2018 NCSBN Annual Meeting - Revalidation in an International Context Video Transcript

Event
2018 NCSBN Annual Meeting

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Presenter
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- [Sara] Well, thank you very much indeed for that lovely welcome. I'm here this morning in place of our former chief executive, Jackie Smith, and I just wanted to start by paying a very short tribute to Jackie who was really the powerhouse behind introducing revalidation in the UK.

If there was ever a woman for whom the term, and yet she persisted was appropriate, it is Jackie who deserves that title of persistence because it's through her persistence and her sheer force of character and courage that she was able to introduce revalidation into the UK for nurses and midwives against some fairly substantial opposition and in a very difficult climate.

So, she's been an inspiration to everybody that works in healthcare regulations certainly and to me. Now, I am delighted to be here. I'm sorry you didn't get Jackie, but I am delighted to be here. And I'm delighted to be here for three reasons. Firstly, because I trained as a lawyer and I spent a long time working in legal environments with lawyers, that kind of stuff, but it was never really something I was very passionate about.

But then I discovered somewhat late in life that I had a vocation for healthcare regulation. And I don't know what your vocation is or how you start your vocation, but I have a number of friends who are nurses, doctors. And when I say, "Well, my vocation is regulation," they look at me slightly strangely, but it is, I absolutely think that working in healthcare regulation is a real privilege because you get to come alongside the most amazing people and help them deliver care to some of the most vulnerable people in society.

So, for me, it's a huge privilege. The second reason I'm delighted to be here is that I love revalidation. I just think it's one of the best initiatives that I've come across in terms of helping professionals to

understand how they can be better, even better than they already are. How they can take control of their own development while at the same time, not imposing excessive burdens on them, excessive bureaucratic burdens.

And it's always a very fine line, I think, in regulation, isn't it? You know, how do you get people to work effectively with you without being oppressive and in some of the things that you do? And finally, because we're introducing revalidation for nurses and midwives, is the most interesting job I've had in 25 years now, and I love it and I just hope that what… I have to say that you will find it interesting and valuable and yeah, so… Well, I thought I would do, is just explain what I'm going to cover in my talk this morning.

So, firstly, I'm going to start off with some background. I don't want to spend too long on the background, but it is important that you understand the context that we work in, what our role is, what we can do, and what we can't here because that very much impacted why we chose to do revalidation in the way that we did. I'm going to cover the standards that we set, the model we used, and why we designed it in that particular way.

And then I want to move onto some of the challenges that we had and how we approached those challenges and I think in the end, overcame them. And then just towards the end, I will cover our experience so far. We're two years in now with revalidation, what have we learned so far? And if I timed it properly, then we'll have some time at the end for any questions that you might have or any comments that you might want to have as well.

So, moving on then. The first thing I want to talk to you about is just like who we are, who are the Nursing and Midwifery Council in the UK? Well, we are the independent regulator for nurses and midwives in the UK. And our role, as it says here, is to protect the public. And we set standards of education, training, conduct, and performance so that nurses and midwives can deliver high-quality care throughout their careers.

So, obviously, fundamentally, like all of you, our role is to protect the public, but that has kind of three sub-objectives to it. We are required, obviously, to promote, protect, and maintain the health and safety of the public in everything that we do, but importantly, we are to promote and maintain public confidence in the professions, and that is a really, really important thing.

I think for regulators, we have to have legitimacy, not just with the people that we regulate, but the people on whose behalf that we regulate. People have to understand and have confidence in the professions and confidence in what we do as well. And finally, to promote, and maintain proper standards and conduct for members of those professions. And no one can work in the UK as a registered nurse or midwife.

Those are protected titles unless you are registered with the Nursing and Midwifery Council. So we are independent from government, but it is the government that gives us the power to do what we do. So we have a slightly challenging relationship with government, they have to clearly be on site.

We can't go off and do what we want to do, we get our legal powers from government. And any changes that we do, any changes that we introduce will need to be consulted on. We consult with a wide variety

of stakeholders, not just professionals, but employers, educators, academics, and unions as well. And everything we change and everything we do doesn't need to be agreed by government, but we are funded by our registrant's.

So, registrants will pay, I think, it's what, it's £120 a year, which I think is about $150, $160 a year to be registered. And they need to do that every year and every three years they need to renew the registration with us. So, our council was set up in 2002 under the piece of legislation called the Nursing and Midwifery Order, which gives us our legal legitimacy.

And we're governed by council of 12 members. There are nonexecutive directors, they are trustees of the charity that we are, we are established as a charity and they are made up...that council is made up of lay members and professional members as well. And they set our strategic direction, so they agree which, you know, what we're going to do and how we're going to do it.

And they also set the standards by which nurses and midwives need to work and these included behavioral standards, which I'm going to talk about in a minute under the code, not just the standards of technical competence that people need to meet. So we also have a set of behavioral competence standards that people need to operate under. So, our role, obviously, is to make sure that nurses and midwives keep their skills and knowledge up-to-date and uphold our professional standards.

And to do that, we maintain a register and we also investigate when people fall short of our standards. And we can take a variety of different actions, but the most serious action that we can take is to remove somebody from the register and to refuse to let them back on again. Another is, we do this for the whole of the UK.

So, this is another slight complexity in our role. You'll see from the map behind me that the United Kingdom is made up of four separate countries, England, Scotland, Wales, and Northern Ireland. And each of those countries has healthcare as a devolved matter, which means that they have their own budget and their own legal responsibilities for healthcare.

So, we don't just negotiate and engage with the Westminster government, which is the central government, but we also engage with them, all the different governments in the other countries as well. So they need to be onsite as well in the things that we do. But we regulate for the whole of the UK. So that's a slight challenge but sort of very interesting at the same time.

