Response to the NMC consultation on revalidation

March 2014

1. Introduction

1.1 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

1.2 As part of our work we:

- Oversee nine health and care professional regulators and report annually to Parliament on their performance
- Conduct research and advise the four UK governments on improvements in regulation
- Promote right-touch regulation and publish papers on regulatory policy and practice.

1.3 We welcome the opportunity to respond to this consultation on the NMC’s plans for revalidating nursing and midwives. This is an important aspect of the regulator’s role that we have consistently recommended the NMC needs to develop in our annual Performance Reviews.¹ Our Standards of Good Regulation stipulate that ‘through the regulator’s continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise’.² Good regulation should assure the public that ‘those who are registered have and/or continue to meet the regulator’s standards’.

1.4 Because of the current uncertainty over the future of the legislative framework underpinning the regulation of health professionals in the UK and social workers in England, now is a difficult time for any of the regulators we oversee to be planning major regulatory change.³ We therefore understand the need for the NMC to consider two distinct phases of reform in which the first could be introduced without having to amend legislation. The proposals on which the NMC is consulting here form the first part of a two-phase process of reform and change.

¹ See http://www.professionalstandards.org.uk/search-results?indexCatalogue=site%2DId&searchQuery=%22performance+review%22&wordsMode=0
³ The Law Commission is currently reviewing the legislation underpinning the nine regulators we oversee, and is due to publish a draft Bill on 2 April 2014: http://lawcommission.justice.gov.uk/areas/Healthcare_professions.htm
would operate within the organisation’s current legislation, while the second phase, which is not discussed in any detail in the consultation documents, would require legislative change. In its consideration of the revalidation strategy in September 2013, the NMC’s Council determined that options for this phase should be reconsidered following the implementation of Phase 1.

1.5 We note that the NMC has used the term ‘revalidation’ to describe their proposals. In our paper on the subject, we explain that the term ‘revalidation’ describes just one of many possible ways of assuring the continuing fitness to practise of health and care professionals. Further consideration may need to be given as to whether this process is proportionate and risk-based, and meets public and employer expectations around revalidation, which are likely to have been shaped by the GMC’s model.

1.6 We support the use of the NMC Code as a basis for the continuing fitness to practise scheme, as this should result in a focus not only on competence but also on conduct, which is an important aspect of professional standards. This is in line with the recommendations we made in our report.

1.7 However, we have concerns about the basis on which these proposals have been developed and the lack of detail in the documents made available for this consultation.

2. Questions about risk analysis

2.1 In Enabling Excellence, the Government explained that the non-medical regulators should ‘continue to develop the evidence base that will inform their proposals for revalidation’. Our own paper on continuing fitness to practise put forward as a general principle that regulators should develop ‘a clear understanding of what professionals do, and of the context in which they do it’ so that they can design their regulatory response to mitigate the risks presented. We also stated in this report that in the interests of transparency, regulators should be clear about what lies behind a decision about how much and what type of regulatory force is needed to mitigate identified risks.

2.2 We note that the Department of Health provided a grant of £189,000 to the NMC in 2010-11 to develop a risk-based framework, in addition to other monies. Our 2011-12 and 2012-13 Performance Review reports urged the NMC to look more closely at the risk profile of its own registrant base with respect to

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5 CHRE, November 2012. An approach to assuring continuing fitness to practise based on right-touch regulation principles. Available at: [http://www.professionalstandards.org.uk/library/document-detail?id=69393f02-d5a3-4ae0-a1bb-a7b437dc3485](http://www.professionalstandards.org.uk/library/document-detail?id=69393f02-d5a3-4ae0-a1bb-a7b437dc3485)

6 See footnote 5.


8 See footnote 5.
revalidation, so we would have expected to see some evidence that the NMC’s proposals were based on an analysis of the types, severity and prevalence of the risks presented by nurses and midwives.

2.3 The single model the NMC is proposing does not take account of the diversity of the register, despite this diversity having been highlighted in an NMC Council paper as a risk: ‘revalidation not [being] fit for purpose due to the great diversity of NMC register, great size and complexity in settings and scope of practice’. In our view, not only is a risk-based approach necessary to ensure the proposals are fit for purpose, it would also allow the NMC to target more of their resources on groups who present higher risks, such as midwives.

2.4 This type of risk analysis might also have provided a sense of the NMC’s aims for revalidation, and therefore of the part that each of the two phases in the implementation model might play in achieving those aims. As such it is difficult to understand how the NMC will evaluate the success of its proposals.

3. Questions about resources and impact

3.1 The consultation documents predict that the direct financial cost to the NMC of the proposals will reach £4.413 million for the introduction of the scheme, with a further £1 million per year of ongoing costs. It would have been helpful to see a breakdown of the calculations underpinning these figures.

3.2 The impact of introducing revalidation on the NMC’s operations – how resources might need reallocating across different regulatory functions, and what additional work the introduction of revalidation might create for the NMC – merits serious consideration. We anticipate that the registration team will be under increased pressure not only with tasks relating directly to revalidation, but also with re-registration applications from those who have ‘lapsed’ from the register through revalidation.

