Nursing & Midwifery Council

REVALIDATION

Annual data report

Year 3: April 2018 to March 2019

FOREWORD

2019 began with an important milestone for the NMC with the introduction of the nursing associate role in England.

This year also marks the completion of the first three years of revalidation and every nurse or midwife who was on our register on 1 April 2016 has now been through the revalidation process. Over 611,462 nurses and midwives have revalidated, and they will be joined in 2022 by the first nursing associates who joined our register in January this year. Once again I am delighted to report that our data shows revalidation continues to be a successful and valuable experience for many nurses and midwives with high numbers choosing to revalidate across all four countries of the UK.

Much has changed in the last three years. We have made significant improvements as an organisation, all of which demonstrate our commitment to being a force for compassion and professionalism. Revalidation was the forerunner of this period of change and I and other colleagues regularly hear that it is regarded as one of the best initiatives we have introduced, as it focuses on the professional development of the people on our register and uses our role to support the conditions in which better, safer care can thrive. This success is not possible without the dedication and commitment of everyone in the health and social care sector; not just those on our register but their employers and representative bodies. So I want to take this opportunity to thank everyone again for their hard work and collaboration so far.

We know that nurses, midwives and nursing associates are working in constantly changing environments increasing in

complexity and demand. Our data gives us the opportunity to influence the sector as a whole by highlighting systemic issues and adding to the richness of data that guides workforce strategies in each of the four countries. In this report we present important new primary data and analysis of work and practice settings by protected characteristics. This will help our understanding of what is needed to help support and sustain the current workforce and the supply of nurses and midwives for the future.

When we introduced revalidation we were clear that it would be implemented through a phased approach, allowing us to understand the impact it was having, so it remains effective, proportionate and affordable across all the countries. We have recently completed a three year evaluation of revalidation and the main findings are that revalidation has been positively received with reflection the most valued element. Bringing people with us and demonstrating that we recognise the value of continuous learning, has been key to our success.

It is clear revalidation must keep pace with changes in practice. It is also clear that we have an opportunity to use it to influence the external health and care environment. We're currently working to develop an ambitious plan for 2020–2025, which will drive forward more improvements and help us support the delivery of safe, high quality and consistent care. As we develop this new five year strategy, we have an excellent opportunity to utilise the first three years of revalidation to review how we want this process to evolve over the next three years and we look forward to discussing that with our stakeholders and partners over the next few months.

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EXECUTIVE SUMMARY

Numbers of people revalidating

Since 2016, more than 600,000 nurses and midwives have renewed their registration through the process of revalidation. The overall revalidation rates across the UK have remained relatively similar throughout years one to three at 93 percent. The revalidation rate (the proportion of people that revalidated from those who were due to), across the UK remains what we would expect, at or above 90 percent in each of the four countries.

Over the last three years, the proportions of people choosing not to revalidate are similar to historical rates under the previous renewal scheme. This suggests that there has not been the loss of nurses and midwives some feared would result from the introduction of revalidation. We've seen a slightly lower rate of revalidation for people practising outside the UK, compared with those in the UK. This is expected as they no longer need to maintain NMC registration and the main reason they give for not revalidating is that they are no longer practising.

Differences in revalidation rates

In this last year, 204,545 nurses and midwives renewed their registration. Revalidation rates across the four UK countries were over 94 percent, consistent with trends from the previous two years. The proportions of people revalidating are fairly consistent across age groups between 21 and 60 years, and then begin to fall. This is in line with what we would expect in terms of individuals planning their retirement, and what we have seen reported to us in our survey of those leaving the register. There is a slight difference between revalidation rates for men and women, but these are in line with historical revalidation rates and do not give any cause for concern.

The numbers choosing to revalidate are largely consistent across all registration types. This is consistent with both year one and year two. Analysis suggests that people holding more than one registration type are more likely to drop one of these at revalidation. Most commonly, registrants previously holding a dual nurse/midwife registration may drop one of these, depending on which one they use less.

There are broadly similar revalidation rates across different ethnic groups but those declaring a disability at the time of revalidation had lower rates compared with those not declaring a disability. This is in line with rates from the previous two years of revalidation and could be driven by the fact that those with a disability may be less likely to be currently working and as a result less likely to gain the necessary evidence for revalidation. Looking at people's recorded reasons for leaving the register, one third of individuals declaring a disability left due to ill health. Preventing barriers to revalidation for people living with disabilities is of paramount importance, and we provide adjustments for those who face any difficulty due to the revalidation process.

Employment, practice and work settings

This year we have carried out new analysis on employment, practice and work settings which has given us some very interesting insights about our register. This intelligence provides the opportunity to inform how we support the people on our register as they make up an integral part of the workforce.

Most people on our register are in direct employment and direct clinical care, most of this being in the fields of adult nursing and general care. Over 50 percent of roles are in hospital or other secondary care settings, with the next most frequently reported setting being community care (18 percent). Most of the midwives on our register work in maternity units or hospitals, while the majority of roles reported by nurses are in hospitals or other secondary care settings (57 percent).

Of the 698,000 people on our register, 11 percent are men. Women dominate a number of roles including midwifery, health visiting and school nursing. In terms of work settings, men are well-represented in the military, ambulance service, trade union and professional body, prison or police services.

Over one third of the people revalidating since 2016 were over the age of 50 and just over one third were between the ages of 21–40. Those working in agencies tend to be slightly older than those who are employed directly, which may be indicative of the flexibility and pay offered by agency work. Some types of practice have a relatively young age profile such as children's and neo-natal nursing, midwifery, military and public health jobs. We see this contrasted with the fields that have an older age profile including quality assurance and inspection, occupational health, education, and universities or research facilities.

People employed via an agency are markedly more ethnically diverse than people in direct employment and over a third of agency roles are done by people of Black British African ethnicity. The fields of adult general nursing and mental health nursing are the most diverse, with Black British African individuals very well represented in mental health and prison settings. Other diverse fields include the home care sector, public health, hospitals and prisons. Some settings have a primarily White British workforce including school

nursing, quality assurance, policy, the voluntary sector, police, military, government and leadership roles.

15 percent of those on our register are trained outside of the UK, and these nurses and midwives continue to make up a valued part of our workforce. There are certain work settings that rely more on these individuals including the care home sector, public health and hospitals or other secondary care settings.

How people are revalidating

Confirmation provides the basis of our assurance that revalidation is being implemented in the way that we intended. This process provides opportunities for engagement and reflection to continue to improve practice. Most people on our register have their line manager as their confirmer in line with our guidance, or another nurse or midwife on our register. Many also cite having regular appraisals which is an important tool to support nurses and midwives in their professional development. We will continue to work with stakeholders to guide the confirmation and appraisal processes as a key component of the revalidation process.

Reasons for leaving

We have carried out research with those who have left the register each year, for the last three years. Additionally when people tell us they are leaving the register rather than revalidate we ask them to provide us with a reason. While concern about not being able to meet the revalidation requirements does feature, it features among a cluster of issues; too much pressure; staffing levels; changes in personal circumstances, and poor pay and benefits.

As we mention above we would expect a higher proportion of those working or living outside of the UK to choose not to revalidate. We also see a lower revalidation rate in those aged over 60 years which is in line with what may be expected as individuals plan for retirement.

Verification

We verify the evidence provided for revalidation on a sample of applications based on the total number of people on our register. Currently, this includes two samples, one of which is selected on a risk basis, and one on a random basis. We will be using the learning from the last three years to develop this model to ensure that our verification process remains robust to ensure public safety, and welcome the opportunity to continue the refinement of this process moving forward.

Evaluation

We have just completed a three-year evaluation of revalidation which has shown that it's having a positive impact on practice, by raising awareness of the Code and providing the opportunity for individuals to reflect on their practice. The sustainability of this is as yet unclear, and we must do what we can to develop the model to ensure revalidation

remains sustainable and robust. One of the keys to the success of revalidation was our ability to build a coalition across all sectors in all four nations. It is vital that any developments of the model both address its continuing ability to support retention in the workforce while at the same time not imposing additional burdens on an already pressured sector.

Our evaluation partners have made a number of recommendations which are designed to ensure that the excellent momentum behind revalidation is not lost as it becomes business as usual. As we begin engaging on the development of our new corporate strategy, we will take this opportunity to discuss with our stakeholders how revalidation can evolve over the next three to five years.

ABOUT THE DATA

We publish this report as part of our commitment to being an open and transparent organisation and to share our learning for the benefit of the healthcare sector as a whole.

The data we are collecting is adding to the richness of our understanding of where people work and how they work. This year for the first time we are publishing an analysis of work and practice settings by protected characteristics.

Sharing our data externally is an opportunity to influence the sector as a whole by highlighting systemic issues. We have already used it as part of our contribution to the workforce strategies being developed by the each of the four countries. We think there is scope for other regulators, employers and NHS providers, and policymakers at local, regional and national levels to use our data to support good policy making.

We are happy to take further suggestions as to what data might be of interest to our partners.

The report is in two sections – a summary of our findings, and a technical annexe which details all of the data we are publishing. Wherever possible, the data reporting is broken down by registration type and by country. In this report, the 'country' means the country of a nurse or midwife's current or most recent practice (for those for whom we have an employer address), or their home address. This means that for most people who revalidated, their country is the country of their current or most recent employment. For those who lapse and for some of the nurses and midwives who are self-employed, it is the country where they live.

The data doesn't include nurses and midwives who submitted a revalidation application but by the end of their renewal month had not had their revalidation application fully processed. Reasons for this may include: they were going through the process of verification, had declared cautions and convictions, had declared a determination from another regulator, or were subject to fitness to practise sanctions.

AIMS & OBJECTIVES

What is revalidation?

Every three years nurses, midwives and nursing associates are required to renew their registration with the NMC to be able to continue to practise in the UK. Revalidation is the set of requirements they must meet, and the process they must go through, in order to successfully renew their registration. Revalidation replaces the previous Post-registration education and practice (PREP) scheme by introducing several new requirements for reflection and engagement. Following extensive public consultation in 2014 and a pilot in 2015 we published our revalidation guidance in October 2015, and the first nurses and midwives revalidated in April 2016.

Why did we introduce revalidation?

We introduced revalidation to improve public protection by making sure that everyone on our register demonstrates their continued ability to practise safely and effectively throughout their career. With revalidation we want to:

- raise awareness of the Code and professional standards expected of nurses, midwives and nursing associates
- provide them with the opportunity to reflect on the role of the Code in their practice and demonstrate that they are 'living' these standards
- encourage them to stay up to date in their professional practice by developing new skills and understanding the changing needs of the public and fellow healthcare professionals
- encourage a culture of sharing, reflection and improvement
- encourage them to engage in professional networks and discussions about their practice.

What are the revalidation requirements?

Nurses, midwives and nursing associates are required to declare via an online form that they have:

- practised for a minimum of 450 practice hours (900 hours for those with dual registration) over the three years prior to the renewal of their registration
- carried out 35 hours of continuing professional development (CPD), of which at least 20 hours must be participatory learning
- collected five pieces of practice-related feedback over the three years prior to the renewal of their registration

- completed five written reflective accounts on their CPD and/or practice-related feedback and/or an event or experience in their practice, and how this relates to the Code, over the three years prior to the renewal of their registration
- had a reflective discussion with another nurse, midwife or nursing associate
- received confirmation from an appropriate person that they have met all the requirements.

In addition they must:

- provide a health and good character declaration
- declare that they have (or will have when they practise) an appropriate professional indemnity arrangement.