So looking at the wider context, you hopefully see from the slide that we are one part of a bigger system of organizations working to make health and care safe. But there's a number of things that impact on our ability to do that on regulation, on how people work that we are not in control off.

So we don't regulate hospitals or other healthcare settings, we don't regulate healthcare assistance, we don't represent or campaign on behalf of nurses and midwives. We don't set staffing levels or salaries, we don't define job descriptions or develop content for training courses, but we do need to engage very carefully with all the people that are responsible for this and, you know, issues such as regulation in hospitals or issues of people's salary.

And these are the things that can impact on what we do because they impact on people's willingness and

comfort with where they're working and that, you know, that creates a system of how happy people are really in terms of what they're doing. So, as I'm sure you know, the majority of healthcare in the UK is delivered through the National Health Service, which is our state-funded health service.

We all pay our taxes and we all have access to healthcare, which is free at the point of delivery. But we do also have mixed provision. So, there are independent hospitals, there are independent and private healthcare providers and sometimes the NHS will outsource care of like nonurgent operations to private healthcare providers as well. So there's a mixed provision. All social care is delivered through private companies.

So, there is, you know, quite an interesting sort of mix around with that. But what it means is that we need to engage with a very wide range of people and, obviously, there are factors that we can't control. So I mentioned salaries and working conditions. There's a very lively debate going on at the moment in the UK about the numbers of nurses and midwives in the system.

You know, there aren't enough nurses and midwives, people are leaving because they don't like to conditions that they're working in, we're not training enough people, we are increasingly reliant on people coming from outside the UK who are trained outside the UK to come and work for us, to come and choose to live and work in the UK.

And we don't always make it very easy for people to immigrate into our country. So, there's a lot of pressure on us because everybody wants to be pointing the finger at everybody else in a situation like this. And so, what we're finding is that people are saying to us, "Well, it's your bureaucratic standards that are making it so difficult for people to get onto the register." And we have to kind of engage with that, and we have to explain why that's not the case, but we also have to make sure that our systems of regulation are proportionate, and that we're not unintentionally standing in the way of people being able to come and work as nurses in the UK.

So that's just a little bit of the wider context that we're dealing with and some of the political messages that we have to handle. And we need to be the heir on the field, really. We need to be engaging with people and explaining why we do what we do because sometimes it's not always clear. And we need to be doing that. So this really is a little bit more about what we do.

I don't know how easy this little graphic is to see, but we have a range of tools in pursuit of our overarching objective for health and safety of the public. So we set the standards to join and remain on the register, so that's very, very important, first of all, so we need to make sure we're setting the right standards. We've just…over the last year, we've been consulting on new standards for nursing, the nursing profession and we're about to start a big engagement on midwifery, what the midwifery standards should look like.

So we have to engage with, again, a wide variety of people to make sure the standards are up-to-date and relevant for nursing practice in the 21st century. We assess education organizations to make sure that those organizations are delivering training courses that will enable nurses and midwives coming out of those training courses, of those degrees to be able to meet those standards.

And so, nursing is a midwifery. They're both degree professions in the UK and we make sure we

approve educational establishment, universities and the like, to make sure that they are delivering training courses that will enable the outcomes that we're looking for at the end of the day. We maintain a register of those eligible to practice and we act when there are concerns about conduct or behavior that doesn't meet our standards.

Ideally, if we do all of the first things well and with the introduction of revalidation as well, which makes people demonstrate every three years how they still maintain our standards. We do all of that right, the little bit at the end where we can take fitness to practice action against people that won't be necessary.

And that's the intention and one of our overarching strategic aims is to reduce the number of cases that we take all the way through to fitness to practice panel. And we're trying to think about lots of different ways where we can leave or change and improvements for people who are failing or not meeting our standards without necessarily taking somebody of gain that drastic step of taking somebody off the register.

Little bit about the register itself. So, we have a registry of approximately 690,000 nurses and midwives, and that's the figure as of April this year. It fluctuates daily. People come on and come off on a daily basis. The vast majority of those are nurses, 35,830 are midwives and an even smaller proportion are nurses and midwives.

Nurse and midwife or two separate professions in the UK and they're two separate registrations as well. So you are either registered as a nurse, or as a midwife, or you can be what we call a dual registrant, which basically means you're a nurse and a midwife and you've got both of those qualifications. And I've just put a couple of figures, really about the numbers of people that we have on the register who are trained outside the UK, but in the European Union.

That's 5% of our register, and you'll see nearly 10% of our register were trained outside the UK and the EU. And we are seeing an increase in those numbers of those people joining our register and we are becoming increasingly reliant, as I said earlier on people coming to the UK to choose to practice. So, I mentioned our behavioral standards. And our behavioral standards are codified, if you like, in the code.

That just explains what we ask people to do. It's not about their technical competence, their technical competence is measured, first of all, when they come out of university and get their degree and that technical competencies monitored and measured by employers when they're on the wards or working in practice. But this is about how they carry out their role.

So you'll see, we expect all practitioners to do four things. So it says it's a series of statements about what we expect practitioners to do. We expect them to prioritize people, to practice effectively as you would expect, to preserve safety, and to promote professionalism and trust. And that's about getting everybody to be responsible for the reputation of the profession and to be willing and able to speak out and challenge one another appropriately and professionally when they see standards are not being met.

And I'll explain why that's so important later on, but that is, that is what's set out in the code. I'm sure this is very similar to the sort of themes and standards that other people set it in terms of regulation. But what we expect revalidation to do is to embed those standards in everybody's day-to-day practice. And

so we've designed the revalidation system so that people are able to reflect on the code, provide evidence that they are meeting the code, and think about how else they might want to practice and what other things they might want to do in order to more effectively meet the requirements of the code itself.

