome – that registrants demonstrate improved responsiveness to patient needs – is also restricted.

Embedding common standards for all nurses and midwives

The revalidation requirements place an increased emphasis on the Code as the central document underpinning good standards in the nursing and midwifery professions. Along with other behavioural

outcomes it is intended that this emphasis in particular should embed common standards across the multitude of settings in which nurses and midwives operate.

The evidence described in this chapter implies not only that revalidation has led to more registrants viewing the Code as central to their practice, but also that this impact has some longevity.

The in-depth interviews with registrants, employers and stakeholders provided some evidence of the beginning of this form of cultural change. For example, some interviewees reported noticing registrants referring to the Code more regularly in order to guide their everyday practice.

"It is nice that people are much more aware of the Code, I do get that quoted at me occasionally and that never happened before revalidation." Midwife, secondary care

In a small number of cases, registrants were able to give specific examples of where their knowledge of the Code had assisted their decision making in challenging situations. Stakeholders who interact with registrants regularly had also witnessed nurses applying the Code to practice with an increased level of comfort.

"The enhanced Code has been very well received; it feels like a very useful document, and people are using it proactively to support them in their practice." Unite

However, as well as embedding the Code among registrants, revalidation aimed to increase employers' awareness of the standards to which registrants must practice. Evidence suggests that this has been achieved to a limited extent. For example, both the survey data and in-depth interviews indicated that employers' engagement was focused on the point at which registrants undertook revalidation. Supporting this, some employers suggested that their engagement was primarily driven by a desire to reduce the risk of staff failing to revalidate, rather than to improve standards.

"We did lots and lots of comms around it. If I'm honest, it was so that we got to the point where if anybody failed to revalidate, they couldn't say they didn't know what they were meant to be doing." Employer, independent

Similarly, the in-depth interviews highlighted the perception that revalidation is a process between a registrant and their regulator, without the need for the employer to get involved.

"The nurse is really responsible and accountable for their own revalidation, but the home managers and regional directors are there to support anybody who has difficulties or who needs confirmation." Employer, independent

Increased culture of sharing, reflection and improvement

It is anticipated that an increased culture of sharing, reflection and ongoing improvement will be fostered by engagement in reflective activities.

The evidence presented in this chapter suggests that many registrants were already incorporating reflection into their everyday practice prior to the introduction of revalidation. It appears that revalidation further embedded these behaviours, or at least awareness of these behaviours (where registrants were already undertaking reflective behaviours but did not previously recognise them as 'reflective practice').

Whether the reported behaviour change reflects real behaviour change or not, the increased emphasis on reflection – which has been welcomed by most registrants - has the potential to contribute to a culture of sharing, reflection and improvement.

"I think it's definitely talked about more. When we have group discussions of a barrier we come across, or we need support and advice on a tricky issue, we use that as reflective practice. It's sort of part of our norm now." Nurse, community setting

Evidence suggests that in cases where formal reflection was already central to a registrant's practice, the additional focus placed on it by revalidation will help to reinforce these behaviours. In cases where registrants are less familiar with reflective practice as a concept, revalidation may encourage them to reflect in a structured and regular manner.

In addition, as noted previously, the evaluation found some examples of where employers were creating new opportunities for reflective practice or improving current practice across wider teams, such as the use of 'reflective sessions'. However, at this stage these are outlier examples, rather than suggesting wider cultural change.

Early discussion of concerns

One of the intended impacts of revalidation is early detection and resolution of concerns with registrants' practice. By creating an overall culture of reflection and encouraging regular appraisals, revalidation intends to facilitate early discussions around areas of concern, leading to the early detection and resolution of problems.

As discussed earlier in this chapter, the data suggests that revalidation may have helped to further embed behaviours relating to reflective practice. Reflection, in turn, could lead to earlier identification and discussion of emerging practice-related issues. However, some interviewees highlighted limitations in the ability of revalidation to achieve this both due to registrants only being required to revalidate once every three years, and the fact that registrants could chose not to reflect on. or discuss, more serious problems.

"As an employer I'm not so sure. You might have a member of staff who you have some low-level concerns about, and you might hope they would reflect on some of the concerns. And you might look at their portfolio and there be nothing in there about it." Chief Nurse, NHS trust

An alternative mechanism by which early discussion of concerns can be achieved is within regular appraisals. It is intended that the introduction of revalidation will prompt employers to introduce regular appraisals where they are not already in place. However, survey data indicated that, in the year revalidation was introduced, the vast majority (89%) of registrants had an appraisal at least once per year. The employers we interviewed also consistently recognised the value of regular appraisals in improving practice. Together these findings indicate that revalidation did not necessarily influence employers to begin having regular appraisals but that, for most registrants, these were already in place.

However, employers did report adapting their existing appraisal processes in response to the introduction of revalidation. This was typically to ensure the materials and processes used in appraisals reflected the aims and requirements of revalidation, for example, integrating the NMC's Code into appraisal requirements. Some employers also adapted their appraisal processes to include sections so they could utilise the evidence registrants gathered in order to revalidate, such as the feedback they collected or their reflective accounts.

Together, these findings indicate that, although revalidation may not have prompted the introduction of regular appraisals, in some cases it will have influenced the content of appraisals. Nonetheless, whether this or other aspects of revalidation will lead to earlier detection of problems is unclear, particularly as employers, confirmers and stakeholders were unsure about the appropriateness of using any discussion that takes place for revalidation in the role of employer.

6 Public protection and regulatory effectiveness

As noted in the previous chapter, revalidation is still relatively new which means it has not been feasible for the evaluation to provide an empirically grounded assessment on many of the longer-term outcomes of revalidation. As such, the same is true for the intended impacts of revalidation outlined in the Theory of Change.

However, it has been possible to collect data that starts to build an understanding of the future of revalidation and performance against some of the intended impacts. Therefore, this chapter outlines any additional evidence on the overall aim of revalidation to enhance public protection, as well as evidence on revalidation as a regulatory change. In doing so, it also begins to focus on the next stages for revalidation.

6.1 Shaping practice to enhance public protection

Through the continuous improvement in the quality of nursing and midwifery revalidation seeks to both increase public confidence in the quality of care from nurses and midwives and ultimately protect public health safety and wellbeing. The NMC designed revalidation as a process to facilitate safe and effective practice in order to achieve enhanced public protection.

To begin to assess progress against these longer-term outcomes and impact the evaluation:

- Measured registrant perceptions of their own ability to practise safely and effectively and the role of revalidation in this; and perceptions of the impact of each of the requirements on the ability to practise safely and effectively.

- Gathered evidence on whether stakeholders and employers thought revalidation had impacted public confidence or protection.

Overall, the experience of revalidation had a positive effect on registrants' perceptions of their individual ability to practise safely and effectively. Statistical analysis showed that those who had revalidated were between 3.1 and 3.9 percentage points more likely to say their ability to practise safely and effectively had got better, than those in the comparison group who had not revalidated.

