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Final Impact Assessment of the General Osteopathic Council's Revalidation Pilot

11 February 2013

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Important notice

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 not completed a full economic impact assessment. We have conducted limited analysis only based on the available data. In this report we have made a number of limited findings and we have outlined a summary of our approach in each instance.

We have also prepared a separate report, 'Final Report of the Evaluation of the General Osteopathic Council Revalidation Pilot.' This document should be read in conjunction with this report.

Contents

1 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.[1].

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 concludes our evaluation and provides an independent impact assessment of the pilot revalidation scheme. 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'[2]. It also provides analysis for the GOsC in relation to the subsequent Command Paper, "Enabling Excellence"[3], 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.'[4]

We have also prepared a separate report, 'Final Report of the Evaluation of the General Osteopathic Council Revalidation Pilot.' This document should be read in conjunction with this report.

1.1 Acknowledgements

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

1.2 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.

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

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

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

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

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.

2 Impact assessment

2.1 Introduction

When considering the impact of introducing a new regulatory regime, regulatory bodies must consider whether proposals will achieve their policy objectives, while taking steps to minimise costs and administrative burdens. For this reason, regulators conduct an impact assessment.

The Department for Business Innovation and Skills (BIS) has published guidance on how to carry out an Impact Assessment, 'The Impact Assessment Toolkit (IAT).' Over the following pages we have provided an outline of what the Impact Assessment could look like for the current GOsC revalidation scheme as piloted. In addition, we have provided a guide that the GOsC may consider using should a full Impact Assessment be required for future schemes.

The IAT outlines that the overall completion of an Impact Assessment should be steered by proportionality of analysis and that the appropriate level of resources should be invested in gathering and analysing data for appraisals and evaluations. Once the degree of proportionality has been determined the approach to data collection can be agreed and the evaluation can take place.

2.2 Proportionality of analysis

The IAT outlines that the level of resources to invest in analysis during the impact assessment process depends on a number of factors. The importance and relevance of these factors to the GOsC's revalidation policy is outlined in Figure 1 below:

Figure 1: Factors to consider when determining the degree of analysis to undertake as part of the impact assessment

Factor	Relevance to GOsC	Importance
Level of interest and sensitivity surrounding the policy	In November 2012 the Council for Healthcare Regulatory Excellence issued a paper entitled, 'An approach to assuring continuing fitness to practise based on right-touch regulation principles.' This paper looks at the role that professional regulation plays in supporting registrants to demonstrate that they are fit to practise throughout their practising lives. This paper has been informed by Right Touch Regulation[5] a previous study which presents a risk-based approach to regulation, and argues that regulators should apply only the regulatory force that is necessary to achieve the desired result. Furthermore, the Command Paper, Enabling Excellence,[6] published in February 2011 indicated that although revalidation schemes should provide "significant added value in terms of increased safety or quality of care for users of health care services" it is important that proposals are proportionate to the risks within the profession. In December 2012, the GMC formally introduced revalidation for doctors and it is this scheme which is likely to be the subject of the most interest for the foreseeable future.	Medium

[5] CHRE, August 2010. Right-touch regulation. Available at: www.professionalstandards.org.uk