For more information on the revalidation requirements and the guidance and support available please visit our website.

THE BIG PICTURE

Revalidation over the last three years (April 2016 – March 2019)

611,462 nurses and midwives successfully revalidated between April 2016 and March 2019.

That's **93%** of the 658,102 people who were due to revalidate.

During this period, **42,167** people (6 percent) chose not to revalidate and left the register. This proportion was steady throughout the three years (7 percent in year one and 6 percent in years two and three). This is in line with the numbers who left the register under the previous PREP system, before we introduced revalidation.

FIGURE 1

Proportion of people who revalidated by country (April 2016 – March 2019)

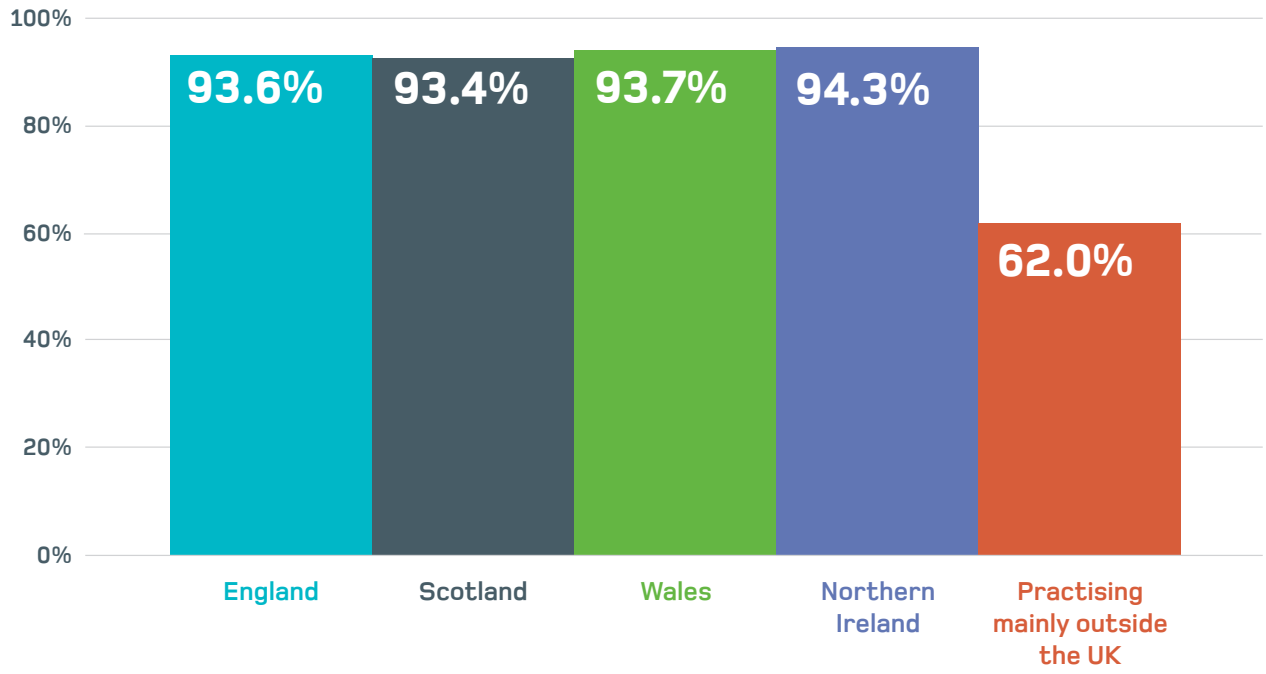
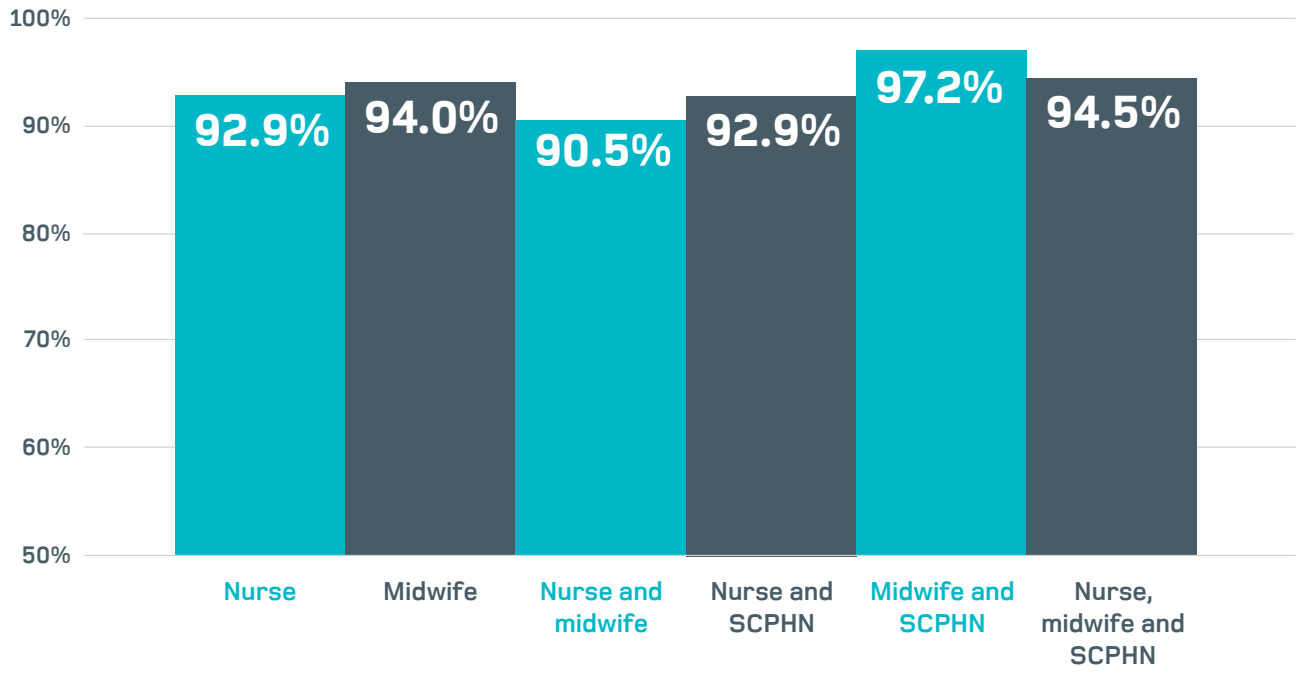


FIGURE 2

Proportion of people who revalidated by registration type (April 2016 – March 2019)



Please note that the axis of this chart starts at 50% rather than 0%.

SUMMARY OF YEAR 3 REVALIDATION DATA (APRIL 2018 – MARCH 2019)

204,545 nurses and midwives renewed their registration in the third year of revalidation.[1]

Across the four countries of the UK, revalidation rates were **94%.**

The percentage lapsing in the four UK countries was likewise very similar, at **5–6%.**

The numbers revalidating

93 percent of all those due to revalidate (including those working or living abroad) between April 2018 and March 2019 chose to revalidate.

Across the UK revalidation rates were very similar, ranging from 94 percent to 95 percent (Figure 3). These figures are in line with historical averages under the previous renewal scheme (PREP). While there are lower revalidation rates for those who work primarily outside the UK this is in line with what we might expect since they are not required to remain registered to practice outside the UK.

The people revalidating

The vast majority of those who revalidated were nurses (94 percent). This is similar to the proportion of nurses, midwives and SCPHNs on our register overall (Figure 4).

The numbers choosing to revalidate are largely consistent across all registration types. This is consistent with both year one and year two. Analysis suggests that registrants are more likely to drop a registration type at revalidation; and the most common change is for people previously holding a dual nurse/midwife registration to drop one of these.

[1] This number includes those nurses and midwives that hold dual registration

FIGURE 3

Numbers due to revalidate vs. numbers revalidating, by country (April 2018 to March 2019)

This chart shows the number of nurses and midwives due to revalidate and the number who actually revalidated broken down by country for the third year of revalidation, April 2018 – March 2019. For each country, the light coloured bar represents those who were due to revalidate, and the dark coloured bar represents those who actually revalidated.