However, this effect was not sustained as one year after revalidation this finding decreased; while 60% said this in the year they revalidated, this dropped to 56% one year after and 53% two years after.

Figure 6.1: 'Thinking about the last year, on a scale of 0-10, how would you rate your individual ability to practise safely and effectively as a nurse or midwife?'

% 'Got better'
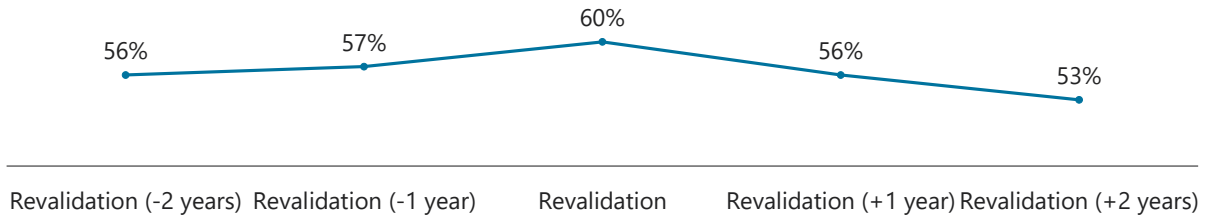
56%	57%	60%	56%	53%
Revalidation (-2 years)	Revalidation (-1 year)	Revalidation	Revalidation (+1 year)	Revalidation (+2 years)

Base (all respondents): 9,244 (-2 years); 12,072 (-1 year); 19,290 (at the point of revalidation); 5,431 (+1 year); 1,743 (+2 years).

Where registrants did think their ability to practise safely and effectively had got better, even after revalidation, most attributed this to revalidation to some extent. Two years beyond the point of revalidation, half (52%) of those who thought their ability to practise safely and effectively had got better, said this can be attributed this to revalidation to some extent, and a further quarter (25%) attributed it to revalidation to a great extent.

**Figure 12: Attribution to revalidation**
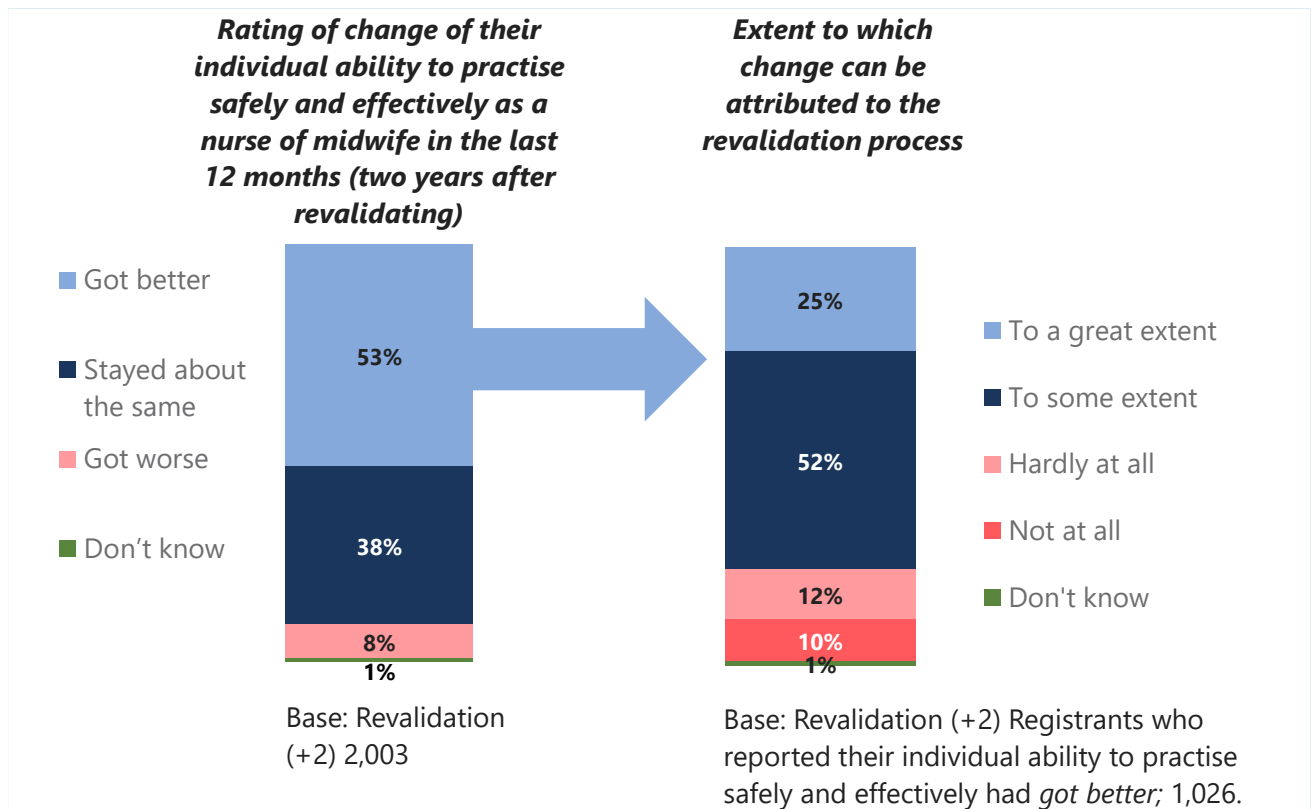
Registrants were asked about the impact of each of the different revalidation requirements on their individual ability to practise safely and effectively. Across requirements, in the year of revalidation a greater proportion said that the requirement had had an impact on their ability to practise safely and effectively than thought would be the case when asked two years before revalidation. For example, 89% thought undertaking CPD had had an impact on their ability to practise safely and effectively in the year

of revalidation, an increase of 7 percentage points from 82% among registrants two years before revalidation.

In addition, for all of the new requirements (other than the written reflective accounts) a slightly higher proportion thought there had been a positive impact on their ability to practise safely and effectively one year after revalidation. For example, while 86% thought having a reflective discussion about their practise had had a positive impact in the year of revalidation, this increased again to 88% one year after. This suggests continuous improvement in this measure, but the longer-term sustainability is still unsure as the proportion decreased again two years after revalidation across new requirements.

