

**Revalidation for Osteopaths  
Revised Report  
15<sup>th</sup> December 2009  
As amended following the  
Council Meeting**



**Abi Masterson Consulting Ltd.**

*... helping you make it happen*

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# Revalidation for Osteopaths

## Table of Contents

<b>Revalidation for Osteopaths: Executive Summary.....</b>	<b>1</b>
Findings.....	1
<b>Introduction.....</b>	<b>4</b>
<b>Background .....</b>	<b>4</b>
<b>The consultation process .....</b>	<b>5</b>
<b>Analysis.....</b>	<b>6</b>
<b>Findings .....</b>	<b>7</b>
Respondent details .....	7
<i>Demographic characteristics.....</i>	<i>7</i>
<i>Table 1 Ethnic Origin Category 1 .....</i>	<i>8</i>
The purpose of revalidation .....	10
Fairness .....	10
<i>Proportionality.....</i>	<i>11</i>
<i>Health.....</i>	<i>11</i>
<i>Impact of gender, race, age, disability, religion, belief or sexual orientation ...</i>	<i>12</i>
<i>Women, age and disability.....</i>	<i>12</i>
<i>Impact of area of practice .....</i>	<i>13</i>
<i>Impact of being on more than one professional register.....</i>	<i>14</i>
<i>Part-time practitioners .....</i>	<i>15</i>
<i>Unintended consequences .....</i>	<i>16</i>
Stages of the revalidation process .....	17
<i>Assessors.....</i>	<i>17</i>
<i>Remediation.....</i>	<i>18</i>
Guidance notes .....	18
The self assessment form .....	19
Evidence .....	20
Special interests.....	21
Continuing professional development (CPD).....	23
Refining and improving the proposed revalidation process .....	25
<i>Cost.....</i>	<i>25</i>
The consultation process .....	26
<i>Equality and diversity.....</i>	<i>27</i>
<b>Issues for implementation .....</b>	<b>28</b>
<b>Discussion .....</b>	<b>29</b>
<b>Conclusions .....</b>	<b>30</b>
<b>Appendix 1: Revalidation for Osteopaths Consultation Questions.....</b>	<b>33</b>

# Revalidation for Osteopaths: Executive Summary

The General Osteopathic Council (GOsC), along with other regulators, is required to develop a revalidation scheme. GOsC developed its proposals with input from the osteopathic educational institutions, the British Osteopathic Association and representatives of regional osteopathic societies, and these were consulted on between February and June 2009. The consultation comprised:

- A consultation package mailed to all registrants in February and a wide range of stakeholders.
- Six regional events at which there was an opportunity for osteopaths to discuss revalidation.
- Completion of a questionnaire on line or in hard copy.

Over 1000 osteopaths attended the regional events and 360 questionnaires were received. The data from these was independently analysed by Abi Masterson Consulting Ltd. A summary of the findings is presented below.

## *Findings*

**90%** thought the overall purpose of the revalidation proposals was clearly described.

**72%** concluded that the proposals seemed fair.

**83%** reported that the proposals were unlikely to unfairly discriminate against osteopaths because of their gender, race, age, disability, religion, belief or sexual orientation.

**68%** said the proposals were unlikely to unfairly discriminate against osteopaths because of their area of practice e.g. educator, researcher etc

**75%** agreed that the proposals were unlikely to unfairly discriminate against osteopaths if they are on more than one professional register e.g. GOsC and General Medical Council.

**73%** thought that the proposals were unlikely to unfairly discriminate against osteopaths because they work part-time.

**77%** thought the four stage model as described (osteopaths having to submit a self-assessment every five years) appeared to offer a feasible process for the revalidation of osteopaths and is likely to meet the needs of both the profession and the public.

**84%** thought the guidance notes were clear, **78%** agreed they were sufficiently comprehensive and **79%** said they made it clear what osteopaths will need to do.

**82%** thought the self assessment form was clear, **86%** found it comprehensive, **69%** said it was relevant and **65%** agreed it was appropriate.

Over **70%** thought the suggested examples of evidence osteopaths would be expected to provide to support their assessments were relevant, appropriate and sufficient and **60%** agree that such evidence would be feasible to collect.

**29%** thought that GOsC should amend the existing CPD arrangements to support revalidation.

## ***Issues for consideration in implementation***

The consultation responses indicated that osteopaths are very keen to get revalidation right. Clear guidance for osteopaths will be essential as will active support for implementation. Careful communication to the public about the purpose of revalidation will also be required.