Why is this important? Well, first of all, it's important for patients and service users. It's really important that they understand what they can expect from the professional that's treating them. And increasing…and I'm sure it's the same in the US, in fact, I'm sure you're ahead of us here, but we're seeing much more in the UK, a culture of patients being, you know, taking responsibility for their own health and being, you know, quite challenging back.

There was a…definitely, there was a culture of deference in the UK in the past, and that's going, that's not there with medical and nursing professionals now. People are challenging the care and it's really important that they're able to do that, and the code can help them do that. The professionals themselves can use it to promote safe and effective practice in their place of work, and that's I mentioned before about promoting professionalism, that's really important.

Employer organizations can use it to support their staff in upholding the standards in their professional code. What we sometimes hear is that, "I understand what I'm supposed to do, but I don't think my employer understands what you expect from me. Can you help me?Can you explain to them what you're expecting me to do, why I can't do that?" And this helps professionals say, "Actually, no, my regulator says that have to do these things in this way, so I can't do it. I know.I can't take that shortcut that you're asking me to take."

And last but not least, educators can use a code to help students understand what it means to be a registered professional and how keeping to a code can help us achieve that. I don't want to labor too much again, on raising a concern, but, we are responsible for investigating concerns about those on our register. So those can be raised by employers, they can be raised by patients, patients' families, or members of the public if they've witnessed an event that they feel is not, you know, representative of good health care.

The types of allegations we might investigate about misconduct, so how someone is not behaving properly, the fact that someone just isn't competent, someone has chosen to work outside the area of their competence and the code makes it very clear that you mustn't do that. They might have a criminal conviction, that's a very interesting one. We often see… We see that when we're looking at to make decisions as to whether people should come on to the register, know how important is it that somebody had a conviction for selling and supplying drugs 20 years ago when they were students but they've turned their life around now and they all, you know, are professional.

How important is that? And public perceptions are changing quite a lot on that point. Not having the necessary knowledge of English. Obviously, it's important that everybody can communicate in English effectively in a medical and healthcare environment, not just with patients and their families, but also with other professionals. And last but not least, having a serious health condition that isn't being managed appropriately.

We wouldn't necessarily take action against someone simply because they were ill, but it's about how they manage their health and what approach they're taking to that. So now, let's get onto our validation,

which is the thing that I am supposed to be talking to you about this morning. What is revalidation and why did we introduce it?

So I think the first thing to say that it is something that the public, and patients, and service users expect. When you talk to members of the public, they are quite surprised that this doesn't happen already. People say to us, "But, woah, you just join a register and then you work on that register for 40 years and nobody bothers to check that you're still competent and you still know what you're doing?"

They find that very surprising. And we've just recently carried out some focus groups with vulnerable patients and service users about their experiences of healthcare and what they expect from healthcare professionals. And I very much support the concept and the principle of revalidation. And I support the way that we have a designed it.

In fact, I think i probably should be a bit tougher. They worry that we're actually a little bit too, you know, being bit too easy on professionals. So, it is a public expectation that nurses and midwives will continue to be able to provide evidence that they are continuingly continuing to be so capable of safe and effective practice. And government expectations, very, very important. Driving public debate and government concerns have been a number of scandals over the past 20 years.

One of the most notorious examples… This is a doctor, not a nurse, but it is relevant, was a doctor called Dr. Harold Shipman who was convicted of murdering many, many of his patients. And he died by his own hand in prison. And although revalidation wasn't…it didn't come down out of the inquiry the subsequent public inquiry into why Dr.

Shipman was allowed to get away with what he did, why nobody noticed that all these people were dying. It became very much part of the conversation about, well, you know, we are aware that doctors and nurses can come on to a register and nobody bothers checking them, so that's got to change. And then, so by 2011, there was a system of medical revalidation about to be launched by the General Medical Council who are responsible for doctors regulation.

And the government produced a paper called Enabling Excellence and that was really basically saying, "We know doctors are doing revalidation, we think that the rest of you healthcare professionals, nurses, midwives, pharmacists, healthcare, other people working in healthcare, you all ought to introduce a system of revalidation as well. And then came the Francis inquiry in the report into the awful, awful failings at a hospital in Staffordshire, which is in the middle of England.

A dreadful situation where many patients were left lying in their own urine, denied basic food, and hydration. When people complained, when families complained, they were treated appallingly by doctors, nurses, and administrators at those hospitals. And it became a national scandal. How could this possibly happen? And the relatives of the people that were treated in this way demanded a public inquiry.

And that was led by Sir Robert Francis, who's a senior lawyer, we call them Queen's Counsel in the UK, his senior lawyer who led this inquiry and it went on for a long time and it introduced a lot of recommendations, particularly around how people can be encouraged and supported when they choose to whistle blow because many people were saying, "Well, I knew this was going on, but I was too scared

to say something about it. I knew that person wasn't doing their job properly. The system wasn't working for me. I didn't know who to turn to."

So, there's a lot in the inquiry, a lot of recommendations about how professionals should whistle blow and how they should be protected when they do whistle blow. And he also said that we, the Nursing and Midwifery Council, ought to introduce a system of revalidation. So, some of the things that came out of that was, we did a joint statement with the General Medical Council on how medical and nursing and midwifery professionals should choose to speak up.

They have a duty of candor, we call it. We say, "You need to speak up. You need to say and speak out when things aren't safe.: And that is a professional duty. And we then also confirmed that we would be introducing revalidation. In fact, our plans, were well underway by 2013, but what this did for us was give us an impetus and say, "Right, we have to introduce it."