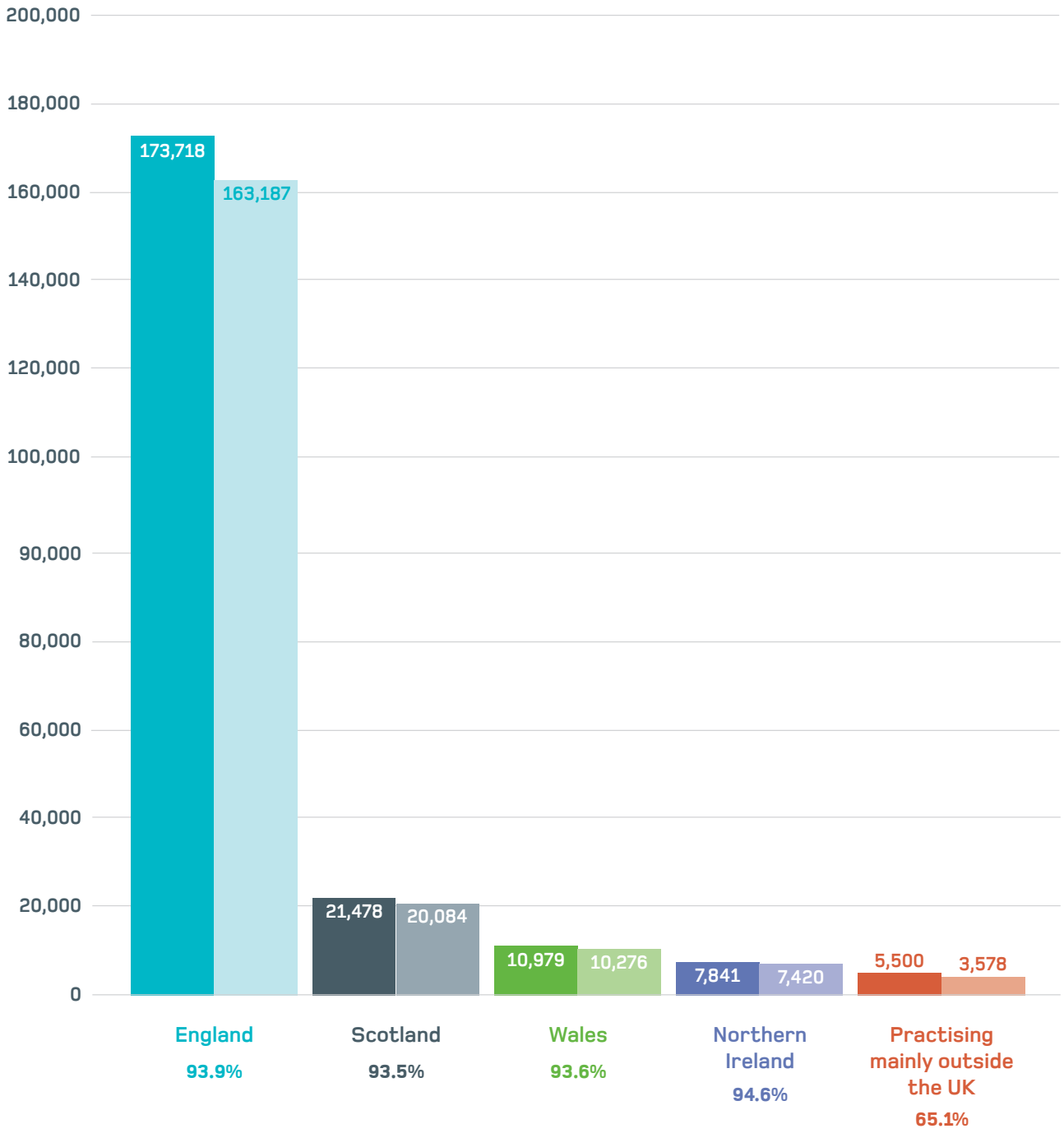
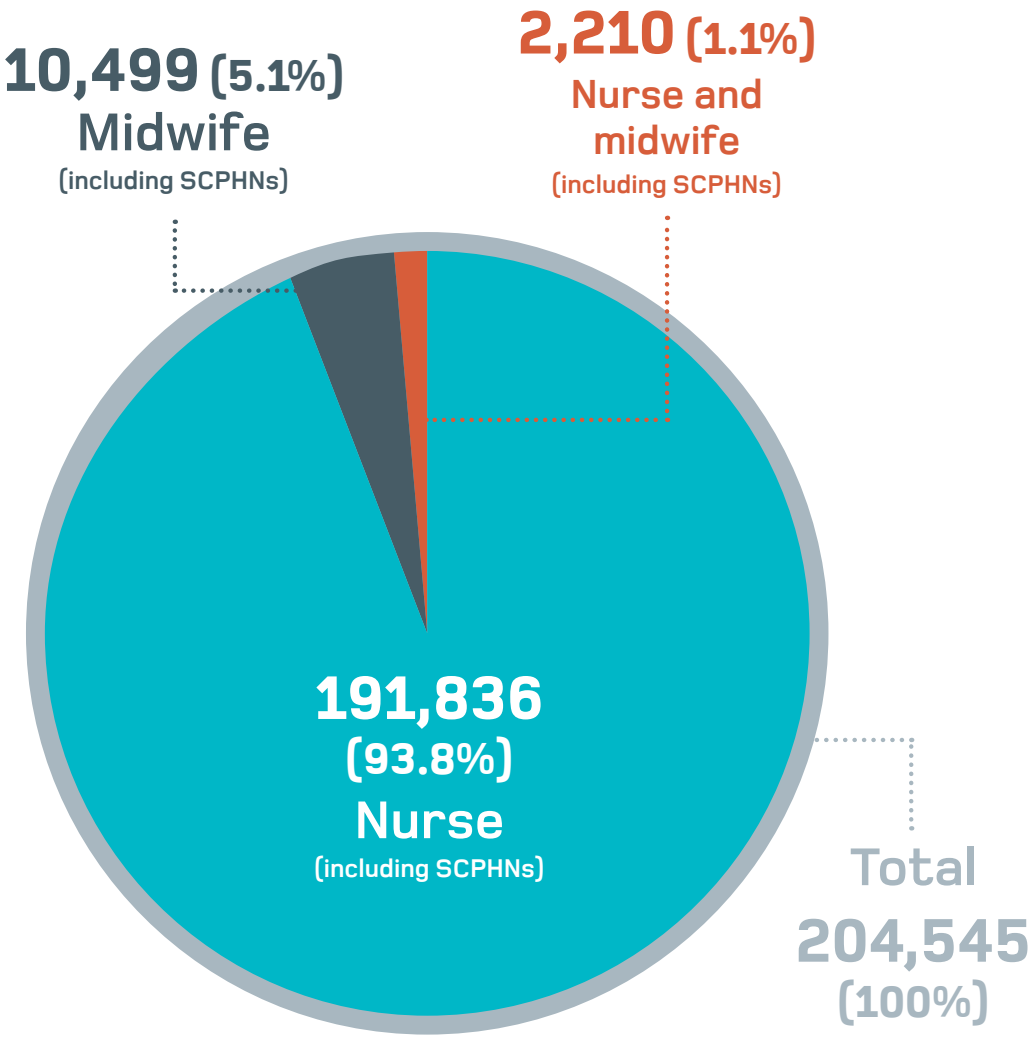


FIGURE 4

Revalidation by registration type (April 2018 to March 2019)[2]

This chart shows the number and percentage of nurses and midwives who revalidated broken down by registration type after revalidation.



[2] This is a nurse or midwife's registration type after their registration is renewed, partially renewed or

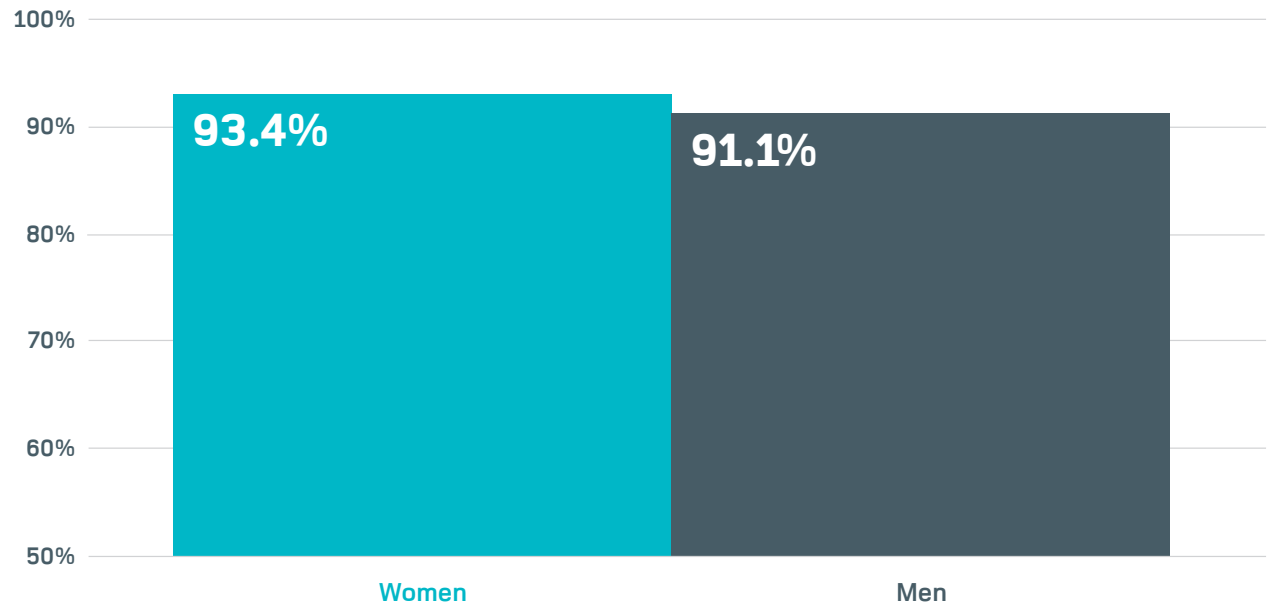
REVALIDATION BY PROTECTED CHARACTERISTIC

Gender

As we would expect, given the gender breakdown of people on the register, the majority of those revalidating are women (90 percent). There is a slight difference between revalidation rates for men (91 percent) and women (93 percent) (Figure 5). Both are in line with historical revalidation rates. The proportions of men and women that revalidated in each of the four countries of the UK is broadly similar.

FIGURE 5

Proportion of men and women who revalidated (April 2018 to March 2019)[3]



Please note that the axis of this chart starts at 50% rather than 0%.

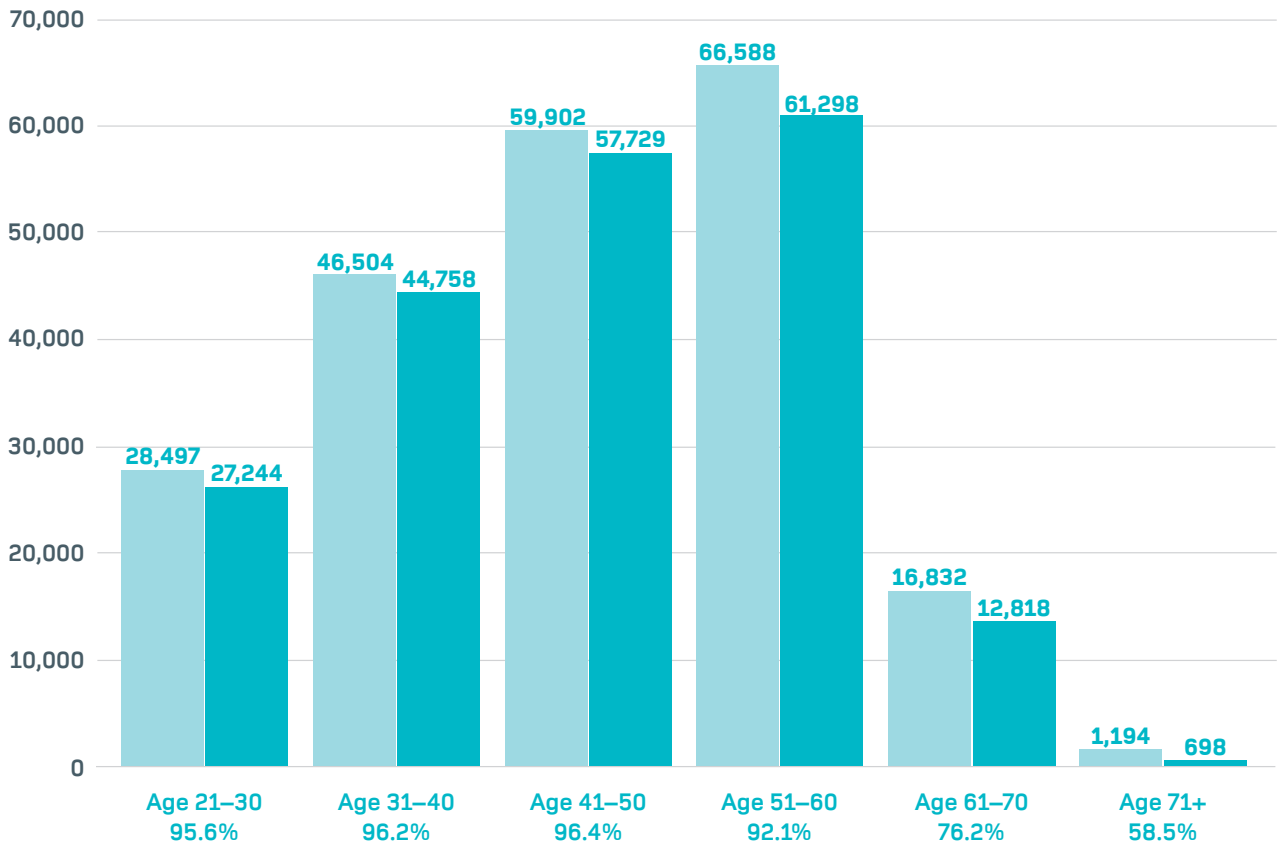
[3] This includes nurses and midwives whose current or most recent practice (those for whom we have an employer address), or their home address is either outside of the UK in the EU/EEA or overseas (outside the EU/EAA).

Age

The highest proportion of those revalidating in 2018–2019 are aged between 41–60 years (58 percent). Revalidation rates are fairly consistent across age groups between 21 and 60 years. However rates fall off between 61 and 70 years (76 percent) and further after the age of 71 years (59 percent).This is in line with what we might expect in terms of individuals planning their retirement and what we have seen reported to us in our survey of those leaving the register. However we do recognise that the reasons for this are complex and we analyse this further on in the report.

FIGURE 6

Proportion of people due to revalidate vs. proportion who revalidated, by age group (April 2018 to March 2019)[4]



This chart shows the number of nurses and midwives due to revalidate and the number who actually revalidated broken down age group for the third year of revalidation, April 2018 – March 2019. The chart also shows the revalidation rate by age group.