Factor	Relevance to GOsC	Importance
The degree to which the policy is novel, contentious or irreversible; and The stage of policy development	The policy is not novel, contentious or irreversible. The revalidation pilot methodology for osteopaths is different to the revalidation scheme for doctors. The GOsC pilot scheme is not based upon peer appraisal, but on a series of criteria which osteopaths must complete in order to demonstrate that they have met the osteopathic practice standards. The research undertaken to date does not indicate that revalidation as a concept is contentious. The format of the scheme has previously been consulted upon. Changes were made as a result of this consultation and incorporated into the scheme as piloted. If the GOsC wanted to reverse its policies on revalidation this would be possible at this stage. The GOsC did not intend for the scheme as piloted to be the final iteration of Revalidation and have committed to further review and consultation.	Low
The scale, duration and distribution of expected impact	Revalidation is expected to have a direct impact on osteopaths. It will also have indirect impacts on osteopathic patients. As at 29 November 2012 there was 4696 osteopaths Registered to practice by the GOsC. In recent years the register has seen a net increase of 150 registrants per annum, (in the region of 250 new registrations per annum). The GOsC expect that the register will continue to grow at this rate in the next few years.	Medium
The level of uncertainty around likely impacts	There is a degree of uncertainty in relation to the impact of the current model of Revalidation. Hence, the GOsC has commissioned an evaluation of the pilot scheme. The anticipated benefits of revalidation, in part, are in line with those anticipated to flow from the revalidation of Doctors. The quantification of the costs and benefits is not fully known at this stage. The GOsC have commissioned this pilot evaluation to provide an insight into these.	Low/Medium
The data already available and resources required to gather further data	The pilot evaluation has provided a significant amount of data regarding the costs of revalidation. There is also secondary evidence available on the benefits of appraisal and reflection on the medical profession that may provide an insight into the potential benefits of osteopathic revalidation. A more accurate reflection on the potential benefits will only be possible with a longitudinal study, involving potential control groups. This would be a disproportionate level of analysis given the anticipated costs and risks of this policy.	Low
The time available for policy development	In their original proposals the GOsC considered that 2014/15 was the timeframe for the implementation and introduction of revalidation. This has not recently been updated. GOsC are conscious that they want to introduce a policy that has been appropriately consulted/piloted rather than introduce a scheme too quickly.	Low

As outlined in Figure 15 above, the overall score is low/medium. Therefore the level of analysis required in the impact assessment is likely to be far less than for the impact assessment associated with the revalidation of doctors. This is in part due to the variation in the degree of interest, scale and availability of data.

[6] HM Government, February 2012. Enabling Excellence – Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers. TSO.

In accordance with the proportionality analysis above, the Impact Assessment Toolkit outlines the following approach for carrying out the impact assessment:

- Level 1: Description of **who will be affected** by the proposals;
- Level 2: Full **description of the impacts;**
- Level 3: **Quantify the effect;**
- Level 4: Put a value on the scale of **impacts by monetising the effect;**
- Level 5: **Monetise fully** all costs and benefits.

On this basis, the proportionate level of analysis for the GOsC revalidation policy at this stage is **a Level 4 analysis**. A full (Level 5) monetisation of all costs and benefits is likely to be considered disproportionate given the risks associated with osteopathy and the challenge in monetising the benefits of the scheme. In addition, given that the final scope and nature of the scheme has not yet been agreed it is not possible to determine the full costs and benefits. However, where possible, monetisation of the costs and an indicative scale of the impact of revalidation have been presented below.

2.2.1 Level 1: Who will be affected? Over what time period?

The time-period over which a typical impact assessment is carried out is ten years.

The stakeholders who would be directly affected by the introduction of revalidation are the 4,696 osteopaths currently on the register as at 29 November 2012. This number is expected to increase by a net of 150 per annum. Therefore by 2022 there are likely to be 6,196 osteopaths on the register.[7]

Patients who seek osteopathic services would be indirectly affected by the introduction of revalidation. According to the Clinical Risks Osteopathy and Management (CROaM) study[8] an osteopath currently sees an average of 33 patients per week.

As at 30 October 2012 there were 4,126 practicing osteopaths on the register. If we assume an osteopath works 47 weeks of the year and patients' typically seek treatment on a bi-monthly basis. Therefore, on an annual basis in excess of one million patients receive osteopathic treatment.[9]

We do not have access to data which would allow us to calculate the typical amount of time that a patient seeks osteopathic treatment or the likely growth rate in the uptake of osteopathic services over the next ten years. Therefore we cannot provide an accurate insight into the number of patients who would be affected by revalidation over a ten year period.