You know, no more kind of debating discussing, let's go down. We have to introduce it and we have to tell people when we're going to do it and we have to tell people and we have to meet that timetable. And we did do so. We introduced our guidance and the final model in October 2015 and the first nurses and midwives began to revalidate in April 2016. So, what is revalidation then?

If you can see, hopefully, you can see pretty well on the slide, there's two boxes in the middle of those little boxes, a pink and a green one. And for me, they represent the heart of what the revalidation model is all about. And that is an opportunity for professionals to reflect on their practice and to think about how they're meeting the code and what else they might want to do, how they might want to improve that practice.

And we're not saying for one minute that people aren't, you know, operating effectively and so that everybody has to improve. That's not what we're saying, but everybody values that opportunity to be able to take time out and have that conversation and reflection with themselves and with other professionals in order to think about what else they can do in terms of their practice. And we're starting to see that people do very much value that.

So, every three years, nurses and midwives are required to renew their registration. That's always been in place since we had our order and in 2001, everyone has always had to renew their registration. But now they do that through a process we call revalidation. So what they have to do is they have to declare through an online system or make a series of online declarations that they have done 450 hours of practice over three years, that they have undertaken sufficient continuing professional development.

So that's 35 hours of continuing professional development, 20 of which must be participatory. And what we mean by that is that they must be engaging with other professionals. It's not just about reading articles and books on the Internet, it's about coming to an event like this. It's about engaging in webinars. It's just about thinking and participating with other people what in terms of their own professional development.

We expect that nurses and midwives will collect feedback from patients and we expect them to collect at least five pieces of feedback either from patients or colleagues or from carers and families. And then they reflect on that feedback and what they've learned through their CPD and write five reflective

accounts. And so that's the pink box, that's the written reflective accounts.

And when they've done those were written reflective accounts, they choose another registered professional, someone that is registered with the Nursing and Midwifery Council, either a nurse or a midwife, they don't have to share the same practice, scope of practice necessarily, but they choose another professional to have a discussion, a reflective discussion about what they've learned, how it relates to the code, and what they're going to go and do differently as they go forward over the next period of time.

And we're quite prescriptive about how they record their reflective accounts, it's not about length the academic essays although if you're an academic and you like writing essays, that's absolutely fine. People can do that. But what we do need to see is that there is some reflection on the feedback they've been given, what that means for their practice, what they're going to do differently, and how that relates to the code.

So that can be bullet points. It doesn't have to be… It just needs to be clear and clear to another person. And then they have a conversation with somebody else and they have that, you know, discussion about what they're learning. At the end of it, if you dropped right down below the reflective discussion box, is a confirmation discussion. And now that can be with any other professional.

We encourage that confirmation discussion to be with somebody who is registered with us, but some people don't always have access to people who are registered with us, particularly people working in the private sector. Maybe if they're working in a private care home which provides residential care for the elderly. They may be the only nurse there, so they may have to go outside sometimes to find people to support them.

But ideally, we want that person to be a registered professional with the Nursing Midwifery Council. And really the point of all of this is that they are accountable and it combats, we feel, professional isolation. It's about demonstrating to somebody else what you're doing and also getting some ideas and some feedback and being able to work with somebody else.

We feel that, you know, lack of accountability and a lack of engagement with other professionals isolates people and can be a factor that drives people into fitness to practice and we feel that that's something that we really need to combat through revalidation. That's why we've designed it the way we have. And then the last two boxes, it's just these are two standard declarations about having suitable professional indemnity insurance for the scope of practice you're carrying out and that you are of sufficient health and character in order to be capable of safe and effective practice.

So they're basically standard declarations. So now I'm going to talk a little bit about the design and implementation phase. So how do we design revalidation and how we implement it. And I think, in particular, how we implemented is something that is very, very important because we spent a long time engaging with people and we worked closely with a huge variety of people to make this happen.

So this also something that we just did on our own. So, I'll tell you a little bit more about that and some of the challenges that we had. Now, I'm sure it's the same here. There is a huge diversity in practice, so we had look at various different models.

Well, would there be a special requirements for people who work with patients? Do we want special requirements for people who work in leadership roles, who don't have, you know, clinical practices, who aren't accessing patients? Not necessarily, do we want special requirements for academics? No, I don't think we do. What we have designed is a system that everybody can use regardless of their scope of practice because the reflections and the evidence that they collect are based on that individual scope of practice.

So if you're a director of nursing and you haven't seen a patient in a long time, you still have a scope of practice and you collect the evidence relevant to your scope of practice, the same way that a nurse working in the emergency ward would do. And I think the first thing to say really about this is that we were very lucky to have learned from the experience of introducing revalidation for doctors.

And it wasn't just me, but I've seen member of my team who went into the NMC to help them develop the model. And we'd seen it firsthand how important it was to understand the diversity of the register and how, if the system was going to have any legitimacy, it had to be proportionate and flexible enough to cover all types of registered practice because we just couldn't, you know, manage all these different separate systems.

It had to cover all types of register practice. And we've already being prescriptive on the collection of types of feedback. The general medical council had a very, very difficult time. They have quite prescriptive about the types of how doctors should collect patient feedback. A lot of doctors were quite resistant about that, patient groups were quite anxious and angry about the resistance to some of the collection of patient feedback, and that became a really big thing and still is a thing that the General Medical Council or working with.

And so, we avoided being prescriptive. One of our challenges is maybe we should have been a bit more prescriptive, but that's for another day. So, we've been prescriptive but say, "Go out, collect feedback." And, you know, "We'd like you to collect feedback from patients, but, you know, think about how it's best for you to do that because it's not always appropriate and it's not always easy to collect patient feedback.