[4] This includes all those who revalidated both in the standard way and through exceptional circumstances.

Ethnic group

The majority of those revalidating declare they are White British (71 percent). Those declaring Black/Black British African ethnicity form the next largest cohort (6 percent).

Revalidation rates by ethnic group range between 87 percent and 97 percent. The lowest revalidation rates are for those declaring Asian/Asian British Chinese (88 percent), and those declaring any other black background (87 percent). Both these groups represent very small numbers and we have not been able to identify any specific barrier to revalidating for either of these groups. Both groups have a relatively high proportion of people aged 61 and over (33 percent of Asian Chinese people who were due to revalidate in this year, and 17 percent of people of any other Black background). It may be that a lower revalidation rate may be more to do with retirement than any specific barrier present as a result of ethnicity. We continue to keep this under review.

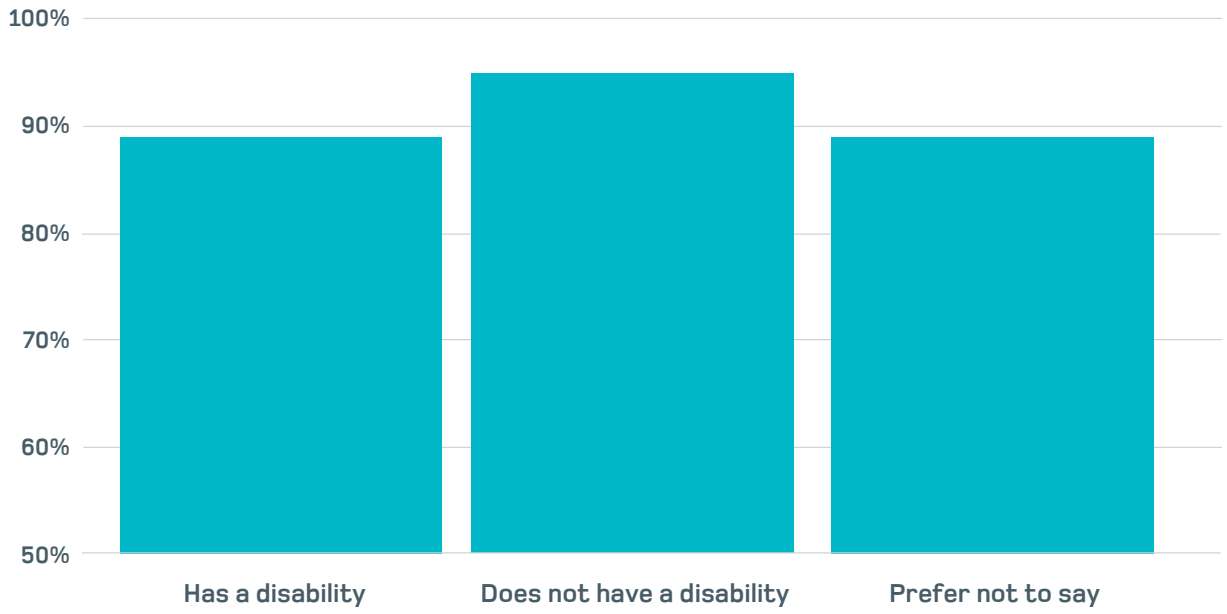
Ethnic group	Number	Proportion
White British	145,521	94%
White – Gypsy or Irish Traveller	65	92%
White Irish	3,844	91%
Any other white background	10,567	90%
Mixed – white and black Caribbean	2,250	96%
Mixed – white and black African	589	96%
Mixed – white and Asian	635	95%
Any other mixed background	792	90%
Asian/Asian British Indian	7,222	97%
Asian/Asian British Pakistani	911	97%
Asian/Asian British Bangladeshi	216	96%
Asian/Asian British Chinese	718	88%
Any other Asian background	8,471	96%
Black/black British African	13,167	96%
Black/black British Caribbean	3,049	94%
Any other black background	360	87%
Any other ethnic group	1,943	94%
Prefer not to say	4,225	90%
Unknown	-	-
Total	**204,545**	**93%**

Disability

4 percent of those revalidating have declared a disability. Those declaring a disability had a lower revalidation rate (90 percent compared with 95 percent for those not declaring a disability). This is a similar picture to the last two years and we think it is driven by the fact that those declaring a disability are less likely to be in work and able to gather evidence for revalidation. People living with a disability are more likely to say they are leaving the register due to ill health (36 percent cited ill health as a reason for leaving, compared to only 2 percent of people without a disability – see the 'Why people choose not to revalidate' section). We make adjustments available for those who face difficulty in revalidating and we discuss those in the next section.

FIGURE 7

Proportion of people who revalidated by whether they had a self-declared disability (April 2018 to March 2019)[6]



Please note that the axis of this chart starts at 50% rather than 0%.

[6] Note: Only one person who revalidated has 'unknown' disability status. The 2,517 people 'due to revalidate' who were unknown, are mainly people who are no longer on the register, mainly because they lapsed instead of revalidating.

EMPLOYMENT, PRACTICE AND WORK SETTINGS

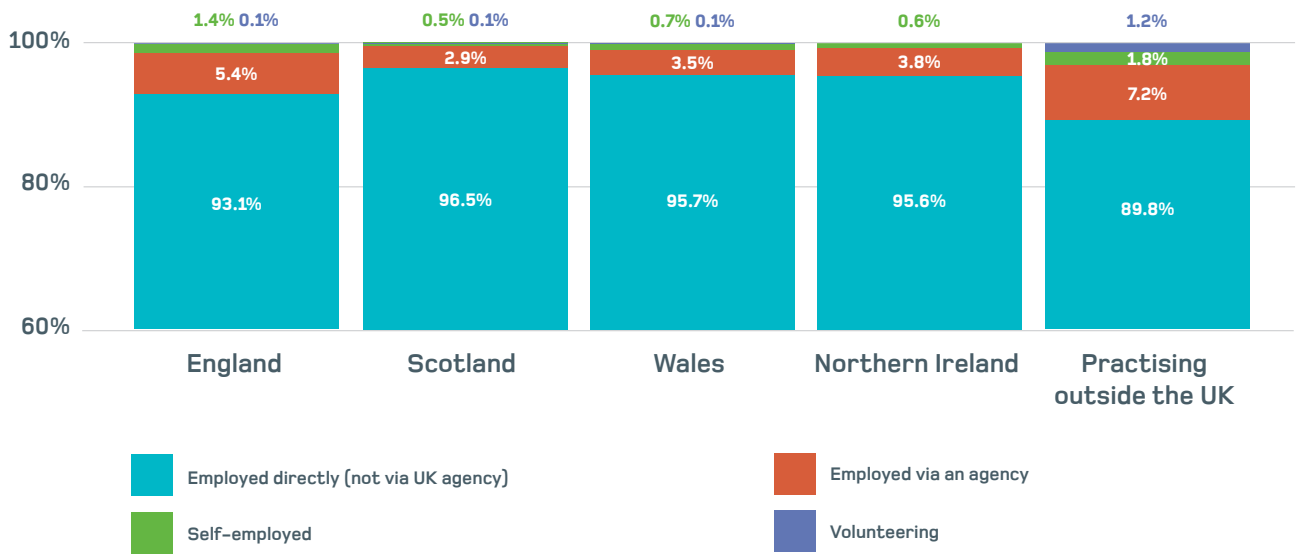
Revalidation gives us an insight into the types of jobs people are doing, where they are working, and how they are employed.

For the first time this year we have analysed the more detailed information we have on employment, scope of practice and work settings by protected characteristics. This analysis has shown some interesting insights which are explored below.

Nurses and midwives can do more than one type of job. At revalidation, we ask people to declare all of the types of jobs that they do to meet the 450 practice hours requirement. This means that someone who is self-employed and who does additional voluntary work could record both employment types at revalidation. The vast majority of jobs people reported in year three (94 percent) were in direct employment, with most of the remainder (5 percent) being through an agency (Figure 8). People reported being self-employed only rarely (1 percent). This is consistent with previous years.

FIGURE 8

Employment types for those who revalidated by country (April 2018 to March 2019)[7]



Please note that the axis of this chart starts at 60% rather than 0%.

[7] This includes nurses and midwives whose current or most recent practice (those for whom we have an employer address), or their home address is either outside of the UK in the EU/EEA or overseas (outside the EU/EAA).

Most nurses and midwives reported working in direct clinical care roles (94 percent), with the majority of that being in adult and general care nursing (64 percent) followed by mental health nursing (10 percent) (Table 2). As we might expect, there are lower proportions of jobs done by midwives in hospital or secondary care than for nurses. There were similar proportions of jobs done by midwives and nurses in community settings, and obviously much higher numbers of jobs done by midwives in maternity units.

A small majority of jobs are in hospital or other secondary care (56 percent). The next most frequently reported work setting is community care, including district nursing and community psychiatric nursing (18 percent). The breakdown across the four countries of the UK is generally similar although there is a higher proportion of care home work settings being declared in Northern Ireland (13 percent of jobs compared to 10 percent in Scotland, 8 percent in England, and 7 percent in Wales and outside of the UK).

TABLE 2

Scope of practice for those who revalidated by country (April 2018 to March 2019)[8]

Scope of practice	England	Scotland	Wales	Northern Ireland	Practising outside the UK*	Total current scopes of practice
Commissioning	1,075 (0.6%)	20 (0.1%)	35 (0.3%)	8 (0.1%)	5 (0.1%)	**1,143 (0.5%)**
Direct clinical care or management – adult and general care nursing	107,341 (63.4%)	13,109 (63.1%)	6,744 (63.5%)	5,221 (66.3%)	2,325 (61.6%)	**134,740 (63.5%)**
Direct clinical care or management – children's and neo-natal nursing	10,719 (6.3%)	954 (4.6%)	551 (5.2%)	408 (5.2%)	242 (6.4%)	**12,874 (6.1%)**
Direct clinical care or management – health visiting	4,121 (2.4%)	696 (3.4%)	355 (3.3%)	201 (2.6%)	62 (1.6%)	**5,435 (2.6%)**
Direct clinical care or management – learning disabilities nursing	2,448 (1.4%)	322 (1.6%)	188 (1.8%)	211 (2.7%)	36 (1.0%)	**3,205 (1.5%)**
Direct clinical care or management – mental health nursing	17,310 (10.2%)	2,557 (12.3%)	1,267 (11.9%)	677 (8.6%)	350 (9.3%)	**22,161 (10.4%)**

Direct clinical care or management – midwifery	9,139 (5.4%)	938 (4.5%)	490 (4.6%)	398 (5.1%)	217 (5.7%)	**11,182 (5.3%)**
Direct clinical care or management – occupational health	1,440 (0.9%)	225 (1.1%)	81 (0.8%)	47 (0.6%)	25 (0.7%)	**1,818 (0.9%)**
Direct clinical care or management – other	3,666 (2.2%)	503 (2.4%)	219 (2.1%)	146 (1.9%)	120 (3.2%)	**4,654 (2.2%)**
Direct clinical care or management – public health	1,063 (0.6%)	138 (0.7%)	57 (0.5%)	79 (1.0%)	55 (1.5%)	**1,392 (0.7%)**
Direct clinical care or management – school nursing	1,838 (1.1%)	155 (0.7%)	114 (1.1%)	57 (0.7%)	56 (1.5%)	**2,220 (1.0%)**
Education	3,322 (2.0%)	393 (1.9%)	197 (1.9%)	150 (1.9%)	117 (3.1%)	**4,179 (2.0%)**
Policy	126 (0.1%)	27 (0.1%)	8 (0.1%)	19 (0.2%)	12 (0.3%)	**192 (0.1%)**
Quality assurance or inspection	850 (0.5%)	84 (0.4%)	46 (0.4%)	43 (0.5%)	32 (0.8%)	**1,055 (0.5%)**
Research	1,372 (0.8%)	154 (0.7%)	66 (0.6%)	28 (0.4%)	24 (0.6%)	**1,644 (0.8%)**
Other	3,348 (2.0%)	499 (2.4%)	200 (1.9%)	185 (2.3%)	97 (2.6%)	**4,329 (2.0%)**
Total	**169,178**	**20,774**	**10,618**	**7,878**	**3,775**	**212,223**

DIFFERENCES BY PROTECTED CHARACTERISTIC

Gender

Of the 698,000 people on our register only 11 percent are men. Those men are well-represented in certain fields of work: they do 28 percent of mental health jobs, 19 percent of jobs in learning disabilities and 19 percent of agency jobs. On the other hand, women dominate a number of roles that involve children. Women do 99.5 percent of jobs in midwifery, 99 percent of health visiting jobs and 99 percent of school nursing jobs. Men are also more likely to work in certain settings. They do at least 20 percent of jobs in the military (29 percent), ambulance service (24 percent), trade union or professional body (21 percent), prison (26 percent) and police service (20 percent). In contrast to this, women do more than 95 percent of jobs in maternity units or birth centres (99.6 percent), schools (98 percent), cosmetic or aesthetic sector jobs (96 percent) and GPs or other primary care settings (97 percent).