Figure 6.2: 'And for each of the individual elements of revalidation, how much impact, either positive or negative, to you think they have had on your ability to practise safely and effectively as a nurse or midwife?'
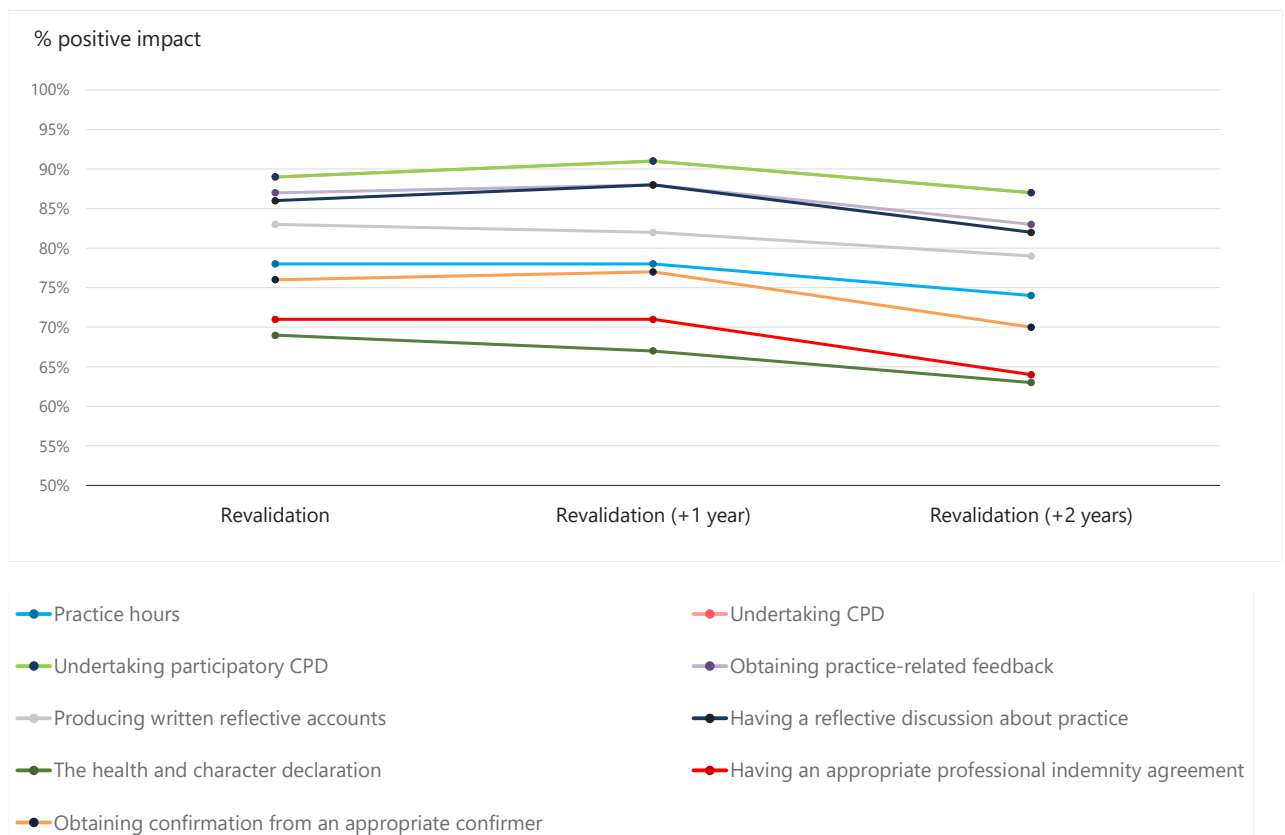
A similar pattern was seen across the requirements when registrants were asked about the impact of on the ability of nurses and midwives in general to practise safely and effectively. However, at each stage, a slightly higher proportion thought the requirement would have a positive impact on the ability of nurses and midwives in general, than thought it about themselves. This difference may reflect a wider theme around registrants reporting that they were already meeting many of the requirements, and therefore could see the value of the requirements more at an overall level, rather than for themselves.

Table 6.1: Proportion saying the requirements will have an impact on the ability of nurses and midwives to practise safely and effectively generally and on them as individuals

		Year of revalidation	One year after revalidation	Two years after revalidation
Base		*20,897*	*6,133*	*2,003*
CPD	General	92%	93%	89%
	Individual	89%	91%	87%
Feedback	General	89%	90%	85%
	Individual	87%	88%	83%
Reflective discussion	General	89%	90%	84%
	Individual	86%	88%	82%

Those representing patients and service-users, as well as stakeholders, appreciated revalidation's role as a process and framework to facilitate safe and effective care. For example, they noted that the aging population, and increased need for specialist health and care support, combined with workforce issues increases the need for nurses (and other medical professionals) to be up to date with the latest practice in several areas in order to ensure safe and effective care for patients.

In addition, these audiences could see the potential for revalidation to act as a 'safety net' to ensure that those nurses and midwives who are unable to maintain the quality and relevance of their practice are identified, and to ensure their skills are improved (e.g. keeping up to date with latest guidance on particular conditions).

Revalidation was seen as more prescriptive than Prep, which participants across audiences thought could possibly provide patients with the assurance that registrants are able to provide safe and effective care. One employer said that they now felt more confident they could reassure patients and the public, because registrants have a process that means they are up to date, effective and safe.

For others, although they could not directly attribute it to revalidation, they did believe revalidation could possibly have had a role or form some part of changes they saw to public confidence in the professions over recent years.

"About 7 or 8 years ago nursing had a tough time...we had the Francis report...and then we seem to be past that, and I don't know if that is just time, or we have this formal process...Whether it has had an impact on public confidence or that is just time passing but I don't think it can do any harm." Chief Nurse, NHS trust

Stakeholders also referred to revalidation as complementing or being 'a tool' that could be used as part of a much wider sector shift towards openness and learning in health and social care in order to enhance public protection. For example, one stakeholder talked about the reflective discussion in this context, saying that it fits with a wider ethos around reflection and can be used to facilitate openness and learning that leads to continuous improvement in patient care.

However, overall, consultations with employers, stakeholders and patient representatives thought it was unlikely revalidation would have achieved the level of cultural change necessary for public protection to have been impacted and highlighted the difficulty in evidencing and isolating any impact of revalidation overall.

Participants also thought the likelihood of revalidation ultimately having an impact on public protection depended on whether any limitations to the current approach are addressed in the subsequent revalidation cycles. This is covered in detail in the section below on regulatory effectiveness.

6.2 Improving regulatory effectiveness

One of the intended impacts of revalidation is improving how effectively the NMC is in carrying out its role as a regulator. As registrants continually improve their practice, the NMC has access to a large volume of new data which can be used to shape learning and in turn improve revalidation and overall regulatory effectiveness.

Stakeholders have across the three years recognised the potential for this data to be used to understand nurses and midwives and the settings in which they work. Stakeholders also highlighted the importance of this, particularly in the context of increasing demands on the workforce and therefore the role or responsibility the NMC has in supporting development of policy or workforce strategy at a UK and country-level. However, stakeholders have yet to see any evidence that the NMC is using this data effectively. Comparison to the way in which the GMC has made data available for interrogation was made as something for the NMC to explore.

In addition, alongside the monitoring carried out by the NMC, this evaluation has for the first three years of revalidation provided the NMC information and evidence on which to adapt and develop revalidation. Stakeholders highlight the importance of the NMC continuing to understand revalidation to be able to continually develop and improve regulatory effectiveness. The final chapter of this report outlines recommendations for how the NMC could continue to collect and use data on revalidation.

