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Final Report of the Evaluation of the General Osteopathic Council's Revalidation Pilot

14 February 2013

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This report has been prepared on the basis set out in our Engagement Letter addressed to Fiona Browne of the General Osteopathic Council (the 'Client') dated 15 March 2010 (the 'Services Contract'). We have not verified the reliability or accuracy of any information obtained in the course of our work, other than in the limited circumstances set out in the Services Contract. This Report is for the benefit of the Client only. This Report has not been designed to be of benefit to anyone except the Client. In preparing this Report we have not taken into account the interests, needs or circumstances of anyone apart from the Client, even though we may have been aware that others might read this Report. We have prepared this Report for the benefit of the Client alone. This Report is not suitable to be relied on by any party wishing to acquire rights against KPMG LLP (other than the Client) for any purpose or in any context. Any party other than the Client that obtains access to this Report or a copy (under the Freedom of Information Act 2000, the Freedom of Information (Scotland) Act 2002, through the Client's Publication Scheme or otherwise) and chooses to rely on this Report (or any part of it) does so at its own risk. To the fullest extent permitted by law, KPMG LLP does not assume any responsibility and will not accept any liability in respect of this Report to any party other than the Client. In particular, and without limiting the general statement above, since we have prepared this Report for the benefit of the Client alone, this Report has not been prepared for the benefit of any other local authority/NHS Trust/Regulatory Body nor for any other person or organisation who might have an interest in the matters discussed in this Report, including for example General Practitioners/Osteopaths, those who work in the health sector, or those who provide goods or services to those who operate in the health sector.

We have also prepared a separate report, 'Impact Assessment of the General Osteopathic Council Revalidation Pilot.' This document should be read in conjunction with that impact assessment.

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1 Executive summary

1.1 Background and context

1. The General Osteopathic Council (the GOsC) ran a consultation on its draft revalidation scheme during the first half of 2009 and published a summary of the consultation findings in December 2009. In response to this consultation, the GOsC revised its overall approach to revalidation. In March 2010, KPMG was commissioned by the GOsC to carry out an evaluation and impact assessment of stage 1 of this revised model of revalidation: the draft osteopathic pilot scheme.
2. The GOsC draft pilot revalidation scheme ran from September 2011 to September 2012. The purpose of the scheme was to collect information about the proportionality and feasibility of the draft model of revalidation. It was also intended to give an indication as to how a revalidation scheme could contribute to the improvement of patient safety, continued fitness to practise of osteopaths and the quality of osteopathic care, as well providing a view in relation to the costs, benefits, risk and impact of the scheme for osteopaths, their patients and the GOsC.

1.2 Our approach

1. Our evaluation has concentrated on assessing the implementation of the scheme and whether participants, assessors and the GOsC consider whether and to what extent the model as piloted is fit for purpose. This is line with the principles of right-touch regulation and the recent guidance set out in the Professional Standards Authority (PSA) report, 'An approach to assuring continuing fitness to practise based on right-touch regulation principles'[1], published in November 2012.
2. We have provided our evaluation of the proposed scheme in this document and in the accompanying impact assessment, based on input from both pilot participants, assessors and other stakeholders. Over the course of the 12 months to September 2012, we collected and collated both quantitative and qualitative data. This was derived from interviews with registrants, assessors, and insurers of osteopaths, the BOA, patients and the GOsC staff. This approach was as agreed with the GOsC prior to the pilot commencing following extensive consultation and was described in detail in our two previous reports C and D.[2]

1.3 Pilot scheme and participation

1. Overall the pilot attracted engagement of almost 10% of registrants (484). Over half of participants (54%) successfully completed the pilot, but 46% of participants did not. In order to successfully complete the pilot, each participant was required to provide a self-assessment of their practice demonstrating their compliance with the osteopathic themes and revalidation criteria. To demonstrate compliance each participant was required to submit a portfolio of evidence and was asked to map their evidence to each of the themes of practice and the revalidation criteria.

[1] http://www.professionalstandards.org.uk/docs/psa-library/november-2012---right-touch-continuing-fitness-to-practise.pdf

[2] http://www.osteopathy.org.uk/uploads/report_d_info_spec_for_reval_evaluation_&_impact_assessment_ozone.pdf

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Our findings

1.4 Self-assessment

1. Of those participants who completed the pilot, 81% provided a completed self-assessment form and 43% of all completed portfolios were judged to have supplied sufficient evidence to meet all of the revalidation criteria. Consequently, it is questionable if the participants accurately self-assessed their performance although as noted later, some reported confusion about whether the participants needed to demonstrate all the criteria may have contributed to this. This challenges the underlying principle of the draft osteopathic revalidation scheme: self-assessment. The draft scheme is based on the requirement for all osteopaths to provide a self-assessment and for the GOsC to then ask further questions and to sample portfolios as required. Any scheme based on the principles of self-assessment therefore is reliant on registrants to complete these accurately.

1.5 Benefits of the scheme

1. Findings from the pilot indicate that many participants reported a change in their osteopathic practice as a consequence of the revalidation pilot. Three quarters of all participants reported that pilot participation meant that they reflected more on areas of their clinical practice. Consistently across the course of the pilot, 40% of participants also reported that their participation in the pilot has benefited their patients. The majority of participants also considered that 'purposeful review' of the Osteopathic Standards of Practice has been beneficial. These findings demonstrate that the participants and patients alike are likely to have benefited from the scheme.
2. However, quantifying and monetising the benefit of the pilot is difficult. For example, improvements in the quality of care or increased public confidence are relatively intangible benefits which require significant research in order to measure effectively. At this stage this analysis has not been possible.
3. We have however noted other qualitative benefits as a result of participants' engagement in the pilot. This is in contrast to KPMG Report A – How do Osteopaths Practise?[3] published in 2009, where we reported at the time that there was very little formal or documented reflection on performance or feedback from patients. Engagement in the pilot and using pilot tools has enabled participants to document their practice. In our discussions with registrants many indicated that they would continue to use the tools to develop their practice in the future.

1.6 Inclusivity of the scheme

1. Our findings indicate that no specific groups of practitioner found the pilot scheme easier or harder to complete. In particular, pre-pilot concerns had been raised regarding those osteopaths who practice part-time. However, these concerns do not appear to have materialised as those who practice for less than 35 hours have as high a portfolio completion submission rate as those who work full-time. The only risk we have identified, although not statistically significant, is that the complexity of the scheme and the requirement to complete a significant amount of paperwork to demonstrate compliance in the form of 'mapping grids' and 'self-assessments' may have made the pilot less accessible for osteopaths with dyslexia. However, the degree of support provided by the GOsC and the independent education support consultant helped to mitigate these risks, although a disproportionate number of pilot participants with disabilities did not complete the pilot.

[3] [3] http://www.osteopathy.org.uk/uploads/how_do_osteopaths_practise_kpmg_reporta_ozone.pdf

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1.7 Complexity of the scheme and registrant time commitment

1. Through our analysis of the quantitative and qualitative data from the pilot, we observed several themes in relation to the feasibility of the draft scheme. These mainly concern the perceived complexity of the scheme and the degree of participant administration required in order to successfully self-assess and submit a portfolio. Participants reported that this was 'at odds' with the highly kinaesthetic nature of osteopathy. For example, one focus group pilot participant commented "I became an osteopath because I didn't like completing admin." However, given that it is an expectation of the Department of Health and indeed the public that osteopaths are up-to-date and fit to practise, it may be that any future scheme and consultation should explore the dichotomy of doing so in a way that provides assurance to the GOsC without a similar degree of administrative burden on the registrant.
2. Given the complexity of the scheme, a number of registrants reported that they left the pilot as they could not 'spare the time' to complete it. In total, osteopaths on average reported that the pilot took up 53 hours of their time over the 12 month period. We estimate that as piloted, the model of revalidation if it were to be rolled out as a five year model would equate to a time investment of 10.6 hours per year for each registrant, at least in the first cycle. If this commitment is considered in light of the PSA's recent guidance in relation to proportional continuing fitness to practice models[4], and the fact that the recently-introduced scheme of medical revalidation estimates an annual commitment for doctors of only 9 hours, the GOsC may need to consider the reasons for this extended time commitment required for osteopaths and whether to reduce this commitment in any future scheme developed.

1.8 Ability to reflect

1. We were also able to observe, through analysis of assessment data and through discussions with assessors, that the degree of reflection and analysis demonstrated by participants was variable. Anecdotally, it was reported to us that newer graduates were better at analysing their performance and self evaluating, than those osteopaths that had been practising for longer. However, the pilot completion rates did not provide data to support these observations, with higher completion submission rates - 64% noted in those osteopaths who had practised for over 20 years, compared to 48% for those with less than 10 years experience. We understand from assessors and the External Educational Support Consultant that many of the participants used tools such as patient feedback and peer review to evidence their practice. However, there was often no evidence within the portfolio to demonstrate that they had actually considered what the feedback meant and how they had reconsidered their practice. In these instances, it is difficult to see the impact that revalidation would have on registrant practice without further feedback and support to these osteopaths.

1.9 Conclusions

1. The completion of the pilot evaluation has provided the GOsC with a significant amount of useful information regarding current osteopathic practice and registrant characteristics that was previously unreported. For example in relation to the evidence of the benefits related to improved osteopathic practice and patient care. In addition, there has been a considerable secondary data collection and research which further supports this knowledge base. A number of the focus groups indicated that registrant practice in relation to gaining patient informed consent could be improved. The GOsC could further support how osteopaths do this in practice.
2. Any future revalidation scheme needs to build upon the valuable experience of all concerned in designing, running and participating in the pilot. Any future scheme should be less complex to operate and complete, and be supportive of the development needs of osteopaths in order to fully realise the potential benefits.

[4] http://www.professionalstandards.org.uk/docs/psa-library/november-2012---right-touch-continuing-fitness-to-practise.pdf

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3. The pilot evaluation also recognises the need for a revalidation scheme which draws on in-practice experience, reflection and peer learning, for all osteopaths, notwithstanding their age, practice setting, years of qualification or type of practice.
4. This evaluation should provide the GOsC with information to support the GOsC to fulfil its statutory function to protect the public and also inform others with a vested interest in the receipt and delivery of osteopathic care, such as patients, osteopaths and osteopathic education institutions.

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2 Introduction and context

The General Osteopathic Council (the GOsC) is the regulator of osteopaths in the UK. It was established in 1997 following the Osteopaths Act 1993. It produced the first statutory register of osteopaths in 2000. As at 29 November 2012 it had 4,696 osteopaths on its register.

The GOsC ran a consultation on its draft revalidation scheme during the first half of 2009, and published a summary of the consultation findings in December 2009. The scheme is intended to ensure that its registrants remain up to date and fit to practise. It includes a four-stage approach which is set out in summary in Section 3 and explained in more detail on the GOsC's website.[5].

In March 2010, KPMG was commissioned by the GOsC to carry out an evaluation and impact assessment of the draft osteopathic pilot revalidation scheme focusing on Stage 1.

This report and the separate impact assessment conclude our evaluation of the pilot revalidation scheme. Evaluations and impact assessments are typically used to understand the costs and benefits of regulatory intervention on the private sector, the third sector and public services. In particular, this report should support the GOsC's response to the overarching policy challenge initially presented in the Department of Health's 2008 Guidance 'Principles for revalidation: report of the Working Group for Non-Medical Revalidation'[6]. It also provides analysis for the GOsC in relation to the subsequent Command Paper, "Enabling Excellence"[7], in which healthcare regulators were required to 'continue to develop the evidence base that will inform their proposals for revalidation over the next year' and will consider whether there is 'evidence to suggest significant added value in terms of increased safety or quality of care for users of health care.'[8]

Of further relevance, the Professional Standards Authority (PSA) report, '*An approach to assuring continuing fitness to practise based on right-touch regulation principles'*, published in November 2012, considered the use of the principles of right-touch regulation and their application to the development of approaches to assuring continuing fitness to practise (which includes revalidation) that is both proportionate and targeted. The report suggested that regulators identify and quantify the risks presented by the professions they regulate in order to develop continuing fitness to practise mechanisms that provide them with the levels of assurance they need to mitigate these risks.