The main issues which are likely to have an impact on implementation and therefore require further consideration are that:

- there may be an in-built bias in the types of evidence required such as complaints policies and audits etc against those who are associates rather than principals, those who are sole practitioners, and locums;
- there may be challenges for those involved in full-time education and/or research in sufficiently demonstrating their clinical skills;
- there may be challenges for those not in clinical practice for example those on maternity leave or sick leave etc.
- those who work very part time e.g. fewer than 8 hours a week may find it difficult to generate the evidence required;
- the proposals are likely to have a greater impact on the earnings of those who work part time;
- the self assessment form needs to be succinct and focused and supported with very clear guidance as to expectations regarding content and length of responses;
- what constitutes a special interest, whether having a special interest poses more or different types of risks with respect to revalidation, whether osteopaths with a special interest should always apportion part of their CPD to that interest and what the balance between specialist and generalist practice should be i.e. if a minimum number of hours should be spent in general osteopathic practice.
- where possible the structure of CPD forms and revalidation forms should be similar so that the systems enhance and support each other;
- further work needs to be undertaken to ensure that the requirements meet the needs of those with a disability.
- all materials need to be produced in disability friendly formats and consideration should be given to enabling responses to be produced in alternative formats e.g. audio-taped;

- consideration should be given as to how the model generally and particularly initial self assessment might be improved.
- more thought may need to be given to the feasibility of evidence collection for osteopaths and the impact on costs for patients;
- the assessment criteria should be published;
- careful selection of assessors will be important and assessors are likely to require reimbursement for undertaking this role;
- GOsC investment in making available particular types of CPD programmes related to clinical audit, first aid and clinical updates etc across the UK may reduce anxiety in the profession and smooth implementation;
- further thought needs to be given generally about how to ensure the process will aid the development of osteopaths and particularly about the availability of appropriate support for remediation;
- safeguards will need to be put in place to guard against plagiarism etc;
- discussions should take place with the other regulators regarding the potential for mutual recognition of CPD and ensuring processes are in place to meet the needs of those with dual registration for revalidation whilst ensuring the protection of the public;
- clarity is required about the costs and benefits of the process (and in particular the potential additional costs for patients);
- further thought needs to be given to the Quality Assurance of the entire process including the quality of CPD courses and assessors.

## Introduction

The report has been prepared for the General Osteopathic Council (GOsC) to inform its work on revalidation for osteopaths. GOsC has undertaken an extensive consultation on its proposals for the revalidation of osteopaths. Responses from the profession and other stakeholders were sought to ensure that the widest range of views were taken into consideration. Over 4,500 copies of the consultation document were circulated i.e. a copy to all osteopaths on the Register as well as other stakeholders including a variety of patient groups, groups with expertise in disability, other regulators, health departments, osteopathic educational institutions. The consultation document was also available to download from the GOsC website.

It is generally accepted that the quality of a consultation process is demonstrated in the rigour with which it is conducted and the transparency of the audit trail. Analysis should be systematic and comprehensive. Interpretation should be well supported by the evidence. The design and conduct of the consultation should allow all perspectives to be identified and the audit trail should include a clear description of the methods of analysis used and report all the findings. These quality attributes have shaped the analysis of the consultation data and development and presentation of this report.

The report begins by briefly outlining the background to the proposals. The consultation process is then described. The analysis of the responses received and the questions which arose at the regional consultation events follows. This analysis is presented in themed sections, which are organised to correspond with the list of questions posed the consultation document. Finally the findings are summarised and issues that are likely to have an impact on implementation are highlighted.

## Background

The Government's 2007 White Paper 'Trust, Assurance and Safety' requires regulators to introduce schemes of revalidation for all healthcare professionals by no later than 2012. It states that revalidation is necessary for all health professionals, in order to:

- demonstrate continuing fitness to practise; and
- restore public confidence in healthcare professionals.

The Government's 2006 'Review of non-medical healthcare regulation' (the Foster report) established a number of principles relating to revalidation. It stated that:

- revalidation is necessary for all professionals
- regulatory bodies must set the standards required in order to maintain registration

- the revalidation system should not only check that the standards have been met, but also aid development.

The Government's proposed timetable for introducing revalidation for the non-medical healthcare professions recommends that there should be pilots of proposed revalidation schemes in 2009-10, with implementation of the final schemes in 2010-11.

The GOsC has been developing its proposals for revalidation since January 2008, with input from the osteopathic educational institutions, the British Osteopathic Association and representatives of regional osteopathic societies. The GOsC is proposing a staged approach comprising 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 indicators of good osteopathic practice. Additional stages such as requesting further information/evidence/clarification, evaluation of practice, and assessment of clinical performance will generally only apply where Stage 1 had highlighted a concern, with the exception of a quality assurance exercise at Stage 2 where a random sample of osteopaths will be asked to submit evidence to support the Stage 1 submission. The Department of Health reviewed the GOsC proposals at the end of January 2009 and confirmed that they are consistent with their expectations.

## **The consultation process**

The purpose of this consultation was to enable GOsC to elicit and understand the views of stakeholders on its proposals for the revalidation of osteopaths. The proposals themselves were developed with extensive engagement with the profession including the British Osteopathic Association, the Osteopathic Educational Institutions, Regional Societies and others. The objectives of this consultation were to give stakeholders enough information to allow informed responses to the proposals, enable GOsC to gauge level of support for and opinions about the proposals, understand any concerns and objections, identify any potential pitfalls and challenges for implementation, offer the opportunity for any new issues to emerge and use all of these insights to inform decision-making. Consultation of this type is also likely to increase the understanding of stakeholders about the topic and its importance and encourage ownership of decisions made.