The rest of this section focuses on the relationship between revalidation and regulatory effectiveness in general looking at:

- The role and perceptions of the NMC; and

- Revalidation as a regulatory tool, including whether it is seen to be proportionate.
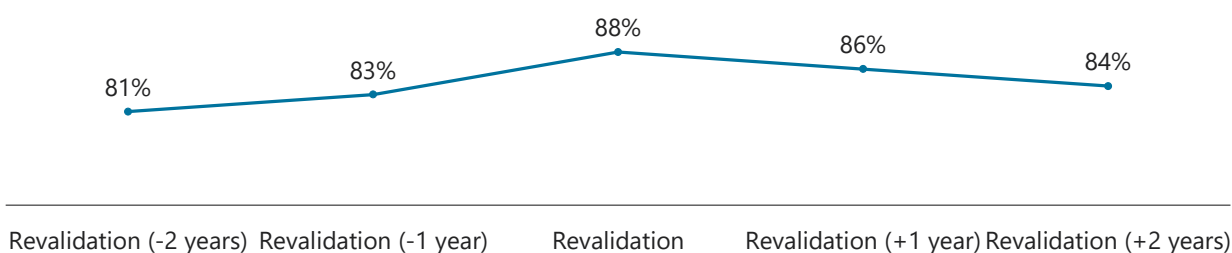
The role of the NMC

Statistical analysis revealed that those who had revalidated were more likely to agree that the NMC has a role in supporting them to maintain and improve their practice than registrants who had not. This ranged from 2.8 to 3.9 percentage points more likely across the statistical models, with this change being driven by a shift in registrants strongly agreeing (registrants who had revalidated were between 5.7 and 7.1 percentage points more likely to strongly agree).

There was also a relationship between the probability of registrants strongly agreeing with this statement in the year of revalidation and the openness to change index, with the effect being greater the more open to change registrants were. Those who scored highest on the openness to change index were 6.9 percentage points more likely to strongly agree with the statement in the year of revalidation then one year before.

Additional analysis across data sources supported this finding and provided further insight into the two years either side of revalidation. While findings dropped over the two years after revalidation, they remained higher than baseline level, with 84% saying this two years after revalidation.

Figure 6.3:   'The NMC has a role in supporting me to maintain and improve my practice'

% strongly agree or tend to agree

81%	83%	88%	86%	84%
Revalidation (-2 years)	Revalidation (-1 year)	Revalidation	Revalidation (+1 year)	Revalidation (+2 years)

Base (all respondents): 10,193 (-2 years); 13,304 (-1 year); 20,897 (at the point of revalidation); 6,133 (+1 year); 2,003 (+2 years).

Across the evaluation, stakeholders have been positive about the introduction of revalidation and the role of the NMC. The NMC has been seen to have handled the implementation of revalidation very well, and this is reflected in how the process has been experienced. Stakeholders said the number of nurses and midwives who had revalidated in the first cycle reflected positively on the NMC, and overall, like registrants much of the initial apprehension that stakeholders may have felt about revalidation had abated.

Stakeholders have not reported any issues with being able to contact the NMC regarding specific issues, and revalidation continues to be discussed in regular virtual meetings between the NMC and the CNOs from the four countries. However, the drop-off in levels of proactive engagement since the beginning of revalidation have been noted. While the NMC is not planning additional communications – such as regular email updates – with stakeholders, there are plans to further engage stakeholders as part of the NMC strategy development.

Revalidation as a regulatory tool

Equality and diversity

In its 2015-2020 strategy document[52], the NMC emphasises its role in promoting equality, diversity and inclusion across nursing and midwifery practice, and makes the commitment that its processes as a regulator will be fair and non-discriminatory. The NMC Code includes an expectation for nurses and midwives to challenge discrimination in their practice, to be mindful of differences and respectful to all patients, service users and colleagues.

In the context of revalidation, as a regulator the NMC is needs to be sure that revalidation process is fair and non-discriminatory. The NMC already holds data on the number of registrants revalidating by protected characteristic[53], however the current evaluation provides additional evidence on the experiences and outcomes of revalidation for different groups.

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[52] https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/strategy-2015-2020.pdf

[53] https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/revalidationreports/revalidation-annual-data-report-year-2.pdf

A key concern during the design of revalidation was allowing flexibility in the model so that it did not mean certain registrants – such as those who took parental leave or worked overseas – could not revalidate. A risk was that revalidation would mean those registrants could not renew, which would affect both individuals and workplaces. To understand this, the evaluation looked at renewal rates over the three years and compared them with rates under Prep.

In addition, the evaluation used statistical analysis to understand differences in the ease with which registrants across demographic groups were able to carry out each of the requirements and differences in the outcomes for revalidation. The analysis controlled for scope of practice and setting to distinguish if any differences were attributable to the fact a demographic group may be more likely to work in a specific setting which shapes differences.

Finally, quotas were set on many protected characteristics for the qualitative interview with registrants to explore any specific issues as they arose.

Across all of the evidence, was no evidence of substantial equality and diversity issues. Most notably, statistical analysis of findings for the key attitudinal and behavioural outcomes for revalidation did not find any variation across demographic groups when the effects of role and setting were controlled for, and differences in renewal rates were limited.

However, some differences across different groups noted throughout this report are summarised in more detail below:

Age

The evaluation found that renewal rates decreased for those aged over 65 when compared with Prep. However, these registrants make up only a small proportion of the total register and many in this category may not have been practising prior to the introduction of revalidation. This was also supported in the qualitative interviews across the evaluation, and particularly in the interviews with lapsers.

Therefore, there is unlikely to be a direct impact on staffing levels or the ability to fill vacant nursing and midwifery posts as a result. Nonetheless, stakeholders highlighted the importance of the NMC continuing to monitor renewal rates, particularly in the context of wider workforce issues and the need to retain staff of all levels and experience.

Ethnicity and gender

While there were no differences in the outcomes of revalidation across demographic groups, the evaluation found that broadly speaking White British and female registrants were more likely to say that they found the many of the requirements easy to meet.

In addition, there were some smaller differences in renewal rates: the revalidation rate was below 90% for the 'Asian/Asian British Chinese' or 'Other black' ethnic groups, and male registrants were slightly less likely to revalidate. However, several categories of ethnicity contain relatively small numbers and in general, differences are small.

The reasons for differences in ease of revalidation are likely to be wide ranging. As noted in the main body of the report, differences in workplace experiences overall could affect experiences of revalidation.

Disability and long-term conditions

There were differences noted in lapsing rates for those living with a disability. However, analysis of active lapsers' data suggested that disability differences in lapsing may be due to ill-health rather than aspects of revalidation. However, relatively few registrants actively lapse and further research may be necessary to fully understand the impact on registrants with a self-declared disability.