Given this mandate, the PSA report, (issued under its former name, the Council for Healthcare Regulatory Excellence (CHRE), entitled *'Right Touch Regulation*[9]*'* published in August 2010 stated that professional regulators should be minded to consider the following principles:

- **Proportionate**: Regulators should only intervene when necessary. There should be a clear purpose or benefit to any proposed regulatory changes which ties into patient safety or improved quality of care
- **Consistent**: Rules and standards must be joined up and implemented fairly. The model should also be inclusive and accessible to all osteopaths regardless of the patterns of Practice.
- **Targeted**: Regulation should be focussed on the problem, and minimise side effects. The model should address the risks and contribute to quality improvement and patient safety.
- **Transparent**: Regulators should be open to keeping regulations simple and user-friendly.

[5] http://www.osteopathy.org.uk/practice/Revalidation/

[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091111

[7] http://www.official-documents.gov.uk/document/cm80/8008/8008.pdf

[8] http://www.official-documents.gov.uk/document/cm80/8008/8008.pdf

[9] CHRE, 2010. Right-touch regulation. Available at: http://www.professionalstandards.org.uk/docs/psa-library/right-touch-regulation.pdf

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- **Accountable**: Regulators must be able to justify decisions, and be subject to public scrutiny.
- **Agility**: Looking forward to anticipate change rather than looking back to prevent the last crisis from happening again.

The analysis which is set out in this report considers the evidence to support the anticipated costs, benefits and risks associated at the pre-pilot stage (pre September 2011) with implementing the scheme. The analysis also considers if the pilot scheme has presented a feasible model for "rolling out" revalidation at a national level to all registered osteopaths.

The GOsC Revalidation Pilot ("the Revalidation Pilot") started in September 2011 for a one year period. Prior to the pilot commencing there were a number of activities undertaken to prepare evaluation materials and to determine the scope of the likely costs and benefits.

This final report has been informed by our four previous reports for the GOsC:

- Report A: How do Osteopaths Practise?[10] Produced by KPMG summarised some of the potential risks associated with clinical practise (including risks arising from the environment). These were informed by the 2007 White Paper, Trust, Assurance and Safety and also the integration of some of the findings from the draft CONDOR complaint report on claims and complaints about osteopaths and the Standardised Data Collection Project – published March 2011.
- Report B: Reviewing the work undertaken by other regulators to outline costs, benefits, financial and regulatory risks[11], identified how other health regulators were addressing revalidation, in particular the costs, benefits and risks of introduction – published November 2010
- Report C: The methods used to identify costs, benefits, financial and regulatory risks outlined the methodology to measure the impact of the Revalidation Pilots. It set out the approach followed during the KPMG Evaluation and Impact Assessment – published April 2011.
- Report D: The detailed specification of information gathered to complete the evaluation of the Revalidation Pilot.[12] The report also detailed the output from focus groups on the costs, benefits and risks that had been envisaged at the pre-pilot development stage – published July 2011.

2.1 Acknowledgements

This review involved meetings and workshops with several internal and external stakeholders; a full list is included in Appendix 1. We would like to acknowledge the contributions from all these participants to our work for the GOsC.

2.2 Limitations of this report

We have prepared this report based upon our discussions with patients, registrants, the GOsC and other persons during the course of our evaluation. We have also undertaken a series of surveys with participants (registered osteopaths) and assessors (selected registered osteopaths) during this review and have collated these findings internally.

We have also used financial and non-financial information provided to us by the GOsC. We have not attempted to verify or audit any of the information provided to us. It therefore follows that further information may come to light which could cause us to change our views.

This evaluation and impact assessment are in relation to stage one of the draft revalidation scheme only. We have not considered stages two to four of the scheme as this was not part of the scope of our work.

[10] http://www.osteopathy.org.uk/uploads/how_do_osteopaths_practise_kpmg_reporta_ozone.pdf

[11] http://www.osteopathy.org.uk/uploads/work_done_by_other%20regulators_kpmg.pdf

[12] http://www.osteopathy.org.uk/uploads/report_d_info_spec_for_reval_evaluation_&_impact_assessment_ozone.pdf

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3 Overview of the GOsC Revalidation Pilot Scheme

3.1 Revalidation

Revalidation is the process which will require healthcare professionals to show, at regular intervals, that they remain up to-date and fit to practise. Osteopaths are already required to renew their registration each year and meet Continuing Professional Development (CPD) requirements before renewing their registration. This requirement as a sole means of assuring fitness to practise has however been questioned recently.[13] Healthcare regulators have been requested by the Secretary of State to gather evidence to inform their revalidation proposals. The policy intent for revalidation is to provide additional assurance to patients that their healthcare professionals remain up-to-date and continue to meet the standards for their respective profession.

Since the inception of the pilot, the regulatory environment has changed. The GOsC has shifted its thinking on how it approaches revalidation and is now at a position where it is considering its revalidation scheme in light of its CPD scheme.[14] In particular registrants are now expected to be up to date and fit to practise. Historically, regulators' schemes of CPD have used an approach based on the hours completed rather than a continual or competency based assessment. In light of recent changes in thinking in this area and the statements from the Health Committee this is no longer considered sufficient.[15] Therefore the nature of the requirement for any future revalidation scheme may need to be considered in light of these developments.

3.2 GOsC Revalidation Pilot Scheme

The GOsC believes that a staged revalidation system is the most pragmatic model for a revalidation scheme. The scheme, as piloted, involves an initial self-assessment form at Stage 1 which every osteopath would complete and submit to the GOsC once every five years. The self-assessment form would help to identify whether individual osteopaths are meeting the key performance measures of good osteopathic practice. Additional stages of the scheme will only apply where Stage 1 had highlighted a concern associated with an osteopath's practice.

The GOsC developed its draft revalidation scheme in line with the Department of Health's 2008 guidance.[16] In 2009 the GOsC consulted on its proposed four-stage Revalidation Scheme and suggested a series of changes to the proposed self-assessment methodology which were incorporated into the current scheme as piloted. It was the GOsC's intention to test only Stage One of the four-stage process within the current pilot. The intention is to consult further on the draft revalidation scheme and the CPD scheme as part of the wider consultation in 2013/14.

3.2.1 Stage 1 of the pilot revalidation scheme: self-assessment

Stage one of the proposed revalidation scheme operated as follows:

- The GOsC provided each participant with a manual to guide them through the Pilot requirements, particularly in relation to the completion of the self-assessment and the accompanying portfolio supporting their assessment of practice.

[13] http://www.osteopathy.org.uk/uploads/cpd_discussion_document_public.pdf

[14] http://www.osteopathy.org.uk/uploads/public_item_16_revalidation_and_cpd_progress_report.pdf

[15] http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1428/142805.htm

[16] Principles for Revalidation: Report of the Working Group for non-medical Revalidation, November 2008 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091110.pdf

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- At the end of the pilot the GOsC asked each participant to complete a questionnaire, known as the mapping grid. The aim of the grid was to allow participants to self assess how their evidence had met each of the following four Osteopathic Themes and the accompanying revalidation criteria:

  Communication and patient partnership

  Knowledge, skills and performance

  Safety and quality in practice

  Professionalism

In order to complete the self-assessment/mapping grid within the Pilot Participant Manual, the GOsC provided participants with a self-assessment tool (SAT) to grade what they considered their degree of compliance was against each of the themes.

To support the self-assessment, each participant was required to compile a portfolio of evidence setting out how they had met each of the Osteopathic themes. Within the pilot manual, to assist in the development of the portfolio, the GOsC suggested that the participants should complete an initial assessment of practice so that they could identify areas where they may not be fully confident in attaining and providing evidence to demonstrate specific revalidation criteria. The GOsC also provided an example of an action planning tool to help participants develop and provide evidence on specific areas of osteopathic practice to enable a rounded portfolio and perspective on practice.

The GOsC mandated that within the portfolio there should be:

- a minimum of one piece of evidence should be provided for each of the four themes and one piece of evidence should be completed every three months;
- at least one of example of evidence which was either:
  - giving information and recording/discussing practice;
  - developing practice; and/or
  - feedback on practice.
- a minimum of one piece of objective and one piece of subjective evidence; and a completed mapping grid and a 100 word explanation of the rationale for evidence submission.

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4 Our Approach

4.1 Methodology – establishing an evidence base

In order to evaluate the revalidation pilot, we conducted a number of activities, including semi-structured interviews, focus groups, source data analysis and online/hardcopy surveys.

4.1.1 Quantitative Information

To understand the characteristics of the participant population we asked each participant to complete a characteristics form before the commencement of the pilot. We collected this information to determine to what extent the population was representative of the whole profession and also to see whether specific characteristics, i.e. gender, disability or age affected an individual's ability to complete the pilot and further their views on revalidation and the impact of the pilot.

In order to canvas the wider views of participants and assessors we surveyed:

- Participants at four intervals during the pilot; and
- Assessors at the beginning and end of their involvement with the scheme.

This enabled us to gain broad perspectives on the participants' and assessors' views and to observe what impact they considered the pilot scheme had on practice, patient safety and quality of care.

We also asked the GOsC staff to maintain a log of all their time spent on pilot-based activities to determine an estimate of the additional time spent by the regulator on revalidation. Cost information also included a full breakdown of disbursements associated with the pilot to assess the nature and scale of costs incurred.

4.1.2 Qualitative Information

To supplement our survey data we held a series of meetings and/or focus groups with:

- Educational External Support Consultant – to understand the support requirements of participants and osteopaths throughout the course of the Pilot and any areas of concern or best practice identified.
- Osteopathic Insurers – we had several discussions with insurance representatives in order to gauge their views in relation to the risk profile of practising registrants, and therefore the potential impact of the introduction of Revalidation.
- Patients – we conducted a focus group with a diverse range of osteopathic patients to consider their views on the care that they receive and their awareness of risks and benefits of osteopathy.
- The GOsC Professional Standards and Executive Team – throughout the course of pilot we held several progress meetings with the GOsC to understand any pilot implementation issues, highlights or concerns.
- British Osteopathic Association – as a representative registrant organisation we spoke with the BOA on several occasions to understand any wider professional perspectives.
- Assessor focus group – at the end of the pilot we held a focus group with assessors to explore their views of the assessment process and the quality of the final portfolios.
- Participant focus group – at the end of the pilot we held a focus group with pilot participants in order to supplement the quantitative feedback gathered through the surveys. We were also able to further gather their views and experiences of being a participant of pilot scheme and submission of their evidence.

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- Non pilot participant focus group – at the end of the pilot period we held a focus group conference call with registrant non pilot participants. The purpose of this call was to capture the views and awareness of non pilot practitioners of the scheme and continuing fitness to practise.
- Meetings with other healthcare regulators – in order to consider the GOsC scheme in context we had discussions with a number of representatives from other professional healthcare regulators and considered their schemes and any recent policy developments.

Prior to the pilot commencing, we also conducted a series of set-up activities with various stakeholders including patients, insurers, BOA, registrants and other healthcare regulators. Full details of these activities are detailed in Report C insert full ref from FB and Report D.[17]

4.2 Evaluating the costs and benefits of the pilot

The pilot scheme of revalidation is premised on the need to enhance the regulatory system and to assess the continuing fitness to practise of osteopaths following qualification and registration. A summary of the pre-pilot expected benefits, as outlined in KPMG's Report C and in full in Appendix 2 is as follows:

- **Better patient outcomes** – through feedback from patients, registrant reflection on own practise and greater overall access to peer practice data, we would expect revalidation to result in better performance by osteopaths. This in turn would result in better patient outcomes.
- **Greater patient satisfaction and confidence** – seeking feedback from patients will allow patients to feel more 'included and centric' to their treatment. It may well also leave patients feeling that that their concerns are addressed in a more consistent manner. This will result in greater patient satisfaction.
- **Improved working practices** – through improved central systems and processes and greater collation and triangulation of information the Osteopathic standards and the standard of education delivered by Schools and Colleges will be enhanced. This in turn will contribute to better patient outcomes and safety.
- **Increased uptake of osteopathy** – in addition to better patient outcomes and satisfaction, a regular system of checking whether an osteopath remains fit to practise may result in an improved perception of osteopathy among both the public and the overall medical community. This may result in greater financial rewards for osteopaths.