This consultation was scheduled to run between February and June 2009. The consultation process comprised:

- A consultation package mailed to all registrants in February including a wide range of stakeholders.

- Six regional events at which there was an opportunity for osteopaths to discuss four key developments facing the osteopathic profession including revalidation for osteopaths.
- Completion of a questionnaire on line or in hard copy. The questions asked are included as Appendix 1.

In response to feedback at the Manchester regional meeting on 27th of June the consultation deadline was extended from 30th June until 12th July.

360 completed questionnaires were received (69 electronically) and the data from five consultation events (Gatwick, Glasgow, Stansted, Manchester and Taunton) were transcribed in full.

## Analysis

As the 2000 Cabinet Office ‘Code of Practice on Written Consultation’ notes (page 4), effective consultations

*“...improve decision-making, by ensuring that decisions are soundly based on evidence, that they take account of the views and experience of those affected by them, that innovative and creative options are considered and that new arrangements are workable... [it] ought also to ensure that so far as possible everyone concerned feels they have had their say or at least that their interests have been taken into account.”*

Consultation analysis therefore is similar to but different from analysis for research purposes. It involves more than just counting the absolute numbers of responses to particular questions. Respondents will frequently express a range of views and conflicting views may often be expressed. Analysis of consultation responses should be rigorous and systematic but enable new points and issues to emerge and ensure that all significant responses are reported. This is because minority views often contain important lessons for implementation. Although the absolute percentages are important for gauging the weight of opinion in relation to particular issues, thoughtful and considered analysis of the qualitative data is vital to illuminate the reasons behind respondents preferred options, why such opinions are held and their likely impact on implementation. Being able to make judgements about the representativeness of views is also important. Finally, what respondents say must also be balanced with other factors that affect decisions, such as resources and statutory requirements<sup>1</sup>.

All data from the questionnaires were entered into a SNAP database and the audio taped discussions at the consultation events were transcribed in full. An “open-

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<sup>1</sup> Audit Commission (1999) Listen up! Effective community consultation.

minded”<sup>2</sup> quantitative and qualitative analysis was undertaken of both data sets. A process of ‘content analysis’ was used to analyse the qualitative data collected. First the responses to each question were reviewed in their entirety to identify recurring themes. These were then grouped into a smaller number of broader themes which will be used to ‘code’ the data and sort the quotes into categories.

As data were entered into the database, they also formed the basis of interim reports to GOsC staff and Council.

This report provides a rigorous and systematic analysis of the full range of responses to the consultation questions and discussions at the consultation events. Direct quotes from the data are used to give a richer picture of the types of responses received; to help put the quantitative findings in context; and to demonstrate the strength of feeling about particular issues.

## Findings

### *Respondent details*

The majority of responses received were from individual osteopaths (98%). Only four responses were received from other health professionals of these four only three identified their profession and these were: Traditional Chinese Medicine, Musculoskeletal/Sports Doctor and GP. No respondents identified themselves as ‘member of the public’.

Only one organisational response was received and this was from Oxford Brookes University who had run a focus group to develop their response.

### Demographic characteristics

The demographic characteristics of respondents are set out in the tables below. Please note that some respondents answered only a few or none of these questions.

Table 1 Marital Status

Category	Percentage
Single	15%
Married	55%
Partner	11%
Divorced	8%
Widowed	1%

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<sup>2</sup> Better Regulation Executive Cabinet Office (2005) Code of Practice on Consultation

### Dependent children

47% of respondents had dependent children.

Table 1 Ethnic Origin Category 1

<b>Ethnic Origin Category 1</b>	<b>Percentage/absolute numbers<sup>3</sup></b>
White	84% (n=302)
Black	1% (n=2)
Asian	1% (n=5)
Chinese	0% (n=0)
White & Black Caribbean	0% (n=0)
White & Black African	0% (n=0)
White & Asian	1% (n=3)
Other	1% (n=4)

Table 2 Ethnic Origin Category 2

<b>Ethnic Origin Category 2</b>	<b>Percentage/absolute numbers<sup>4</sup></b>
English	67% (n=242)
Irish	2% (n=8)
Scottish	2% (n=8)
Welsh	3% (n=10)
Caribbean	1% (n=2)
African	0% (n=0)
Indian	2% (n=6)
Pakistani	0.3% (n=1)
Bangladeshi	0% (n=0)
Chinese	0% (n=0)
Any other white	11% (n=40)
Any other black	0% (n=0)
Any other Asian	0% (n=0)
Any other Chinese	0% (n=0)
Any other mixed	0.3% (n=1)
Any other background	0% (n=0)

### Disability

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<sup>3</sup> Absolute numbers are also presented as the percentages obscure minor variations because the numbers are so small

<sup>4</sup> Absolute numbers are also presented as the percentages obscure minor variations because the numbers are so small

3% (n=12) reported having a disability and the self reported<sup>5</sup> types of disability were Diabetes (n=3), Myalgic Encephalitis (n=1), Multiple Sclerosis (n=1), Dyslexia (n=4) and Rheumatoid Arthritis (n=1).