There were differences in experiences for those with long-term conditions. For example, registrants with a long-term condition were more likely to say that they had received no form of support from their employer to help them to successfully revalidate (9% of those with a long-term condition said this compared with 6% of registrants without a long-term condition). In addition, slightly higher proportions of registrants with a long-term condition found meeting revalidation requirements difficult, compared with registrants without a long-term condition: at the point of revalidation, 13% of registrants with a long-term condition said that they found collecting enough practice-related feedback difficult, compared with 10% of those without a long-term condition.

Overall, as noted above, the evaluation did not find substantial equality and diversity issues. In addition, the NMC is planning possible additional work on the experiences of their processes among those with protected characteristics. The NMC may want to make revalidation a key part of this, particularly bearing in mind the findings above, to ultimately understand in more depth where extra support would be beneficial.

Regulatory assurances in the model

There are two main mechanisms built into the revalidation model that provide additional assurances to the NMC as a professional regulator: confirmation and verification.

The process of confirmation, intends to make nurses and midwives accountable for their own practice and improvement, providing an additional layer of assurance (as well as increasing support and engagement).

Verification allows the NMC to monitor compliance with the requirements of revalidation for a proportion of those registrants who have submitted their application to revalidate.

Both mechanisms play a key role in ensuring that revalidation is seen as more robust than the previous Prep regime.

Confirmation

The findings suggest that registrants viewed the process of confirmation as an effective assurance measure as part of revalidation; at the point of revalidation, most registrants (85%) agreed that confirmation will successfully ensure that all registrants have complied with revalidation requirements, and three quarters (76%) agreed that confirmation will prevent nurses and midwives from making inaccurate declarations as part of revalidation.

As noted earlier, registrants typically said that undergoing confirmation was a beneficial part of the revalidation process as it made them feel more accountable for their actions, and this was particularly the case when confirmation took place with somebody more senior.

Employers had developed specific approaches around confirmation, reinforcing the NMC's recommendation for the confirmation to take place with a line manager as they also saw value in the confirmer being more senior.

Across audiences, confirmation was also seen as a more robust assurance than anything built into the approach for Prep.

"Before really, they would have just ticked the boxes and the NMC would take their word for it, whereas now they have that confirmation that everything is in place." Employer, independent

However, despite the overall positive view that confirmation will prevent inaccurate declarations being made, 8% of registrants did not think that confirmation would do this. There were also some concerns expressed across the qualitative work that confirmation could still allow registrants to 'slip through the net' because it is possible for people to hand-pick a particular colleague to be their confirmer. Employers and stakeholders also identified this risk, with one suggesting that it allowed more senior registrants to select their peers.

One patient representative also explicitly questioned the disconnection of confirmation and overall fitness to practise, given the confirmer does not confirm the registrant is fit to practise. They suggested that from a public perspective you would expect revalidation to be about an individual's fitness to practise, and that for revalidation to have the desired outcomes a more robust check is required.

Verification

As registrants engaged with revalidation, their awareness of verification increased, and this continued beyond the year of revalidation; 94% were aware of verification in their year of revalidation and this increased to 98% one year after their revalidation. However, this may be because registrants became more aware of verification by taking part in the survey over time.

The in-depth interviews showed that registrants did have a general idea of what verification was and what it involved, but many were unsure exactly how people were chosen and when it would be.

"I understand that they can call that up, but it's only very soon after you've revalidated, is that right? ...It's a random selection isn't it?" Nurse, secondary care

Nonetheless, the proportion of registrants agreeing that it is important for the NMC to check registrants have complied with revalidation requirements was high overall and increased in the year of revalidation to 93% (from 88% two years before revalidation), staying consistent in the two years after this.

A broadly similar pattern was seen when registrants were asked if verification will deter registrants from submitting fraudulent applications and when asked if verification encourages registrants to maintain evidence. Two years before revalidation, 79% thought that verification would deter registrants from submitting fraudulent applications, rising to 87% in the year of revalidation, and remaining similar beyond this with 86% saying this two years after revalidation. Similarly, although slightly higher overall, 87% agreed verification would encourage registrants to maintain evidence two years before revalidation, which rose to 92% in the year of revalidation and this remained at this level.

Figure 6.4: 'Verification will deter registrants from submitting fraudulent information in their revalidation application.'

% strongly agree or tend to agree
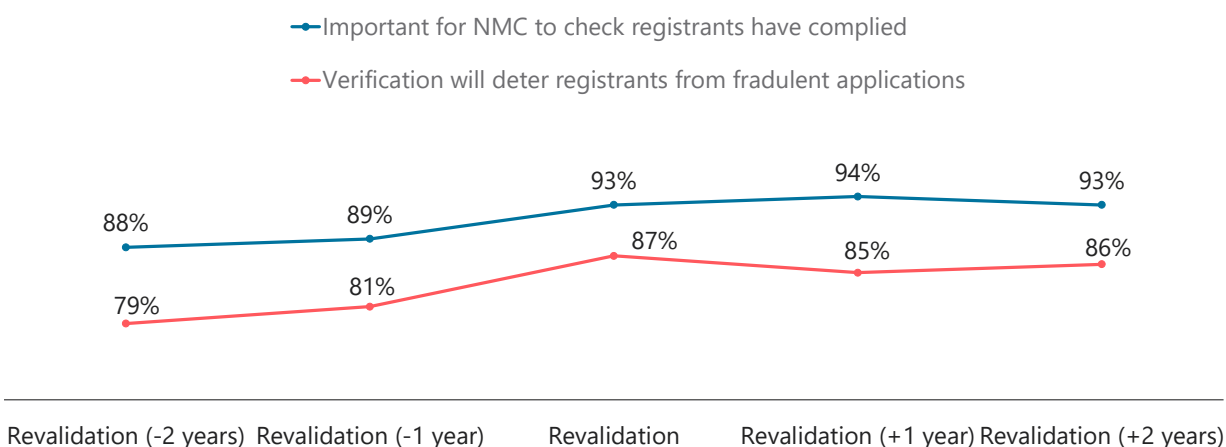
Base (all respondents): 10,193 (-2 years); 13,304 (-1 year); 20,897 (at the point of revalidation); 6,133 (+1 year); 2,003 (+2 years).

Stakeholders and employers saw verification as having a major role to play in ensuring that revalidation is a more robust process than Prep.

"Prep went so far but people viewed it as a reasonably weak system in that very few people were called up to talk through what they'd done" Employer, independent

Nonetheless, there were some potential future barriers raised across the evaluation. Firstly, stakeholders reported an ongoing lack of information on the verification process throughout the first three years, and this was an area of concern for them. Secondly, as noted above, many registrants did not know anybody who had been selected and this made them question the process of selection, suggesting adapting the approach to include selection by, for example, setting may be effective.

"I think they should say 'we will randomly select from this region, 5 documented evidence of revalidation from your unit...they've said they will but they never have to my knowledge. Nobody in my unit has had to do that and it's been 3 years, and we're a big unit" Midwife, secondary care

Proportionality

One of the key concerns about revalidation was that for it to be successful registrants would need to see any burden from the process as proportionate to the benefits.