Age

Of those individuals who have revalidated since April 2018, 36 percent were over the age of 50 years, while 35 percent were between the ages of 21–40 years. When thinking about current and future workforce planning, it is useful to know which settings, jobs and employer types have larger proportions of older people in order to be anticipatory in planning and to meet the needs of an ageing workforce. Those working in agencies tend to be older with 7 percent of those aged 61–70 years employed via an agency compared to only 4 percent of those aged 21–30 years. This could be indicative of the flexibility and pay offered by agency work.

The age profile of people in different scopes of practice and work settings varies markedly (Figure 9). Some scopes of practice and work settings have a relatively young age profile overall, with over half of jobs done by people aged between 21–40 years. This age group does over half of all jobs in children's and neo-natal nursing, 42 percent of midwifery jobs, 46 percent of jobs in maternity units or birth centres and 53 percent of jobs in the military. In contrast, in some work settings and scopes of practice over half of people are aged 51 and over. These include: occupational health (59 percent), quality assurance or inspection (59 percent), education (53 percent), inspectorates or regulators (63 percent) and universities or other research facilities (55 percent). Trade unions or professional bodies, insurance or legal settings and the voluntary or charity sector are all also dominated by individuals aged 51 years and older.

Ethnicity

Based on this analysis, we see a relationship between ethnicity and the type of nursing and midwifery jobs that people undertake. For example, people employed via an agency are markedly more ethnically diverse than people employed directly. 73 percent of jobs done through direct employment are by people of White British ethnicity, with 5 percent by people of black/black British African ethnicity. In comparison, 36 percent of jobs done via an agency are by people of Black African ethnicity, and 35 percent are by people of White British ethnicity (Figure 10).

People in the fields of adult general care nursing and mental health nursing are the most diverse in terms of ethnicity. Almost one third (32 percent) of jobs in adult and general care nursing are done by people who are not White British. Mental health nursing has a high proportion of people of Black British African ethnicity, 16 percent of jobs done in mental health nursing are done by people of Black British African ethnicity, compared to 7 percent of all jobs done by this group overall.

In the least ethnically diverse work settings and scopes of practice over 80 percent of nursing and midwifery jobs are done by White British people, compared with the 71 percent of jobs done by White British people overall (Figures 11 and 12). These are: school nursing (86 percent), quality assurance or inspection (86 percent), policy (81 percent), the voluntary or charity sector (88 percent), police and military (both 84 percent), governing bodies or other leadership settings (81 percent) and the ambulance service (85 percent). Work settings with the most ethnically diverse nursing and midwifery workforce include the care home sector, public health organisations, hospitals or other secondary care and prisons. Almost half (49 percent) of jobs in the care home sector are done by people who are not White British, with 13 percent done by Black/ Black British African people. Around one third of jobs in public health organisations and hospitals or other secondary care are done by people who are not White British (34 percent and 32 percent respectively).The work setting with the highest proportion of jobs done by people of Black/Black British African ethnicity (17 percent) is prisons.

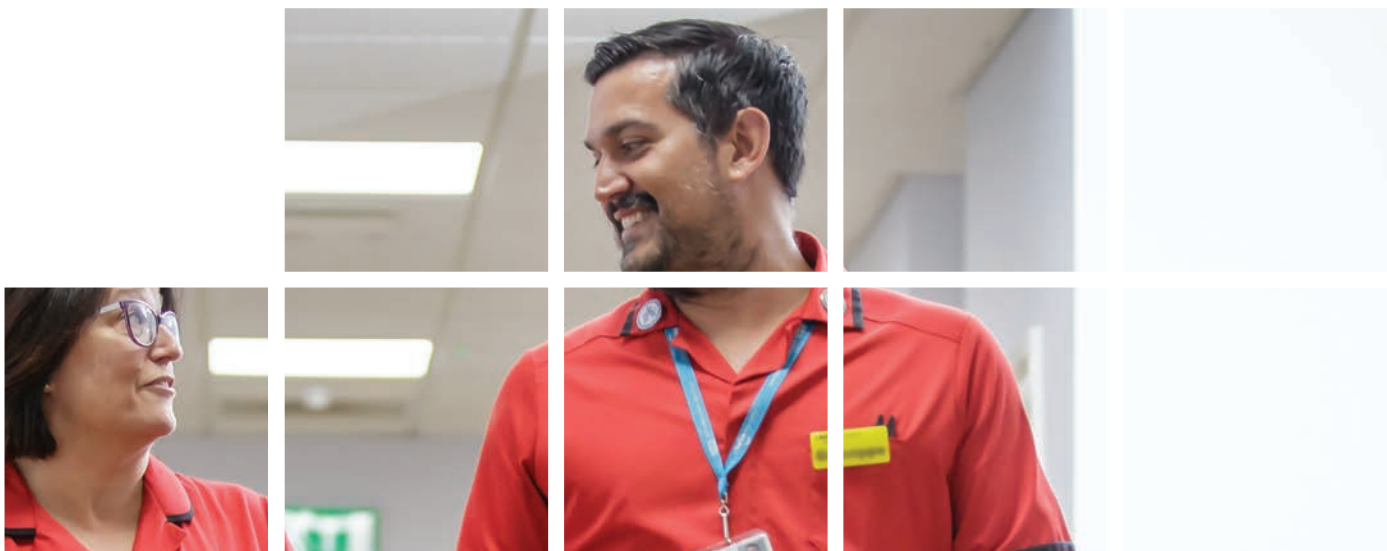


FIGURE 9

Jobs done by people revalidating by scope of practice and age group (April 2018 to March 2019)

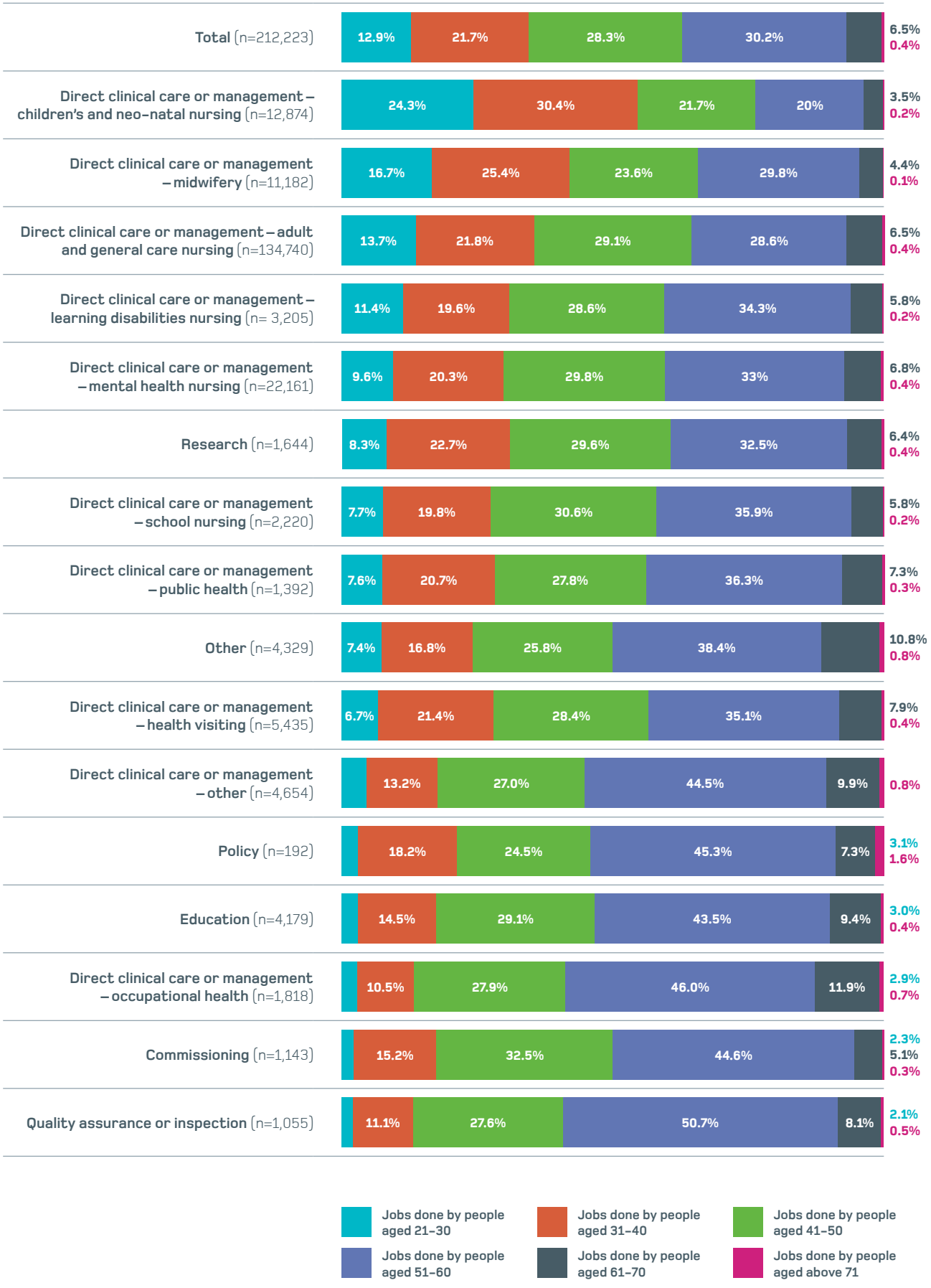


FIGURE 10

Employer types by most common ethnic groups (April 2018 to March 2019)[9]

[9] Please note that the charts in this section show only the three most common ethnic groups – White British, Black African and Any other White background. The other ethnic groups (including unknown and prefer not to say) have been grouped together, as individually they make up a small proportion of the whole group. The data are presented in this way in order to bring out the key differences by ethnic group for the larger ethnic groups.

