



**RCN Policy and International Department
Policy briefing 10/14
October 2014**

A comparison of international systems for nurse revalidation – lessons for the UK

Australia, Canada (Alberta, Ontario and Yukon)
Ireland, Italy and Slovakia

RCN Policy and International Department

020 7647 3597

international@rcn.org.uk

www.rcn.org.uk/policy

Contents	Page
1. Introduction and structure of this paper	3
2. Revalidation in the UK – where we are now	4
3. International case studies	6
4. Australia	7
5. Canada	12
6. Alberta (Canada)	12
7. Ontario (Canada)	16
8. Yukon (Canada)	19
9. Ireland	22
10. Italy	24
11. Slovakia	26
12. Conclusion: Lessons for the UK	28

Annexes:

Table 1: The international revalidation landscape – a quick snapshot	31
-----------------------------------------------------------------------------------	----

Introduction

This briefing has been written to help inform the Royal College of Nursing's (RCN's) view on the proposed reformed model of nursing revalidation in the UK. Its contribution is to examine the structures of revalidation in the context of nurses (as opposed to healthcare professionals more widely) across a selection of countries where revalidation is required. These are: Australia, Canada (the provinces of Alberta, Ontario and Yukon), Ireland, Italy and Slovakia. These countries were selected for the following reasons:

- there is a significant amount of available literature which focuses on the experience and evolution of revalidation in several of these case studies - especially Canada and Australia
- the RCN enjoys strong communicative relationships with many of the professional nursing associations and trade union bodies in these countries. These insights have been invaluable in helping to direct the analysis of this paper
- the RCN is committed to ensuring that its international comparative work is genuinely global in scope. As such, this paper uses case studies which have immediate relevance to the UK but which also consider different cultural and political traditions in order to get a fuller view of revalidation and its variant structures.

While consideration was given to including the United States and New Zealand in this report, it was decided that the US provided an excessively complicated case study as each state operates very different requirements. New Zealand was not included on the basis that the analysis provided on Australia gave sufficient focus to the Oceania region and that focus should need to be shared more globally.

This briefing does not attempt to draw any definitive conclusions about revalidation rather it is intended to contribute to the wider debate about what type of revalidation system might be most suitable for nurses in the UK.

Structure of this paper

In order to make the material contained in this report more accessible, the findings for each country case study have been presented thematically. Four key themes have been identified and are explored throughout each country case study. These were selected from the results of an RCN member's survey in January 2014 which sought feedback on the Nursing & Midwifery Council's (NMC's) proposed revalidation model.¹ The survey revealed significant concerns that the infrastructure and resourcing required for the NMC's revalidation proposals is not yet in place in order to be fit for purpose.

¹ RCN, Response to the NMC consultation on revalidation, April 2014, available at: http://www.rcn.org.uk/_data/assets/pdf_file/0004/568336/7.14_RCN_response_Revalidation.pdf (accessed on 15 April 2014)

The four key themes are:

- **the use of third-party confirmation for fitness to practise.** The question asked to RCN members was, ‘Who should provide third party confirmation of the continuing fitness to practise of a nurse or midwife?’
- **the use of patient feedback.** The question asked to RCN members was, ‘Do you agree or disagree that learning and improving from feedback is more important than whether feedback is positive or negative?’
- **minimum CPD requirements.** The question asked to RCN members was, ‘Which of the following do you consider to be acceptable measures of Continuing Professional Development (CPD) activity?’
- **systems of audit and quality control.** The question asked to RCN members was, ‘How best could a nurse or midwife provide evidence of meeting the requirements for revalidation to the NMC if required to do so?’

At the end of each country section there is an ‘Observations for the UK’ summary which considers how the current debate for a future revalidation model could be informed and improved by taking note of international developments around these themes. In addition, the final conclusion section of this paper (page 27) identifies holistic lessons for the UK, drawn from all of the international examples studied in this briefing.

Revalidation in the UK – where we are now

The current revalidation system has been largely in place since April 1995. The NMC sets the standard for revalidation as part of its core function² through the post registration education and practice (PREP) standards. Currently, these require that all registered nurses complete a minimum of 35 hours of CPD over three years (which can include coaching, reading, conferences and other learning-related activities). However, in May 2014, the NMC announced that the CPD PREP standard would be reformed as part of the future revalidation model. The three-year learning requirement will increase from 35 hours to 40 hours and at least half of this time must be dedicated to ‘participatory’ learning activities such as training courses, mentoring and colleague shadowing.

The NMC also requires that nurses compile a record of their development activity in case they are requested to submit to an NMC audit. Finally, all nurses must declare every three years that they are in good health and physically able to practise.

² NMC, accessible at: <http://www.nmc-uk.org/Nurses-and-midwives/Revalidation/> (accessed on 17 March 2014)

The Royal College of Nursing (RCN) is aware that many nurses struggle to meet the mandatory CPD requirements and that the NMC has, in the past, not possessed the human and financial resources necessary to police the current system effectively.³ It is also indisputable that in the past, the NMC only audited a very small number of the total re-registrations submitted to it - potentially compromising the deterrent factor of its audit function.

One of the key recommendations of the Francis Inquiry report which scrutinised serious failings in care at the Mid-Staffordshire Trust between 2005 and 2009, was that the Nursing & Midwifery Council (NMC) should proceed with introducing a system of revalidation for all UK registrants.⁴

Following the publication of Francis's recommendations (February 2013), in September 2013 the NMC launched a public consultation on a new model for revalidating nurses on its register. The key facets of the proposed structure are that:

- nurses should self-declare their continued fitness to practise by meeting the requirements of the revised NMC Code;
- nurses should continue to complete required hours of practice and learning activity through continuing professional development (CPD);
- nurses should actively seek third-party feedback to review and improve the way they work; and
- nurses should receive confirmation from someone well placed to comment on their continuing fitness to practise.

The NMC has scheduled a 'phased-in' approach for the new model with a pilot system due to begin in December 2015.