Table 3 Sexual orientation

<b>Category</b>	<b>Percentage/absolute numbers<sup>6</sup></b>
Bisexual	0.6% (n=2)
Gay woman/lesbian	1% (n=5)
Gay man	0.6% (n=2)
Heterosexual/straight	76% (n=274)
Other	1% (n=4)

Table 4 Religion/belief

<b>Category</b>	<b>Percentage/absolute numbers<sup>7</sup></b>
No religion	33% (n=120)
Buddist	2% (n=7)
Jain	0% (n=0)
Hindu	0.8% (n=3)
Sikh	0.6% (n=2)
Baha'i	0% (n=0)
Christian	35% (n=126)
Jewish	2% (n=8)
Muslim	0.8% (n=3)
Other	7% (n=24)

#### Hours worked

33% work part time and amongst those self-defined as part time, the number of hours worked ranges from 5 to 45 but the majority reported working between 16 and 20 hours a week. Three respondents said they were currently not practising (two because they are on maternity leave and one didn't give a reason), one said they were semi retired hence only working part time and another said that it depended on their state of health.

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<sup>5</sup> Some respondents chose not to disclose

<sup>6</sup> Absolute numbers are also presented as the percentages obscure minor variations because the numbers are so small

<sup>7</sup> Absolute numbers are also presented as the percentages obscure minor variations because the numbers are so small

## ***The purpose of revalidation***

90% thought the overall purpose of the revalidation proposals was clearly described. Of the small proportion who raised concerns most of these related to a resistance to revalidation in principle, a disagreement that a revalidation system of the type proposed improves safety for patients and anger at being treated the same as other health professionals as the following quotes illustrate.

*“Because the government have ‘told’ the GOSC they ‘must’ do this. The government’s objectives are not clear. This is an inappropriate, knee – jerk reaction to Harold Shipman.” (Respondent 176)*

*“Specific question, Slide 3, Point 2, ‘Revalidation would help to restore public confidence.’ Do we have any evidence that there’s any deficiency of public confidence in relation to osteopaths or is that more relating to doctors?” (Gatwick, Question 4)*

*“Do you really believe this is going to make a safer profession, because we fill a form in and you catch a few people on the edge? So if we all fill it in well and we all look great on paper, that doesn’t make us safer, it doesn’t make us more professional. It means you collect data for data’s sake and we’re just ... it’s a waste of time.” (Manchester, Question 24)*

*“To be seen to be safe via this process does not guarantee a “safe” practitioner. More time will be spent ‘demonstrating on paper’ one’s safe practice, rather than actually working, loss of income. Effort becomes disproportionate to outcome.” (Respondent 322)*

*“The problems were in the orthodox sector due to individuals acting illegally or unprofessionally osteopaths were registered after most of these events and cannot be associated with them”. (Respondent 10)*

## ***Fairness***

72% concluded that the proposals seemed fair. For many of those raising concerns there were anxieties about particular groups within the profession such as sole practitioners, part-time workers, maternity leave, practitioners in full time education, newly qualified practitioners and associates:

*“Some of the categories could be difficult for a sole practitioner to answer – e.g. when details of training are reqd.” (Respondent 34)*

*“Part time, new graduate and associate osteopaths will have a large 'administrative' burden and unnecessary level of responsibility with the proposals regarding practice management.” (Respondent 76)*

*“How is this revalidation procedure going to work with someone taking time off for childbirth or travelling or any other reason? Eg: I stopped working 6 months ago when I got pregnant. I may not start again for another year. And I may even have another child soon...” (Respondent 102)*

*“The process for becoming revalidated is dependent on demonstrating clinical skills, managing risk and being in clinical practice. Osteopaths involved in full time education will not have the evidence to present, to sustain registration”. (Respondent 342)*

*“They seem to discriminate against those in sole practice (as resources + time are consumed) & associates who are not in a position to influence policy in the practice within which they work eg sole practitioners would have difficulty providing complaints procedures, so clarity about how this would be achieved would be helpful.” (Respondent 252)*

### Proportionality

For others it was about proportionality:

*“No, not in their current form, I am not convinced that they are proportionate to the risk osteopaths pose to patients nor are the current proposals transparent in terms of how osteopaths will be assessed.” (Respondent 356)*

*“It appears long winded – Osteopaths are self employed and do not get paid for CPD or now revalidation, Surely it can be condensed to get the information required without taking hours to complete (estimated hours required to complete 10–20 hours) Time must be taken from hours that would normally be relaxation away from work...”(Respondent 19)*

### Health

Particular issues were also raised such as the requirement for practitioners to state that their health is good:

*“Is it fair that we have to be in good physical health to work as an osteopath? Section 3 Are any other professions required to state this*

*at revalidation? This should not form part of requirements for revalidation.” (Respondent 351)*

#### Impact of gender, race, age, disability, religion, belief or sexual orientation

83% reported that the proposals were unlikely to unfairly discriminate directly or indirectly against individuals because of their gender, race, age, disability, religion, belief or sexual orientation. However this figure may be influenced by the demographic characteristics of the respondents e.g. only 3% reported having a disability.