FIGURE 11

Jobs by scope of practice and ethnic group (April 2018 to March 2019)

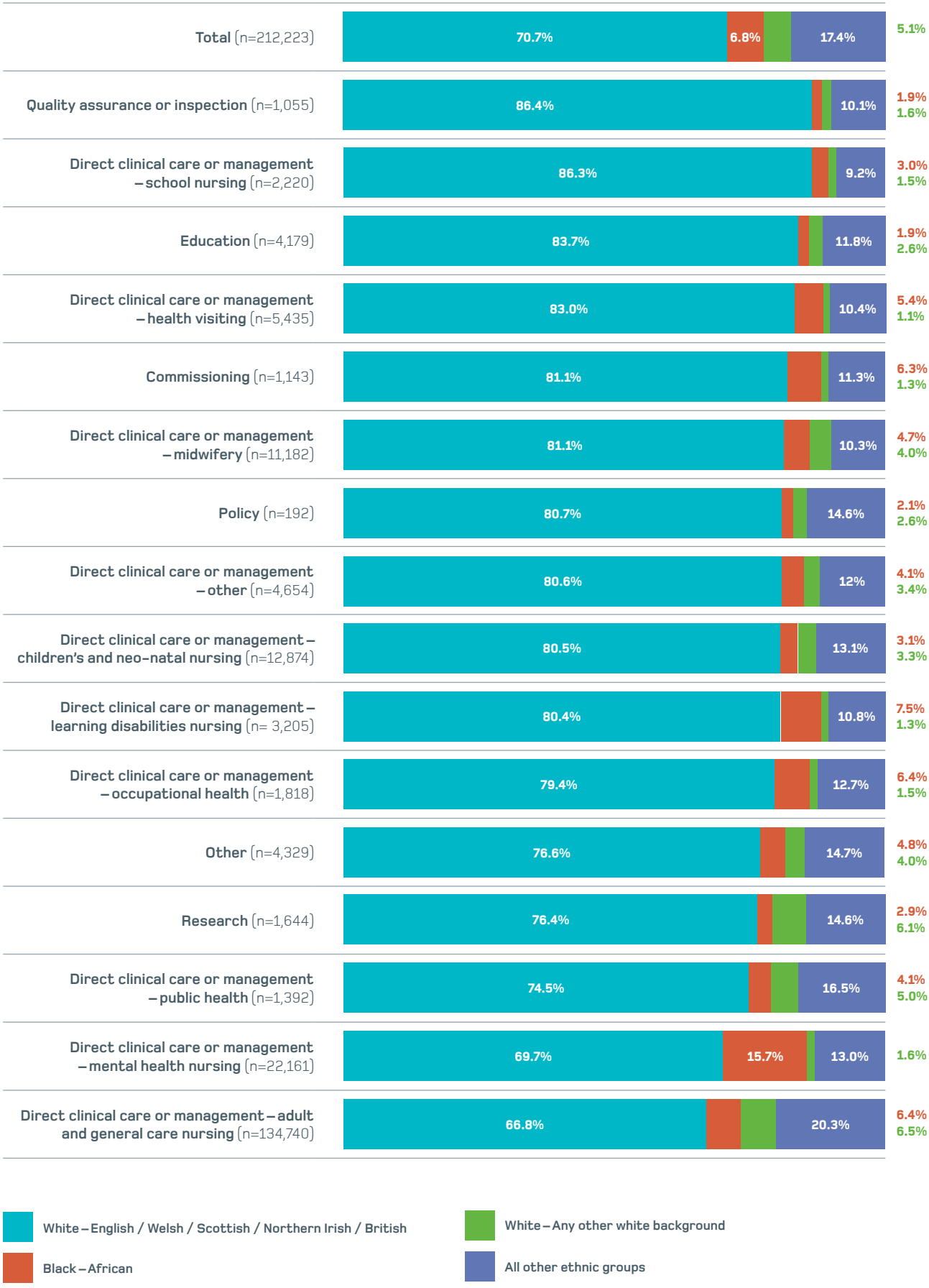
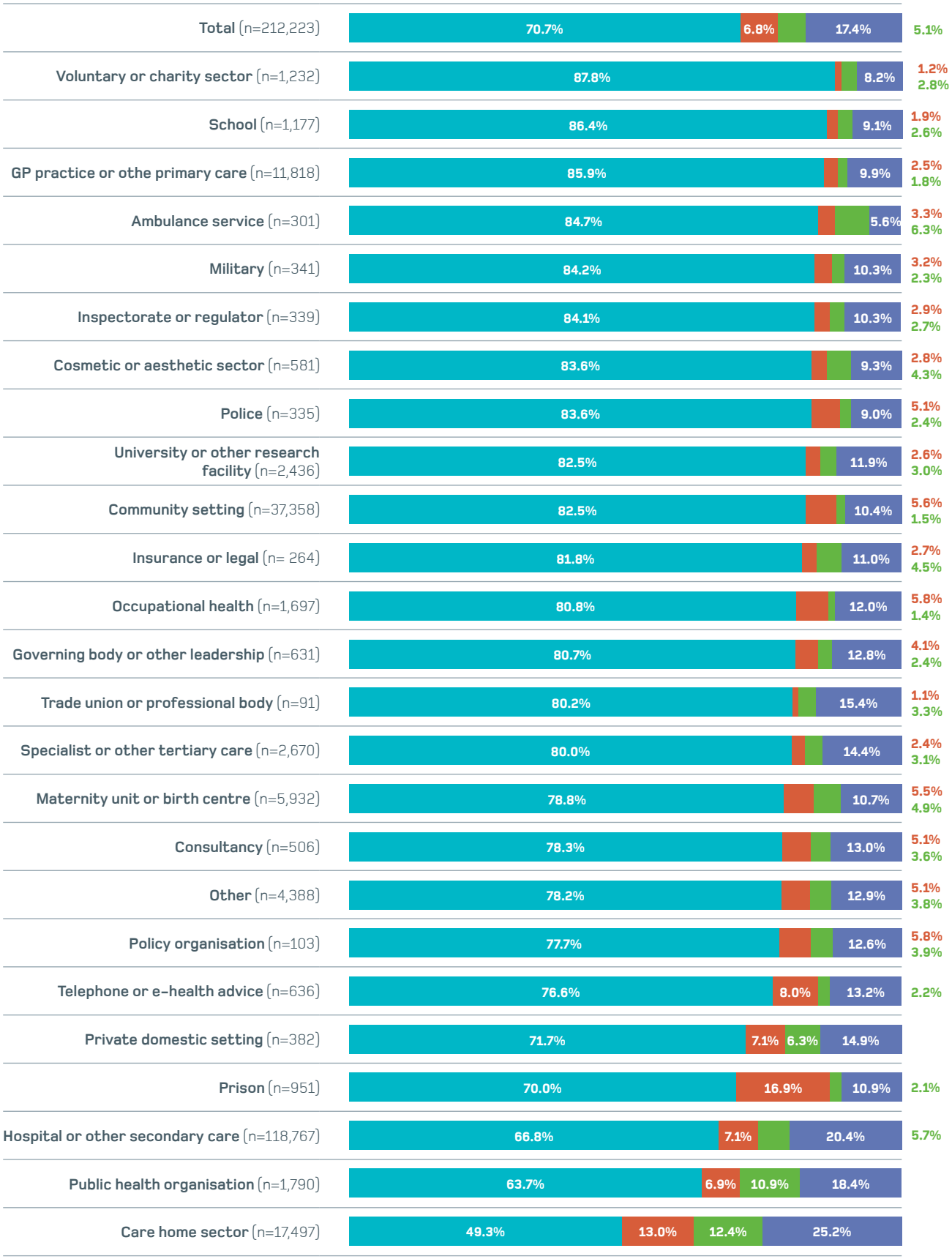


FIGURE 12

Jobs by work setting and ethnic group (April 2018 to March 2019)



Country of training

Many of the individuals on our register are trained outside of the UK, and these people make up a valued part of our workforce. Almost one quarter of jobs (22 percent) through an agency are done by people who trained outside of the EU/EEA, compared with one in ten jobs for those in direct employment (Figure 13). Adult general care nursing is the scope of practice with the highest proportion of jobs done by people trained outside of the UK (21 percent). There are certain work settings that rely more on individuals trained outside the UK including: the care home sector (39 percent), public health (20 percent), and hospital or other secondary care (19 percent). Work settings with highest proportion of people who trained in the UK include: the police (95 percent), the military (98 percent), community settings (97 percent), and the voluntary or charity sector (97 percent) (Figure 14).

FIGURE 13

Employer types by training country (April 2018 to March 2019)