The RCN's view

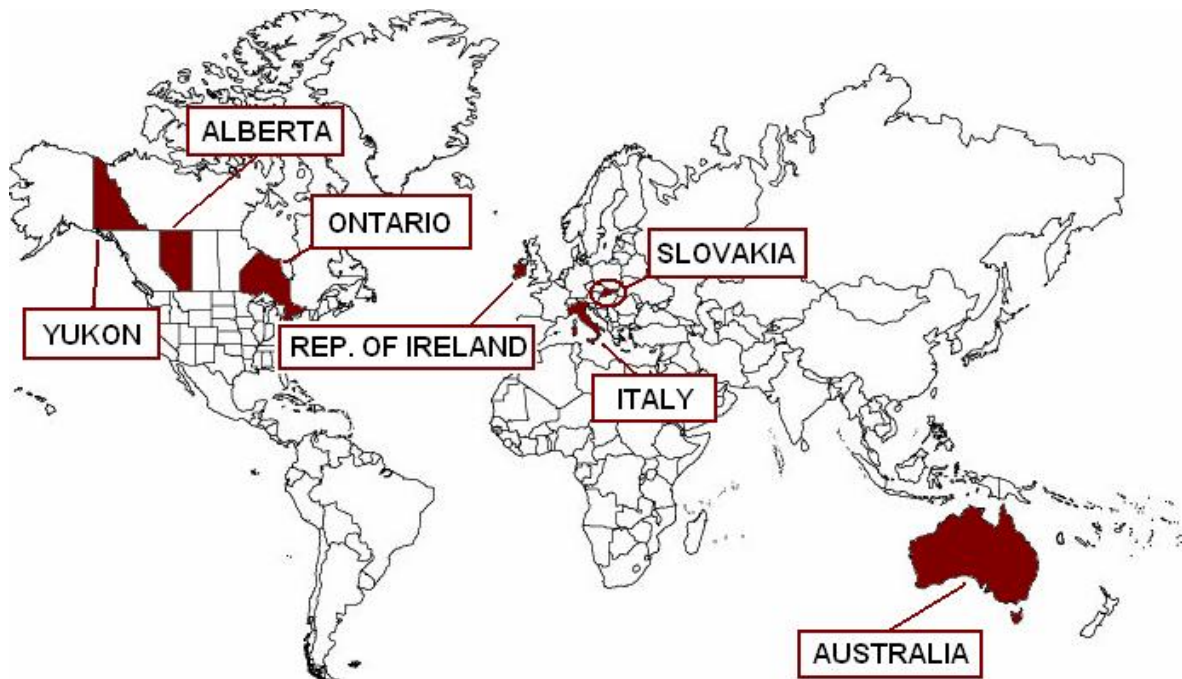
The RCN supports the underlying intentions of revalidation. Most nurses agree that revalidation will help to protect patient safety and to support a culture of professionalism. But thousands of our members have also shared with the RCN the real and reasonable concerns they have that the infrastructure and resourcing required is not yet in place for the NMC's revalidation proposals to be fit for purpose.

The RCN's formal response to the NMC revalidation proposal can be found here: https://www.rcn.org.uk/_data/assets/pdf_file/0004/568336/7.14_RCN_response_Revalidation.pdf

³ RCN, Briefing on NMC revalidation proposals, accessible at: http://www.rcn.org.uk/_data/assets/pdf_file/0006/558519/04.14_RCN_Briefing_on_the_Nursing_and_Midwifery_Council_consultation_on_a_proposed_model_of_revalidation.pdf (accessed on 17 March 2014)

⁴ Francis Inquiry report, available at: <http://www.midstaffpublicinquiry.com/sites/default/files/report/Volume%203.pdf> (accessed on 17 March 2014)

International case studies – Introduction



Formal revalidation for nurses and midwives is a comparatively new and uncommon feature of the international nursing landscape. It is therefore difficult to find case studies from other countries which can help inform how effective the model being proposed in the UK might be. For example, only 12 of the 28 member states of the European Union require that nurses be revalidated.⁵ Outside of Europe, Australia enacted legislation in 2010 requiring that all nurses undertake a minimum of 20 hours of CPD every year in order to revalidate; although securing managerial appraisal or patient feedback are not included in this process.

It is important to note that the design and function of each of the revalidation systems studied in this paper have been heavily influenced by unique country-specific circumstances as well as global healthcare challenges, such as: addressing workforce pressures, concern over the competence of nurses and the diversification of patient needs.

In certain countries such as Ireland, Italy, Slovakia and the UK, models of revalidation are determined through a top-down legislative approach in which regulators are held accountable to political authorities. Other countries such as Canada have delegated revalidation to provincial/state authorities where independent regulatory bodies operate, often doubling-up as professional associations. This reflects the versatility and variety of international revalidation approaches.

⁵ These comprise: the UK, Belgium, Bulgaria, Cyprus, the Czech Republic, Estonia, Ireland, Italy, Latvia, Lithuania, Romania and Slovakia.

Australia: The Big Picture

In 2010, revalidation was moved away from Australia's states to the federal level. Two key events contributed to this change in process. The first was a report in 2005 by the Productivity Commission, which found that the previous system of different re-registration and competence requirements for nurses moving within Australia was exacerbating nursing shortages and recommended a single national standard to help address this problem.

The second key event was the Garling Report in 2008, which investigated a series of care failings at hospitals in the state of New South Wales. The report concluded that the acute sector and wider healthcare services in the state were "on the brink", with 22 per cent of the entire state nursing profession eligible for retirement in 2011. The report also noted that many of the nurses in public hospitals were junior nurses with insufficient senior staff available to supervise them.⁶ Although the Garling report did not specifically recommend a minimum CPD standard for nurses, its findings were used at federal-level discussions on how relicensing could be both streamlined and improved.

To address these concerns, the Coalition of Australian Governments (COAG) reformed the Nursing and Midwifery Board of Australia (NMBA) by granting it centralised control over the revalidation function, thereby turning it from a state to a federal-level authority. It also created the Australian Health Practitioner Registration Agency (AHPRA) whose role is to vet the formal educational training for nurses across the country in order to ensure that a federal standard of quality in training and learning is met.

Australia: Key findings on the use of third-party confirmation for continuing fitness to practise

Revalidation occurs annually in Australia and the deadline for submitting a renewal request is 31st May. The NMBA conducts the annual revalidation of all of Australia's nurses. The NMBA revalidation process is conducted online and does not require nurses to undergo an employer appraisal or seek any form of third-party feedback.⁷ The NMBA is principally concerned that nurses undertake a minimum of 20 hours⁸ of CPD per year and that they inform the NMBA of any disciplinary proceedings.

⁶ New South Wales Government (2008) *The Garling Report*. Available at: http://www.dpc.nsw.gov.au/_data/assets/pdf_file/0003/34194/Overview_-_Special_Commission_Of_Inquiry_Into_Acute_Care_Services_In_New_South_Wales_Public_Hospitals.pdf (accessed on 14 April 2014)

⁷ Nursing & Midwifery Board of Australia, accessible at: <http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Supporting-Documentation.aspx> (accessed on 21 March 2014)

⁸ Nursing & Midwifery Board of Australia, 'Information on CPD' accessible at: <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/CPD-FAQ-for-nurses-and-midwives.aspx> (accessed on 21 March 2014)

Australia: Key findings on the use of patient feedback as an indicator of performance

There is no requirement for nurses to secure patient feedback as a means of relicensing, or as part of an employer appraisal process. Neither is there any significant political or professional discussion taking place which might see this idea become prominent in the near future. As with the UK, the Australian system attempts to integrate the principles of nurse self-declaration with the provision of credible evidence of professional development. Patient feedback on either of these areas is not currently viewed as necessary.

Australia: Key findings on the use of minimum CPD requirements

Nurses in Australia must undertake at least 20 hours of CPD every year in order to revalidate.

This mandatory requirement forms part of Australia's self-reflective practice in which nurses identify their forward-learning needs for the year, plan which CPD events they will attend and then record relevant learning outcomes, as well as reflect on the value of those activities.⁹

Although the annual CPD requirement is mandatory, employers are not legally required to ensure that they provide nurses sufficient time to meet this and a number of Australia's nursing unions have cited a lack of employer support as a significant problem. Fortunately, the NMBA's definition of CPD-related activities is sufficiently wide to allow nurses some flexibility in how they meet this requirement.

Accepted CPD activities can include:¹⁰

- reflecting on feedback and keeping a practice journal
- participating in clinical audits, critical incident monitoring, case reviews and clinical meetings
- developing skills in IT, numeracy, communications, improving own performance
- writing or reviewing educational materials, journal articles, books
- reading professional journals or books
- developing policy, protocols or guidelines
- working with a mentor to improve practise
- presenting at or attending workplace education, in-service sessions or skills workshops
- undertaking relevant online or distance education.