2.3 Level 2: Full description of the impacts

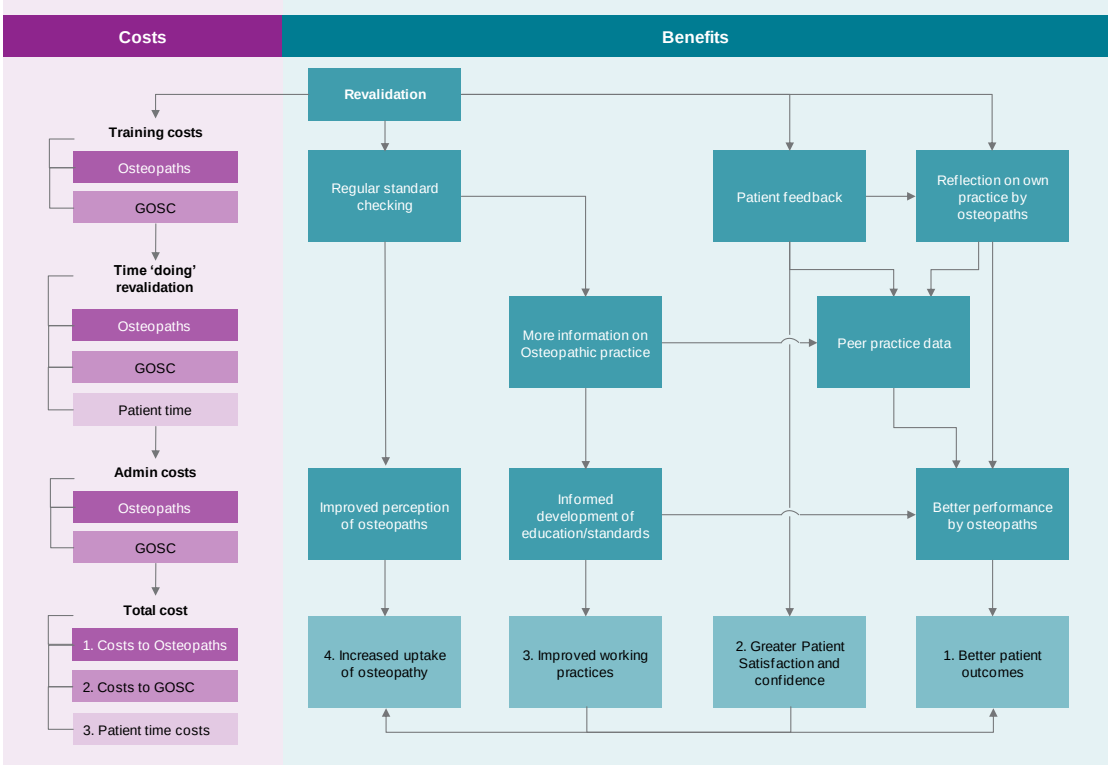
The next stage of analysis focuses on the positive and negatives impacts of revalidation, and the groups that these costs and benefits fall onto. Figure 2 below shows the main impacts of revalidation and the drivers of those impacts.

[7] Current estimates based on data provided by the Head of Professional Standards November 2012

[8] http://www.osteopathy.org.uk/uploads/croam_summary_report_final.pdf page 8

[9] Calculation provided by the Head of Professional Standards December 2012

Figure 2: Main impacts of revalidation and the key drivers of those impacts



2.4 Benefits

The pilot scheme of revalidation is based on the need to enhance the regulatory system and to assess the fitness of osteopaths to practise following qualification and registration. The expected benefits are 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.

The full realisation of the benefits of any revalidation scheme is dependent upon a number of enabling processes and activities and the avoidance or mitigation of risks to these. For example, in the case of the GOsC scheme enabling processes could be described as:

- A robust QA process of participant portfolios to ensure that standards are maintained and FtP issues identified.

- Procedures for failing to engage in revalidation should be enforced and the osteopath should be removed from the register.
- Thorough review of participant self-assessments should be undertaken to flag if risks are appropriately identified.
- Training resources and guidance should be made available, either directly by the GOsC or by a private provider accredited by the GOsC.
- Information should be managed and collated by the GOsC over several years and from several sources including FtP, CPD, revalidation and insurance claims and triangulated to provide useful directions of trackers of progress for the profession.
- Engagement by osteopaths and professional organisations would aid in the swift adoption of the principles and practices.

2.4.1 Stakeholders

Stakeholders necessarily will experience different benefits:

- **Patients** – should receive safer and more consistent standards of care and will have the assurance of a regulatory regime which proactively monitors standards of practice.
- **Osteopaths** – will have a clear and coherent system of continuing assessment which will facilitate self-reflection and promote personal goal setting. This will enhance the credibility of the profession, not only in the eyes of other osteopaths but from the perception of the wider healthcare sector which may impact on the volume of onward referrals and uptake of osteopathic services.
- **Public** – will have assurance of improved efficiency and value for money of the osteopathic care system
- **The GOsC** – will have an enhanced framework and an additional instrument to carry out its regulatory duties. It will also have access to more information on the practice settings, and practise of its registrants.