Similarly, we also identified other benefits, which may improve patient outcomes, although, these have not been monetised, including:

- improvements in osteopath practice record keeping;
- an increase in the degree of information available on osteopath practice habits;
- change in the culture of the accountability of the profession may also be realised.

In order to model the potential costs and benefits of the revalidation pilot we used evidence generated from both the qualitative and quantitative sources outlined in full in Report D.

The benefits of healthcare are mainly qualitative and as such they are typically harder to quantify and therefore more difficult to model than the costs. The costs of the pilot revalidation scheme are inputs that can be measured by testing and piloting procedures and processes. These generate typical costs such as length of registrant time to complete tools and quantification of training costs. However, even where benefits can be quantified, these are outputs of the model adopted, such as better patient care, and we envisage would be experienced by a greater number of people over a longer time frame.

[17] http://www.osteopathy.org.uk/uploads/report_d_info_spec_for_reval_evaluation_&_impact_assessment_ozone.pdf

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The introduction of any new regulatory policy has inherent burdens and associated costs, as monitoring, reporting, assessment and other activities all have associated real of opportunity costs. However, it is imperative that the costs of the GOsC scheme of revalidation are proportionate to the benefits. From our review of the current scheme we have identified the following costs:

- the direct cost of producing the portfolio (registrants);
- the cost to the regulator, the GOsC, of running the system;
- the cost of providing and taking part in revalidation training sessions (registrants and assessors);
- the cost of patient time of providing feedback.

There are also a number of other non-quantifiable costs which may result, such as the reduction in registrant time engaging with patients due to time spent completing the requirements of revalidation.

The full realisation of the benefits of revalidation depends on a number of enabling processes and activities and the avoidance or mitigation of risks to these. The avoidance of costs is also dependent upon the mode of revalidation that the GOsC opts for and the degree of support and registrant time that it requires to be invested. The benefits and costs of revalidation are explored in more detail within the impact assessment at Appendix 2.

In our analysis we have presented, where possible, a picture of the costs and benefits of both the pilot scheme and then also for the roll-out of revalidation were this model of revalidation to be introduced across the whole of the profession.

4.3 Evaluating the risks of osteopathy

In order to enhance registrant practice and demonstrate that the scheme is proportionate, it is necessary for the GOsC to consider whether the scheme addresses and mitigates the key risks associated with osteopathy. The current proposed Revalidation Pilot model is mapped against the Osteopathic Practice standards.

As outlined in Report C and shown in full in Appendix 2, there are several types of risks which the osteopathic profession is exposed to. Broadly the three main types of risks where revalidation is likely to have the most impact are:

- Clinical risks – risks to patients arising from the nature of the patient's complaint and the associated consequences of this.
- Competency risks – risks arising from the practitioners lacking the necessary skills or knowledge to diagnose and/or manage conditions or use appropriate equipment.
- Contextual/environmental risks – features of the environment in which the practitioner operates.

In particular, we understand from discussions with registrants and the GOsC that competency risk is where revalidation is likely to have the greatest impact as this risk arises from a lack of practitioner skill. It is assumed that greater reflective practice, which is encouraged by the pilot revalidation scheme, is likely to address this risk.

In addition, Report C identified that implementation of Revalidation had a number of risks for the GOsC. These were determined to be:

- Financial and capacity – the risk that the GOsC will not have sufficient capacity to be able to meet its financial obligations to finance the roll out of revalidation.
- Regulatory risk – the risk that a change in laws and regulations will materially impact the ability of the GOsC to meet its regulatory responsibilities.

We have used both the cost, benefit and risk frameworks which we established specifically for this project to support us in assessing whether the scheme as piloted is proportionate and feasible.

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Our evaluation has concentrated on assessing the implementation of the scheme and whether participants, assessors and the GOsC consider the model as piloted is fit for purpose or could be adapted to ensure its fit for purpose. Where we have observed benefits we have also noted how these might be incorporated into a future scheme. We have provided our evaluation of the proposed scheme, based on input from both pilot participants, assessors and other involved parties in the section below and within the Impact Assessment.

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5 Findings from the pilot

5.1 Pilot registrant sample

In Report C, 'Report on the methods used to identify costs, benefits, financial and regulatory risks', we proposed that the GOsC should recruit a representative pilot group. This was to enable the findings to be able to be extrapolated to the total registrant population. The pilot was advertised and Expressions of Interest were received from approximately 750 osteopaths. The number of registrants that submitted a formal commitment to participate was 484 in late August 2012. This represents an overall participation rate of approximately 10% of the profession.

As is shown in the table at Appendix 4 the overall population generally mirrors the percentage of the overall osteopathic profession as at September 2011. This population is also broadly representative of the nature of the practice settings where osteopaths routinely practice as derived from our research conducted as part of report A.

Areas where we consider the pilot population may have been under-represented and limit our ability to make comparisons are:

- osteopaths under the age of 30;
- osteopaths living outside the UK;
- osteopaths who are black or from an ethic minority group;
- newly-qualified osteopaths;
- osteopaths who deliver adjunct therapies.

It should also be recognised that the above populations are only small in number see Appendix 3.

All our findings within our analysis in the sections below are presented in percentage terms of those that responded to particular questions within each survey. Results are not presented in light of the total survey respondent population.

A full breakdown of the pilot population is provided at Appendix 4.

5.1.1 Analysis of pilot participants and duration in the pilot

Overall 263 participants, which represents nearly 55% of the 484 individuals who enrolled on the pilot at the start, submitted a portfolio to the GOsC. During the course of the pilot, a number of individuals notified the GOsC or KPMG that they would no longer participate. However, 109 of the 221 leavers, which represents nearly half of all leavers and 23% of those who enrolled on the pilot, did not notify the GOsC of their intention not to submit a portfolio or that they had left the pilot.

From the 484 individuals who originally enrolled on the pilot, we identified:

- 58% (141) of female participants submitted a portfolio, compared to 50% of men
- Of the 18 enrolled participants under the age of 30, 33% (6) submitted a portfolio. This compares to 54% (163) of those aged 31 – 50 and 57% (85) of those aged 51 plus.
- 53% (151) of participants who routinely spend more than 50% of their time practising on their own submitted a portfolio.
- 9 out of 26 (34%) participants who indicated that they had a disability or preferred not to say whether they had a disability submitted a portfolio.
- 64% (105) of those participants who have been within the profession over 20 years completed a portfolio, whereas 52% (86) of those who have been in the profession between 10 and 19 years and 48% (66) of those who have joined within the last 10 years completed a portfolio.

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- The nature of an osteopath's hours of work did not significantly impact upon their ability to complete the pilot. We found that 52% (124) of those participants who indicated that they worked less than 35 hours per week completed the pilot, and in fact 57% (133) of those who work more than 35 hours per week submitted a portfolio.

Throughout 2012, participants gradually dropped out of the pilot. Of the 221 individuals who left the pilot:

- 13 had left by end of December 2011;
- 34 by end of March 2012;
- 50 by end of June 2012;
- the remaining 112 participants left by October 2012.

All of those participants who left the pilot were asked to provide a reason for their exit. We identified that of the 221 who did not complete the pilot:

- 46% did not notify the GOsC of their intention to not submit a portfolio and complete the pilot;
- 23% provided no reason why they could not complete the pilot;
- 13% cited health or personal reasons;
- 16% cited lack of time;
- the remaining 2% found the pilot either too difficult or provided another reason why they did not complete the portfolio.

Of the 102 leavers who did not notify the GOsC of their intention to leave the pilot, 67% were aged between 40 and 50. However, as a percentage of those who took part in the pilot, probably the most significant drop-out rate was in those aged under 30. Of the 18 participants under the age of 30 years of age, 8 dropped out (44%) of the pilot.

5.2 Portfolio submission

Of the 484 enrolled on the pilot, 263 participants submitted portfolios to the GOsC in October 2012. As outlined in Section 4, the GOsC mandated that there should be specific areas of evidence within the portfolio.

In order to determine whether each osteopath provided the required evidence and in the correct format, all assessors were asked to provide a summary of compliance for each portfolio reviewed. To inform our evaluation, it was important for us to determine the effectiveness of the self-assessment process and specifically to what degree the participants completed the tools.

5.2.1 Completion of the self-assessment mapping grid

We identified that 81% of participants completed the self-assessment mapping grid. This grid demonstrated how the participant felt they had met the Revalidation criteria and the Themes of Osteopathic practice.

Of those who completed the grid, we understand from data collated from the work of the assessors that 69% of the 263 portfolios demonstrated evidence of all four themes of osteopathic practice and 43% included evidence to demonstrate all of the revalidation criteria. We understand from the GOsC that there was confusion on the part of the pilot participants in relation to the number of themes that they had to demonstrate and many considered that they only had to submit three forms of evidence.

However, 94% of those who submitted a self-assessment grid managed to demonstrate, at least partially, all of the Themes of osteopathic practice and 84% managed to demonstrate some evidence of meeting the revalidation criteria.

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5.2.1.1 Accurate completion of the self-assessment mapping grid

The success of this model of revalidation scheme is based upon the requirement that osteopaths self-assess their performance against a mapping grid and submit this self-assessment to the GOsC. The GOsC would then review these grids and request portfolios to substantiate self-assessments in a select number of cases.

Therefore, for this model of revalidation to be successful it is necessary for the grids to be accurate and reflective of the information contained within portfolios. As part of our evaluation we asked assessors whether this was the case. We identified that 56% of the completed mapping grids were actually reflective of the evidence presented within the portfolio. In the instances where the mapping grid was not accurate, we understand that this was because the assessor:

- could not agree the supporting evidence to the grid;
- did not agree with the participants' view that the evidence demonstrated the criteria it was intended to; and/or
- the evidence was not present within the portfolio.

5.3 Findings from the pilot participant surveys in detail

In order to gauge the views of participants throughout the lifecycle of the pilot, KPMG commissioned a survey of all participants at the end of each quarter of participation. Each survey focused on a combination of:

- time-specific questions so that we could determine how participants felt the pilot was working at that point in the process;
- core questions so that we could also monitor how views may/may not be changing during the course of the pilot.

Figure 1: Completion Rates of KPMG evaluation surveys

	Survey 1	Survey 2	Survey 3	Survey 4
Period covered	October 2011 to December 2011	January 2012 to March 2012	April 2012 to June 2012	July 2012 to September 2012
Sample size	374	306	249	226

In each of the sections below we have provided an overview and commentary of our findings from the four surveys.

Of the 374 respondents to survey 1 we identified that there were many reasons why participants wanted to participate in the pilot, this is shown in Figure 2 below.

We identified that 96% of participants wanted to participate as they were keen to know how revalidation may affect them in the future and 85% wanted to contribute to the development of the profession. Through discussions with osteopaths during the course of our evaluation, we understand that many felt that *"revalidation was coming"* and they wanted to be able to contribute and ensure that it was, *"more useful than the PPP exercise"*[18] and that many *"had experiences of the GOsC's PPP process which were fairly negative."*

[18] Professional Profile and Portfolio exercise 1997 to 2000.

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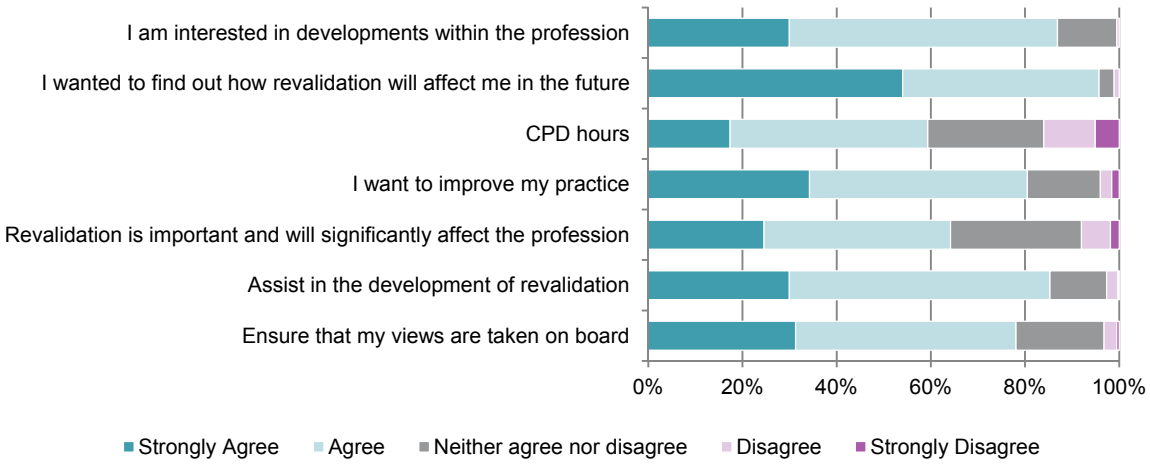
Figure 2: Reasons for participation on the pilot scheme



5.3.1 Participant support and guidance

In each of the four surveys, we asked participants whether they felt that the GOsC had provided them with all the support they needed to complete the pilot. The GOsC provided a training session for all participants and various means for participants to contact the GOsC and KPMG directly. The GOsC operated a telephone, email question and answer service as well as a Moodle platform for participants to voice general views and share areas of concern.