Among the key challenges facing the mandatory CPD system in Australia are:

⁹ "Mandatory continuing professional development requirements: what does this mean for Australian nurses", BMC Nursing, available at: <http://www.biomedcentral.com/1472-6955/12/9> (accessed on 14 April 2014)

¹⁰ Queensland Nurses Union, available at: <http://www.qnu.org.au/nursing-issues/national-registration/current-releases/keep-tabs-on-your-cpd> (accessed on 21 March 2014)

- growing financial pressure and uneven funding patterns. Although nurses are able to request financial support for reasonable costs associated with professional development activity, this is not always available and many nurses fund their own training¹¹
- the current system in Australia focuses only on minimum hours spent on CPD and not the frequency of engagement. Research undertaken by Guardini has shown that retention of clinical skills and knowledge are more effectively serviced by regular education and revision, as opposed to a minimum CPD requirement.¹² The absence of a universal understanding of what constitutes “regular” education for nurses makes addressing this issue particularly difficult
- Australia’s huge geography has focused attention on the accessibility of CPD to nurses, especially for those who work in remote areas and/or who possess only limited internet connectivity.¹³ Although this might not be as significant for the UK context, it is nonetheless important that the UK considers how accessibility to CPD opportunities can be maintained and expanded, especially if revalidation is to become increasingly linked to a minimum amount of study time.

Australia: Key findings on systems of audit and quality control

Audits of random samples of health practitioners occur periodically throughout the year. If an individual is selected for audit, they will receive a written audit notice from AHPRA which includes a checklist that outlines what supporting documentation is required to demonstrate that the individual meets the standard(s) being audited. Among the key areas that are checked are:

- statements on criminal history – AHPRA uses an independent service provider to check criminal history which is conducted at no additional cost to the nurse
- minimum CPD requirement – An audited individual must provide evidence of the CPD activities that they have undertaken to meet the minimum annual requirement of 20 hours. Evidence should include dates of when training took place, a brief description of the outcomes and the number of hours spent in each activity
- recency of Learning – The individual must demonstrate that the CPD learning they submit falls within the relevant one-year period of the audit scope

¹¹ BMC Nursing, available at: <http://www.biomedcentral.com/1472-6955/12/9> (accessed on 21 March 2014)

¹² Guardini I, Talamini R, Fiorillo F, Lirutti M, Palese A: The effectiveness of continuing education in postoperative pain management: results from a follow-up study. *J Contin Educ Nurs* 2008, 39(6):281-288

¹³ BMC Nursing, available at: <http://www.biomedcentral.com/1472-6955/12/9> (accessed on 21 March 2014)

- professional indemnity insurance arrangements – Evidence must be provided that an appropriate degree of insurance is currently held and valid. A copy of the provider's policy is sufficient.¹⁴

In December 2013, the NMBA and APHRA announced that they planned to significantly expand their programme of random audits across all nursing classifications.¹⁵ Although no specific reason for this increase was given, statistics provided by the NMBA show that between December 2012 and December 2013 the number of registered nurses and midwives across Australia rose by five per cent from 338,000 to over 354,000.¹⁶ This indicates that the auditing system has come under increasing pressure and that in order to maintain assurance over a larger workforce, additional auditing resources are required.

An interesting comparison with the NMC's audit procedure is that it identifies cases for audit based on perceived risk and random selection. The Australian regulator on the other hand has sought to minimise the risk element early, by requiring that nurses evidence recency of learning in their initial submission (ie that all CPD undertaken falls within the correct revalidation cycle). This perhaps allows the NMBA and APHRA to control their auditing costs more effectively.

Australia: Observations for the UK

- It is notable that there is no requirement for nurses to secure third-party input in order to revalidate, in spite of a holistic review of its regulatory system in the wake of the 2008 Garling Report, which like the Francis Inquiry, raised concerns over significant care failures.
- Mandatory CPD was introduced as a new federal requirement, although various state regulators had operated similar requirements beforehand. This suggests that there is a growing belief that the provision of firm evidence of professional development should accompany systems of self-reflection and declaration.
- The NMBA has increased its random audit selection, reflecting the growth and variety of the nursing profession. The UK could potentially learn from this case study how to both improve the robustness of its existing auditing system, while continuing to expand its sampling to reflect natural growth within the profession.
- A lack of support by employers and limited financial assistance for CPD-related activities has been cited as inhibiting long-term learning. A 2012 report by BMC Nursing has found that regardless of the acknowledgement of both employer and nurses for the need for professional development, the pressure for meeting

¹⁴ NMBA, 'Audit systems', available at: <http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Audit.aspx> (accessed on 11 April 2014)

¹⁵ Australian Nursing Federation, available at: <http://www.actanf.org.au/index.php/2013/12/20/urgent-new-for-all-nursesmidwives-nmba-random-audits/> (accessed on 11 April 2014)

¹⁶ NMBA, 'Quarterly statistics', available at: <http://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx> (accessed on 11 April 2014)

these requirements lies too heavily with nurses.¹⁷ A lack of employer support is also a significant problem in the UK context.

- Although intermittent employer support presents a significant challenge for nurses when it comes to fulfilling their revalidation requirements, the NMBA has made efforts to ensure that accepted CPD activities are sufficiently varied and flexible.

¹⁷ BMC Nursing, available at: <http://www.biomedcentral.com/1472-6955/12/9> (accessed on 14 April 2014)

Canada: The Big Picture

A significant portion of the focus of this paper is given to the Canadian models and this is because the RCN has been able to gather a variety of first-hand insights into how individual systems of revalidation work. It is important to note however that there are very significant cultural and practical differences between the Canadian and UK regulatory examples. For example, Canada does not operate a standardised pre-registration standard of nursing education nor is there a national mandatory requirement for minimum hours of clinical practice before a student graduates. As a result, it is important when discussing lessons for the UK from the Canadian models discussed below, that this systemic difference in approach and outlook is understood.

The overriding difference between the Canadian and UK revalidation structures is that, unlike the UK where regulation is considered to be the responsibility of one centralised body (the NMC), with intermittent input from employers, the public and others, the Canadian system enshrines in law a system of joint responsibility whereby the regulator with its limited resources and capability is empowered to require that employers first and foremost bear the responsibility for identifying bad practice and relaying this back to the regulator. This system of joint responsibility seems to be a key reason for the success of the regulatory systems operated across Canada.

On a macro-level, Canada shares many notable similarities with Australia, including: a comparable population size, income levels and similar patient health needs. While both countries used to operate similar nursing regulatory systems for many decades, the last ten years have seen a significant divergence in approach. Whereas Australia has shifted away from a provincial/state system of multiple regulatory systems in favour of a single federal authority and minimum CPD requirements (see above entry for Australia), Canada has retained its de-centralised approach to revalidation.

In spite of its decentralised approach, Canada's provinces do not exhibit strikingly different models of nursing revalidation. On the contrary, the evidence indicates that there has been a gradual, voluntary shift by the provinces towards a more standardised system, with individual regulatory bodies dropping minimum CPD hours in favour of self-reflection and continuous skills improvement. Differences between provincial models do remain and are explored in more detail in the sections below. However, the pressing need to limit delays in the movement of healthcare workers between territories would appear to act as a significant incentive for the harmonisation of provincial systems.