2.5 Costs

The introduction of revalidation for osteopaths under the model as piloted, as with the introduction of any new policy, has inherent burdens and associated costs which must be borne by the profession and the regulator. It is essential that the costs must be proportionate to the benefits. We have identified the following expected costs:

Figure 3: Costs associated with the revalidation pilot

Cost	Measure	Comments
Portfolio production time	■ Osteopath time cost ■ Time cost of patients and colleagues providing feedback	This is the time cost for osteopaths in producing and updating their portfolios.
Revalidation training cost – participants and assessors	■ Training time cost – delivering training ■ Training time cost – attending training ■ Logistical costs of developing, delivering and attending	This is the cost as incurred by the GOsC for the pilot. If this were rolled out, then it may not be appropriate for the GOsC to bear these costs.
Regulation cost	■ GOsC staff time cost ■ GOsC disbursements	The cost to the GOsC of running the regulatory system – including, collating information from registrants, reviewing self-assessments, organising further assessment

Cost	Measure	Comments
Self-assessment and portfolio review time	■ GOsC time to review self-assessments ■ Assessor cost to review portfolios	This cost is likely to be an annual cost to the GOsC.

In addition to the costs outlined above, there are a number of other non-quantifiable unintended consequences/disadvantages of implementing revalidation in line with the pilot methodology:

- Reduction in time spent by registrants carrying out other CPD activities;
- Reduction in available time of the GOsC to pursue other activities; and
- An increase in the numbers of osteopaths leaving the register and potentially the volume of un registered practitioners may increase.

In addition to the above costs of the pilot, one must also consider the additional costs of rolling out the pilot for the entire population. This is considered in greater detail in the next section.

2.6 Level 3-4: Quantify and where possible monetise costs

There is a two stage process for identifying the costs of revalidation:

- The first is to outline the costs of the pilot.
- The second involves identifying the impact of rolling out revalidation in accordance with the methodology as piloted.

2.6.1 Identifying the costs of the pilot

The main costs associated with the revalidation pilot are:

- Training Costs;
- Time Doing Revalidation;
- Administration Costs.

The detailed quantification and monetisation of these costs is provided below. One of the key assumptions used in the table below is that of the opportunity cost of an osteopath's working hour. We take this to be the FTE hourly charge by osteopaths for their services.[10] There is a wide amount of variance on this data and the average rate has been used as a proxy.

[10] Data derived from the KPMG characteristics survey, September 2011.

Figure 4: Quantification of costs associated with the revalidation pilot

Item	Quantification	Cost per unit	Full pilot cost
GOsC Pilot consumable costs: ■ Assessment fees (consultant time) ■ manual/material development ■ communications (online portal) ■ assessor recruitment (ext panellists) ■ participant training ■ IT ■ assessor fees (training, moderation, expenses, portfolios)	■ Time/expenses ■ External invoices	Various	£171,988
GOsC Administration time	■ Staff costs	Various in line with salary costs	£61,047
Participant training	■ Opportunity cost (time) of participants attending 1 day training session	£60 per hour average charge out rate	£155,610
Participant participation time	■ Opportunity cost (time) of participants	£60 per hour average charge out rate	£980,280
GOsC Evaluation of pilot	■ External invoice	Various rates	£190,063

In addition, there are several costs which we have not included within our analysis above as we do not have sufficient information to accurately quantify these:

- Patient time involved in the completion of patient surveys;
- GOsC administration time pre pilot and post 19 November 2012.

It is also assumed that the remuneration paid to assessors for their time spent marking portfolios and attending moderation days is equivalent to fees generated from their practice. No additional opportunity cost has been allowed for.

We have not provided for an opportunity cost for the participant time costs already incurred as part of the current CPD processes. We have assumed that revalidation time spent on the current pilot was in addition to the current scheme of CPD.

The overall estimated cost of the Revalidation Pilot is therefore £1,558,989.

2.6.2 Identifying the costs of roll-out of the scheme as piloted

The GOsC is committed to designing a revalidation scheme which has been fully consulted upon by the profession and is fit for purpose.