In the qualitative comments offered a significant proportion reported finding this question irrelevant as illustrated by the following quotes:

*“Why do these facts need to be known – in this document race, sexual orientation, religion are to be declared. To what end?” (Respondent 27)*

*“This question irritates me. Is this political correctness gone mad?” (Respondent 357)*

*“Qs re Ethnicity, sexual orientation & religious beliefs are irrelevant, patronising, even condescending. I will never answer that – I’m simply a human being & do not wish to be sub categorised.” (Respondent 107)*

A few others, in their qualitative comments suggested that it would take time for the impact (if any) of gender, race, age, disability, religion, belief or sexual orientation to become apparent.

*“This may be something that could possibly occur but may only become apparent should a case arise in due course once this scheme is in place.” (Respondent 97)*

#### Women, age and disability

Of those who felt the proposals might be discriminatory this concern related to women, older practitioners and practitioners with particular types of disease condition or disability:

*“Yes. Those in part-time practice are very often female because of child-care requirements and may be practising from home, meaning that evidence of practice procedures, external feedback may be more*

*limited than for e.g. an associate or principal in multi-practitioner environment.”(Respondent 356)*

*“Age: – older osteopaths are unable to do the amount of work they used to therefore work part time but then have the same revalidation costs in time, money and effort.” (Respondent 298)*

*“The proposals clearly discriminate against those with Autistic Spectrum disorders, many of whom, if not most, will be good Osteopaths but they will find several of the questions incomprehensible, unanswerable or hopelessly ambiguous, and they will also have great difficulty in identifying suitable documentary evidence.”(Respondent 75)*

*“As an M.E. sufferer I am constantly exhausted + would need an extension to handing in the forms if suffering a particularly bad attack. “ (Respondent 127)*

*“I understand currently you can only reply in writing. This could cause problems to those of us with learning difficulties. Some help for example submitting the answers on tape, would be appreciated. I am doing this with help and not being limited to a set time frame helps!” (Respondent 201)*

*“Visual impairment: the format of this printed document i.e. the colour scheme makes it difficult for anyone with a visual impairment to access the document easily...”(Respondent 328)*

There were also concerns that the impact of this discrimination might be cumulative:

*“The current proposals will be hardest upon the smaller practices – maybe those run from home even. The practitioners in this category are more likely to be women, those who are older and those who have certain types of disability. “(Respondent 311)*

Suggestions about how this direct or indirect discrimination might be prevented were restricted to extending the time period for those taking time off for maternity leave and religious beliefs, and not sharing such data (ethnicity, gender, disability etc) with assessors in case it biased them.

#### Impact of area of practice

**68%** said the proposals were unlikely to unfairly discriminate directly or indirectly against individuals because of their area of practice e.g. educator, researcher etc. Of

those who raised concerns these related to ensuring sufficient hours are spent in practice, and the challenge of having a low number of patients or specific types of patients only:

*“The amount of time in practice may vary according to their teaching or research commitments. Therefore their ability to provide evidence & audits may be impacted.”* (Respondent 232)

*“Might be limited if your patient list is a) specific b) low in number in order to provide relevant examples.”* (Respondent 227)

Some suggested that there should be a different set of questions or a different form for these groups.

*“Proposals to include questions of teaching and research, if that is the main focus of their practice in section 1”* (Respondent 208)

*“Sections 2 and 3 would be impossible for a full-time researcher. Osteopathic research needs to be encouraged so some allowances would need to be made in this circumstance.”* (Respondent 251)

#### Impact of being on more than one professional register

75% agreed that the proposals were unlikely to unfairly discriminate directly or indirectly against individuals if they are on more than one professional register e.g. GOsC and General Medical Council, Health Professions Council, Nursing and Midwifery Council. There was a general request that CPD should be transferable between and/or mutually recognised different regulators and some respondents suggested that there should be liaison between the different regulators so that individuals on more than one register do not have to repeat the process more than once in the same year and one respondent even suggested that there should just be one umbrella register:

*“Different CPD/revalidation process means, what may be fine for one profession such as nursing, with relevant education & training may not be for osteopathy – is there provision for the transfer of skills? Such as patient contact, clinical hours?”* (Respondent 136)

*“CPD for other than Osteopathy should be credited I am on the GMC and also need medical CPD. Also need medical acupuncture CPD. I find 12 month timescales for CPD difficult to arrange – I often end up doing some CPD just to get the hours in rather than waiting for some more valuable CPD.”* (Respondent 149)