Alberta: Introduction

The process of revalidation is handled by the province's independent nursing regulator – the College & Association of Registered Nurses of Alberta (CARNA) which combines the role of regulator and professional association. All nurses practising in Alberta are legally required to have an active membership with CARNA and it is a criminal offence to practise nursing with a lapsed membership.

As with Ontario and Yukon, Alberta utilises a 'self-reflective' model. CARNA requires that at the beginning of every year, registrants select a 'learning priority focus' from CARNA's principles of practice (these include areas such as, "improving the quality of the education I provide to fellow nurses" or "improving my confidence in handling emergency care needs"). Registered Nurses (RNs) need only select one priority focus for the coming year, Nurse Practitioners (NPs) and nurses from outside the province must select two.

Revalidation takes place annually with each registered nurse required to evidence CPD, referred to as the 'Continuing Competence Program' (CCP) by CARNA. In 2010, CARNA dropped minimum CPD hours for its nurses in favour of a stronger focus on self-assessment and reflection.

The revalidation process is broken down into three stages with requirements varying according to whether the applicant is a Registered Nurse (RN), a Nurse Practitioner (NP) and whether they are registering from outside the province of Alberta. To clarify, in the Canadian context, NPs are registered nurses who typically have a higher level of education and a more specialised skill-set compared to RNs.¹⁸

The 'Albertan/Yukon model' combines the role of regulator and professional association, although neither of these organisations takes on the role of advocating for nursing concerns. This has been assumed by the provincial and national unions and this has been cited as limiting the ability of the regulator/professional association to understand the pressing challenges facing nurses.

Alberta: Key findings on the use of third-party confirmation for continuing fitness to practise

Alberta is the only case study looked at in this paper where third-party feedback forms part of the revalidation requirement. However, it is important to note that CARNA does not set strict prerequisites on who should provide feedback. This can be done formally, as in a performance review, or informally, through a casual conversation for example. CARNA's guidance states, "members are required to collect and document feedback about their practice from a minimum of one other person who is familiar with both their practice and their role and responsibilities."¹⁹ This indicates that nurses do not need to secure line manager appraisal or patient input and so differs very significantly from the design being currently considered by the UK's NMC.

In addition, the provincial union, United Nurses of Alberta (UNA) has historically opposed any move towards requiring managerial sign-off for nurses to revalidate. In the early 2000s for example, UNA partnered with the Canadian Nurses Association (CNA) and others to oppose a CARNA initiative, which would have required that student nurses about to graduate secure managerial feedback from their place of work, confirming their suitability to practice at a professional level. The measure was

¹⁸ Alberta, Canada available at: <http://www.albertacanada.com/opportunity/working/hc-nurses-registered.aspx> (accessed on 15 March 2014)

¹⁹ CARNA, available at: <http://www.nurses.ab.ca/Carna/index.aspx?WebStructureID=5795> (accessed on 21 March 2014)

eventually dropped by CARNA who compromised by publishing guidance (in 2009) for staff overseeing student placements on how to ensure effective supervision of practice.²⁰

A key trigger for the union's opposition to CARNA's employer feedback proposal was widespread concern that the system of managerial sign-off could be open to abuse, potentially allowing student nurses to be prevented from practising if the individual responsible for confirming their competence harboured a personal agenda. A similar concern has been raised in the current UK debate, with the NMC's suggestion that nurses seeking to secure revalidation after three years should obtain some form of third-party feedback (potentially from their line manager). The RCN's formal response to the NMC's consultation has highlighted the need for robust guidance as to the assessment method and that clear criteria should be used by an assessor in order to protect against abuse.²¹

In 2010, CARNA completed a consultation which recommended that an additional stage be added to the revalidation process, tentatively referred to as 'Competence Assessment'. This will include the use of practice visits, multi-source feedback (360 review) or other methods to assess competence in the practice setting²² and bring Alberta even closer in line with practice in Ontario where 'Practice and Peer Assessment' forms a key part of the audit process (see below). CARNA has agreed to take forward the proposal which would not include a minimum CPD requirement for nurses.

Alberta: Key findings on the use of patient feedback as an indicator of performance

There is no requirement for nurses looking to revalidate their license in Alberta to secure patient feedback. In addition, discussions between the RCN and the Canadian Nurses Union (CNU) do not indicate that this is likely to be a topic of reform in the near future.

Alberta: Key findings on the use of minimum CPD requirements

There is no legal provision which stipulates a minimum CPD requirement and/or cost sharing ratios with employers and so the experience of nurses varies according to the attitude of their specific workplace. Nurses can negotiate with their employers on how much time to engage in learning, and cost sharing between practitioner and employer is not uncommon. In terms of costs for CPD and protected development time, there are a large number of CPD providers who charge varying costs (or sometimes none at all) for their services.

²⁰ CARNA, 'The Graduate Nurse: Scope of Practice' (December 2009), accessible at: http://www.nurses.ab.ca/Carna-Admin/Uploads/grad_nurse_scope_of_practice.pdf (accessed on 02 April 2014)

²¹ RCN, 'Response of the Royal College of Nursing to the Nursing and Midwifery Council consultation on revalidation' (March 2014)

²² CARNA, Revision to current CCP program, available at: <http://www.nurses.ab.ca/Carna/index.aspx?WebStructureID=5060> (accessed on 14 April 2014)

Alberta: Key findings on systems of audit and quality control

CARNA does not have an extensive auditing infrastructure. Its online system will flag to the college if a registrant has not provided sufficient information to warrant relicensing in which case CARNA will email the registrant to request more information. A small selection of registrant files are randomly selected for scrutiny but CARNA does not provide details as to what assurance processes (if any) these go through.

Following this stage, registrants develop a forward-looking learning plan. This is the final stage of the annual revalidation process and includes four key components. 1) Identify a learning objective, 2) Identify learning activities to deliver this objective, 3) Establish a completion date for learning activities, and 4) Evaluate the impact of completed learning on your practice.²³

Alberta: Observations for the UK

- Alberta's regulatory system exhibits a mixture of advantages and drawbacks. On the one hand, nurses are entrusted to take charge of their own development and this has been credited with increasing public trust in nurses and demonstrating something of a "coming of age" for the profession.
- Many of the provincial colleges combine their role of regulator with that of a professional association. This enables nurses to readily access learning modules, courses and to upload their development progress all within a single source.
- However, there have been concerns that the combination of regulator and professional association limits the ability of nursing staff to express concerns about the effectiveness of the regulatory system, which leaves provincial and national unions as the only viable forum to express concern.
- As a result, changes to submission requirements, audit practices and other systems can be passed with minimal consultation with nursing staff.
- Nursing unions across Canada, such as United Nurses of Alberta (UNA), have expressed concern at the growing imbalance in how responsibility for CPD is shared between employers and employees. For example, in contrast to the UK, where there exists a mutual responsibility on employer and employee for a nurse's learning and development, the Canadian approach has been to weigh this responsibility much more heavily with the nurse. This suggests that nurses in Canada, despite being technically autonomous for their own development are potentially exposed to significant employment risk if they are unable to secure the development time they need.
- As there are no minimum CPD requirements, none of the three Canadian examples grant nurses protected time to undertake any training - this must be negotiated with employers.