In survey 1, 73%, of respondents *strongly agreed* or *agreed* that the GOsC had provided them with sufficient support, whereas, 57% of respondents in surveys 2 and 3 considered the support sufficient. In survey 4, albeit under half of those who completed the pilot responded, 72% of those said that the GOsC support was sufficient. Overall the feedback in relation to the degree of GOsC support offered appears positive.

Figure 3: The GOsC provided me with all the support I needed as part of the recruitment process

Table	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Survey 1	17.00%	56.00%	18.00%	7.00%	2.00%
Survey 2	8.40%	49.40%	34.60%	6.80%	0.80%
Survey 3	11.10%	46.00%	30.30%	10.60%	2.00%
Survey 4	19.60%	53.30%	10.90%	8.70%	7.60%

Qualitative feedback provided by participants at our focus groups suggested that although the face-to-face training session was useful, many left the session unclear on the exact requirements of the pilot. For example, many were unsure on how to use the tools and how to adequately meet each of the criteria.

When asked in survey 4 if the support and guidance at the beginning of the pilot was clear, 11% of respondents agreed with this statement. Significantly, 44% of respondents to survey 1 considered that the training GOsC provided was exactly the preparation they needed and when asked in the final survey 35% of respondents agreed with this statement. (See Figure 3 above). We understand from the GOsC that in November 2012, advice was provided to participants in relation to the use of patient feedback.

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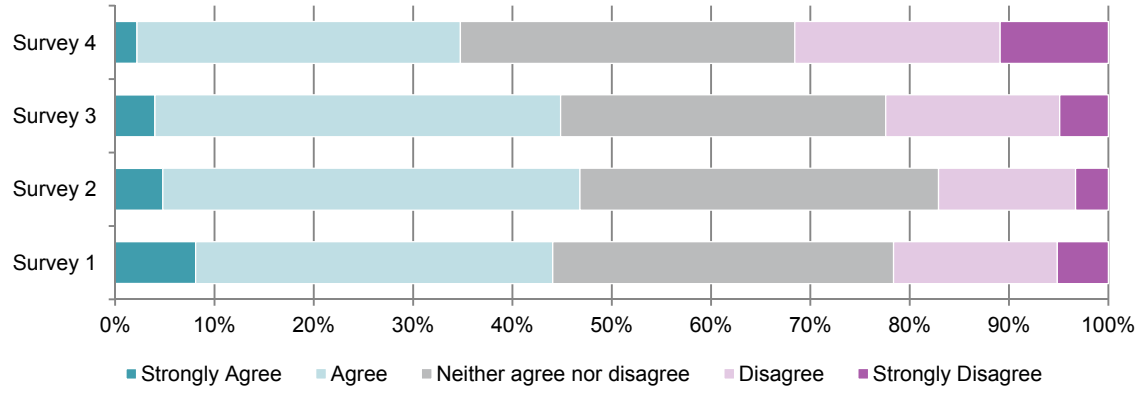
Figure 4: The training GOsC provided me with was exactly the preparation I needed



5.3.2 Materials

Each of the pilot participants was provided with a detailed Revalidation Manual setting out the requirements of the pilot, examples of each of the tools that participants could choose to use to complete their portfolio and an example of the final mapping grid. Nearly a third of respondents considered that the materials provided were *not adequately explained* or *were not clear*. However, notwithstanding this fact, 54% of respondents to survey 1 (as shown in Figure 5 below) considered that they knew what they needed to do to complete the portfolio.

Figure 5: Survey questions in relation to training and materials

Question	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The materials that the GOsC has provided me with have been fully explained and are clear	9%	37%	23%	22%	9%
I know what I need to do to satisfy the requirements needed to complete my portfolio	9%	46%	24%	18%	3%
I could have completed the templates without any training from the GOsC	2%	13%	25%	39%	21%

As is shown in the table above, 15% of respondents considered that they could have completed the templates without any training from the GOsC, and nearly a fifth of participants *strongly disagreed* with this statement.

5.3.3 Tools

Within the Revalidation Manual, the GOsC provided a list of tools from which participants could select if desired which would enable them to demonstrate achievement of each of the Revalidation Criteria and Themes.

The most popular tools used by participants were patient feedback, case presentations and practice documentation. More specifically:

- Patient satisfaction surveys aimed to provide the practitioner with patient expectation information and their perceptions on the quality of care provided.
- A case presentation – practitioners select a specific patient they have treated and then reflected on how the treatment and outcomes for this patient.
- Practice documentation included patient records and other information regarding a registrants practice.

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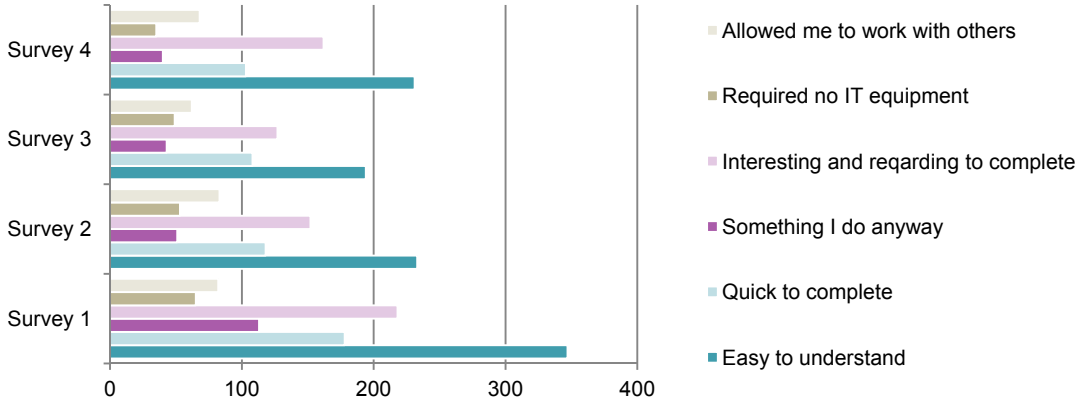
For me and my practice to benefit more I need to try some of the tools I wouldn't normally use, as overall I'm in favour of revalidation but my experience so far is not supporting that, as I've played safe & done things I do anyway. Perhaps this reflects that the pilot is over complicated as I've gone for 'easy' options. ***Pilot Participant***

The majority of participants reported that they selected these tools as they were easy to understand, quick and interesting to complete. This is shown in Figure 6 below.

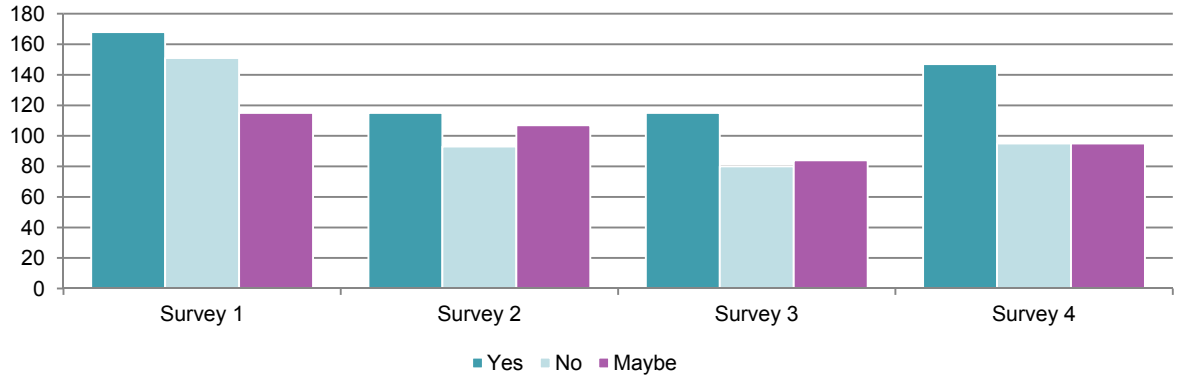
Figure 6: Reason for selecting tool



Throughout the pilot participants nearly three quarters of respondents reported that the completion of the tools helped them to reflect on their current clinical practice.

If revalidation were about safety there would be no point. The aim of revalidation is to improve standards in the profession. Particularly making us more reflective and making us do some clinical audit! ***Pilot Participant***

Figure 7: Completion of the tool helped to reflect on current clinical practice



Furthermore, throughout the pilot, in the region of 37 to 44% of respondents considered that completion of a tool changed the way in which they practiced.

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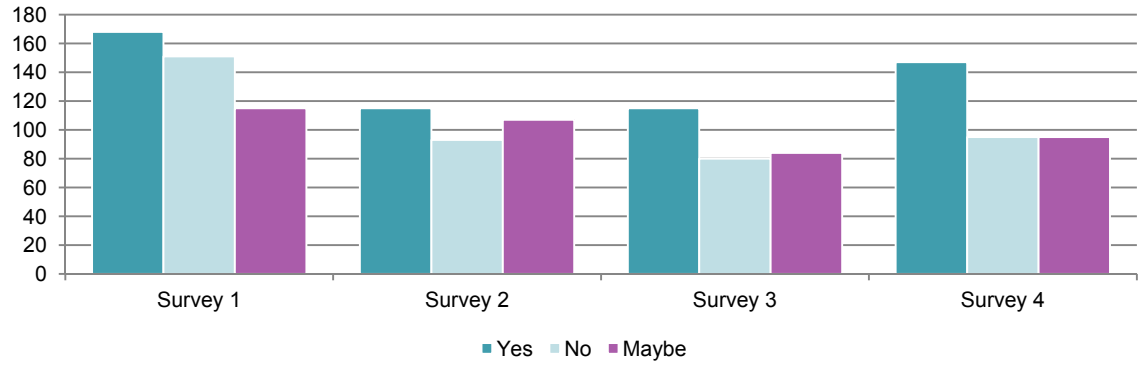
Figure 8: Completion of the tool changed future practice



Following this year's audit, we have identified a couple of key areas which need improvement, particularly the use of written material as part of patient information. Since the audit we have undertaken research and development of these leaflets and meet regularly in the clinic to discuss our progress. ***Pilot Participant***

5.3.4 Time spent on the pilot

Overall participants reported that they spent varying amounts of time on the revalidation pilot during the course of the 12 months. A summary of the average time spent is provided in the table below. We found that on average participants spent 53 hours on revalidation activities over the course of the pilot.

Figure 9: Hours spent per quarter on average by pilot participants on revalidation

Quarter	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Average (hours)	12.9	10.7	11.1	19.63

5.3.5 Pilot participant IT literacy

From our initial characteristics survey we know that there is diversity in the degree of IT skills across the osteopathic profession. Of the 484 pilot participants and those that responded:

- Nearly all participants have used internet search engines or email.
- However, 72% of participants have not used or are at beginner-level in the use of online forums.
- 83% have not used or are at beginner-level in the use of teleconferencing facilities.
- 86% of participants are either at intermediate level or above in the use of 'Microsoft Word'.

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Figure 10: Self-assessed pilot participant IT literacy

	Internet search engines	Email	Excel	Word	Power Point	Video camera	Telecon-ferencing	Online forums
Beginner	30	23	149	50	132	157	102	159
Expert	138	175	51	113	54	34	12	25
Intermediate	302	272	194	294	158	137	69	106
Never used	3	2	66	14	123	138	285	180
No response	10	12	23	13	17	18	16	14
(blank)	1	0	1	0	0	0	0	0
Total	**484**	**484**	**484**	**484**	**484**	**484**	**484**	**484**

During the course of the pilot support was provided by an External Educational Support Consultant for participants and assessors via telephone, email and Moodle[19]. Email support was provided where requested and these emails related to:

- participants having difficulty logging on to Moodle;
- participants requiring support or guidance with portfolio development; and/or
- participants commenting on the pilot process.