Given that the GOsC has committed to further review and consultation post stage 1 pilot, a full consideration of the costs of roll out of the pilot has not been undertaken.

However, if such a scheme were adopted then the GOsC would need to consider the likely long term costs of roll out. Once the GOsC has approved the scheme and the associated

costs, it would then be possible to compare these to the likely benefits envisaged over the same timeframe.

We have provided below a number of areas of consideration for the GOsC:

- What will the methodology for the roll out of the scheme look like? – Would a self-assessment scheme work based on the findings from the pilot? What guidance would be required to strengthen the self-assessment process?
- What would GOsC's role be in any future scheme? – Would the GOsC want to be involved in the training of particapnts and asessors?
- How often would the GOsC ask registrants to revalidate? – Would revalidation be on a 5 year cycle?
- What would be the likely efficiency gains for registrants to be achieved through completion of multiple cycles of revalidation? – Is it likely that assumptions could be made in relation to the time taken to complete revalidation over multiple cycles?
- Will the GOsC undertake a review/evaluation of the new scheme - Would these costs be accounted for?
- What is the expected growth rate in the number of osteopaths?
- How would phases two to four of the revalidation scheme operate in practice? - What resources would be required?

2.7 Level 3-4: Quantify and where possible monetise benefits

The main benefits of revalidation are as follows:

- Better patient outcomes;
- Greater patient satisfaction and confidence;
- Improved working practices;
- Increased uptake of osteopathy.

Trying to accurately quantify and monetise these benefits however 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[11]. We understand that there is limited data or indicators from which to measure whether standards of care are improving in osteopathy. Furthermore, it is also difficult to identify whether revalidation is 'singly' responsible for these improvements.

One way in which the GOsC could consider measuring the benefits of revalidation may be by calculating the likely effect of revalidation on the size of the osteopathy market. To do this we:

- Assume that revalidation will result in greater confidence among both patients and NHS commissioners, and then it is likely that this may lead to an increase in the demand for the services of osteopaths.[12] (However, we are aware that no in-depth patient and commissioner surveys have been commissioned in this area.) and
- Assume that this increase in confidence will result in an increase in demand for services, and then it would be possible to infer that this may result in an increase in revenue to the osteopathy sector.

[11] In the case of the medical revalidation of doctors, bespoke research was conducted in order to gauge the likely improvements in quality from revalidation. However, given the different risk profile between doctors and osteopaths, this research is not of direct relevance to the analysis here.

[12] The KPMG surveys indicated that osteopaths think that patients and the NHS consider that revalidation will lead to an increase in confidence in osteopathic services.

The question therefore for the GOsC to consider whether an incremental rise in demand for osteopathic services would justify the costs of the revalidation process as it is currently designed. Alternatively, if the GOsC assume that revalidation will incrementally increase the uptake of osteopathy services by X%, then they could consider whether the costs incurred would justify this level of expenditure.

In order to answer the above question, the first step is for the GOsC to estimate the existing market value of the osteopathy sector. This is difficult to accurately estimate however it is possible to identify a potential range using the assumptions in Figure 5 below:

Figure 5: Estimating the size of the osteopathy sector

Item	Details and assumptions
Average hourly rate of osteopaths	£60
Average hours worked per week (per KPMG survey)	35
Weekly revenue per osteopath	£2,100
Number of weeks worked per year	47
Total number of osteopaths	4,696, (4,126 practicing)
Total market size in 2012	= 4,126 x 47 x £2,100
Item	= £407,236,200
Alternative	
Average hourly rate of osteopaths	£60
Hours worked per week	24.75 (33 patients seen on average - appt time 45 mins)
Weekly revenue per osteopath	£1,485
Number of weeks worked per year	47
Total number of osteopaths	4,696, (4,126 practicing)
Total market size in 2012	= 4,126 x 47 x £1,485
	= £287,974,170

Based upon this analysis we estimate that the current 'market size' of osteopathy, measured in terms of potential revenue earned by osteopaths, is estimated to be in the range of between £287 and £407 million per year.

However, we understand that the data used to inform this estimate has not been sufficiently validated and that there are a number of assumptions underpinning this analysis. For example, in the alternative scenario we have based our assumption on the number of hours worked per week on the research undertaken by the CROAM study[13] where it was reported that osteopaths see on average 33 patients per week. We have estimated the length of the consultation for the purposes of the above calculation.