²³ CARNA, CCP Requirements, available at: <http://www.nurses.ab.ca/Carna/index.aspx?WebStructureID=5830> (accessed on 14 April 2014)

- Alberta's unions have successfully opposed past plans to require employer sign-off as evidencing fitness to practise (although this applied only to nursing students preparing to graduate). Concerns over potential abuse of the system were insufficiently addressed by CARNA and this led to the proposal being dropped. The NMC has yet to present guidance on how its proposal to integrate third-party feedback (possibly including employer appraisals) for UK nurses will deflect similar concerns.

Ontario: Introduction

The process of revalidation is handled by the province's independent nursing regulator – the College of Nurses of Ontario (CNO). As with Alberta, the CNO focuses heavily on self-assessment and reflective learning. It was the first province in Canada to pioneer a system which dropped minimum hours of CPD in favour of delegating far greater autonomy to nurses when it comes to continued development. Revalidation takes place every year and is subject to each nurse evidencing CPD, but as with Alberta, the amount of time spent on CPD-related activities is the choice of each nurse.

Since 1 April 2014, all practising nurses in Ontario are required to purchase Professional Liability Protection (PLP), unless this is already provided by their employer, as a prerequisite for revalidating. As part of the CNO's audit process, practising nurses may have to provide evidence of an active PLP coverage, in addition to current requirements. Ontario is one of only two international case studies looked at in this paper (the other being Australia) which formally includes PLP coverage within its revalidation requirement. As with the other Canadian case studies, nurses practising in Ontario are legally mandated to have an active membership with the regulator and it is a criminal offence to practise nursing with a lapsed membership.

In terms of structure the Albertan and Ontarian regulatory systems differ in one important respect. In Alberta, the regulator is also the professional association, whereas in Ontario there is what is termed the 'nursing triangle', with the regulator, professional association and trade union functions separated out to different bodies. The Registered Nurses Association of Ontario (RNAO) is the provincial professional association which focuses on best practice, knowledge dissemination and lobbying, and the Ontario Nurses Association (ONA) provides union support services.

Although there are exceptions to this view, the separation of professional, trade union and regulatory functions has been cited as enabling a 'competitive collaboration' between the three key pillars of the Ontarian regulatory system. This ability to work together has resulted in all three bodies successfully lobbying the Ontarian government to increase its financial support to nurses for CPD-related activities in 2003 and 2012.

In 2013, the UK regulator for 15 health and care professionals, the Health & Care Professions Council (HCPC) published a study of Ontario's revalidation system. The purpose behind this work was to use the findings to inform the council's internal discussions as to how revalidation of their members should be instigated. Although

the study found significant procedural similarities between the Ontarian system and the proposed NMC model, it noted that, "...in contrast to how the purpose of revalidation has often been perceived in the UK, these [Ontario's revalidation structure] programmes are focussed on quality improvement (...) rather than quality control."²⁴

The report noted significant benefits of Ontario's system, such as a high degree of support among health care workers for the model, as well as strong systems of assistance for those who fall short of meeting their development needs. However, it also noted significant negative aspects, such as a heavy reliance on self-assessment which left open the chance of overly optimistic assumptions about an individual's strengths and a potential dilution of learning focus.

The report also cited cost as another significant area of interest and the evidence is not immediately clear as to whether an Ontarian 'system' would increase or lower costs in comparison to the proposed NMC model which is set to cost each nurse £120 per year from 2015. Ontarian nurses in 2014 will pay the equivalent of £95 in annual membership/revalidation fees - excluding any CPD training.²⁵ This is low when compared to Alberta (£327)²⁶ and Yukon (£430).²⁷ The reason for this disparity is likely due to the fact that the Albertan and Yukonian regulators combine the role of professional association with that of a regulatory body. When professional association fees (as charged by the Registered Nurses Association of Ontario) are added to the regulatory cost, then the figure paid by Ontarian nurses would be approximately £264²⁸ which is still competitive when compared to other provincial systems. A table detailing the respective cost per nurse for revalidation in the UK and the other international examples in this paper is available in Annex 2.

Ontario: Key findings on the use of third-party confirmation for continuing fitness to practise

The CNO focuses heavily on self-assessment and reflective learning. It was the first province in Canada to pioneer a system which dropped minimum hours of CPD in favour of delegating far greater autonomy to nurses when it comes to continued development.

Nurses are encouraged (but not required) to seek third-party feedback in helping them to identify future learning objectives. The CNO advises that each registrant

²⁴ HCPC, 'An exploration of quality assurance programmes in professional regulators in Ontario, Canada' (2013), available at: <http://www.hpc-uk.org/assets/documents/1000361CReportofinternationalrevalidationstudy-FINAL.pdf> (accessed on 27 March 2014)

²⁵ Ontario College of Nursing, 'Fees for 2014', available at: <http://www.cno.org/become-a-nurse/about-registration/application-membership-fees/> (accessed on 26 March 2014)

²⁶ CARNA, fees information, available at: <http://www.nurses.ab.ca/Carna/index.aspx?WebStructureID=590> (accessed on 10 April 2014)

²⁷ YRNA, fees and general information, available at: <http://yrna.ca/general-information/> (accessed on 10 April 2014)

²⁸ This figure takes the £95 equivalent revalidation fee and adds the average membership charge for the Registered Nurses Association of Ontario which is CN\$308 (£169) to give a total approximation of £264.

seek feedback from a person whose opinion they respect and who is at least familiar with their professional role.²⁹ There is no formal proscription for who can and cannot provide feedback and any information which is collected is confidential and not reviewed by the college.

Ontario: Key findings on the use of patient feedback as an indicator of performance

There is no requirement for nurses to secure patient feedback in order to revalidate. In addition, there is no indication from the research done by the RCN that this is being considered as a future option.

Ontario: Key findings on the use of minimum CPD requirements

The CNO does not require nurses to complete a minimum number of hours of CPD. However, discussions between the RCN and the RNAO indicate that this might change in the long term. Concern has been expressed over potentially high levels of non-engagement with the professional development side of the revalidation process and a mandatory minimum CPD standard has been identified as a potential tool to help combat this problem. There are currently no official discussions at this stage, and the CNO has no statistics on the suspected rate of non-engagement with CPD within the nursing workforce.

As with Alberta and Yukon, the Ontarian system allows for a large number of CPD training providers who charge varying costs (or sometimes none at all) for their learning modules. Nurses can negotiate with their employers on how much time to engage in learning, and cost sharing between practitioner and employer is common. However, there is no legal provision which stipulates a minimum CPD requirement and/or cost sharing ratios with employers, and so the experiences of nurses vary according to the attitude demonstrated within their specific place of work.

The Ontarian government does provide significant financial support to nurses for CPD related studies. In 2003 for example, the professional association, the regulator and the state union collaborated in advising the state government to guarantee each nurse in the region CN\$1,500 (£821) every year for development needs. In addition, in 2013, a similar lobbying effort saw the government agree to a one-off CN\$60,000 (£32,836) grant for primary care nurse development initiatives.

Ontario: Key findings on systems of audit and quality control

Ontario has developed a robust audit system known as 'Practice Assessment and Peer Assessment'. Each year, the college selects nurses to participate in this process, during which the college will review the learning plans of those selected and require that candidates complete objective multiple-choice tests based on selected practice documents. All nurses selected for assessment will have their learning plan and assessment results reviewed by a Peer Assessor who is a college-assigned

²⁹ CNO webcast, available at: <http://www.cno.org/learn-about-standards-guidelines/educational-tools/webcasts/myqa-webcast/> (accessed on 15 March 2014)

nurse with an in-depth understanding of the college's practice standards, guidelines and QA requirements.³⁰

However, although this model has been championed as leading the way in terms of robustness and quality, concerns have been raised that as a consequence of focusing on a more complicated model without an increase in fee membership revenue, the sample of audited individuals will invariably decline. An important consideration for the UK is likely to be how to balance the need for robust systems of audit without undermining the need to gain assurance over a sufficiently large pool of registrants.