Overall, the use of the Moodle online platform virtual learning environment space was encouraging with 351 of the 484 participants logging onto the system at least once. This site was used by the External Educational Support Consultant to develop and upload materials for both participants and assessors, for posting in online forums, providing updates and checking participation.

Through discussions with the External Educational Support Consultant, we understand that the main objective of the Moodle site, to encourage peer interaction, was probably not achieved, as the site was predominantly used as a resource site rather than a discussion forum.

5.3.6 Impact of the pilot and views on revalidation

In order to gauge the impact of the revalidation pilot and participants' views on revalidation we asked participants a series of questions at the end of quarter 1 and quarter 4.

Although these results demonstrate that the pilot has had an impact on participants and their perspectives on revalidation, survey 1 was open to all to complete and just over three quarters of participants, 374 out of 484, chose to complete this. However, survey 4 was only completed by those who submitted a portfolio and could therefore be considered be more positive about the impact of – revalidation.

5.3.6.1 Impact of the pilot on the participant population

- Consistently over both surveys, 79% of participants felt that the revalidation pilot had made them more aware of the revalidation standards of practice. This was also mentioned within the participant focus groups where attendees commented that they had scrutinised the standards and considered how they actually apply these in practice.

[19] A free, open-source PHP web application for producing modular internet-based courses that support a modern social constructionist pedagogy.

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- Overall there was no great shift in participants' perspectives in relation to the revalidation pilot's impact on the standards of care provided. In total just over a third of participants agreed with this statement.
- In terms of the effort required to participate in the pilot many felt that the pilot activities duplicated many of the activities that they already performed as part of their practice. In survey 1, 20% of participants agreed with this statement whereas a third of respondents in survey 4, made up of those participants who submitted a portfolio agreed.
- Overall we identified that in the region of a quarter of participants considered that the pilot meant that they worked more closely with other osteopaths than previously.
- Significantly just over three quarters of respondents to survey 1 considered that participation in the pilot meant they reflected more on areas of their clinical practice. Although this reduced slightly to 68% in survey 4, maybe signifying that the individual who completed the pilot found self reflection easier even before joining the pilot, this demonstrates the impact that the pilot had on the cohort.

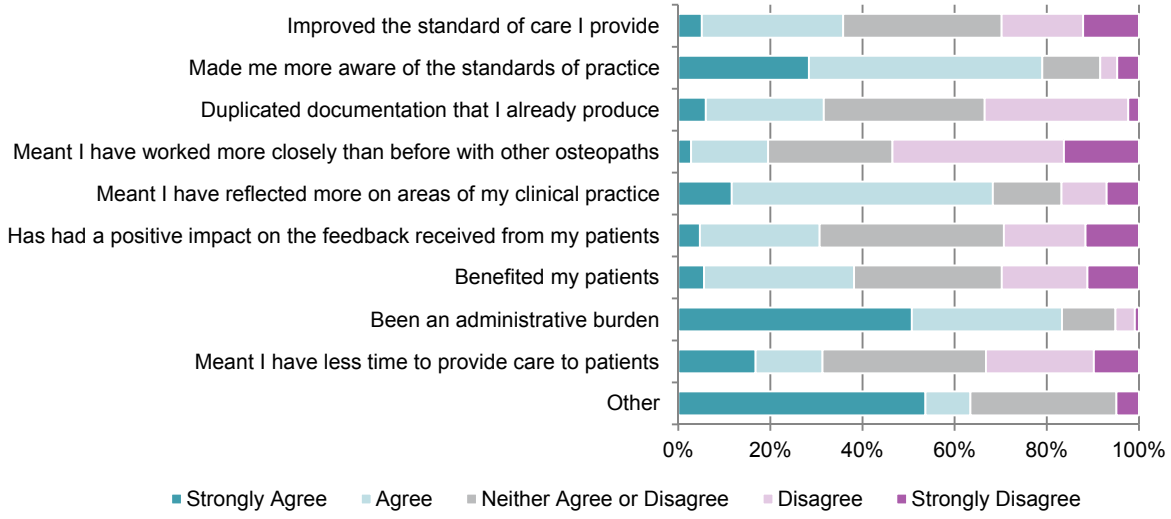
> *I have where possible reflected on what weaknesses it has shown. Generally I am spending a little longer with a new patient, checking in several ways through the treatment process that they understand what I intend to do, with consent and explaining more of a long term plan to them.* ***Pilot Participant in relation to their use of patient feedback***

- Consistently 40% of participants reported that their participation in the pilot has benefited their patients.

> *I have improved my explanation to patients of diagnosis, treatment and prognosis. I spend more time helping the patient take control by giving lifestyle advice, postural improvements and exercises. I have improved my plan of action with my patients.*
> ***Pilot Participant***

- However, results from survey 4 indicated that participation has also been considered an administrative burden 83% of participants either strongly agreed or agreed with this statement, and 31% considered that as a consequence they have have less time to care for patients.
- Of those who completed the pilot, 83% considered it was an administrative burden in comparison with 37% of respondents in survey 1.
- In survey 4 a third of participants considered they had less time to spend with patients in comparison with a fifth in survey 1.

Figure 11: Impact of the revalidation pilot, survey 4



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5.3.6.2 Participant views on revalidation

In order to assess the views of participants both before and after the pilot, we asked participants a series of questions in relation to revalidation generally. We identified:

- Nearly half, 46% of respondents to survey 1 considered that revalidation will positively contribute to the whole of the profession.

> *The test for 'benefit' of revalidation is that it significantly improves patient outcomes or safety – the operative words here are SIGNIFICANT and OUTCOMES – improving patient satisfaction (which is already high as shown by the GOsC's own survey) is not the same as improving the outcome. And osteopathy is a low risk therapy, so it is unlikely that SIGNIFICANT improvements in safety will come as a result of revalidation, particularly using this process.* ***Pilot Participant***

- A fifth of participants considered that the benefits of revalidation will outweigh the costs.

> *Costs are not significant and on balance I think that the process is overall worth doing – it just needs to be more streamlined and targeted.* ***Pilot Participant***

- A third of respondents to survey 1 considered that revalidation is well thought out and planned, but only a fifth of those who completed the pilot (ie the respondents to survey 4) agreed with this statement.
- A third of participants who responded to survey 1 considered that the scheme is fit for purpose, but only a fifth agreed in survey 4. In fact half of respondents disagreed with this statement.
- Initially in survey 1 nearly half of participants considered that the quality of patient care would improve if osteopaths engaged with the pilot. However, by survey 4 only a third agreed.
- We also asked participants whether they thought that revalidation would have a positive impact in the eyes of other osteopaths, patients, the NHS and other healthcare professionals. Broadly the views did not dramatically change across this period. However, respondents' views on the impact that revalidation will have on other groups' perspectives was diverse. For example, we identified that a quarter of participants considered that revalidation would have a positive impact in the eyes of other osteopaths, whereas nearly half considered that it would in the eyes of patients and other healthcare professionals.

> *Revalidating Osteopathy will only have benefits in the eyes of the NHS and others if they are aware that we are doing it. I have doubts that anyone will know apart from us. I also don't really think that the patients will be really interested. I think we do a good, careful and thoughtful job the revalidation may help us realise that.*
> ***Pilot Participant***

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Figure 12: Participant views on revalidation survey 1