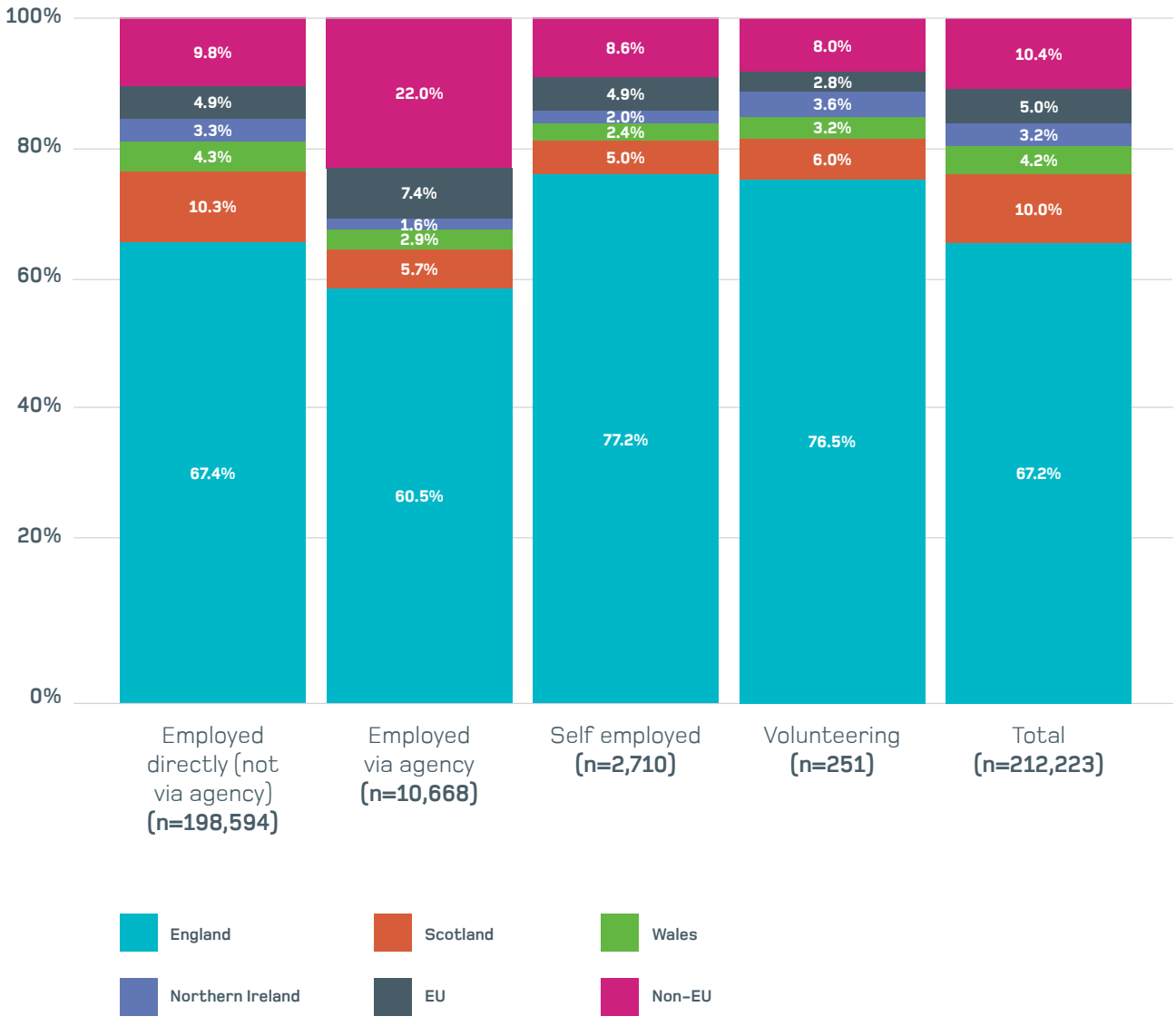
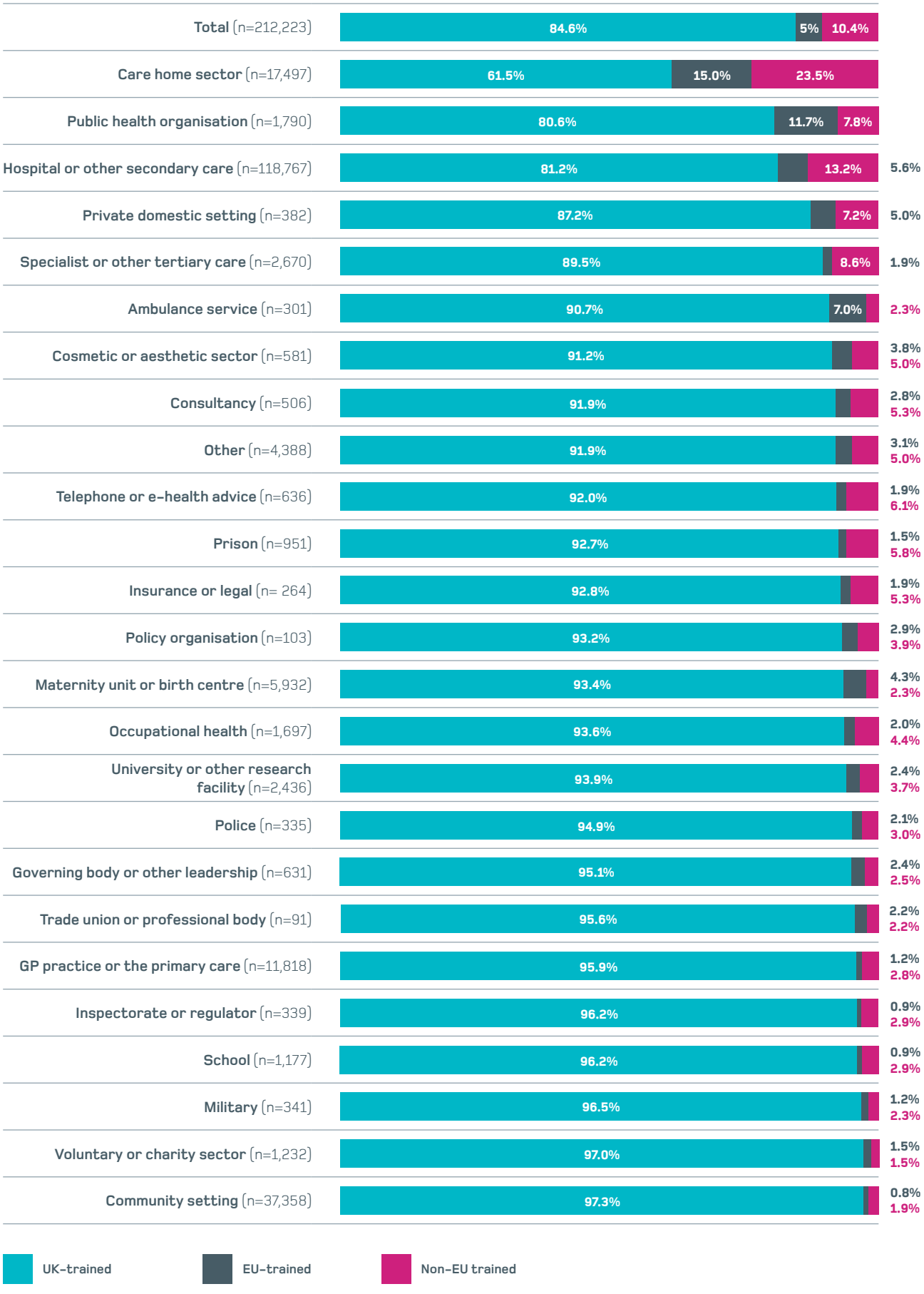


FIGURE 14

Jobs by work setting and training country (April 2018 to March 2019)



HOW PEOPLE REVALIDATED: CONFIRMATION AND APPRAISAL

We require everyone who revalidates to have a confirmation discussion, ideally with a line manager. This assures us that revalidation is being implemented in the way that we intended.

The majority of people revalidating choose their line manager (69 percent) as their confirmer and this is in line with our preferred approach. In most cases, the line manager acting as the confirmer is also an NMC registrant. The next most frequently reported confirmer type is another registered nurse or midwife (31 percent) and again this is in line with our guidance. Only a very small proportion choose anyone else.

There are some differences reported by country. For example, Northern Ireland has the highest proportion of people choosing a line manager who is an NMC registrant as a confirmer compared to England, Wales and Scotland. The proportions of nurses and midwives choosing a confirmer who is registered with the NMC is broadly similar, although a larger proportion of nurses choose an NMC registered line manager, while a larger proportion of midwives choose another NMC registered nurse or midwife to be their confirmer.

We also consider appraisal to be an important tool to support nurses, midwives and nursing associates in their professional development. Most people (97 percent) told us that they had a regular appraisal and this proportion is largely consistent across all four countries. Nurses and midwives in Scotland are more likely to report that they don't have a regular appraisal (6 percent compared with less than 3 percent in the other UK countries). Nurses and midwives who have an NMC registered line manager are more likely to report having a regular appraisal than those who don't (98 percent compared with 87 percent).

Applicants requiring additional support to revalidate

When we introduced revalidation we knew that some nurses and midwives wouldn't have had sufficient time to gather enough evidence to meet the revalidation requirements. Therefore, we allowed people under these exceptional circumstances to continue to meet the previous renewal requirements. Over the last three years the number of people renewing their registration in this way reduced from 1 percent of those revalidating in year 1 to only 0.3 percent in year 3. The largest proportion of people revalidating through the 'exceptional circumstances' process (46 percent) are between the ages of 31 to 40, and 97 percent are women. This is what we would expect as a frequent

reason for not having sufficient time in practice is being on maternity leave.

Those who go through the 'exceptional circumstances' process are also more likely to declare a disability (14 percent) than those who go through the standard revalidation process (4 percent).

This was a transitional arrangement for the first three years of revalidation only and this option is now not available. There will still be reasonable adjustments available for those who are experiencing barriers to revalidating. These adjustments include additional time or alternatives to submitting online applications.

WHY PEOPLE CHOOSE NOT TO REVALIDATE

In all four countries of the UK, between 5–6 percent of people who are due to revalidate leave the register instead. The proportion is higher among people who practise outside of the UK (around one third don't revalidate).

When people tell us they wish to leave the register, we ask them to give a single reason for doing so. This year, 52 percent of people who were due to revalidate but did not, gave us a reason for leaving, (Figure 15).

Most people cite retirement (53 percent) or not practising (35 percent) as their reason not to revalidate. Ill health and not meeting the revalidation requirements are cited by similar proportions of people choosing not to revalidate (5 percent and 6 percent respectively).

As we would expect, a higher proportion of those working or living outside the UK are more likely to choose not to revalidate. The majority of these people (72 percent) say they are leaving the register because they don't practise anymore. There are some differences between UK countries in the proportions citing retirement as a reason for leaving. England has slightly lower proportions citing retirement than the other three UK countries. This is probably due to the age profile of nurses and midwives in these countries.

A small proportion of people (6 percent) said that they were leaving the register because they were unable to meet the revalidation requirements. For nurses, the biggest difficulties are meeting the practice hours requirements (48 percent); undertaking the reflective discussion element (47 percent); obtaining practice related feedback (34 percent); or completing the written reflective accounts (35 percent). In some cases, these aspects may be linked as if an individual is not carrying out sufficient practice it will be difficult to obtain feedback or carry out a reflective discussion.

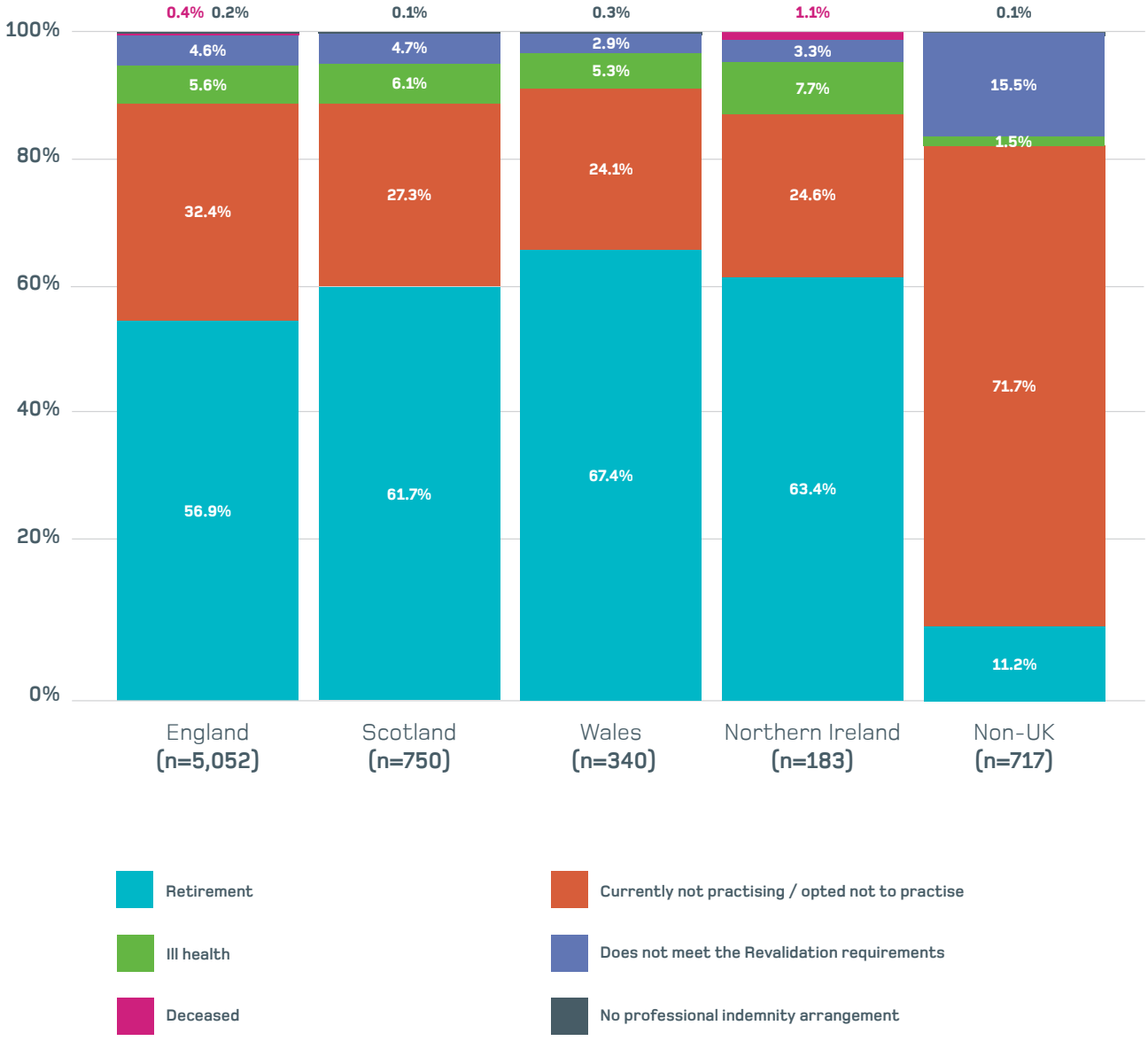
When considering how to address these points we must recognise that our register is for nurses, midwives and nursing associates practising in the UK. We think that revalidation has highlighted the fact that under the previous scheme it was easier to stay on the register without being able to meet the requirements for continuing safe and effective practice.