Ontario: Observations for the UK

- There is a growing debate within Ontario as to whether a mandatory CPD requirement should be re-introduced in order to mitigate the risk of non-compliance with the self-reflective process. Although many key stakeholders strongly support the self-regulatory model, a greater emphasis on practical education and mandatory levels of evidence to be provided to the regulator are gaining traction.
- There is a strong view shared by the unions, the professional association and the regulator that managerial sign-off as a precondition for revalidation to happen should not be pursued.
- Evidence suggests that all three key bodies – the professional association, the regulator and the state union have collaborated in securing CPD funding initiatives from the government. In 2003 for example, these efforts successfully resulted in the provincial government guaranteeing each nurse in the region CN\$1,500 (£821) every year for development needs. In 2013, a similar lobbying effort saw the government agree to a one-off CN\$60,000 (£32,836) grant for primary care nurse development initiatives.
- Concern has been expressed by the professional associations and the unions that nurses live in “fear” of the regulator. To take one example of this, a webinar on mental health issues which aimed to promote best practice amongst nurses had to be cancelled - allegedly because participating nurses were concerned if the CNO recorded what they said.
- A lack of transparency and engagement with the nursing workforce has been cited as a key weakness of the CNO, one which limits its practical understanding of key nursing challenges and long-term trends.

Yukon: Introduction

The process of revalidation is handled by the province's independent nursing regulator – the Yukon Registered Nurses Association (YRNA). Revalidation takes place every year and is subject to each nurse evidencing CPD (although there is no

³⁰ College of Nurses of Ontario, available at: <http://www.cno.org/en/myqa/practice-assessment-and-peer-assessment/> (accessed on 29 May 2014)

mandatory number of hours required). As Yukon has no institutions of higher education for nursing, the territory is dependent on practitioners from Canada's other provinces. As a consequence, YRNA tends to closely follow the systems and trends evidenced elsewhere in Canada.

As with Alberta, YRNA combines the role of regulator and professional association which explains its unusually high fees for registrants (£430).³¹ All persons intending to work as a registered nurse in the Yukon must be registered with YRNA prior to commencing work. In 2000, YRNA reformed its revalidation system by dropping minimum CPD hours and specified courses to a model more similar to that operated in Ontario and Alberta.

Yukon: Key findings on the use of third-party confirmation for continuing fitness to practise

As with the other Canadian examples, nurses are not required to seek any form of third-party (including managerial) feedback to demonstrate continuing competency to practise. At the beginning of the revalidation year (April), nurses looking to revalidate must complete an online self-assessment form in which they indicate their existing competence across a set of areas such as, "can practise in accordance with relevant legislation" and "fulfils duty to report". There is no penalty if a registrant indicates a low-degree of competence in any of these areas. YRNA actively encourages its members to be honest in assessing their learning needs.³²

Yukon: Key findings on the use of patient feedback as an indicator of performance

There is no requirement for nurses to secure patient feedback as a means of relicensing or as part of an employer appraisal process. Neither are there any significant political or professional discussions taking place which might see this idea become viable in the near future.

Yukon: Key findings on the use of minimum CPD requirements

There is no minimum CPD requirement and/or cost sharing ratios with employers, and so the experiences of nurses are likely to vary according to the attitude of their specific workplace.

Nurses can negotiate with their employers on how much time to engage in learning. Cost sharing between practitioner and employer is not uncommon. In terms of costs for CPD and protected development time, there are a large number of CPD providers who charge varying costs (or sometimes none at all) for their services.

³¹ YRNA, fees and general information, available at: <http://yrna.ca/general-information/> (accessed on 10 April 2014)

³² YRNA Self-Assessment Form, available at: <http://yrna.ca/wp-content/uploads/SelfAssessSheets2013.pdf> (accessed on 15 March 2014)

Yukon: Key findings on systems of audit and quality control

YRNA does not appear to have an extensive auditing infrastructure and it provides little public information on what systems it operates to ensure quality control.

There does not appear to be a provincial-level nursing union in Yukon, although there is an industry-wide organisation – the Yukon Employees' Union (YEU) - which might include nurses among its membership.³³ In 2012, the provincial government updated the Registered Nurses Professions Act to require that employers immediately report Registered Nurse's potential unsafe practice to YRNA.³⁴ This continues YRNA's general trend of standardising its systems with those observed in Alberta and Ontario.³⁵

Yukon: Observations for the UK

- As with the rest of Canada, Yukon does not require any form of third-party confirmation for fitness to practise.
- Patient feedback is also not required by the regulator and there is no indication of this being introduced in the long term.
- There is no minimum CPD requirement - although this might change depending on developments occurring elsewhere in Canada. It is notable that Yukon appears to follow the trend set in Ontario and/or Alberta and if Ontario proceeds to consider a minimum CPD requirement (as discussed above), then Yukon is likely to follow suit.

³³ Yukon Employees' Union, available at: <http://yeu.ca/> (accessed on 11 April 2014)

³⁴ YRNA, available at: <http://yrna.ca/wp-content/uploads/YRNA-Employer-Report.pdf> (accessed on 02 April 2014)

³⁵ YRNA, Employers Guide, available at: <http://yrna.ca/wp-content/uploads/YRNA-Employers-Guide-2013.pdf> (accessed on 02 April 2014)

Ireland: The Big Picture

The Irish Nursing Board (INB) and the National Council for the Professional Development of Nursing & Midwifery (a directorate within the Department for Health) share the responsibility for revalidation. The former maintains a register - membership of which is mandatory for all Irish nurses and the latter produces guidance on training and CPD programmes - ensuring that these are kept up-to-date and relevant for patient needs.

As of 2014, Ireland is still in a state of transition. Revalidation does occur every year but it does not require employer or third-party appraisals. Unless evidence of malpractice is brought against an individual nurse, renewal is largely automatic upon payment of an annual fee (100 Euros).³⁶ Any sort of performance review or 'fitness to practise' appraisal is left to the discretion of nursing employers. In addition, although the Board encourages nurses to undertake CPD and does itself provide numerous courses and conferences,³⁷ they do not (as yet) require that nurses provide evidence of having done so as part of the relicensing process.

Although the practical operation of the Irish revalidation system is similar to the current UK model (see below), many of its key features are significantly different. Unlike the UK, there is no mandatory CPD requirement in Ireland, nor are nurses required to undertake an annual appraisal with their employer.

Ireland: Key findings on the use of third-party confirmation for continuing fitness to practise

The Irish model does not require employer or third-party appraisals. However, since developments in Ireland closely parallel those occurring in the UK, a decision by the NMC in favour of third-party assurance for fitness to practise could see a similar approach eventually introduced in Ireland.

Ireland: Key findings the use of patient feedback as an indicator of performance

The Irish model does not require any form of patient feedback for revalidation.