And we also offered flexibility in who could be the reflective discussion partner and who could be the confirmer partner as well. Again, the medical revalidation model has embedded in statute, in the law that a senior doctor has to make a recommendation about a doctor's fitness to practice to the General Medical Council.

And, again, that, you know, caused a great deal of anxiety, and debate, and tension within the profession. So we've avoided that. In fact, we completely decoupled revalidation from fitness to practice. What we say is that what you're doing is you're trying to demonstrate you still are capable of safe and effective practice. What we're not asking anyone else to do is make a decision and make an assessment of your fitness to practice.

Ultimately, that's our job if there is a problem, but what we were seeing with doctors was that some people were kind of waiting for revalidation before they started to bring up issues. They were too scared. Some employers, some other colleagues were too scared to bring up issues and said they were waiting

for the revalidation point to be able to say, "Oh, good. I'm now going to raise a concern about this doctors fitness to practice."

And so, we've avoided all of that. And what we say is, "Look, you know, if there's a concern about fitness to practice, you raise it now." You don't wait for two and a half years when that, you know, person is due to revalidate. Do it now, and that's what you're expected to do as an employer. That's what you're expected to do as a colleague. And I think that's really important because that's one of the ways we were able to allay fears and anxieties.

This isn't about an assessment of you, it's very much led by you as a professional. No one is going to be breathing down your neck and saying, "Well, I'm not sure you're good enough." You're not having to do another exam, this is about you and your own development. Instead, we've sold it as an opportunity to take time out to develop and reflect, and this is how it has been largely received.

I mentioned right at the beginning that we need government approval to change our rules and for a variety of complicated reasons, we weren't going to be able to get that approval. So we weren't going to be able to change our rules, we had to work within our existing rules. And we made a virtue out of the fact that we weren't able to do that by basically saying to people, "Look, we have an existing system of renewal of registration, so we're going to build on that.

So this is really all about just being more specific about the types of CPD. This is all about CPD with being more specific about the types of CPD we expect you to do and how we expect you to deal with it. So you're already doing some of these things already and it won't be too difficult for you to then build on this and do revalidation. So that was a big help for us as well. So I mentioned at the start we had a wide range of stakeholders in the healthcare system and as well as each country having its own system of healthcare regulation, they have their own healthcare regulating systems regulators as well.

So that's some added areas of complexity. And nurses and midwives don't work in isolation, they work as part of multidisciplinary teams now. They work with doctors and pharmacists and other healthcare professionals. So, we have a lot of people we needed to engage with. So all of these people were our partners during the delivery of revalidation.

And we set up formal program boards in each of the four countries like you would for any change initiative, so each of the chief nursing officers for that particular country would chair that program board and those boards had risks and issues, logs and papers and policy papers would be taken to those boards so that we could gain agreement on what we were doing across all of the countries of the UK.

There were lots of less formal stakeholder meetings as well. So we had our own revalidation stakeholder group. We brought people from across the healthcare system to talk about what we were doing, getting ideas, asking for their advice and support. And there were lots and lots of conferences that we went to. It became… we started to build an anticipation of revalidation.

And I was very struck by the colleague yesterday on the panel for international regulators when she said about…colleagues from Jamaica said about building a drum beat for change. And we started to build that drum beat out there. So, wherever there was a conference on continuing professional development or revalidation and they wanted us to be there, we were there. It didn't matter where it was in the UK.

Some of them were, you know, great prestigious conferences like this and some of them were little events in small community halls. But if it was about revalidation, we were there telling people what it was about and allaying fears. I think most importantly, we were willing to listen. We listened to what people were saying to us and changed when we had to. We piloted our original model from January to June in 2015.

And our original model was… Sorry. Was all about you know, people collecting a portfolio of evidence and then submitting it to us and we would have a look at that and we realized that that really wasn't going to work through the pilots. So that's how we've ended up with a system of online declarations. So we consulted and we changed and we showed that we were willing to change and that built goodwill, I think.

And we developed very good guidance. We developed case studies with real nurses and midwives. Here's how, you know, we used the pilot to say, "Here's how you might do it." And when senior nurses, senior professionals in the field were willing, we got them to do case studies and we developed this amazing, well, I think is amazing.

I didn't develop it, so I'm not claiming my own credit here. A microsite within our website that contains everything you need to know in a very user-friendly way about revalidation, whether you're an employer, whether you're somebody seeking to revalidate or, you know, even if you're a patient, you can see very easily what nurses and midwives need to do. So, I think the result of this is that we have a system that everybody has a stake in.

People own revalidation about people coming up to me two years later and they're saying to me, "You know what, Sara, we did not introduce revalidation so that, you know, this could happen." So, I'm accountable as the person leading on this to lots of people out there to make sure that we stay truthful and faithful to the model that we introduced. Finally, I just mentioned very quickly conflicting political agendas.

I'm being political with a small P effectively. It wasn't a party political issue but, essentially, lots of people wanted lots of different things from revalidation. Some people wanted it to be a very strict system. Some people were concerned about the burdens on people in an otherwise pressurized system and so we had to kind of navigate our way through that. And, again, engaging, talking, debating, compromising was the way that we did that.

So what's our experience so far been? Well, it's been very, very positive. I have to say, we are very pleased. We all, as we say, not complacent, but we are cautiously optimistic that we aren't getting to where we need to be. So, what we got here is just a little slide that explains the results from two years in.

And this is a summary of the second year results. And these are very similar to the first year results and it might be helpful to explain why we report it in this way. One of the main concerns that government had about us introducing revalidation was that people would leave the profession. It would be too much, it would be too much of a burden and we'd have less nurses and midwives as a result of it.