3.3 In addition, evidence from the GMC suggests that the number of fitness to practise referrals from employers increased in the run-up to the introduction of revalidation for doctors – a similar increase could be anticipated for nurses and midwives, and be planned for. The NMC’s scrutiny of revalidation evidence submitted by registrants could also lead to a more sustained increase in the number of fitness to practise (FtP) referrals, putting further demands on the FtP function. It would be helpful to understand how the NMC will prepare for such an impact on their operations. The FtP function is already under much pressure,

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10 In The State of Medical Education and Practice in the UK 2013 (General Medical Council, October 2013), the GMC reported an increase by two-thirds, between 2007 and 2012, of complaints from employers leading to a GMC investigation, which they suggested could be attributed in part to employers anticipating the introduction of revalidation. This report is available at: http://www.gmc-uk.org/publications/23435.asp. Accessed 18/03/14.
as illustrated by the Health Committee’s statements about the backlog of cases in its report of the NMC Accountability Hearing in 2013.\(^\text{11}\)

3.4 The consultation paper lacks any consideration of the compliance costs or broader impact on employers, the workforce, and the provision of care. The resources required for nurses and midwives to complete their own revalidation activity, in addition to the work involved in third party confirmation and feedback, should be carefully evaluated and costed. It is worth noting that recent research published by the Department of Health Revalidation Support Team found that revalidation was taking doctors longer than had been anticipated.

3.5 A further impact will come from those who, under the proposals, are ‘not able to revalidate’\(^\text{12}\) and therefore lapse from the register. This could make large numbers of nurses and midwives unable to practise because they are no longer registered. This wider risk, which is directly linked to the proposal to allow those who ‘fail’ revalidation to lapse from the register, needs to be carefully evaluated and planned for by employers and service providers.

4. Questions about the revalidation process

4.1 In addition to the above, we are concerned that some vital questions about this scheme remain unanswered at this stage of the development process.

4.2 We have attempted in the figure at Annex A to represent, in the form of a graphic, a generic continuing fitness to practise model. This is based on the various models that have been developed or are currently in development among the regulators we oversee. The following points in our response are made with reference to the numbers in this graphic.

**Length of cycle (1)**

4.3 The NMC is proposing a three-year cycle. While we understand that this cycle has been chosen to fit with the current renewal legislation, the absence of any proper discussion of the optimal cycle length based on an evaluation of risk makes it difficult to comment. It also opens the NMC up to criticism and inevitable comparisons with the GMC, whose cycle is two years longer for a profession that is arguably higher risk.

**Continuing fitness to practise requirements on the registrant (2)**

4.4 These requirements are set out in the consultation documents but they lack detail. The NMC will require the nurse or midwife to have sought and received third party feedback (from ‘patients or peers, etc’), which should have informed their reflection on their practice, and third party confirmation (from ‘employers where applicable’) that they are fit to practise. This raises a number of key questions:

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\(^{11}\) House of Commons Health Committee, December 2013. *2013 Accountability hearing with the Nursing and Midwifery Council*. TSO.

\(^{12}\) We discuss the question of what might constitute ‘failure to revalidate’ in paragraph 4.14 below.
• Who will be eligible to provide third party feedback and third party confirmation?
• How will the NMC make sure that the system functions for all job settings while providing comparable evidence of continuing fitness to practise for all registrants?
• How will the NMC ensure that feedback and confirmation are reliable? For example, a line manager may be reluctant to provide negative feedback for their own staff for fear that it might call into question their own competence as a manager. Peers may also be unwilling to be critical of each other.
• Will registrants be required to demonstrate that the third party feedback has informed reflection on their practice (as is suggested in the description)? If so, how? If not, what is the value of the third party feedback?

4.5 Without answers to these important questions, it is difficult to comment further. The NMC could perhaps turn to some of the work carried out by the other regulators to help with the detail. For example, some (GDC, GOsC) are looking at the learning cycle (practice, analysis/feedback, reflection, application, improved practice) as a tool for self-reflection and self-reporting for continuing fitness to practise. This could perhaps be of use to the NMC in thinking about how registrants might demonstrate that third party feedback has informed their practice.

Submission requirements and method of submission (3)

4.6 It is not clear from the NMC proposals what information it will require registrants to submit for the revalidation audit, nor how they will be required to submit it.

4.7 As we commented in our paper on lapsed registration\(^\text{13}\), the NMC is one of the few regulators not to offer online renewal of registration. Confirmation by the registrant that they have met the continuing fitness to practise requirements, which will be included as part of the renewal process, and subsequent submission of evidence will presumably have to be made via a new process. The NMC is working to a relatively ambitious timetable, and the operational details needs to be considered at an early stage in order to assess the viability of the proposals.

4.8 There is also the question of how long registrants will be given to submit their evidence once they have been selected. The system will need to allow for the possibility that registrants may, for entirely legitimate reasons, such as being away on holiday or not in work, not be in a position to respond immediately to the request for further information.

Sampling (A)

4.9 The NMC is proposing only to require evidence that the revalidation requirements have been met from a sample of registrants. Although the

consultation documents explain that the sampling will be partly random and partly risk-based, questions about how the risk-based sample will be chosen, what the ratio of random to risk-based will be, and how large the overall sample will be remain unanswered (see section 2 above).