Ireland: Key findings on the use of minimum CPD requirements

Technically, the Irish system does not set a mandatory CPD requirement for nurses looking to revalidate. According to the latest CPD report authored by the European Federation of Nursing Associations (EFN), Irish nurses took on average two days of CPD-related activity per year³⁸ and there are various incentives available for nurses to take more time in addition to this, including a large number of courses advertised

³⁶ Irish Nursing Board Frequently Asked Questions, accessible at: http://www.nursingboard.ie/en/reg_faqs.aspx#faq2 (accessed on 18 March 2014)

³⁷ Irish Nursing Board CPD directory, accessible at: <http://www.nursingboard.ie/en/cpd-directory.aspx?cat=0> (accessed on 18 March 2014)

³⁸ EFN, Country report on continuing professional development in nursing, accessible at: <http://www.efnweb.be/wp-content/uploads/2012/11/EFN-Report-on-CPD-June-2006-Final-rev-22-10-2012.pdf> (accessed on 14 April 2014)

by the INB.³⁹ However, since 2012, the government has been steadily moving towards a minimum requirement. As with the UK, funding for CPD in Ireland is split between contributions from the individual nurse, their employer and the government.

Ireland: Key findings on systems of audit and quality control

The INB conducts audits of education providers every five years in order to ensure that qualifications are kept up-to-date with best clinical practice.⁴⁰ This approach shares some similarity with the Australian model, although a separate body is responsible for this function which allows the NMBA to focus exclusively on health practitioners. The IBM does not provide any public details of audit processes for registrants.

Ireland: Observations for the UK

- There is no requirement for nurses in Ireland to gain third-party or patient feedback in the revalidation process.
- Compared to the UK, the Irish revalidation model appears to rely less on its monitoring systems. However, there is evidence that this is gradually changing, with ongoing discussions looking at a minimum CPD requirement (since 2012). It seems entirely plausible that legislators in Ireland will wait to see what the final NMC reforms look like before deciding on this issue.
- Even though CPD is not mandatory, there is strong uptake in annual development opportunities (two days per year).⁴¹ This indicates that nurses in Ireland potentially receive stronger support from employers than is maybe the case in the UK.

³⁹ Irish Nursing Board, accessible at: http://www.nursingboard.ie/en/professional_practice.aspx (accessed 17 March 2014)

⁴⁰ INB, available at: http://www.nursingboard.ie/en/edu-guidance_registrants.aspx (accessed on 14 April 2014)

⁴¹ EFN, Continuous Professional Development Report (2006), available at <http://www.efnweb.be/wp-content/uploads/2012/11/EFN-Report-on-CPD-June-2006-Final-rev-22-10-2012.pdf> (accessed on 17 March 2014)

Italy: The Big Picture

In Italy, revalidation occurs every three years and is handled by the National Programme of Continuous Education in Medicine (EMC) - a government agency which is separate from the principal nursing body (the National Federation of Nursing Colleges (IPASV)). In theory, each nurse is able to select their own respective training focus (similar to the Canadian model), but a high degree of bureaucracy and the fact that nurses must pay for any training undertaken means that uptake of training rarely exceeds the mandatory requirement of 150 credits every three years. For context, the Italian credit system is not easily translatable for the UK context, as different CPD opportunities will carry different credit values. In addition to this minimum requirement, Italy also imposes an upward cap of no more than 225 credits per year. This would be difficult to achieve anyway as hospital managers are not required to agree a forward-looking twelve month development plan with nurses and so training needs may not always be agreed.

Italy: Key findings on the use of third-party confirmation for continuing fitness to practise

There is no requirement in Italy for nurses to gain third-party or patient feedback in the revalidation process.

Italy: Key findings on the use of patient feedback as an indicator of performance

The Italian model does not require any form of patient feedback for revalidation.

Italy: Key findings on the use of minimum CPD requirements

Nurses must undertake a minimum of 150 credits of CPD-related activity every three years, with an upward cap of no more than 225 credits. Poor financial incentives and a lack of employer support have been cited as limiting the effectiveness of the mandatory requirement to deliver lasting impact on quality of care.⁴² There is no protected time for CPD in Italy.

Italy: Key findings on systems of audit and quality control

There is little public information available on how and whether the regulator actually audits samples of its registrants.

Italy: Observations for the UK

- There is no requirement in Italy for nurses to gain third-party or patient feedback as part of the revalidation process.

⁴² EFN, Continuous Professional Development Report (2006), available at <http://www.efnweb.be/wp-content/uploads/2012/11/EFN-Report-on-CPD-June-2006-Final-rev-22-10-2012.pdf> (accessed on 17 March 2014)

- Italy's system of CPD provision has been described by one of the country's many professional bodies, the National Association of Nursing Associations (CNAI) as "education with no guarantee of real development or career progression"⁴³. Other observers have concluded that the Italian revalidation system faces significant challenges in the areas of "employer support, the ability to balance home-life, work and study, the need to improve self-esteem and confidence and the possibility of improved chances for promotion"⁴⁴.
- Unlike the UK, Ireland, Canada and Australia, Italy does not allow nurses to self-declare that they have met their CPD requirements. Nurses are required to secure documentation which confirms their attendance for any course they undertake and to submit these to a government agency, which then calculates the number of credits awarded.
- As there is no protected time allocated for CPD, this raises potentially significant challenges for nurses who work for employers who may not see much value in CPD activities.
- The Italian model raises interesting questions about the role of mandatory training in offering evidence of CPD to meet revalidation requirements. The differentiation between mandatory training (where employees get release to attend) and CPD is not well defined but nurses are likely to need to have this clarified.

⁴³ Ibid.

⁴⁴ Elisabetta Trincherò, "Examining the antecedents of engaged nurses in Italy: Perceived Organisational Support (POS); satisfaction with training and development; discretionary power" (2013), available at: <http://onlinelibrary.wiley.com/doi/10.1111/jonm.12143/full> (accessed on 18 March 2014)

Slovakia – The Big Picture

Revalidation in Slovakia occurs every five years and is administered via decrees from the Slovakian Government under legislation affecting “health service employees and their further education”.⁴⁵ In terms of structure, revalidation in Slovakia has changed relatively little since the country separated from the centralised, communist system of Czechoslovakia. Slovakia’s revalidation structure follows a similar pattern to the UK, Ireland and Italy although it should be noted that the regulator is directly controlled by the government which is a unique feature.

Slovakia: Key findings on the use of third-party confirmation for continuing fitness to practise

There is no requirement in Slovakia for nurses to gain third-party or patient feedback in the revalidation process.

Slovakia: Key findings on the use of patient feedback as an indicator of performance

The Slovakian model does not require any form of patient feedback for revalidation.

Slovakia: Key findings on the use of minimum CPD requirements

Revalidation is entirely dependent on each nurse acquiring and registering a minimum number of CPD credits with the regulator (100 within each five-year cycle). Slovakia calculates credits on two parallel systems. The first is job continuity. If a nurse maintains consistent employment for four years, this immediately grants them 50 credits (50 per cent of the required total).⁴⁶

The second system assigns a certain number of credits for each CPD activity according to their format, duration and reoccurrence. As an example, if a nurse attends a training conference which lasts no longer than three hours, this counts as one credit. Training which falls between three to six hours in length is equivalent to two credits. Teaching other nurses is worth 10 credits and attendance at an international event is worth 15 credits – irrespective of how long the event lasts.

Slovakia: Key findings on systems of audit and quality control

There is little public information available on how and whether the regulator actually audits samples of its registrants.