The process evaluation found that, while the time registrants spent on revalidation varied, overall the ease of the process and meant that revalidation was typically not seen as overly burdensome.

At the same time, the outcomes evaluation findings in Chapter 5 also highlighted many of the key benefits to revalidation identified across audiences, such as reflection and greater focus or engagement with CPD.

Alongside this, a key strength identified across audiences was the formal regulatory structure revalidation represented; even where registrants were already carrying out some of the requirements revalidation provided structure and legitimised this work. This was a view also expressed by employers and stakeholders, who saw revalidation overall as an additional layer of scrutiny and assurance.

"My view is very very positive...it gives an additional element of scrutiny from the regulator point of view" Employer / stakeholder

Across audiences this formality was seen to better reflect the professional status of nurses and midwives, and meant it was more visible both to the public and to other health care professionals. Many registrants spoke about the positive effect this had on morale and, as noted earlier, it meant revalidation could become a tool or mechanism to reassure patients and service users.

Nursing's reputation had gone right down among the public so I realise that, as a profession, we need to regulate ourselves. So this is part of the process. It should have been something that was done years ago" Nurse, secondary care

This meant that participants could simultaneously believe that individual registrants did not necessarily need to engage a great deal with revalidation, but that it could still be an effective process and symbol of professionalisation.

However, the consequence of this was that revalidation did not always feel proportionate. Given registrants typically felt like they were already meeting many of the requirements, and that their employers made them accountable, they found it harder to identify benefits for themselves. This meant that the administrative work around revalidation felt more burdensome, and particularly so where registrants were using their personal time to complete revalidation.

"It will always be something I have to spend extra time doing in my own time...so I suppose in that sense, no, for me personally [not proportionate], but for others it might be different" Nurse, primary care

In this respect, revalidation set minimum expectations that many believed they were already meeting, rather than outlining what 'good' would look like which meant they did not feel benefits to the degree they had expected.

"Well, I don't get any benefit. I feel that you don't get any benefit out of it. It's such something you've got to have - it's a paper exercise really." Nurse, primary care

This was a sentiment recognised among employers, who saw their employees were meeting the standards set by the requirements and therefore may not realise the benefits, even where employers could still see the overall value.

"A lot of the feedback from the nurses [I employ] is that they don't really feel that it's worthwhile, but I do...I think it's very useful to be able to look back at what we're doing in different settings and be able to reflect on that. I think it's what we're doing anyway, but just formalising, putting it in writing" Employer, agency

In this context, the limitations of revalidation and the requirements identified in the previous chapter became more apparent to participants across all audiences, and in particular employers and stakeholders who have more of an oversight of registrants and revalidation. For some, this led them to question the evidence base behind specific requirements. Examples included: questioning the definition 'practice' for practice hours (for example, whether some registrants could be using activities they would not count as nursing or midwifery practice to count towards the practice hours); how the number of hours for CPD had been decided; and whether the same value of the requirements would be felt in the next stages of revalidation.

'We need to be clearer about what practice hours are. There are roles that do not require you to be a nurse and there can be a bit of play around. it is a bit of a grey area' Employer, Trust

"Where did that number come from, 450 hours, and the CPD hours - where do these things come from?...It would be good for registrants to understand where these things come from and what the logic of that amount is." Employer, Independent

This offers further context to the findings on the sustainability of outcomes; there is a risk that, as registrants question the requirements and proportionality of revalidation, the positive effects identified may not continue.

Overall, therefore, while many saw revalidation as a positive foundation, they questioned how the NMC will maintain the momentum, and highlighted the need to strengthen the model beyond this point.

"I think there's a place for it and it's really important that there is something in place like that - but at the moment, it's just not tight enough." Nurse, primary care

At the same time, stakeholders, employers and registrants also recognised that the NMC's register is broad and there are many different roles and settings across nursing and midwifery. Therefore, it was also seen as important that the NMC continues to retain a level of flexibility in the model. The final chapter of this report includes recommendations on how the NMC could look to achieve this balance.

7 Reflections and recommendations

This final chapter brings together learning from across the first cycle of revalidation, considering how well revalidation has performed against the intended objectives and outcomes to date and what this means for the next stages of revalidation.

7.1 Key reflections

The first cycle of revalidation progressed well and proved to be mainly successful against its objectives. There were no substantial issues with the process, and from the statistical analysis, positive effects were identified relating to nurses' and midwives' understanding of the Code and shifts in attitudes and behaviours. Revalidation was a contributing factor to these improvements, alongside other factors.

- Over the first three-year cycle the revalidation process—including the improvements made by the NMC during the first cycle—has proven to be a success. The vast majority of registrants (93%) completed the revalidation process as required, and most registrants reported that the process was straightforward with minimal burden.

- The findings suggested that there may be some groups of registrants who would benefit from additional support with certain elements of revalidation (particularly those working in settings with few other registrants) to ensure consistent experiences across the workforce.

- As a model, revalidation has performed well against the desired outcomes. The statistical analysis demonstrated that, across the evaluation outcome measures, there was a positive effect among those who had revalidated compared with those who had not.

- The reflective elements of the revalidation model were particularly valued by registrants, employers and stakeholders. Registrants were aware of how to reflect, the importance of reflection, and the direct impact that reflection could have on their individual practice. The requirements around reflection provided a good example of where revalidation acted to further embed behaviours that registrants were already engaging in before its introduction. This contributed to heightened awareness of the benefits of reflection in general.

- Revalidation also demonstrated success in placing increased emphasis on the Code. Statistical analysis found not only that revalidation led to more registrants viewing the Code as central to their practice, but that this impact had some longevity. It could therefore be inferred that revalidation may facilitate the embedding of common standards for all nurses and midwives in the future.

- Revalidation can be said to have improved responsiveness to patient and service user needs to a lesser extent. Although statistical analysis demonstrated a small increase in the proportion of registrants who reported actively seeking practice-related feedback, the proportion who reported this was low overall and the increase was not sustained post-revalidation. There was evidence that registrants experienced barriers to actively collecting feedback from patients, and passively collected feedback - which was often used - was seen as less likely to lead to meaningful change.

- There was also limited evidence on the extent to which revalidation has met its objective of encouraging early discussion of concerns. As discussed, the evaluation found that revalidation encouraged reflective practice among registrants, which forms one potential mechanism of identifying concerns. However, there were concerns that registrants may not choose to reflect on serious issues, limiting scope for this to encourage early discussion of issues. In addition, an alternative route to identifying concern, was intended through the link between revalidation and regular appraisals. There was some evidence that employers altered the content of appraisals to focus more on the activities emphasised by revalidation, such as reflection. However, there were also limitations identified around the overlap of the role of reflective discussion partner or confirmer and employer during appraisals, which means this also may not be sufficient to identify emerging issues.