We also surveyed **those who left the register between May and October 2018**, asking them for their reasons. In total, 3,504 people responded to this survey. Respondents were asked to select the top three reasons why they chose to leave the register from a list of 18 options. Less than 20 percent (658 people) said that they were 'concerned about not being able to meet the revalidation requirements'. People in older age groups (aged 61–70 years) were more likely to select this option than younger groups (21–30 year olds). For example, 19 percent of people aged 61–70 years said they were concerned about not being able to meet revalidation requirements in contrast to 12 percent of 21–30 years who cited this as a reason for leaving.

The independent evaluation has confirmed that no group is at a significant disadvantage, but we will continue to monitor the reasons why people choose not to revalidate.

FIGURE 15

Reasons for leaving by country (April 2018 to March 2019)[10]



People with a disability are more likely to say they are leaving the register due to ill health (36 percent of disabled people cite ill health as a reason for leaving, compared to only 2% of non-disabled people) (Table 3). We can make adjustments for those who face difficulty in revalidating.

[10] This chart only includes those people who told us that they wanted to leave the register (rather than those who simply chose not to revalidate or not to pay their annual fee), and for whom we have a recorded reason for doing so. If someone left both at the point of revalidation and because they were ceasing to practise, both of the reasons have been counted. Where an individual has lapsed both their nurse and midwife or SCPHN registration, their reason for lapsing for each of these registration types would be counted.

TABLE 3

Reasons for leaving by self-declared disability (April 2018 to March 2019)

Reason for leaving	Has a disability	Does not have a disability	Prefer not to say	Unknown	Total
Retirement	183 (35.1%)	2,980 (54.3%)	245 (47.1%)	353 (68.8%)	**3,761 (53.4%)**
Currently not practising / opted not to practise	124 (23.8%)	2,036 (37.1%)	187 (36.0%)	138 (26.9%)	**2,485 (35.3%)**
Ill health	190 (36.4%)	117 (2.1%)	49 (9.4%)	15 (2.9%)	**371 (5.3%)**
Does not meet the revalidation requirements	21 (4.0%)	336 (6.1%)	36 (6.9%)	–	**393 (5.6%)**
Deceased	3 (0.6%)	11 (0.2%)	1 (0.2%)	6 (1.2%)	**21 (0.3%)**
No Professional indemnity arrangement	1 (0.2%)	7 (0.1%)	2 (0.4%)	1 (0.2%)	**11 (0.2%)**
Total	**522**	**5,487**	**520**	**513**	**7,042**

THE VERIFICATION PROCESS

Verification is one of the tools we use to gain assurance that nurses, midwives and nursing associates are complying with the revalidation guidance and meeting our requirements. The possibility of being selected for verification encourages people to meet our requirements. Selecting and reviewing a sample of applications enables us to have a high degree of confidence that everyone revalidating is acting in this way.

Checking every single application would be a disproportionate approach as well as operationally impracticable. We select both a risk-based sample and a random sample to verify. We have used standard statistical methodology (frequently used by polling companies) based on the size of the register, the level of certainty we require and the margin of error we are prepared to accept. We have chosen a 95 percent level of certainty and a margin of error of +/-3 percent.

As well as monitoring compliance for the whole register, we are also testing to see if there are any nurses and midwives who represent a greater risk of not complying with the requirements. We have categorised potential risks into three main types:

- the individual's own characteristics
- the practice environment they work in
- the organisational context they work in.

We have chosen not to use people's individual characteristics as a risk factor due to the lack of information we have to objectively identify any particular characteristics as well as the potential for unlawful/unethical discrimination. Instead we test for risks according to practice environment (whether the individual has an NMC registered line manager) and organisational context (whether they have an annual appraisal). People who have neither are categorised as high risk. People with one but not the other are categorised as medium risk. Someone is low risk if they have both an NMC registered line manager and an annual appraisal. Those in the high and medium risk groups have a greater chance of being selected for verification than those in the lower risk group.

Verification isn't about auditing the quality of the information we receive. It's about collecting information to increase assurance that people are meeting the requirements. We ask those who are selected for verification for the following information:

- a breakdown of practice hours that have made up their required 450 hours
- details of the type of practice they undertook
- where they carried out the work
- confirmation of CPD hours and the types of courses that they undertook
- confirmation of their arrangements for professional indemnity insurance.

Finally we contact the confirmer to verify that they carried out the confirmation discussion and that the discussion covered the areas specified in the guidance. We also ask the confirmer to state how they qualify as a confirmer.

Analysis

There are small differences in the proportions of people in the medium and high risk groups by ethnicity. We aren't clear why this might be but will continue to monitor this. There may be a relationship between scope of practice and work settings. For example, we know that a high proportion of agency workers are black African, and it may be that agency workers are less likely to have access to a line manager who is registered with the NMC or regular appraisals. There is no difference in risk breakdowns between those who say they are disabled, and those who are not.

Looking in more detail at scope of practice we can see that a higher proportion of people working in policy, quality assurance and inspection are in the medium or high risk categories. From the analysis of work settings we can see that the cosmetic sector has a much higher proportion of people in the high risk category (27 percent) than any other work setting and only a third (31 percent) are in the low risk category. In comparison, 82 percent of people working in care homes, and 89 percent of people working in community settings, are in the low risk category.

Identifying potential areas of risk is a complex matter. There are many factors that impact on a professional's ability to deliver safe and effective care and we will continue to use our organisational learning from fitness to practise cases and from our education quality assurance work to further our understanding in this area.

THE EVALUATION OF REVALIDATION

Fundamental to where we go next with revalidation is the evaluation carried out by Ipsos MORI. We began this in 2016 shortly after the first nurses and midwives revalidated. This year marks the publication of the final evaluation report. We are very encouraged to see that the great feedback we have received is supported by these detailed and helpful findings, which show people believe revalidation is having a positive impact on their ability to practise safely and effectively. Even more importantly there is evidence that this change is being sustained.

Key highlights

People find the process straightforward and valuable. There is no evidence of any group being at a significant disadvantage or evidence that revalidation is leading to a reduction in numbers on the register. Nor is there any evidence that the burden placed on nurses and midwives and their employers is disproportionate. Where there are differences in revalidation rates our analysis suggests this is largely due to roles or work settings rather than the revalidation requirements themselves, and we will seek to address this through developments in our guidance.

Nurses and midwives value the opportunity to reflect, in particular the opportunity to discuss reflections with another NMC registered professional. Many perceive this as the most valuable part of revalidation. People not only understand the importance of reflection but can see the benefit it has had for their practice. This is true even for those already committed to reflective practice; revalidation has encouraged them to reflect further.

Another strong theme is that professionals increasingly see the Code as central to their everyday practice. It is seen as helpful, easy to read and understand and flexible enough to apply to a variety of individual practice settings. Revalidation appears to have helped individuals improve their practice by asking them to focus their reflection and subsequent actions around the Code.

The opportunity to carry out meaningful CPD is central to revalidation. The evaluation has shown that a focus on recording CPD leads people to reflect more on the training they undertake as well as taking a more thoughtful and proactive approach to training than they had done before. Finding time and support to carry out CPD can be a problem; many have supportive employers but this support can vary. This is reflected in our own surveys of those choosing to leave the register, which show that lack of time to do CPD can be a factor in this decision.

It is clear that employer's value revalidation too and the evaluation suggests that more work can be done with employers in terms of sharing best practice; especially outside the larger trusts.

We recognise that cultural change is a process. We know that there is more to do if we are to build on the great foundations that have already been laid. We are pleased to see that our stakeholders agree we have an important role to play in encouraging better, safer care and that revalidation is seen to be complimenting a wider shift towards openness and learning in the sector. We need to make sure we continue this momentum.

How we might improve

Nurses and midwives have been positive about our communication and guidance but some are seeking a more directive approach from us in terms of revalidating in different practice settings and the roles of confirmer and reflective discussion partner. This is particularly true for confirmers who are not registered with the NMC. Some people have concerns about how the quality of reflective accounts could vary and whether the confirmation process is robust enough for everyone.

Effective feedback is key to meaningful change and we think we can do more to provide guidance in this area. People report that the quality of feedback is variable with nurses and midwives sometimes being passive recipients of feedback rather than seeking it proactively. This might be best achieved by moving away from specifying numbers and focusing more on quality. We also recognise that there can be barriers to collecting feedback, particularly from people who use services, patients and their families. We want to work with patient representative groups and others to understand what support we can provide to help overcome these barriers.

There is strong support for confirmation which is seen as providing assurance that the requirements are being met. While the principle of verification has strong support, understanding of the process is still poor. There is a perception that the confirmation and verification process are the same thing, as well as a view that not many people are subject to verification. This risks leading to a belief that if someone were not to take their revalidation seriously, they would not experience any negative consequences. This has the potential to weaken public confidence in revalidation.

We had hoped that one outcome of revalidation would be that concerns about safe and effective practice would be raised earlier, leading in time to a possible reduction in the number of Fitness to Practise referrals. There is little evidence that this is the case and we need to consider whether that is an outcome we should continue to pursue or whether the best way forward would be to focus on how we can support those on our register to develop professionally.

Where next?

The evaluation has shown that the existing model has performed well and that it provides a good foundation for future development. We can see that the principles and outcomes of revalidation reflect and support changes in the sector overall and we intend to continue with the existing model; albeit in an improved and strengthened form.

How far we pursue changes to the model will be dictated by a number of factors not least the impact on the health and social care sector as a whole and our future direction as an organisation. We know that revalidation will need to be flexible enough to support people on our register to develop into changing roles and enable them to work closely with teams and other healthcare professionals so that they have the skills and experiences required to move into different ways of working. It is vital that any developments of the model both address its continuing ability to support retention in the workforce while at the same time not imposing additional burdens on an already pressured sector.

The evaluation team have made some very interesting suggestions for how we might do this. Given the success of the reflective elements of revalidation in particular, they recommend we consider building on these to focus on ongoing learning and development. We should be more specific about how to collect constructive feedback (including feedback from patients, people who use services and their families) as well as providing clear examples of what good looks like for CPD in particular roles or settings.

They also recommend we review our approach to verification and look at how to make the process more visible. They suggest we provide more examples of how to carry out confirmation and reflective discussions.

Finally they recognise, as we do, that one of the keys to the success of revalidation was our ability to build a coalition across all sectors in all four nations. They encourage us to continue working in partnership across the whole sector with an excellent communication and engagement strategy. We welcome these recommendations and will continue to seek further views from as many people as possible as we develop our new strategy for 2020–2025.

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