⁴⁵ Jaap Koot MD MBA, ‘Continuing Professional Development in the European perspective’, accessible at: www.quality.healthnet.sk/docs/final/cpd_eu.doc (accessed on 18 March 2014)

⁴⁶ EFN, Continuous Professional Development Report (2006), available at <http://www.efnweb.be/wp-content/uploads/2012/11/EFN-Report-on-CPD-June-2006-Final-rev-22-10-2012.pdf> (accessed on 17 March 2014)

Slovakia: Observations for the UK

- As of 2012, the Slovakian government was overhauling its system for calculating the credit value of specific CPD activities but has expressed no intention of dropping this system entirely.
- In terms of funding, CPD activities are paid for through a combination of contributions from nursing employers (such as hospitals) and general taxation.

Conclusion: Lessons for the UK

The RCN recognises the challenges involved in designing a revalidation system which will be both effective and proportionate, given the size of the NMC register (approximately 670,000 registrants as of 2013). The evidence provided by the international examples looked at in this paper suggests that the following lessons may be considered in the design of a future UK model.

The use of third-party confirmation for fitness to practise

- Results from a 2014 RCN members' survey on the NMC revalidation proposal evidenced a strong fear among many UK nurses of conflating an employer and regulatory process if workplace appraisals were to be used as part of revalidation. The purpose of appraisal (for employers to review job performance) and revalidation (to confirm fitness to practise) are completely different⁴⁷.
- There are potential challenges facing the effective implementation of a combined employer appraisal and revalidation function. Moves towards the integration of care for example, which have gathered pace in Scotland, means that nurses may be required to secure fitness to practise confirmation from a line manager who doesn't belong to the nursing profession.
- Mandatory managerial feedback in order to revalidate has no international comparison (within the examples explored in this paper). The example of Alberta (Canada) shows that past efforts to introduce a similar system for students was dropped after concerns over the impartiality and suitability of employers to verify a registrant's suitability to remain on the register could not be adequately addressed.
- The available evidence suggests that there is no precedent for nurses being required to formally seek patient feedback in order to be revalidated. The practice of self-reflection is designed to encourage nurses to consider the patient experience and learn from it. This is not to suggest that the idea of formal feedback from patients is necessarily ill-advised but that caution should be applied to make sure that the legitimate concerns of nurses regarding how the model might work are addressed.

The use of patient feedback

- A strong majority of respondents to the RCN survey (86 per cent)⁴⁸ agreed that only a fellow registrant was competent to provide a meaningful decision as to whether a nurse is meeting the standards of the NMC Code and should therefore be revalidated.

⁴⁷ RCN, 'Response of the Royal College of Nursing to the Nursing and Midwifery Council consultation on revalidation' April 2014, available at:

http://www.rcn.org.uk/_data/assets/pdf_file/0004/568336/7.14_RCN_response_Revalidation.pdf.

⁴⁸ Ibid.

- As with third-party feedback, it is notable that none of the countries studied in this paper require that patient input on a nurse's performance be sought for revalidation. Once again, this is not to suggest that the recommendation is ill-advised, (many of the RCN's members who responded to the online survey expressed support for this principle) but there are strong concerns on the part of nurses as to how the system might work.

Minimum CPD requirements

- Within the UK, the RCN has consistently called for protected CPD time for nurses and supports the principle of minimum learning hours. The RCN members' survey on the NMC's proposed revalidation model highlighted that the current lack of employer support for CPD is a concern which cannot be underestimated.
- Of the case studies looked at in this paper, only three (Australia, Italy and Slovakia) mandate minimum CPD hours. It is noticeable that over the last few decades, many of Canada's provinces have dropped minimum CPD requirements, in favour of individual learning plans centred on specific competencies and nursing principles.
- However, discussions between the RCN and the RNAO, suggest that future reform of the revalidation system in Ontario could involve a minimum CPD being re-introduced. It should be noted however that no formal discussions on a minimum CPD requirement are currently taking place in Canada.
- Current research indicates that the retention of clinical skills and knowledge benefit from regular education and revision as opposed to intermittent, tick-box CPD activities.⁴⁹ Furthermore, findings from the RN4CAST study, which analysed 12 acute care settings (nine of which were in Europe) has suggested that patient care is significantly enhanced when degree-level education is made available to nursing staff.
- Taking this into account, it is arguable that mandatory CPD time requirements - while still relevant - need to be supplemented by additional support systems which help to connect continuous professional development to the future healthcare challenges of the UK, such as co-morbidity. Delivery of this long-term aim would likely be helped by providing protected CPD time, enabling nurses to focus on what their genuine future learning needs are, rather than reacting to artificial time-constraints which can undermine learning outcomes.
- The Australian revalidation experience also strongly indicates that effective CPD systems are dependent on existential support structures such as effective financing, a progressive view by employers to requests for CPD time and accessibility for nurses working in remote regions.

⁴⁹ Guardini I, Talamini R, Fiorillo F, Lirutti M, Palese A, 'The effectiveness of continuing education in retrospective pain management' (2008), pp. 281-288

- The financial cost of revalidation is of critical importance and a balance is needed for ensuring that any system is both financially sustainable and able to deliver the quality of service that the public and nursing profession expects. There is more work to be done in establishing a revalidation model which adequately balances the resource considerations of both registrants and employers.
- The cost of revalidation is something that will have to be considered carefully if the final UK revalidation model is to gain the trust and support of nurses who will both fund and be vetted by it.

Systems of audit

- The new UK revalidation system will likely need to audit a larger number of nursing submissions than hereto has been the case, with methods that are resource efficient and practical. The UK has a variety of options to consider in order to deliver this.
- Ontario's focus on improving its specific audit procedures has caused a reduction in the number of cases it can audit at any given time. The risk here is that absolute assurance over the entire nursing workforce is weakened, unless additional resources can be found.
- In contrast to Ontario, Australia has focused on expanding the reach of its audit capability, rather than increasing the depth and rigour of specific procedures. The risk here is that while the volume of cases looked at is larger, procedural robustness is potentially diminished.
- However, it should be noted that this paper has found little evidence pointing to a correlation between the type of audit system a revalidation model utilises and patient care outcomes. Ontario and Australia, which operate very strong (albeit very different) audit systems do not appear to evidence significantly greater care outcomes compared to Ireland, Alberta or Italy, where audit structures receive less focus and resources.

Annex One: The international revalidation landscape – a snapshot

The table below gives an indication of how varied global revalidation structures are. The information included in the UK entry describes the model currently being consulted on by the NMC.

Country	Is revalidation/relicensing legally required?	Are minimum CPD hours required as part of revalidation?	Is third-party feedback required for revalidation?*	Does the regulator provide direct access to CPD?	Do nurses fund the professional regulator outside of general taxation?	How often does revalidation occur?
UK	Yes	Yes	Yes	No	Yes	3 years
Australia	Yes	Yes	No	No	Yes	Annually
Canada (Alberta)	Yes	No	Yes	Yes	Yes	Annually
Canada (Ontario)	Yes	No	No	No	Yes	Annually
Canada (Yukon)	Yes	No	No	No	Yes	Annually
Ireland	Yes	No	No	Yes	Yes	Annually
Italy	Yes	Yes	No	No	No	3 years
Slovakia	Yes	Yes	No	No	No	5 years

*This could include managerial sign-off on competence to practise and/or feedback from peers or patients