So what we did was we made sure that we published once the renewal rates were prior to revalidation

and post revalidation and what you're seeing here, a 94% validation rate across the UK is entirely consistent and, in fact, an improvement on the previous rates of renewal, so we're able to demonstrate to everybody that we are not creating problems in the profession and, in fact, people are choosing to revalidate and that they're valuing it.

I won't talk too much about this, but you can see the different revalidation rates by country. They're very similar revalidation rates by profession as well. And you'll see, obviously, that probably, as you would expect, the vast majority of people are revalidating in England. So, how do we know that it's working? This is a bit of a challenge and it's a very, very legitimate question because we aren't and we can't review every single nurses or midwives portfolio of evidence and approve or disapprove it.

The sheer volume of 690,000 people, we can't do that even if we're only doing a third of the register each year. We've taken an approach, an assurance approach that says, "Well, we are going to develop a package of assurance. So the first thing that gives us the assurance is the reflective discussion with NMC registrants. And we're talking to those reflective discussion partners and getting their feedback about what they're seeing.

And what we will do is we'll sometimes check in with that person and we'll say, "Did this discussion happen? Do we have, you, know, written evidence of that?" The next piece of assurance we have is a confirmation discussion with another professional. Again, we will check in sometimes with it with that person and say, "Did this confirmation discussion happen? We're carrying out an evaluation and we are verifying a proportion of our applications.

It's a very small proportion of our applications at the moment, but when we select people, on a random basis and also on a risk basis depending on where they work and the kind of environment that they work in and we ask them, we say, "Okay, can you give us evidence that you've met the requirements, please?Can you tell us about your practice hours?"

We look to see where his practices were, in fact, registered practice. Did you do appropriate CPD? Does it relate to your scope of practice? Did you have this confirmation discussion? Did you have this reflective discussion? You know, all of these things we check in with people. So, we are finding that in some cases, the evidence for this is not forthcoming and those individuals are choosing to take themselves off the register at that point.

If they seek to readmit further down the line, they will then have to produce all their revalidation information before we allow them to readmit. And the decision to allow them to readmit will be taken by the registrar or by one of our nominees and assistant registrar. So that's very important, it's not an automated process.

We look very carefully and we look at the reasons, "Well, why didn't you provide us with that information? Why didn't you revalidate when you were supposed to?" Our main challenge is that people are not hearing about this because we're doing quite a small proportion and there is a perception out there that might be quite easy to make false declarations and that's something we really need to be careful of because it risks undermining the legitimacy of the model.

But we are going to do more about this. So what about those who don't comply? I've mentioned those

who refused to do it or lie about doing it, but there are people who choose not to remain on the register. And we've carried out a number of surveys with people who take themselves off the register.

We call it lapsing. They take themselves off the register. And we've done that. The first survey we did was for people who took themselves off the register, regardless of whether their revalidation was due or not, and asked them why. And their top reasons were retirement, 50% of people thought of retirement. They were no longer practicing, so again, in an older age group and they were too ill to practice. And my heart went out a little bit.

Again, the international regulation panel yesterday…the colleague from Amman who said nurses can retire at 42. Wow, in the UK, we can retire at…nurses can retire at 55, especially if they've been working in the National Health Service. So that is an issue for us especially if the system becomes more pressured. Why would I continue to do this? Now, revalidation is mentioned but it's a six most important reason for people leaving.

So we're not complacent that revalidation isn't a factor, but it isn't the top factor in people choosing to leave. The second type of a survey that we did was about for those who are due to revalidate and told us they weren't revalidating because they couldn't meet the requirements. We asked them about that. What they're saying to us is the majority, they can't do the reflective discussion, or do the written reflective accounts, or meet the practice hours.

And these three things are linked, we find, because if you're not doing the practice hours, and bear in mind, 450 hours over 3 years is not a lot of practice to be doing. If you can't even do 450 hours, you probably aren't doing very much work. You probably aren't plugged into a professional network. You're not going to be able to find someone to do reflective discussion or, you know, get feedback from. So these were the most common requirements.

And so, again, not complacent, but we think, well, those people probably shouldn't be on the register and it's not really revalidation that's driving them off, it's the fact that they are not practicing any longer. Slightly more worryingly, people declaring a disability have a lower revalidation rate and they're more likely to declare lapsing for reasons of ill health. So we need to look into that a little bit.

We're working closely with employers and unions about what we can do to provide support to people with long-term health conditions. If it is appropriate for them to stay on the register, how can we make reasonable adjustments to our processes to enable them to revalidate, to enable them to stay on the register? But it is also important that for public safety, that everybody who remains on the register must be capable of safe and effective practice, you know, if that's the case.

However, unfortunately, it's not right that we allow people to remain, but we're going to try and work that out quite carefully with unions and employers. So now a little bit about the evaluation design and progress of this. We decided we would take a real-time evaluation approach. So the evaluation kicked off about three months after revalidation was launched because we want it to be happening at the same time because we want the evaluation to give us the assurance that the model's working and if it isn't working, then, you know, help us get some ideas about what we can do in terms of the changes that we might be able to make.

Now, it is what the researchers are tell us, the researchers, the Ipsos Mori, a well-known polling company and Evaluation Company in the UK. They tell me that it's a theory-based evaluation. I'm not a research professional so what I can tell you about that is that, what this means, it means three things. That they are looking at the process of revalidation.

So they're assessing the processes that makeup revalidation and trying to understand the impact that those processes are having. They're also carrying out a longitudinal assessment of outcomes and their impacts and they're doing that through a registrants survey. So, they've picked a cohort, three cohorts of people and before people who have just revalidated, people who do to revalidate next year, and people who are going to revalidate two years ahead.