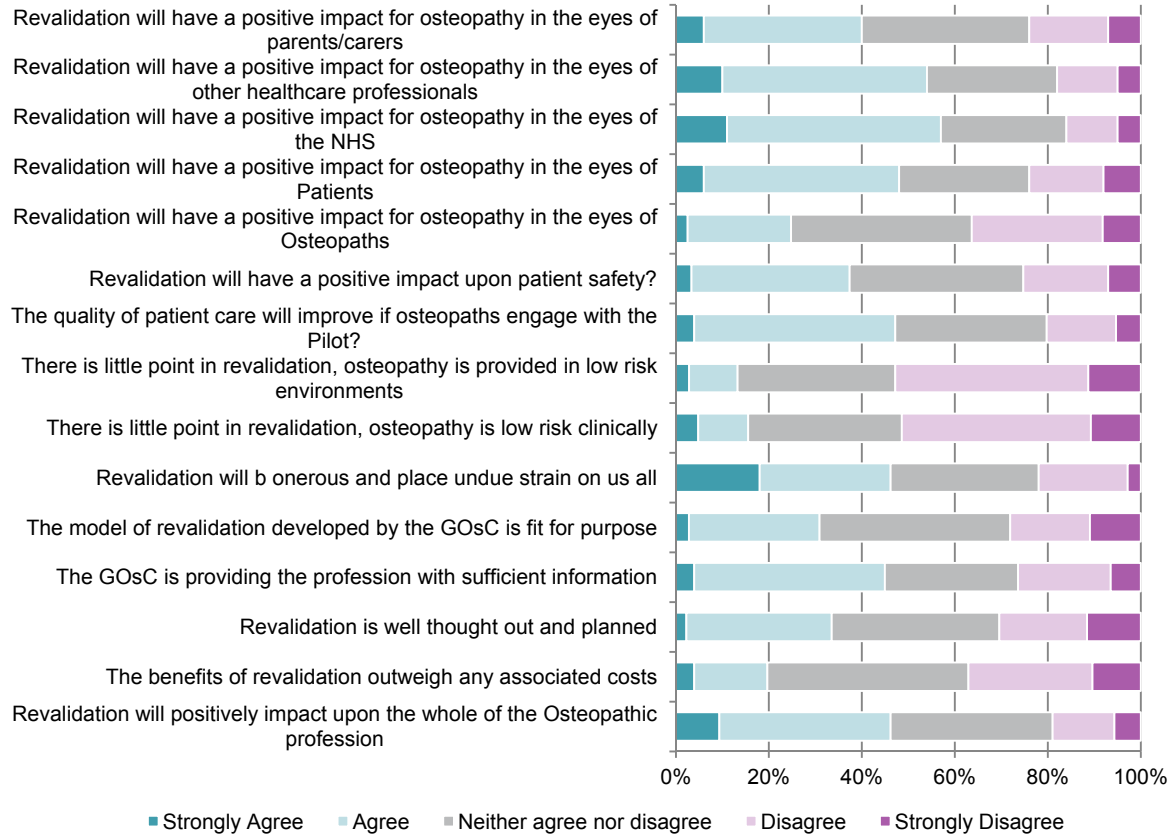

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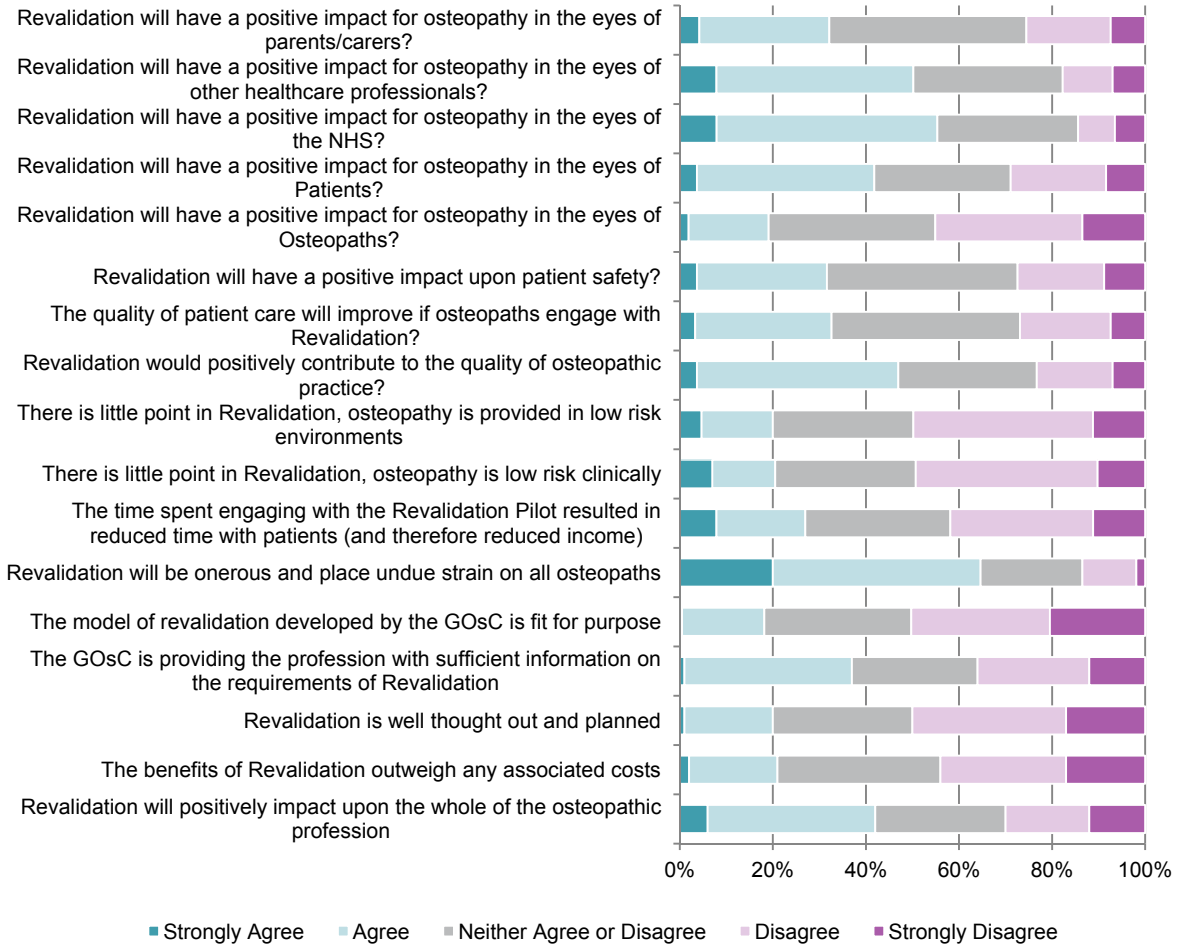
Figure 13: Participant views on revalidation, survey 4



Many participants also reported at the participants' focus group that the pilot gave them an opportunity to consider the practical application of the Osteopathic standards.

> *A greater understanding of the process of revalidation and of the requirements in the Practice Standards document. I now have a number of policies in place, thanks to the pilot!* ***Pilot participant***

5.3.7 Views of pilot assessors

Overall the GOsC recruited 31 assessors to review the participant portfolios. These individuals were interviewed by a selection panel including GOsC Council members, a nominee from the BOA and a nominee from the Council of Osteopathic Educational Institutions, to ensure that individuals with the necessary skills were chosen.

Assessors were invited to a training day in May 2012 and introduced to the purpose of the pilot and their role in assessing the portfolios of evidence. Overall the feedback from assessors based on data provided by the GOsC indicated that the sessions were useful and provided them with the opportunity to meet with other assessors, clarify their role and talk through how the assessment would work in practice. Each assessor was paid expenses for travel to events (interview, training and moderation), time to undertake training, plus a fee of £50 per portfolio they assessed.

During October 2012 each assessor received eight or nine portfolios for review. Assessors were given two weeks to review and complete their evaluation of each of the portfolios submitted. Each assessor

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was then asked to attend a moderation day so that assessors could meet up and read other portfolios and completed assessment grids. At this session assessors also provided feedback and presented examples of good portfolios and discussed and agreed gaps in portfolio evidence.

5.3.7.1 KPMG assessor surveys and focus group

KPMG asked each assessor to complete a survey at the beginning of the pilot and a survey at the end of the pilot. In total all 31 recruited assessors completed survey 1 and nearly half of the assessor cohort completed survey 2. We identified that many assessors wanted to engage as they were interested in developments within the profession. Others commented that they were keen to understand how revalidation would impact on their practice and gain an insight into what would be required.

In relation to the assessor training offered, 79% of assessors said that the training prepared them to effectively carry out the assessor role although through discussions with assessors we understand that they perceived that the training offered differed between the two events. The overall view was that although it was useful, assessors would have benefited from an event closer to the time that they actually reviewed portfolios and would have liked to have seen a worked example of a good portfolio so that they were aware of what they should be expecting to see. We also identified that nearly all the assessors were aware of what the GOsC expected of them in the role.

In relation to their views on revalidation generally, we asked whether they considered if the benefits of revalidation would outweigh the costs associated. We found that over the course of the pilot the views of assessors stayed constant, demonstrating that assessors were fully aware of the scope of the pilot before it commenced.

> *If revalidation was part of our CPD requirement, and we were able to evidence the criteria over a period of time with the ability to access courses as needed e.g. how to process information, it would not seen like it was a test that you had to pass. In its current state the revalidation will be seen as a test that needs to be passed and will mean that osteopaths will not be reflective and do what they feel is the correct answer rather then what they do.* ***Pilot Assessor***

However, there were a number of areas where the views of assessors have changed over the course of the pilot and these are shown in Figure 14 below. In particular we identified that there was:

- a decline in the number of assessors who thought that revalidation would have a positive impact on osteopathic practice and its ability to improve the quality of patient care;
- an increase in the number of assessors who thought that revalidation was burdensome.

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Figure 14: Assessors views on the impact of revalidation

	Survey 1	Survey 2	Variance
The benefits for osteopaths engaging with the Pilot outweigh any associated costs (e.g. the time to carry out revalidation activity).	39.13%	38.46%	(0.67)%
The Pilot will positively contribute to the quality of osteopathic practice.	47.83%	38.46%	(9.36)%
The quality of patient care will improve if osteopaths engage with the Pilot.	39.13%	26.09%	(13.04)%
Osteopaths will find the Pilot process burdensome and may not wish to participate.	69.57%	84.62%	15.05)%
Revalidation will have a positive impact for osteopathy in the eyes of osteopaths.	30.43%	15.38%	(15.05)%
Revalidation will have a positive impact for osteopathy in the eyes of Patients.	43.48%	46.15%	2.68%
Revalidation will have a positive impact for osteopathy in the eyes of the NHS.	60.87%	69.23%	8.36%
Revalidation will have a positive impact for osteopathy in the eyes of other healthcare professionals	65.22%	61.54%	(3.68)%
Revalidation will have a positive impact for osteopathy in the eyes of parents/carers.	43.48%	30.77%	(12.71)%

Overall, before participation on the pilot, 73% of assessors thought that their participation on the pilot would positively contribute to improving their own practice. However after the pilot, 85% of assessors agreed with this statement highlighting the personal benefit that many felt they gained through participation. Many commented that it gave them a good opportunity to critically evaluate their own practice and learn through review of other portfolios.

I have seen some excellent evidence which has triggered questions about my own practice both on a management and clinical level. Seeing what other clinicians do well or not so well is invaluable to me as a practitioner. ***Pilot Assessor***

Through the surveys and from focus groups we understand that portfolios took between 3-5 hours to review and provide feedback. We also understand through discussions at the focus group that in total assessors spent in the region of 50-60 hours on pilot activities over the 12 month period. In addition, assessors explained that the remuneration provided by the GOsC for marking portfolios did not adequately compensate assessors for the time taken to mark each portfolio.

I personally would never be prepared to undertake this work again unless a realistic pay structure was established by GOsC for assessors. The bureaucratic load placed on us has been overwhelming and personally I am glad this is now finished. ***Pilot Assessor***

Through discussions with assessors, we understand that they felt they could identify those portfolios submitted by recent graduates. Their rationale was that these were the portfolios that were able to best demonstrate that they met the criteria and often were ‘well-maintained portfolios.’ Several assessors commented that they thought the reason for this was because these individuals would be ‘used to completing paperwork which was what this exercise was testing’.

Simplify and clarify. The assessment manual is ridiculously long, convoluted and very unclear in places. Participants who I have talked to believe they only need to map and mention SOME components of the competences which is not what I have been told at assessor meetings. The process has been designed (unfortunately) by people within osteopathic education. Recently qualified osteopaths will have little problem with the design as they are used to completing reflective portfolios and self-assessing etc. Osteopaths who qualified earlier than say 5 years ago will be left confused, short tempered and frustrated by the repeating, seemingly 'stating the obvious' nature of the portfolio format and might perceive this as ticking the boxes exercise that

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has little to do with helping or actively assessing them (their view). ***Pilot Assessor***

Assessors also commented that they considered the degree of analysis in the pilot portfolios was lacking in places. In particular, assessors commented that although participants had used tools to support peer review, and had carried out patient questionnaires, there was often no evidence within the portfolio to demonstrate that they had used this information to critically evaluate their own practice. From our analysis of completed portfolios, we know from assessors that 74% of participants were able to demonstrate a process of analysis in their portfolio. This reinforces the views we heard from assessors that they considered that some participants felt that it was very difficult to reflect on their practice without being seen to criticise their practice and expose themselves to risk of scrutiny by the GOsC. In addition, one assessor commented that the pilot scheme "assumes that osteopaths are able to write reflectively" whereas no formal training is currently offered to osteopaths in this area.

Overwhelmingly the assessor group considered that the tools developed by the GOsC meant that the current scheme as piloted was too complex and too repetitive. Many commented that the volume of mapping grids and self-assessments meant that there was too much paperwork to complete, which participants often could not fully comprehend and therefore accurately fill in. They also commented that the complexity of the evidence requirements, for example, the need to provide examples of subjective and objective evidence, confused many participants. We also understand that there was a degree of confusion in relation to the number of pieces of evidence that participants thought they were required to submit, as many considered that only three tools needed to be completed not four.

Based upon the current model of revalidation the assessor focus group considered that they would each have 'passed' about 2 out of the 8 or 9 portfolios they reviewed. Although none of the assessors were asked to consider if they would have identified any fitness to practise issues, we understand, although only anecdotally, that some assessors were concerned with the practice habits of some participants, in particular in relation to informed consent.[20]

5.3.8 Views of Osteopathic Insurance organisations

As part of our evaluation we have periodically held discussions with representatives from the insurance profession in order to understand their view on the key risks within the osteopathic profession and the impact that revalidation may have on these. Anecdotally, we were informed that since the introduction of osteopathic registration in 2000, the risk profile is perceived to have reduced. However, there are still a number of reported incidents every year, relating to issues such as practice management and patient consent. We were also informed that many of the claims relate to practice linked to adjunct therapies (such as acupuncture).

5.3.9 Views of patients

As part of our evaluation, we also met with a number of patients who are currently in receipt of osteopathic care. This was a diverse group of patients and they were all grateful for symptomatic relief they gained as a consequence of their osteopathic treatment. Through discussions with this patient group there was unanimous support for the standard of care they receive. However, they also identified certain areas of practice where they considered that practitioners may wish to improve. These were mainly focused around communication skills and consent.

In general it was felt that osteopaths exhibited care and concern towards patients. However, there was a feeling that on occasion practitioners became 'more familiar' as treatments progressed. Again this was not perceived as an issue unless the osteopath failed to communicate how they were continuing to provide care, or seemed to be less concerned. For example, one patient commented that the osteopath answered their phone during a consultation; another commented that the osteopath went into another room and treated another patient. One patient of longstanding osteopathic care felt that the osteopath failed to explain adequately what they were going to do and 'just got on with the treatment'.

[20] As part of the pilot process all participants were provided with feedback in relation to their portfolio. We understand that all areas of concern were reported back to participants through this mechanism.

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The entire patient group indicated that they would be happy to give formal feedback to their osteopath to support continual improvement, although few were currently asked, as long as it would not jeopardise any subsequent care. Patients also reported that if they did not 'get on' with the osteopath, then they were likely just to not go back to that practice or ask for a different practitioner rather than let the practitioner know.

5.3.10 Other professional healthcare regulators

In Report B we reviewed the work undertaken in relation to revalidation by other regulators. As part of our evaluation of the GOsC scheme we have recently held discussions with a number of professional healthcare regulators to ascertain how these organisations have developed their revalidation schemes in the last 18 months. We understand that some of the regulators may consider combining their existing Continuing Professional Development (CPD) schemes with their proposed revalidation schemes so as to minimise the burden placed on registrants whilst meeting the needs of the regulator to demonstrate that their registrants are continually up to date and fit to practise.