In order to identify the true impact of revalidation, the GOsC will also need to consider the counter-factual of what would happen without revalidation. (For example, the natural increase in the size of the sector due to the natural growth in the number of osteopaths – i.e. 3% each year.)

[13] http://www.osteopathy.org.uk/uploads/public_item_17_adverse_events_research_report_and_next_steps.pdf

The monetary impact of revalidation is then the result of two factors:

- The simple proportionate increase in revenue that happens due to the increase in demand for services due to revalidation;
- The time it takes between the introduction of revalidation and this increase to take place. (For simplicity we could assume this is a constant linear increase from the year it is first experienced.)

2.8 Conclusions on the impact assessment

Our analysis has identified that if the GOsC can determine the scope and, consequently, an accurate cost base of a full scale revalidation scheme, either based on the current model or an amended model, then it may be possible for the GOsC to carry out a full cost benefit impact assessment.

However, the GOsC should be mindful that cost-benefit analysis is only an indicative measure of the proportionality of the process. A cost-benefit analysis provides decision-makers with an indication of the required increase in overall returns to the sector that must be generated in order to justify the costs associated with a policy decision.

Given that we are aware from discussions with the GOsC that the scheme as piloted may change and will be consulted upon further before implementation a full cost-benefit analysis has not been presented in this report.

In particular, the results of the pilot and feedback from osteopaths showed that a number of participants did not complete the pilot, submitted incomplete mapping grids and provided mapping grids not reflective of portfolios. Given these findings, it is possible that if the pilot had been rolled out in its current form, then the GOsC may not have been able to make a revalidation decision without incurring significant administrative and assessment costs. This may also lead to delays in the process and consequently the timeframes in achieving benefits.

In addition, given that the scope of our analysis focused on Stage 1 of the pilot revalidation scheme, we have not considered the nature and costs involved in Stages 2-4 of the scheme. Any future impact assessments, to accurately measure the costs and benefits of osteopathic revalidation would need to cover all stages of revalidation so as to provide the GOsC with the necessary information to make informed decisions.

Appendix 1 Equality and Diversity Initial Screening Assessment

The Department of Health (the Department), like many other public bodies, has a legal duty, in the exercise of its functions, to have due regard to the need to:

a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Equality Analysis is the process by which the Department seeks to meet its legal requirements in conjunction with the Department's Single Equality Scheme (SES) and to narrow the health inequalities that exist in England between people with particular characteristics.

In Report D, an initial screening of the Equality Impact Assessment (EIA) was carried out to ensure that GOsC carefully considered the Revalidation Pilot and its likely impact of their work on different communities or groups. This exercise involved anticipating the consequences of the Revalidation Pilot on different communities and making sure that any negative consequences were eliminated or minimised and opportunities for promoting equality and equity were maximised. In this report we have updated the initial screening process for the GOsC to consider.

It should be noted that as the pilot only covered stage 1 of the GOsC Revalidation Scheme and as such any further pilots should reassess the impact.

The updated initial screening assessment is provided overleaf.