And they follow those cohorts through as they go through revalidation. So last year, we just got people who just revalidated and now we've asked them again, it's the same questions, "What do you think about revalidation a year afterwards? Have you forgotten all about it?" Encouragingly, people say, "No, no, I haven't forgotten all about it. It wasn't kind of once in a lifetime event, I'm starting to collect my evidence for my next revalidation now.I'm still thinking about it. It's still a thing that I'm doing."

So that is pretty encouraging. And the last thing that makes up their evaluation is whether the benefits outweigh the burdens. Because there are burdens, you know, there's extra work that people have to do. They're all very, very busy. So we just need to make sure that those burdens are proportionate and that they mean something and they have some value. The big challenge, of course, is the measuring the impact on public protection, and this is very similar to the challenges we had when I was working at the GMC.

How do we evaluate whether this is actually going to make a difference to public health? It's very difficult to establish causality across specific outcomes. There are so many different things that impact on patient safety. It's very difficult. I think it's going to be very difficult for us to say, "Well, revalidation is that single silver bullet, but I think this evaluation will be able to tell us, enable us to tell a story as to the positive impact that revalidation is having on practice and therefore what a positive impact it will be having on the system in itself."

So I'm… Probably need to speed up a little bit actually. So, apologies, but a couple more slides. There are some key messages from the evaluation. As I've said, there are no adverse effects on renewal rates or any difficulties experienced by any particular group of nurses or midwives, so that's great. There's nobody in any particular practice setting that says, "Well, it was fine for all of those people, but it's not fine for me". Everybody can revalidate, which is one of our key objectives.

And there are some early signs of behavior change evident. What people are reporting back to us is that this is, you know, this is actually great. It just makes me look at the code. It's not that I didn't know that it was a code of practice, I knew that, but it's maybe look at it more carefully. It's made me realize the benefits that it brings to my practice. It's given me some kind of power and control over my practice and I think it can have a positive impact.

People report that they really like that reflective discussion aspect. They want that to be the most… They feel that's the most beneficial aspect of revalidation. And every time I go to a conference like this and the UK, when nurses and midwives are present and they've done revalidation, I say, "Yeah, some of it's

annoying, but I really liked the reflective discussion part of that really, really helps me.

But the researchers say to us, "Listen, you know, you've done some very good guidance, but it's time to update it. It's a little bit out of date.It doesn't reflect everybody's particular circumstances. So you need, in particular, to provide better guidance on how to judge the quality of reflection." And this is really difficult. How do you judge the quality of somebody else's reflection?

So we're going to have to think very carefully about that. But what some reflective discussion partners are saying to us is that, "Look, I've seen these, some of these written reflections and they're rubbish. This person hasn't reflected at all. And, you know, they just say, "Well," and we say, "Well, you don't think they've reflected, tell them they haven't reflected. You know, you get to say whether they have or not. So go back and tell them that."

And that's fine. We want people to do that, but equally, there are some purists that think a reflective discussion should be a very detailed, you know, piece of academic research along guess, say a big bad helper, about how bad a nurse I am, and how all the things I need to do to improve. That's not what we want either. So we've got to try and get that balance for people. Also, guidance on practice-related to feedback. What is practice-related feedback?

Does a thank you card, is that feedback? If somebody says, you know, you did a fantastic job caring for my mother in her dying days. We really appreciate what you did. Is that feedback? Well, I think it can be. But, you know, a card, thank you card that says, "Oh, you're lovely nurse. Thanks ever so much." That's not necessarily feedback.

The first example is something where, you know, you demonstrated compassion, you gave us confidence, you helped us. Those are all code-related things and that can be on a piece of card as well as it can be on an email or on a feedback form. Also, been criticized by the researchers for letting some of our engagement with our partners slip. Inevitably, revalidation, you know, is a little bit of a victim but the success, as far as we're concerned at the NMC, which we've limited resources, that we've moved our resources onto other projects now and we've neglected some of our stakeholders, and that's not right and they're not very happy about that.

So we need to find new ways of engaging with them and making sure that we can still keep that impetus, that drumbeat for a revalidation and the fact that the people still really see it as something that is theirs, that isn't something that's imposed on them by the regulator. We do need to increase awareness of verification. People have lost their registration and been taken into fitness to practice as a result of some of the things that they've done.

You wouldn't really think that we would have to explain to people that conflict… that conflict of interest means not getting your husband to sign off your revalidation portfolio. But apparently, some people need that explained to them, so we need to put that out there. A bit frustrating. And last but not least, we need to consider the purpose of our alternative support arrangements, how do they help people, you know, what reasonable adjustments can we make more still maintaining our standards?

So, our next steps then. I've said we're going to review and update our suite of guidance and we're going to engage on those changes in the autumn and publish ideally in December. We're going to end our

transitional arrangements, and I haven't really mentioned these, but these are arrangements that we have in place for if somebody has not been in practice for sufficient time in order to be able to do some of the revalidation requirements.

And that was because we published our final model any six months before some people would do to revalidate. Now, we've been quite generous and we've extended that period now. And people are now coming to us and saying, "I haven't really had enough time to do this and we're looking at them and saying, "Well, you've been practicing for the last two and a half years, so I'm not really sure what you've been doing because it's been everywhere. So, no, that's not really…you don't get to benefit from the transition arrangements.

But, you know, there will be people that followed through no fault of their own and spectacularly horrific life events, you know, they were on their way, they were nearly there with revalidation and then they got cancer or a partner died, or something awful happened to them. And we need to think about how we still give those people some time and opportunity to revalidate so we don't lose good people through no fault of their own.

And that's particularly valuable in terms of the support we can give to those with longer-term health conditions. And finally, we are from spring going to review the model. Everyone keeps telling us, "Well, this is phase one. " This is our stakeholders…are telling us this. Nurses telling us this. This is just phase one. "This is, you know, this is easy. We want you to make it harder. We want, you know, it needs to be more robust."