### Part-time practitioners

27% thought that the proposals might unfairly discriminate directly or indirectly against individuals because they work part-time and this related to the volume of patients seen and the associated impact on opportunities for learning and undertaking the range activities required, the impact of being part time on income and therefore access to CPD, and the proportionately greater burden of the revalidation paperwork. Although most respondents realised that the important thing was ensuring competence:

*“The volume of paperwork and documentation would be the same if you were part time or full time or in a large or small practice. The burden would be greater on individual and part time practitioners. “*  
(Respondent 353)

*“How part-time is part-time, and how much part-time is insufficient practise? Small numbers of patients may mean difficulty in answering some questions.”*(Respondent 286)

*“...on the revalidation form it says about the number of hours you do Osteopathy, now I work part-time because I’m having a family, what assurance are the GOsC going to say when they look at my form and say ‘I do ten hours or two hours’ and somebody else does 70 hours, I don’t have enough data possibly in order to fill in the revalidation form if I’m doing a small amount of hours. I’m hoping by the time this comes out that I’ll be working a lot more because my children will be more grown up, but I am sure there are other people in the same situation that don’t do it full-time and are going to really struggle with finding patients consultations to pull from. Reading through it threw me slightly, I just couldn’t answer these questions, I don’t have enough information...”*(Glasgow, Question 7)

*“Maybe. A part time worker has less available money to spend on CPD i.e., attending expensive conferences which may be considered as more valid CPD from local case studies evenings with local colleagues.”*(Respondent 20)

*“It might be argued that the work involved filling out the forms was onerous for somebody working part time, although I think all osteopaths have to reach the same standard regardless of full or part time. “* (Respondent 91)

Some also suggested that in the future there may/should be a minimum hours requirement:

*Like a lot of other osteopaths, I work part-time. Is there going to be some sort of minimum hour requirement or minimum patient number requirement in order to be considered that you are practicing at sufficient frequency and professionalism? (Gatwick, Question 23)*

*"There are issues about how much a person need to be in practice in order to maintain competence in the handling of patients"*  
(Respondent 216)

Practical ways respondents suggested for addressing this that would reduce the burden on part timers and indeed all osteopaths and that would also meet with the safety and competence requirements included ensuring the paperwork to be submitted is as focused and succinct as possible, and increasing the amount of on-line study opportunities.

#### Unintended consequences

44% suggested that they could foresee unintended consequences arising from implementation of these proposals. These included issues such as osteopaths wrongly ending up at stage 2 because they have misunderstood the forms, expense and time required resulting in people having to leave the profession, a focus on the detail of the process i.e. development of policies, audits and so on rather than the purpose i.e. safer practice, and even a shift to osteopaths working in bigger practices:

*"If stage one forms are filled in poorly (due to lack of guidance maybe) much time, cost + processing will be spent chasing competent osteopaths."* (Respondent 254)

*"...unless fees/CPD/self-assessment/courses are proportionate to income, there may become a point where I feel I would be better off leaving the profession, than finding the funds to fulfil requirements - indeed may not be able to."* (Respondent 13)

*"Osteopaths will develop an "evidence generating" mentality, writing fire evacuation policies, referral protocols etc. which will really say nothing about fitness to practice."* (Respondent 75)

*"A move towards corporate osteopathy and away from community practice in a manner similar to many dental practices. Where continuity of care is reduced. This produces a profession more easily regulated but there is less personal service for the patient."*  
(Respondent 125)

Some concerns were also raised about practitioners 'gaming' the system:

*“The revalidation process at stage 1 could be entirely copied for subsequent 5 yearly submission! De-validating the process.”* (Respondent 27)

*“People lying on the forms. Spot cheeky “mystery shopper” patients. A formal written examination.”* (Respondent 68)

### ***Stages of the revalidation process***

77% thought the four stage model as described with each osteopath being required to submit a self-assessment every five years appeared to offer a feasible process for the revalidation of osteopaths which is likely to meet the needs of both the profession and the public. However it is worth noting that there were no responses from patients or patient representative organisations.

Some concerns were expressed about the reliance on self assessment, ensuring the process was a simple and straightforward as possible, and whether five years is the appropriate time period:

*“We are clinicians. If GOSC really wants to revalidate with a view to ensuring safe clinical practice, I don't think you can rely on self-assessment. The most dangerous aspect of practice is not knowing what you don't know (to quote Donald Rumsfeld!) Only some form of exam can bring this to light.”* (Respondent 90)

*“Too long winded! It should be streamlined and be more practical not political. For example question 1 a & b will have the same answers for most osteopaths”* (Respondent 19)

*“Why 5 years? Do you expect an individual's clinical practice to change significantly over such a short space of time?”* (Respondent 139)

*“Is the five-year cycle actually set in stone? ... Because it seems to me ridiculously short period if this is something that we have to keep doing. Five years is nothing in a professional life. I would go for something much longer in-between.”* (Gatwick, Question 2)

### **Assessors**

Several respondents also requested more detail as to the detail of each stage of the process and in particular who would be carrying out the assessments:

*“No indication is given regarding (i) the make-up of the assessment (panel/person) (ii) what form remediation will take, how assessed & what time scale (iii) Methods/modes of appeal. (iv) Percentage of random sampling (v) how the rolling selection of osteos is divided.”*  
(Respondent 318)

*“Who is going to do the assessing, how will they be trained, will they be paid? The PPP process was only viable because a relatively small number of osteopaths gave a vast amount of time for free and I do not think anyone would be prepared to do that again”* (Respondent 216)

*“Does the process, which looks very fair and very reasonable at least on first assessment, but the way a process works is on the individuals within it. In this case the key people in terms of the trust of the profession will be who the assessors are, what their skills are, how they will be chosen – would they come from an inner circle of people known to the GOsC or would there would be a more open and transparent method of selecting them and choosing them?”*  
(Stansted, Question 2)

*“Can I be reassured that your panels will themselves be totally current with all the changes which are going on in the base knowledge?”*  
(Stansted, Question 16)

### Remediation

Some concerns were also expressed about assuring the quality of courses to support remediation:

*“Just a quick question about the remediation process because CPD currently, the courses that are provided by any provider are not regulated in any way or checked for quality. I was interested to know how one would remediate on the basis of no quality control on provision of CPD.”* (Gatwick, Question 7)

### ***Guidance notes***

84% thought the guidance notes were clear and 78% agreed they were sufficiently comprehensive. Indeed one respondent felt the guidance notes gave too many hints as to the ‘right’ answer:

*"The guidance notes often make the questions self-answering e.g. "if not, do you have any plans to do so?" The answer, of course, is yes."*  
(Respondent 75)

Although **79%** responded that the guidance notes made it clear what osteopaths will need to do, some areas were identified as requiring further attention including giving more guidance on the amount and detail of information expected, whether some of the examples are truly examples and optional or are in fact required, and whether acknowledging areas of weakness could be detrimental to GOsCs view of the osteopath, and whether there would be an appeals process:

*"Need more guidance on volume of answer – this has the potential to be many hours of detailed work and documentation."*  
(Respondent 131)

*"The notes suggest possibilities but it is easy to expect that all the information is areas that we all required to achieve e.g. question 18 is clinical audit going to be compulsory."* (Respondent 185)

*"I've recently relocated and have a very small practice and I'm probably going to spend more time doing practice audit than I am actually seeing patients, and I wonder how hard-line you're going to be on the sort of health and safety stuff. Because it's obviously very relevant but it's not something... you know I've far more interest in reading research and finding out about patient needs in my own professionalism than I am about formalising those bits about my front room."*(Taunton, Question 7)

*"Unclear as to impact on the osteopath of section 5 p20 (19a) Reflection on weak areas of practice. Must we all have weak areas? Does such an admission make an osteopath vulnerable?"*  
(Respondent 310)

*"...this is an important thing and has potentially catastrophic effects if you are deregistered. Presumably there's going to be a proper appeal process to... if somebody is in danger of that situation."*  
(Taunton, Question 12)

## ***The self assessment form***

The respective percentage responses about the self assessment form are as follows:

- a) clear **82%**
- b) comprehensive **86%**
- c) relevant **69%**

d) appropriate **65%**

Some concerns were expressed about whether it was all appropriate and relevant to those practising as associates and locums, whether or not there should be a minimum hours requirement and that the system may just reward those who are good at filling in forms rather than practising osteopathy:

*“Aspects of 'practice management' are not relevant/appropriate to all practitioners – far too much about 'health & safety', practice policy for associates... (see 5 &10)”* (Respondent 76)

*“...locum practitioners who only spend a few weeks in practises may not be able to show documentations for practice running/dealing with complaints. It's not really relevant for them.”* (Respondent 102)

*“The form will not evaluate whether an osteopath is fit to practice, simply how good they are at completing forms. A random sample of osteopaths should be audited & screened at their practices in the same way as with tax returns. They should automatically progress to stage 2 or 3 even without concerns.”* (Respondent 141)

## ***Evidence***

The respective percentage responses about the suggested examples of evidence osteopaths would be expected to provide to support their assessments are as follows:

- a) relevant **73%**
- b) appropriate **70%**
- c) sufficient **74%**
- d) feasible to collect **60%**

Concerns included time taken to collect, the availability of these sorts of evidence especially clinical audit results and complaints, and an inbuilt bias for large practices rather than single-handed practitioners:

*“Very time consuming so osteopaths may not bother, which defeats the object! Also, what is to stop us in 5 years just using the same answers & evidence? Need to be more focussed & clinical.”* (Respondent 26)

*“In 27 years of practice I have not had a complaint + so cannot provide an example of such, (6.d)”* (Respondent 84)

*“Every practice is different. The large urban ‘car park’ osteopathic practices, I am sure would have no problem providing every document asked for. A ‘one-man’ equally professional practice, would have difficulty in providing evidence like e.g. clinical audit outcomes – simply because I haven’t got any!” (Respondent 152)*