Overview

Area	Summary
Short description of proposals	The purpose of the pilot was to collect information about the proportionality and feasibility of the draft osteopathic revalidation scheme. This includes a view about the costs, benefits, risk and impact of the scheme for osteopaths, their patients and the GOsC, and an indication how it could contribute to the improvement of patient safety and the quality of osteopathic practice. The pilot although not commissioned as such, also supported the Department of Health's requirements for non medical revalidation as recently set out in the Command Paper, Enabling Excellence, published on 16 February 2011[14].
Overall intent	A Revalidation Scheme should be proportionate and not unfairly discriminate against specific groups of individuals. The pilot aims were: ■ To explore the impact of stage 1 of the proposed scheme, in terms of equality and diversity, on particular groups of osteopaths'. ■ To explore benefits of implementing Stage 1 of the Revalidation Scheme from the perspectives of patients and the public, osteopaths and the GOsC. This includes views about whether the scheme contributes to quality improvement or patient safety. ■ To test the impact of the stage 1 on all groups of osteopaths – including those identified in the Revalidation Consultation to ensure that there no unfair discrimination. ■ To explore and calculate additional costs of learning how to use the revalidation tools and associated guidelines. ■ To explore and calculate additional costs of using the tools in practice over a five year period. ■ To explore and calculate additional costs of completing the self-assessment form over a five year period. ■ To explore and calculate the cost of delivery of stage 1 of the revalidation scheme if it was to be rolled out to the profession over a five year period. ■ To estimate the numbers of osteopaths who are unable to demonstrate the required standards using the tools available. ■ To gather feedback about the utility of the revalidation guidelines and tools from osteopaths and from other stakeholders. ■ To gather feedback about the revalidation assessment criteria from osteopaths and from other stakeholders. ■ To gather feedback about the supporting materials including by using an online discussion forum, FAQs etc. ■ To gather feedback about the support required by participants during the pilot, the support available and to make recommendations. (This includes information about the use of the FAQs, online discussion forum, use of the podcasts, videos, and the number and types of telephone/email enquiries during the pilot.) ■ To gather feedback about the support required by assessors during the pilot, the support available and to make recommendations. (This includes information about the use of the FAQs, online discussion forum, use of the podcasts, videos and the number and types of telephone/email enquiries during the pilot.) ■ To consider the implications, potential numbers and discussions with osteopaths who do not provide all the required information on first submission to inform the development of Stage 2 of the revalidation process. (Any sample is unlikely to be representative because the pilot was all volunteers and it has been suggested that the pilot volunteers are less likely to practice at lower than the required standards.

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

Area	Summary
Identified stakeholders	These are the identified stakeholders: ■ Osteopaths ■ Pilot participants representing the characteristics of practice outlined in Appendix A to KPMG Report C. ■ Pilot assessors recruited in open competition against published competencies. ■ KPMG – Evaluation and Impact Assessment ■ External education support consultant and GOsC Professional Standards team. ■ GOsC staff – impact on all staff of pilot. ■ DH – Guidelines produced by the Department of Health may influence the course of the pilot. ■ Osteopathic patients ■ PSA ■ Insurance companies ■ Osteopathic interest groups.

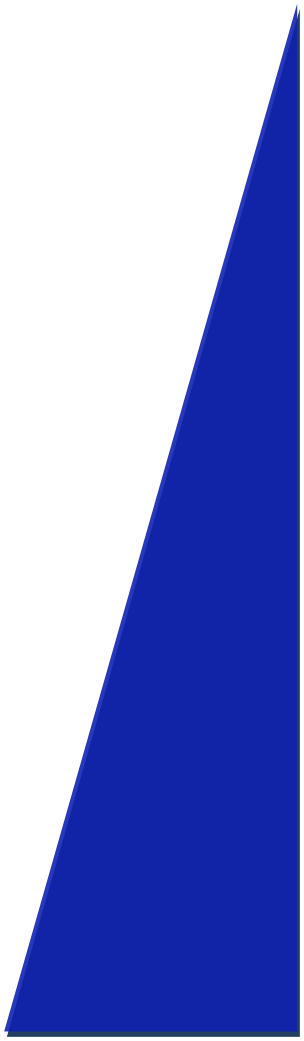
How could the policy have a significant impact on equality in relation to each area?

Area	Summary
Age	The pilot was un representative of registrants aged under 30 relative to the wider profession. However the completion rate of the pilot was less for this group. Therefore this would need further investigation to ensure that there was not an unconscious negative impact for this group.
Disability	The completion rate for those registrants who declared a disability / or preferred not to say, was lower than for the average rate. Those registrants with reported dyslexia also completed at a lower rate. This may have been as a consequence of relatively low numbers in these groups and not be material. However this should warrant further consideration for future schemes to ensure that there was not an unconscious negative impact for this group.
Ethnicity	The pilot was un representative of individuals who are black or from an ethnic monitory group relative to the wider profession. Therefore this would need further investigation to ensure that there was not an unconscious negative impact for this group.
Gender (including trans-gendered people)	None identified
Religion or belief	None identified
Sexual orientation	None identified
Socio-economic groups	None identified
Will the pilot create any problems of barriers to any community of group?	None identified