So, we're going to start that conversation from the spring and see what we might do to make it a more robust yet proportionate and effective model. And I have gone on a little bit. I wanted to live a little bit more time than I have for questions, but thank you very much for listening to me. I hope you found it interesting and relevant.

And we have five minutes for questions, if anybody would like to ask any questions. And I don't know what set up for doing that is where there's microphones or not, but…-

[Laura] Oh, good morning.

- Good morning.

- Laura Hudson from Iowa. My question is, what has the burden been on your staff to implement the process?

- Yeah, big burden. It has to be said. We had a special project team to introduce revalidation, but then that special project team, like all special project teams, was diverted into other things. We've created… It doesn't sound many, but five additional senior staff to manage all the queries coming from revalidation and actually for the first year, those five staff were utilized quite strongly and I, obviously, I was utilized quite a lot as well in terms of dealing with some difficult cases but now those people have been redeployed onto other things.

They still look at revalidation, so the burden is reducing, but I would say the burden was quite strong in

the two years up to the introduction of revalidation in the first year of implementation and then it tails off a little bit. So you do need to think about that. - [Phyllis] Phyllis Mitchell from Vermont. Thank you for your presentation. I think we all struggle with, how do we maintain competency and how do we evaluate kind of continuing competency.

I guess I have a couple of questions. One that kind of dovetails the audit process. So it sounds like some of it is at a station. Did you do your CEUs or whatever? And others, it sounds like you're uploading documents into your system. And I guess my second question is, so if you could respond to that.

And then my second question is, do you have nurses unions in? And what kind of pushback? I was a clinical educator in a small hospital in Vermont and I couldn't get the nurses to do anything because it wasn't written in the contract. So, thank you.

- Yeah, no. Well, I'll take the just the first point. Just a point of clarification because it is a bit confusing what people have to do. They just need to…they need to go online, we have a system called NMC online and they make a series of declarations that they have met all of the requirements of revalidation. And we then will audit a certain proportion of those declarations and say, "I see you say you've done 450 practice hours. What were those practice hours?What were they in? What did you do? What kind of CPD did you do?Give us some more information."

So, the only documents people are… They are uploading their own documents, but we tell them they need to develop their own portfolio and keep it. So in case we come to them and ask them questions, then they can answer those questions. So that's what they need to do. In terms of the unions, I think they'd been fantastic. We have a number of health nursing and midwifery unions. We have the Royal College of Nurses and Midwives.

They were very, very key stakeholders. There's two Royal College of Nurses, Royal College of Midwives. And then there's other unions as well, I think two or three united in unison of the two unions. We had to get them onside early. We were to get them, we're lucky that they care very much about what that, you know, what their members do, or their members… They care very much about patient safety.

And I think there's something maybe, I don't know, I'm speculating here about the culture of the National Health Service. It's about, we're all in this for patients and so unions, while they might want to protect some of their members, they will say they can't afford to be seen as being difficult about patients. So, yeah, it's tough, but you need to get them onside however you can. -

[Maryanne] Hi, good morning. Over here.

- Oh, hi. Sorry.

- It's Maryanne Robinson from CGFNS International. Thank you very much for a very informative presentation. I was wondering, how did you determine the 450 hours as being adequate for minimum competence?

- So that was written into our legislation in 2001. I think many of us feel that it isn't remotely sufficient in terms of maintaining competence, but that is what the legislation says. And at the moment, just for

reasons of parliamentary time, government have other things on their mind like Brexit, other things like that.

It's very difficult to get them to engage with us on the changes that we need. So that's really how we got there. And I'll be honest, I've no idea how we got just forefront for 450 hours. It's far too low, in my personal opinion. - [Mark] Good morning.

Mark from Texas. One of the areas of concerns that you listed was not having the necessary knowledge of English. Is that in code or in rule, or is there a language requirement with your registry?

- Yeah. There's a language requirement if you haven't been trained in the UK. So if you're trained outside of the UK, in either in the EU or overseas, it's in our rules in our order that we have a responsibility to make sure that everybody has a necessarily knowledge of English, and that's something that we can take minutes to practice action even if they don't, but people need to demonstrate that they've done that either through the aisles test or we now use the OET test as well.

And there's a number of other pieces of evidence that we will accept if someone, for example, been trained in the US you know, they've been practicing and being registered in the US, we will accept that as evidence of language. - [Megan] Hi, I'm Megan Williams, Delaware Nurses Association. My question has to do with advanced practice nurses, you obviously mentioned the registry you have that covers nurses and nurse midwives.

I'm curious where nurse practitioners, nurse anesthetists, and nurse specialists may fit in.

- Okay. Nurse practitioners in the UK tend to be… It's not a specific title. It tends to be somebody who's working in a general practice with a doctor who will, you know, take on a lot of those roles and more senior role. We don't regulate APNs or other types of specialisms.

People are able to kind of note, I have annotations as what specialisms that they have, for example, prescribing that kind of thing, but we don't regulate APNs. And actually, there are APN associations in the UK, they're saying, "Hang on a minute. This, we know we want you to do this. This should be what you're regulating. So that is a bit of a gap there where they sit, where physicians, assistants sit as well, that's something that's growing in the UK.

They're not regulated either. So, yeah, that's a big question which we don't have an answer to, I'm afraid.

- Thank you.

- Okay. I have a big thing in front of me that says, "Last question." So, I think I probably need to say that's the last question. But I'm, you know, absolutely, as I say, very honored to have been invited here today. And thank you very much for your questions and for your interest in engagement. Thank you.