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6 Implications of the pilot findings

Overall, just over half of the 484 pilot participants (54%) completed the revalidation pilot. As is outlined in section 5.1.1 many participants chose to not complete the pilot due to the time commitment required. However, the majority of participants who did not complete the pilot did not provide the GOsC with a rationale for their non-completion.

The pilot was a voluntary exercise and we understand from participant survey 1 that many participated in the pilot as they were keen to understand revalidation for their future practice. Therefore, we have assumed in our analysis that should this scheme be rolled out across the profession as a mandatory requirement, then this high drop-out rate of registrants would be unlikely to be replicated. Despite this assumption, a number of registrants commented to us during the course of the evaluation that the introduction of revalidation, particularly the current model and its complexity, may lead to a number of practitioners choosing not to re-register with the GOsC.

If we base our analysis on those 54% of participants who completed a portfolio, and assume that this group is representative of a first year revalidation pilot cohort, we can infer that a significant number of registrants would not have passed stage 1 of the pilot scheme without providing more detailed evidence to substantiate their self-assessment. We have based this inference on the data we received from the pilot assessors outlining pilot participant information in relation to the submission and completion of mapping grids/self-assessments.

We also understand that even of those who completed the mapping grids the evidence contained within the grids was not wholly reflective of the evidence presented within portfolios, which in itself would undermine the robustness and reliance that the GOsC would be able to place on these self certifications.

Our assumptions are based on the following analysis:

- Although the GOsC asked all participants to complete the mapping grid/self-assessment demonstrating that they had met the Themes of Osteopathic Practice and the Revalidation Criteria, 95% of pilot participants submitted their portfolio including this self-assessment, and 85% of these participants fully completed the self-assessment form. Consequently, if this had been the first year of the scheme and potentially a fifth of the profession had been asked to revalidate, 81% of registrants would have provided a self-assessment and met this necessary minimum requirement. This would have had substantial cost implications for the GOsC as it would mean that a number of registrants would be required to provide portfolios of evidence and the GOsC would be likely to incur considerable costs evaluating these and potentially undertaking detailed investigations into registrant practice as appropriate.
- We also understand from pilot assessors that many of those participants who submitted a self-assessment/mapping grid did not accurately map the evidence in their portfolio to the mapping grid. In fact, assessors reported that 21% of portfolios did not match the information contained within the portfolio and a further 23% of portfolios partially matched the self-assessment. As the integrity and feasibility of the scheme relies on the individual accurately completing the self-assessment the GOsC may need to consider the rationale for these deficiencies and the nature of the scheme.
- In addition, for any revalidation scheme to be effective, mechanisms should be available to the registrant to be able to demonstrate that they are continually up-to-date with the relevant practice standards and are fit to practise. The GOsC model of revalidation is based on this premise and through reflective practice asks registrants to self-assess their practise against the Revalidation criteria and the Themes of Osteopathic practice. We found from the pilot that 43% of those who submitted a portfolio provided sufficient evidence to demonstrate achievement of all the revalidation criteria, and whilst 37% partially provided sufficient evidence, just over a fifth, 21% of those who submitted a portfolio did not provide the necessary evidence to satisfy that they had met all the criteria. Therefore, if some of the revalidation criteria and/or themes are difficult for

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osteopaths to demonstrate, then more guidance may be required in relation to these particular areas.

In order for the GOsC to reduce the regulatory cost burden of any future developments of a revalidation scheme so as to be in line with the spirit of "Enabling Excellence"[21], given the above findings from the pilot the GOsC would need to consider the reasons for the:

- poor portfolio submission rate;
- lack and inaccurate completion of the self-assessment forms;
- the provision of inadequate evidence in relation to the Revalidation criteria and the Themes of Osteopathic practice.

6.1 Costs and benefits

Detailed analysis of the costs of the pilot and the impact if the scheme as piloted were to be rolled out are detailed further in the impact assessment at Section 7. Before the pilot commenced the potential costs outlined were the administrative running of the pilot scheme both for registrants and for the GOsC. Given the required increase in costs if the scheme were rolled out in this manner it could place an additional regulatory burden on the GOsC, registrants and the wider Health Sector if the price of osteopathic care were to rise to cover the increased costs.

However, in response to the Enabling Excellence call for evidence that any revalidation schemes do significantly improve patient care; the piloted scheme registrants' response indicates that some improvements to patient care can be attributed to it. Furthermore given that 8 out of 10 participants reported that doing the pilot had made them more aware of the Osteopathic Standards of Practice it would seem to indicate that this was also a benefit.

6.2 Risks

6.2.1 Risks for the GOsC

The GOsC had a specified budget for the pilot scheme and analysis of the total spend for the pilot indicates that the financial and capacity risk for GOsC was to a large extent unsubstantiated as the GOsC did not incur costs in excess of this budget. However, given that less than half of all of the completed portfolios contained evidence to support all of the revalidation criteria, the reliance on the mapping grid or self-assessment by registrants without in-depth review by the GOsC assessors may mean that the risk could remain with any future scheme that the GOsC rolls out an enhanced review may mean that this risk remains.

6.2.2 Risks for registrants/patients

In recent years the GOsC has commissioned a number of research studies focusing on the risk profile of osteopathy, particularly in relation to adverse events and the views of patients. In addition, we understand through discussions with registrants, the GOsC and insurers that the risk profile of osteopathy has changed in recent years. These risks relate to both environmental and clinical risks as outlined pre pilot.

- The overall message from the '*Patient Expectations Research (2009 to 2010)*[22] was overall highly positive for the osteopathic profession. In private practices, over 96% patients were satisfied, and 69% of the most widely held expectations were being delivered well, many extremely well. Osteopaths appeared to be proficient in providing clear explanation and specialist expertise, an empathetic relationship and shared decision-making, as well as a flexible service and good value for money.

[21] http://www.official-documents.gov.uk/document/cm80/8008/8008.pdf

[22] http://www.osteopathy.org.uk/resources/research/Osteopathic-Patient-Expectations-OPEn-study/

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- The *'New Graduates Preparedness to Practise research report'*, March 2012[23] looked at how prepared graduates of osteopathy training courses are for practice. The aim of the study was to find out whether further support is required to help osteopaths make the transition from student to practitioner. This study characterised new registrants' initial practice as likely to be 'safe, if not always effective.'
- In the section focusing on colleagues' and employers' evaluations of new graduates practice it outlined that most felt that New Registrants could explain treatments to patients in ways which were accessible and understandable. However, there were some reservations about New Registrants' responses to patients' anxieties, frustrations and pain; their management of challenging situations and liaison with other professionals.
- It reported that professionalism involves self-monitoring of strengths and weaknesses and a career-long commitment to continuing learning. The great majority of respondents to the New Registrants' Survey reported that were confident (or very confident) they could recognise their strengths and weaknesses. However, data from the Colleagues' and Employers' survey highlighted variability: individual variability in self-awareness and, at aggregate levels, variability across different areas of professional practice.
- The CONDOR[24] study examined the nature and frequency of complaints made regarding osteopaths and insurance claims against them during the period 2004-2008. This study identified that the majority of complaints were associated with standards of clinical care (68%) and a further 21% were in relation to the conduct and competence of practitioners.
- Within the (CRoAM)[25] report patients reported lower levels of gaining consent than those osteopaths surveyed. Around 12% osteopaths reported patients experiencing a major adverse event over span of career. The report suggested that major clinical events are rare, but do occur and that osteopathy is a low risk, not a no risk intervention. It said that consideration should be given to setting up a reporting and learning framework to support osteopaths, particularly those who work alone, to discuss in a blame free forum patient safety with peers and management. It also reported that many do not discuss their clinical work with others.

6.3 Development of a future scheme

An important part of our evaluation is to give consideration to the development of a future scheme of revalidation for osteopaths. In doing so, we have considered the following key points:

- The risks associated with osteopathy;
- The time required for osteopaths to complete the scheme compared to other schemes of professional revalidation;
- The scope and complexity of the scheme;
- The accessibility of the scheme to all osteopaths;
- Training requirements prior to roll-out;
- Use of tools by registrants;
- Long term requirement for external educational consultant support;
- Registrant revalidation support and guidance;
- Use and cost of assessing portfolios; and
- Merging the revalidation requirements with a model of CPD.

[23] http://www.osteopathy.org.uk/uploads/new_graduates_preparedness_to_practise_report_2012.pdf

[24] http://www.osteopathy.org.uk/uploads/complaints_and_claims_against_osteopaths_2004-2008_public.pdf

[25] http://www.osteopathy.org.uk/uploads/public_item_17_adverse_events_research_report_and_next_steps.pdf and http://www.osteopathy.org.uk/uploads/public_item_17b_annex_b_croam_summary_report_final_gosc_7_12.pdf

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1) Risks associated with osteopathy

Overall, recent research conducted suggests, as shown in section 6.2.2 above, that osteopathy, although considered to be low risk does present some risk to patients. We also understand that the level of Fitness to Practise Complaints is low,[26] particularly in comparison to other healthcare professional regulators. Consequently, it is important that any scheme the GOsC adopts is proportionate and specifically addresses the risks of osteopathic practise. This demonstrates the need for a revalidation scheme which draws on in-practice experience, reflection and peer learning, for all osteopaths, notwithstanding their age, practice setting, years of qualification or type of practice.

2) Registrant time commitment

We estimate that as piloted, the model of revalidation if it were to be rolled out as a five year would equate to a time investment of 10.6 hours per year for each registrant, at least in the first cycle. If this commitment is considered in light of the PSA's recent statements in relation to proportional continuing fitness to practice models[27], and the fact that the recently introduced scheme of medical revalidation estimates an annual commitment for doctors of only 9 hours, the GOsC may need to consider the reasons for this extended time commitment required for osteopaths. We understand that both pilot participants and assessors consider that this time commitment was largely driven by the complexity and burdensome nature of the model scheme as piloted.

3) Complexity of the scheme requirements

There was strong feedback from pilot participants and pilot assessors, both in the surveys and at the focus groups, that there was "too much to do, the manual was very complicated and the language too complex." In particular, feedback from our focus groups suggested that the manual was "overwhelming", may have been "better presented in 'bite sized' chunks" and that it was written in "education-speak". This of course provides the GOsC with helpful feedback for the development of future models of revalidation

> *Simplify, simplify, simplify…….* ***Pilot participant***

4) Inclusivity of the scheme

The GOsC will need to ensure that any future scheme developed is fully inclusive and accessible. We understand from analysis of the leaver population that of the 26 participants who indicated they had a disability or preferred not to say they had a disability that 17 left the pilot and did not submit a portfolio. We also understand that 6 out of 17 had dyslexia or a similar disability. From discussions with pilot assessors and the External Educational Support Consultant, we understand that, even for those participants who submitted portfolios, there was a degree of evidence of poor record-keeping and standard of writing skills. Consequently, we observe that a simpler scheme clearly communicated is likely to be more successful and inclusive.

5) Pre roll out training requirements

The nature of the scheme also meant that participants and assessors considered that face-to-face training is a necessary should a similar scheme be rolled out. We understand through discussions with osteopaths that many practitioners feel that they learn most effectively when interacting with others rather than simply reading literature or guidance.

Although many participants found the training session useful, some left the session 'confused'. If this model were rolled out the GOsC may need to be clearer in its communications with registrants and provide more case studies and examples of their requirements. Significantly, 391 participants completed the GOsC's training session which was offered, 350 in person and 41 online (although the

[26] http://www.osteopathy.org.uk/resources/publications/fitness-to-practice-annual-reports/

[27] http://www.professionalstandards.org.uk/docs/psa-library/november-2012---right-touch-continuing-fitness-to-practise.pdf

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GOsC are not aware whether all these participants completed the training). Many participants also commented that in addition to the initial training refresher, further training was required and that more time to run through how to use each of the tools effectively was needed. Given this and the fact that the GOsC provided these training sessions in-house, any future scheme will need to address this requirement.

Another consideration is the cost of the sessions; it is likely that this may ultimately fall on the registrants. This may impact on the number of practitioners who attend training sessions and ultimately scheme compliance. Therefore, it is essential that the GOsC are mindful of the need to reduce the complexity of the scheme which may mean that the burden of providing training is similarly minimised.