Area	Summary
Will any group be excluded because of the pilot? **Will the pilot have a negative impact on community relations?**	No to both.
Will the policy have a negative impact on human rights? **Will the policy have a negative impact on the equality to all groups?**	We conclude the policies considered in this screening do not contravene the Human Rights Act 1998 and are compatible with all domestic and European legislation. See general comments below.
General comments	At pre –pilot focus groups registrants expressed views that specific types of individuals may find the requirements of revalidation more onerous than others, the characteristics identified included: ■ Those osteopaths who practise alone; ■ Non practicing part time practicing osteopaths; ■ Those registrants who are already working to full capacity may not have time to meet the requirements of revalidation; ■ Those osteopaths who are less able to use ICT to complete the self-assessment form/tools. The findings from the pilot do not seem to indicate any groups other than those highlighted in the specific sections above found it harder or easier to complete the pilot scheme. However anecdotal evidence from registrants and assessors indicates that a having a lack of ICT skills may have a negative impact for some: For example: 72% of participants have not used or are at beginner level in the use of online forums. ■ 64% of those participants who have been within the profession over 20 years completed a portfolio, whereas only 52% of those who have been in the profession between 10 and 19 years and 48% of those who have joined within the last 10 years completed a portfolio. ■ The nature of an osteopath's hours of work did not significantly impact upon their ability to complete the pilot. ■ 52% of those participants who indicated that they worked less than 35 hours per week completed the pilot, and in fact 57% of those who work more than 35 hours per week submitted a portfolio.
Promote equal opportunities	No impact
Get rid of discrimination	No impact
Get rid of harassment	No impact
Promote good community relations	Potential positive impact. A quarter of all participants reported that the pilot supported them to work more closely with other osteopaths.
Promote positive attitudes towards disabled people	No impact
Encourage participation by disabled people	No impact

Area	Summary
Consider more favourable treatment of disabled people	No impact
Promote and protect human rights	No impact
What is the evidence for your answers to the above questions?	KPMG has undertaken a review into the demographic of the osteopathic population as well as the approaches undertaken by other healthcare regulators in respect of revalidation: ■ 'Report A – How do Osteopaths Practise?' produced by KPMG summarised some of the potential risks associated with clinical practice based as defined in the 2007 White Paper – Trust, Assurance and Safety Report A also summarised some of the key attributes of the profession which are detailed in the previous section 'General Comments. ■ 'Report B – A report on the review of the work undertaken by other regulators to outline, costs, benefits, financial and regulatory risks' identified how other health regulators were addressing revalidation, in particular the costs, benefits and risks. Through the course of this work KPMG has worked extensively with a wide range of stakeholders and has worked with the GOsC to identify how the evaluation of the pilot specification could be altered and how it can be rigorously tested to ensure that the specification is proportionate to the risk of practicing osteopathy. All pilot participants completed an equality and diversity characteristics form on enrolment on the pilot and the results, numbers of portfolio completions and leavers of the pilot were analysed against this data set. The tools within the GOsC pilot participant pack included tools that encourage group and peer working. Therefore, this may have had a positive impact upon relationships within the osteopathic community. In addition, the introduction and promotion of revalidation may have a positive impact upon the public's perspective of the profession and may encourage more general practitioners to refer patients to osteopaths and more people to consider independently approaching an osteopath for treatment.
What does available research say?	The National Council for Osteopathic Research 'Standardised Data Collection Project. Standardised data collection within osteopathic practice in the UK: development and first use of a tool to profile osteopathic care in 2009' [15] The overall aim of this project was to develop and pilot a "Standardised Data Collection" tool (SDC) for the collection of patient-based data within osteopathic private practice in the UK. The project provided baseline pilot data for comparison with future snapshot surveys, as well as providing information about a number of important issues relevant to professional practice, policy, regulation, and future research. This review found that referrals to an osteopath by a practitioner were found to be relatively low, with a total of 13% of patients referred by their osteopath to another practitioner. The osteopaths had considerable interaction with the patients' GPs. Almost half the patients (48%) had visited their GP prior to visiting the osteopath. In contrast, only 6% had been referred to the osteopath by their GP.
Have you thought about commissioning new data or research?	The GOsC have committed to further pilots and consultation on their revalidation scheme.

[15] http://www.osteopathy.org.uk/uploads/standardised_data_collection_finalreport_24062010.pdf



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