- The evaluation evidence indicated that employers provided support to registrants at the point of revalidation. However, interviews with employers and registrants suggested that this was more about minimising the perceived risks to registrants lapsing associated with revalidation, rather than a recognition of revalidation's benefits to the workforce necessarily. This raises a concern that, as revalidation becomes more embedded, engagement from employers could decline; this poses a particular risk to the model, as the NMC cannot enforce changes among employers.

- A key strength of revalidation evidenced across the evaluation was the structure it provided and that it validated certain pre-existing behaviours and attitudes among registrants. Ultimately, it provided greater assurances than Prep that registrants were meeting minimum standards. Its formality was also seen to better reflect the professional status of nurses and midwives.

- However, there was evidence that many changes in behaviours and attitudes were focused on the point of revalidation, rather than being sustained. It may also be that any changes identified were based on the expectations of and level of engagement with revalidation in the first cycle, rather than the nature of the requirements themselves, bringing into question the longevity of change.

- Therefore, while the successful implementation of the model on such a large scale, and the positive contribution to changes in outcomes provide a good foundation for the next cycle of revalidation, there remain questions around the sustainability of change, and the potential for revalidation to achieve its longer-term outcomes.

7.2 Considerations and recommendations

Over the course of the evaluation, a number of future considerations and recommendations have been outlined for the NMC with the intention of improving both the experience of revalidation and to increase the chances of revalidation delivering its intended outcomes. The ways in which the NMC has already or proposes to address these are outlined in Chapter One.

This section focuses on the next stages for revalidation and considers ways in which the NMC can look to improve the likelihood that revalidation will achieve its intended impact. Considerations and suggestions made to the NMC over the evaluation that we think should continue to be a focus are also included.

Approaching change

As noted, the evaluation found that much of the success of revalidation in the first cycle lay in the implementation of the model and embedding it across nursing and midwifery, as well as the contribution it was seen to make to positive shifts in attitudes and behaviours.

The evaluation also found that, to maximise the outcomes and potential for sustainability, the next stages for the NMC should be around strengthening and tightening the model. However, the challenge lies in making changes to the model that do not then risk the successful implementation seen in the first three-year cycle.

The approach the NMC takes to change also needs to account for the parameters identified in the initial design of revalidation including:

- Ensuring the model is applicable to all the register, regardless of scope, role or setting, and bearing in mind the protected characteristics of registrants.

- Bearing in mind the principles of proportionate regulation, and not unnecessarily adding burden to the workforce.

- Working within the current legislative framework for the NMC.

Therefore, the recommendations outlined below have been shaped with this in mind, focusing on ways in which the NMC can:

- Strengthen the current model and maintain momentum without risking the foundations established in the first three years.

- Maximise the positive view of revalidation as a regulatory change and the role of the NMC in this.

- Look to collect additional information that can then be fed back into the revalidation process and model.

Alongside the suggestions below, we recommend that the NMC carries out additional work exploring the evidence base for the requirements. The review of evidence underpinning the design of revalidation and links behind the Theory of Change found that the evidence available, at that time, was limited. In addition, the evaluation found that registrants could not always see benefits to the requirements, and stakeholders and employers questioned the strength of the model. Therefore, in further evidencing the requirements, the NMC will not only tighten the assumptions behind the Theory of Change, but also ground any changes made to the requirements or overall model in the evidence, allowing for longer-term planning beyond the next cycle.

In the meantime, changes to the model following the first cycle do not necessarily need to involve adding new requirements or increasing the number of hours asked of registrants; they can instead focus on improving the quality of how registrants revalidate.

Therefore, as the starting point for change, we recommend that the NMC presents the current model as the minimum expectation and reshapes aspects of the requirements to encourage wider learning and development, complementing this with additional communications and work with employers.

Build on the reflective elements

The reflective discussion was consistently shown to positively affect awareness, understanding, attitudes and behaviour; it was also one of the most valued elements of revalidation.

Over the course of the evaluation the NMC has made changes to documentation on reflection and has reviewed the guidance on who should and should not be a reflective discussion partner with a view to strengthen this requirement. We recommend that the NMC maintains this focus beyond the first cycle building on the positive findings for reflection.

For example, the NMC could look to:

- Incorporate ways to encourage registrants to reflect on their previous reflective discussion and any learning since they last revalidated, including any changes to their practice.

- Ground the guidance much more in an established model of reflection, which could be done while still retaining flexibility in how registrants approach it. This is another way in which building the evidence base around the requirement could strengthen it. Although the NMC recommends models that registrants could use, much more could be done to shape materials and guidance around the models and approaches. It may be useful to engage with academics who specialise in reflection to support changes.

- Ensure reflective discussion partners understand the value in constructively challenging other registrants and provide them with tools to do so. Employers could also be more directly encouraged to provide feedback to registrants, discussing it with them in a constructive way.

- Provide reflective discussion partners with guidance on how to review reflective accounts – for example with a checklist - as an inconsistent approach to assessing quality was evident in the evaluation (both whether quality is to be assessed, and if so against what criteria).

The NMC could also look for other ways to bring a narrative of ongoing learning and development into the process. For example, the online platform and application process could be adapted so registrants are required to enter their top three learnings from revalidation. This would also provide the NMC with a valuable source of data.

Focus on the type of CPD

We suggest that the NMC looks at evidence on the relationship between the type of CPD carried out and the intended outcomes for revalidation, rather than focusing on the number of hours.

The current requirement for the number of hours of CPD (and participatory CPD) could then remain, but the NMC could provide additional supporting material to help registrants decide the types of CPD they carry out. Examples of what 'good' looks like for specific roles or settings could be provided and grounded in the evidence.

Make the feedback requirement more meaningful

We continue to recommend that the NMC looks to adapt the feedback element seeking to make it more meaningful to registrants, and ensuring feedback is used in a constructive, critical and helpful way.

The current approach intends that getting feedback from patients and services users will in turn result in greater responsiveness to patient need and improvements in practice, ultimately impacting public protection. However, to make the feedback element more meaningful the NMC could reassess these assumptions and the evidence for the relationship between feedback and responsiveness to patient needs and improved practice. For example, it may be that constructive feedback from colleagues on clinical competence or working with patients is more valuable and meaningful for shaping responsiveness to patient need and ultimately more likely to better protect the public. The NMC could then encourage and support registrants to seek feedback from colleagues as well, ensuring the feedback focuses on constructive assessments of their responsiveness to patient and service user need, or aspects of their role most related to this for non-patient facing registrants.

Other ways in which the NMC could reframe the feedback requirement to be more meaningful without adding burden include:

- Outlining the principles and value in constructive feedback in guidance documents, based on evidence where possible.

- Doing more to encourage reflection on the feedback overall, and potentially suggest at least one reflective account is focussed on feedback.

- Suggesting that registrants could use the feedback in discussions with their employer and during appraisals.

- Including a requirement for at least one piece of feedback to be discussed with the reflective discussion partner;

- Reduce the number of pieces of feedback but include a means for people to describe how they have used this feedback constructively.