6) Use of revalidation tools

Many of the pilot participants and assessors reported that the pilot scheme gave them an opportunity to work with other practitioners and consider their own skill set. Nearly three quarters of participant respondents to survey 4 reported that the completion of the tools helped them to reflect on their current clinical practice. Furthermore, throughout the period in the region of 37%-44% of respondents considered that completion of a tool changed the way in which they practiced. Given that the majority of respondents completed the three most popular tools, patient feedback, case presentations and practice documentation it would appear that completing these pieces of evidence does have an effect on the registrants practice. Therefore, any future scheme may benefit from the incorporation of these tools.

Any scheme may also be further enhanced if it incorporated the use of tools which are quick and easy to complete. Participants cited these factors as the main reasons why they selected the tools they did in their portfolio. From our analysis we understand that tools such as multi source feedback and case audits were less well used as participants considered they were more difficult to complete and time consuming. Further guidance or training may be required in this area so as to encourage the use of tools such as these and others such as peer review so as to broaden the evidence base used by registrants to develop their practice.

7) *IT Literacy*

We identified from our characteristics survey of the pilot participant population that there was diversity in the degree of IT skills. We understand that nearly all participants have experience in using search engines or email. However, a smaller amount of participants had experience in using online forums (72% of participants have not used or are at beginner-level in the use of online forums). We also understand through discussions with osteopaths throughout the course of our review that the level of IT proficiency throughout the profession is not high. Therefore, the GOsC will need to consider how much reliance is placed on using IT solutions during the roll out of any revalidation scheme and the GOsC will need to ensure that any scheme is fully accessible to those individuals who are not familiar with IT programmes so as to ensure that all registrants can adequately complete the GOsC's requirements.

8) Use of external educational support

In addition to the initial training sessions the GOsC also provided and facilitated support to participants throughout the course of the pilot. This was provided in house and by an External Educational Support Consultant. Should the scheme be rolled out to all registrants the GOsC would need to consider whether this degree of support could be provided, particularly without any internal recruitment.

9) Continuous registrant support

In addition, we understand that a degree of support was provided throughout traditional routes such as the telephone however other support was provided remotely online. In our focus groups participants commented that the initial training offered was good, but there was too much reliance on internet support. The GOsC's Moodle site received mixed feedback. Those limited number of participants who were familiar with these types of forums used this forum as a means of

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communication with the External Educational Support Consultant. However, the majority felt that Moodle was not user friendly and difficult to understand and chose to not actively use it. Given the low levels of IT literacy amongst the pilot population, particularly in the use of online forums this is not surprising.

10) Use of revalidation assessors

When considering the development of a future scheme the GOsC will also need to consider the manner in which it chooses to evaluate registrant performance and role of the assessor. Many of the assessors commented that the remuneration paid by the GOsC did not meet the time costs associated with marking a portfolio. Considering this and the average hourly osteopathic wage of £60 (KPMG Participant survey) and that the average portfolio took more hours to review than anticipated, the GOsC may need to consider the expense that may be incurred should a scheme of this nature be rolled out, and the degree to which reliance can be placed on self-assessment.

11) Combination of scheme with a model of CPD

In KPMG's Evaluation Report A published in 2009, we identified that most osteopaths undertake around double the required 30 hours of CPD with about 51 hours undertaken directly related to osteopathy. We also identified that most osteopaths did not record all the CPD they did as this was too time consuming. Therefore, we know that osteopaths generally are undertaking a degree of CPD and are 'happy' to dedicate additional out of work hours to develop their practice but that the documentation side of this practice is less developed. This is similar to our findings from the pilot scheme, generally participants could see the value in revalidation and the activities it encourages, such as peer interaction and self-reflection however keeping an accurate record of this activity and the administration side of revalidation is where they need further support.

We understand through discussions with some other healthcare regulators that they may consider combining their existing CPD schemes with their proposed revalidation schemes. The rationale behind this is to minimise the burden placed on registrants whilst meeting the needs of the regulator to demonstrate that their registrants are continually up to date and fit to practise.[28]

[28] http://www.osteopathy.org.uk/uploads/part_i_item_8_-_continuing_fitness_to_practise.pdf

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Appendix 1 Stakeholder engagement

To supplement our survey data we held a series of meetings and/or focus groups with a number of stakeholders during the course of the pilot. A full listing is provided in the table below:

Stakeholder group	Details of our engagement
Educational External Support Consultant	■ Telephone conference call in March, June, September and November 2012.
Osteopathic Insurers	■ Telephone conference call with a group of Osteopathic Insurance organisations in December 2011 and October 2012.
Patients	■ A focus group on 12 June 2012 with 6 patients face to face and 3 patients dialled into this focus group.
The GOsC Professional Standards and Executive Team	■ We have had several progress meetings with the Professional Standards Team throughout the course of the pilot.
British Osteopathic Association (BOA)	■ Catch up meetings with the BOA
Participant focus group	■ Focus group on 13 November 2012 with six pilot participants.
Assessor focus group	■ Focus group on 15 November 2012 with seven pilot assessors.
Non pilot participant focus group	■ Telephone conference call on 31 October 2012 with a group of 4 registrants who were not enrolled on the pilot.
Meetings with other healthcare regulators	■ Numerous meetings over the course of 2011 and 2012.

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Appendix 2 Pre-pilot – anticipated costs and benefits framework

	Costs	Benefits
GOsC	Extent pilot imposes new or additional costs upon the GOsC e.g. greater administrative costs or increase in non value adding activity.	Positive impacts generated for the GOsC e.g. more streamlined delivery of regulatory functions or improved perception with other stakeholders.
Osteopaths	Costs for the osteopath would include the time spent engaging with revalidation pilot (potentially forgoing patient income).	The benefits of engaging with the revalidation pilot will be explored and could include enhanced CPD. The evaluation will include actual and perceived benefits.
Assessors	Costs will be explored for assessors. An example potential cost could be the time taken engaging with revalidation (training etc) is not financially viable with reference to the volume of work undertaken.	Potential benefits will be explored. Examples could include improvement of own practice through peer observation of other osteopaths (this will not be undertaken by the GOsC assessor team).
Patients	The extent to which patients are more willing to utilise osteopaths.	Benefits could include higher quality provision and reduced sub-optimal outcomes and reduced complaints.
Health sector	Potential costs to the wider health sector will be evaluated with information collated through stakeholder consultation. These could include additional regulatory costs, which may require regulators to rebalance internal budgets to account for this.	The benefits will be explored and could include lower onward referral (therefore lower treatment costs overall).

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Pre pilot anticipated risks

	Risk	Description	In practice
The GOsC	**Financial and capacity risk**	*Evaluation of revalidation in relation to financial and capacity risk* The risk that the GOsC will be unable to meet its financial obligations in relation to revalidation and that it will not have adequate grant monies (£402,000 total funding) to cover the costs of running the pilot, and that the cost of the full scale roll out is prohibitive.	Consider if there are particular risks faced by the GOsC around the financing of both piloting and full revalidation e.g. whether the organisation has sufficient capacity to deliver this and it can be funded.
	Regulatory risk	*Evaluation of revalidation in relation to regulatory risk* The risk that a change in laws and regulations will materially impact a security, business, sector or market. A change in laws or regulations made by the government or a regulatory body can increase the costs of operating a business, reduce the attractiveness of investment and/or change the competitive landscape.	The extent to which regulatory changes may affect osteopaths' businesses, become burdensome or adversely impact the way they practise, resulting in some registrants choosing not to stay on the register. In the Report A focus groups there was some intimation that if revalidation is perceived as too burdensome some registrants may choose not to stay on the register.
	Reputational risk	*Evaluation of revalidation in relation to reputational risk* In addition regulatory risk can span much further to cover the risks associated with public, patient and other healthcare professionals' perceptions of the pilot revalidation scheme and its implementation.	Patients may have greater confidence in the osteopath as a result of the revalidation pilot which would indirectly impact upon the profile of the GOsC.
Registrant	**Environmental risk**	*Evaluation of revalidation in relation to environmental risk* Environmental risk is inherent in the nature of the current sphere in which osteopaths practice. Report A – How do osteopaths practise, summarises some of the potential environmental risks associated with osteopathy.	From Report A and the White Paper "Trust, Assurance and Safety"[29] we know that registrants who practise in their own home are perceived as being of a higher environmental risk than those who may practise in a group practice. We also know from the focus groups we hosted as part of report A that osteopaths themselves consider that they are exposed to some risk, through practising at home.
	Clinical risk	*Evaluation of revalidation in relation to clinical risk* Clinical risk is an avoidable increase in the probability of harm occurring to a patient. Events or incidents occur in daily practice that will, or could potentially, affect the quality of patient care. The research carried out in relation to adverse events will contribute to this.	For osteopaths the level of clinical risk is dependent upon the manner in which they practise and the techniques that they deploy.

[29] http://www.official-documents.gov.uk/document/cm70/7013/7013.pdf

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Appendix 3 Analysis of the pilot cohort

In the table below we have provided a breakdown of the pilot population.

	Registrant population	Pilot participant population October 2011 (actuals)	Pilot participant population October 2011 (percentage)
Gender			
Male	*51.00%*	210	*43.4%*
Female	*49.00%*	251	*51.9%*
Not disclosed	*0.00%*	23	*4.8%*
		484	*100%*
Age			
30 or under	*14.00%*	18	*3.7%*
31 to 40	*27.00%*	90	*18.6%*
41 to 50	*36.00%*	210	*43.4%*
51 to 65	*20.00%*	135	*27.9%*
66 or older	*2.00%*	13	*2.7%*
Not disclosed	*0.00%*	18	*3.7%*
		484	*100%*
Geography			
England	*86.23%*	430	*88.8%*
Northern Ireland	*0.52%*	2	*0.4%*
Republic of Ireland	*1.82%*	1	*0.2%*
Wales	*2.34%*	17	*3.5%*
Scotland	*3.12%*	26	*5.4%*
Other UK	*0.26%*	0	*0.0%*
Non UK	*5.71%*	7	*1.4%*
No disclosed	*0.00%*	1	*0.2%*
		484	*100%*
Disability			
Yes	*3.00%*	18	*3.7%*
No	*97.00%*	441	*91.1%*
Not disclosed	*0.00%*	25	*5.2%*
		484	*100%*
Ethnicity			
White	*82.00%*	425	*87.8%*
Black or Minority Ethnic Group	*18.00%*	26	*5.4%*
Prefer not to say	*0.00%*	33	*6.8%*
		484	*100%*
Sole practitioner			
Yes	*57.00%*	287	*59.30%*
No	*43.00%*	171	*35.33%*
Not disclosed	*0.00%*	26	*5.37%*
		484	*100%*
Alone			
Yes	*57.00%*	245	*50.62%*
No	*43.00%*	171	*35.33%*
No response	*0.00%*	68	*14.05%*
		484	*100%*
Newly qualified (2-5 yrs)			
Yes	*28.00%*	69	*14.26%*

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	Registrant population	Pilot participant population October 2011 (actuals)	Pilot participant population October 2011 (percentage)
No	*72.00%*	403	*83.26%*
Not disclosed	*0.00%*	12	*2.48%*
		484	*100%*
Part time practitioners			
Yes	*50.00%*	237	*48.97%*
No	*50.00%*	235	*48.55%*
Not disclosed	*0.00%*	12	*2.48%*
		484	*100%*
Teaching or research			
Yes	*25.00%*	110	*22.73%*
No	*75.00%*	362	*74.79%*
Not disclosed	*0.00%*	12	*2.48%*
		484	*100%*
Adjunct therapies			
Yes	*67.00%*	184	*38.02%*
No	*33.00%*	245	*50.62%*
Not disclosed	*0.00%*	55	*11.36%*
		484	*100%*
Deliver osteopathy as home visits, either exclusively or part of practice			
Yes	*30.00%*	170	*35.12%*
No	*70.00%*	274	*56.61%*
No response	*0.00%*	40	*8.26%*
		484	*100%*
Locum Osteopaths	*4.00%*		
Yes		59	*12.19%*
No		345	*71.28%*
No response	*0.00%*	80	*54.79%*
		484	*100%*
Intimate examination	*22.00%*		
Yes		146	*30.17%*
No		330	*68.18%*
Not disclosed	*0.00%*	8	*1.65%*
		484	*100%*

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