**Scrutiny process and threshold for pass, pass with remediation and fail (4)**

4.10 The consultation documents contain little detail about how submissions will be scrutinised, in particular we would have liked to understand:

a) What standards submissions will be assessed against
b) What will constitute a pass (renewal) and a fail (lapse)
c) The procedure for making decisions about a registrant’s continuing fitness to practise, and
d) How these decisions will be quality assured.

4.11 The Code is currently being revised, and we understand that as a result the NMC is unable to set out in any detail which standards registrants will be assessed against. It is difficult to comment on the overall value of the proposals when such a core component is yet to be determined. It would be helpful to understand more about, and have the opportunity to comment on (a) and (b) above.

4.12 The effectiveness of the framework for decision making will determine whether or not the procedure picks out those registrants who are failing to meet the standards – again we would have liked to see more detail on this element of the framework ((c) and (d)) which, unlike (a) and (b), is not dependent on the content of the Code.

**Response to non-submission (5) and failure to meet the standards of continuing fitness to practise (6)**

4.13 Once the NMC has requested the submission of a portfolio by a registrant, there are two possible negative outcomes:

- The registrant fails to engage with revalidation (5), or
- The registrant engages but does not meet the standards (6).

4.14 The consultation paper states that ‘if a nurse or midwife is not able to revalidate, they will lapse from the register’, but is not clear whether this is intended to capture scenario 5, scenario 6, or both. We would hope to see different responses to each of these to ensure that:

- The reason for which a registrant is no longer registered is properly recorded and publicly available where appropriate
- The regulatory action taken is proportionate to the risks presented, while ensuring that the public is protected.

4.15 The GMC, for example, will defer a doctor who has not met the standards, but will not renew the licence of a doctor who has not engaged in the revalidation process.
The NMC’s proposed approach presents a particular problem for situations in which registrants show signs of falling just short of the standards expected of them, but do not meet the threshold for a fitness to practise referral. In these situations, the NMC can either keep them on the register and take no further action or allow them to lapse. The former fails to protect the public while the latter is disproportionate and could have a serious impact on the workforce and provision of care (as discussed in paragraph 3.5 above). There is no third option of continued registration with remediation (8). It is also unclear what the NMC’s policy would be for registrants applying to return to the register having lapsed under these circumstances.

4.17 The NMC may be constrained by its legislation at present, but an indication that it is aware of the problem and working towards both short and longer-term solutions would be helpful.

Opportunities and criteria for fitness to practise referral (7)

4.18 There are several points in the revalidation process when the NMC could identify concerns about a registrant that meet the threshold for referral to the fitness to practise function. While the criteria for referral through revalidation should be no different to the criteria for concerns that arise from other routes, it would have been helpful if the NMC had explained the points at which such concerns will be likely to arise and the sorts of situations that might trigger a referral.

Appeals (9)

4.19 The consultation document is silent on the matter of appeals for registrants who have been removed through the revalidation process. We assume that there will be no change to the right to appeal against a decision made about renewal of registration, nor to the procedure in place. However, the introduction of the revalidation process, which involves subjective, judgement-led decision making on the part of the NMC, may result in a qualitative change to the grounds on which renewal appeals are based. The number of appeals is also likely to increase significantly, and we would like to hear more from the NMC about how they are preparing for these changes.

5. Conclusion

5.1 Through our Standards of Good Regulation, we seek assurance that the regulators we oversee have the means of ensuring their registrants remain fit to practise. As the NMC’s proposals stand, we feel they raise more questions than answers, and as a result we cannot state with any confidence that they will provide this assurance. There is much still to be done to fill in the essential detail of the plans, and the NMC has set itself a challenging timetable, which we

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hope will not impede the quality of either the development work or implementation.

5.2 The consultation survey will collect the views of a range of stakeholders, but we hope that the NMC will also develop the robust evidence base, particularly around risk, which appears to be lacking currently. If developing this evidence base is not possible within the timescales set for Phase 1, it should become the cornerstone of the strategy for Phase 2.

5.3 In addition, there is a lot to be learnt from the sizable body of research and development work carried out by the other regulators we oversee on the topic of continuing fitness to practise, and we feel that the NMC could benefit from exploring this valuable resource.

6. Further information

6.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

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ANNEX A: Figure – a graphic representation of the continuing fitness to practise (CFtP) process

1. CFtP cycle

2. CFtP ACTIVITY

3. Registre selected for CFtP scrutiny

4. Scrutiny of submission

5. 2nd chance at submission (optional)

6. CFtP ‘fail’

7. CFtP conditional ‘pass’

8. CFtP ‘pass’

9. Renew with remediation

10. Renewal

11. Removal

12. Appeals

13. FtP referral

Regulator determines:
1. Length of cycle
2. CFtP requirements
3. Submission requirements
4. Scrutiny and thresholds
5. Response to non-submission
6. Response to CFtP ‘fail’
7. Remediation options and enforcement
8. Remediation points and criteria
9. Appeals

KEY
PURPLE – regulator / standards authority
BLUE – registrant