The NMC is carrying out work with patients and service users on how they want to be asked for feedback to support registrants, and we agree this should be a focus.

There were barriers identified to approaching patients and service users for feedback and the NMC could also do more to support registrants in doing this. As part of this, the NMC could work with other professional regulators to create common approaches for collecting and using feedback not just from patients but from other healthcare professionals.

Continue to review the verification process

Over the course of the evaluation, the NMC has carried out some work to assess the effectiveness of the current verification process, testing a random sample approach alongside the risk-based model.

We recommend that the NMC continues to review verification, ensuring a robust process is maintained that verification serves its purpose. One way that could be explored as part of this would be to take an employer-level or regional focused approach in addition to the risk-based approach.

This could include selecting an employer or region with all, or some, of those due to revalidate in a timeframe being selected for verification in addition to those selected based on risk or at random. This could increase the visibility of the verification process, maintaining the effect it has in deterring non-compliance.

In addition, the NMC could explore ways to collect more in-depth or qualitative data for a proportion of those selected for verification in the future. For example, a short interview could be carried out with registrants, asking them to both confirm aspects of their revalidation, as well as some open-ended questions on revalidation and the intended outcomes; registrants could talk through a reflective account, or outline the learning from the experience, or discuss changes to their practice based on CPD or other elements. This would add additional assurances and provide an additional source of data for the NMC to use.

We recommend that the NMC reviews the format in which registrants are required to input information at the point of verification to ensure consistency with how registrants are asked to, or advised to, record information during revalidation.

Focus on employers

The Theory of Change highlights that the success of revalidation is reliant on employers' behaviours and attitudes. As with registrants, the positive outcomes for the first three-year cycle could be based on the expectations and concerns employers had (for example, concern about registrants lapsing).

Ideally the NMC would make changes that shape how employers had to engage with revalidation that would strengthen the model. However, the NMC faces two challenges in this respect:

- Employers of nurses and midwives are wide ranging and not always easy to define.

- The NMC cannot impose structural changes in settings or instruct employers.

Part of this risk can be absorbed through the flexibility in the model, as the NMC can encourage greater quality in how registrants revalidate, without registrants risking their registration if employers do not adapt.

However, if overall employers of nurses and midwives do not continue to engage with revalidation this would could negatively affect the likelihood of achieving longer-term outcomes.

Therefore, the NMC should:

- Focus on ways to continually engage employers, encouraging the changes needed for revalidation to succeed. We recommend this forms part of the communications strategy outlined below, but that additional strands of work are planned. This could include working with stakeholders who are able to influence employers across the multiple sectors and settings registrants work in.

- Encourage employers to make changes alongside any implemented for registrants. For example, supporting employers to implement structures to collect constructive feedback from patients and service users, and to work with registrants to reflect on feedback in a constructive way.

- Do much more to encourage similar behaviours that were shown to be beneficial in larger NHS trusts among employers such as those in the voluntary sector and care homes. For example, more could be done to encourage these employers to help registrants identify a confirmer or reflective discussion partner.

- Work with employers in larger trusts to provide support mechanisms and structures for the wider local health economy.

Revisit the guidance and support

Over the first cycle of revalidation the NMC has made changes to the guidance and documentation.

In addition, the NMC is currently considering the ways in which additional support or guidance targeted at non-NMC confirmers could enhance non-NMC confirmers' confidence in carrying out the role. We recommend the NMC continues to focus on this.

The recommendations outlined in this section are likely to necessitate further changes to the guidance and the NMC may want to release any updated guidance at the same time as planned communication activities around changes.

While there were no substantial equality and diversity issues evidenced, there may be additional targeted support the NMC could provide to groups who reported finding the process harder. In particular, we recommend the NMC revisits the guidance and support provided to registrants in settings with fewer other registrants, including those who are self-employed, as well as carrying out more work looking at revalidation among those with protected characteristics as outlined further below.

Reshape the communication strategy

Over the first cycle of revalidation the NMC has maintained levels of communication with registrants as they approach revalidation, sending targeted emails and updating the website over the first cycle.

As revalidation continues the NMC should ensure those registrants who are newly qualified still receive at least the same level of communication to ensure their first experience of revalidation is positive.

However, communications with all nurses and midwives beyond the first cycle will be important to ensure the momentum behind revalidation continues and increase the likelihood of sustainable change.

We suggest the NMC develop a communication strategy and plan that avoids positioning revalidation too much as 'business as usual' for registrants who have already completed revalidation and instead positions revalidation more as an ongoing journey, communicating how the recommended changes form part of this.

Carry out additional data collection and monitoring

As noted, one of the intended outcomes for revalidation is for the NMC to utilise the large volume of data revalidation generates to continue to develop revalidation and improve overall regulatory effectiveness.

Alongside the NMC's own review of the monitoring information and work with audiences across the sector, the evaluation has provided the main source of information for the NMC on revalidation. It will therefore be important for the NMC to have a clear plan for continuing to monitor and learn from revalidation beyond the first cycle.

Some of the recommendations above could lead to the NMC holding much richer information, such as the collection of qualitative information through the verification process, or ways in which the online platform could be adapted.

Other ways in which the NMC could look to monitor and review revalidation include:

- Work with other regulators to look at the data and assess ways it could be used to support the workforce or shape regulatory processes as part of the shared aim of public protection.

- The NMC has work planned to follow the end of evaluation to review all NMC processes in terms of the impact on registrants with protected characteristics. We continue to recommend that alongside this the NMC continues to monitor lapsing rates and work to diagnose the causes of issues or difficulties for particular groups should be continued. This will ensure any issues arising for registrants yet to undertake revalidation are detected and can be addressed.

- Look to repeat some of the survey questions to understand patterns in attitudes and behaviours, and whether the same pattern is seen in the second cycle, or if there is an increase or decrease at the point of revalidation.

- As new roles appear on the register – as is the case with nursing associates – the NMC should monitor that revalidation is achievable and beneficial for these new roles across settings.

- Look to create key performance indicators (KPIs) around the next stages for revalidation and changes made. The evidence review could be used to develop some of these, while others could look to focus on collection of data around the longer-term outcomes.

- Alongside stakeholders, the NMC should look for ways to continually engage with employers around revalidation, particularly as models of employment shift and change with sector changes. As noted, there are also limitations to the evidence the evaluation could collect from employers and the NMC may want to continue to explore the option of an additional survey of employers as part of its ongoing monitoring.

Ensure revalidation is 'future-proof'

Workforce challenges and changes to the register mean the NMC should look to periodically carry out future proofing assessments of revalidation. For example, changes to the sector mean nursing roles in particular are likely to move beyond the more traditional roles and settings and into the community working more closely with other teams.

These changes may mean the skills and experiences needed also change and revalidation should adapt to allow for that and reflect it. Workforce issues also mean the sector may adapt further to allow for more flexible working and it will also be important the revalidation is approached in the same way to account for different ways of working.

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