*“...about the clinical audit. A lot of people in this room are sole practitioners, they’re doing everything from taking the money from patients and doing all patient notes and everything else that we do every day. It feels that there might be a slight bias towards those practices who have receptionists, who have a person who can actually detail all of the information that we get and catalogue stuff. It’s slightly taking away from the business of taking care of our patients to be writing audits on a regular basis and trying to do all the extra paperwork that it’s possibly suggested this service wants. (Gatwick, Question 7)*

Indeed there was a suggestion that the sources of evidence suggested might say more about the practice rather than the individual practitioner:

*“I think what you’re doing here is assessing practices rather than osteopaths. What if you get five osteopaths in a practice who have no control over things you want them to demonstrate?” (Manchester, Question 13)*

## ***Special interests***

In the draft self assessment form being consulted on it says *“Whilst the GOsC does not currently recognise any specialist or advanced practice in osteopathy, it acknowledges that osteopaths have special interests which may be the focal point of their practice. Therefore the GOsC wishes to take account of special interests when it revalidates an osteopath...”* which provoked a lot of comment from respondents. Some questioned the definition of special interest. Others argued that it was unfair to treat osteopaths with a special interest or interests differently and were unconvinced that having a special interest necessarily posed an extra risk to the public. Still others were supportive of the need for particular updating in the osteopaths area of special interest.

In terms of what constituted a special interest concerns were raised about definition and the implications for assessment:

*“When does something become a special interest as opposed to just part of your general practice?” (Taunton)*

*“Under clinical practice of osteopathy Question 2a) – Different types of patient (infants/elderly/sports) are grouped with an osteopathic technique (cranial) – this does not make sense. You do not declare a special interest in soft tissue or articulation (also taught at undergraduate levels) – so why cranial?” (Respondent 312)*

*“Q 2 not clear – do we refuse treatment to babies, infants, children, women who may be pregnant, the elderly, dental patients, sports people if we haven't done postgrad special training – do we not treat visceral or medical conditions. We may not be promoting ourselves or seeing what we do as special.” (Respondent 208)*

*“...how can a judgement be made on special interests which are outside the sphere of experience of those reviewing the self assessment form?” (Respondent 162)*

*“Revalidation must be overseen by a range of overseers with sufficient knowledge of all aspects of osteopathy so that practitioners with interests in visceral, cranial or paediatrics are not discriminated against.” (Respondent 244)*

*“The other question I had is about this issue of specialist practice which Adrian just raised. I'm interested in how the assessors ... how we'll be assessed and will the assessors have...you know, will there be a requirement for the assessors to have experience of the kinds of areas of practice that we bring up? And also how will the GOsC ... are the GOsC going to provide guidelines about what constitutes a specialist area of practice? Because I see osteopathy as a whole, I see it as general practice, and I see it as a set of principles that can be applied to anyone.” (Stansted)*

The rationale for treating osteopaths with special interests differently was thought to be unfair and unconvincing by some:

*“The proposals discriminate against practitioners using cranial techniques, or treating infants & the elderly & sports injuries (page 12) 2a) b) c) d) osteopaths specialise 100% in osteopathy” (Respondent 310)*

*“More examples needed on Q18 Q2 to illustrate what you mean by “potential risks” and “steps” to “reduce additional risk” associated with special interest areas. “ (Respondent 245)*

*“I have a concern about the risk related to specialism within Osteopathy, the way we're taught is the cradle to grave approach,*

*we're all supposed to be able to treat all ages, all conditions and it seems that we're splitting into three, Paediatrics, Animals and Sports all have institutions relating that special application of Osteopathy and it seems that in the long term you're viewing a register with a split, much like the nursing register has a split for various specialities and that there's an extra onus on you to get more education relating to an area that you might have more interest in. At what point does an interest become a speciality? What point do we need then extra evidence to support that speciality and if we do need extra evidence to support interests, for example children, does that exclude Osteopaths who haven't declared that as an interest, from treating children? It creates a lot of problems, dividing that bit about the risk and risk related to specialism."* (Glasgow)

On the other hand some respondents did support the need for osteopaths undertaking particular updating in their areas of special interest:

*"If there are going to be areas of special interest, then CPD should require a certain number of hours or percentage devoted to that special interest."* (Respondent 343)

### ***Continuing professional development (CPD)***

29% thought that GOsC should amend particular elements of CPD to support revalidation. Others thought that the current CPD requirements should be sufficient for revalidation:

*"Make the CPD return (along with a good disciplinary record) be sufficient for ongoing revalidation."* (Respondent 1)

Suggestions for amendment included numbers of CPD hours, how to integrate CPD with revalidation, availability of courses, quality of courses, funding and whether current GOsC expectations regarding CPD hours and content were too/not rigorous enough, and once again whether there should be a minimum hours of practice requirement was raised as an issue:

*"Reduce the number of CPD hours required the year the stage 1 Revalidation document is required as it is a big chunk of time out of clinic to do both in one year."* (Respondent 31)

*"Combine CPD with revalidation & assess both every 5 years."* (Respondent 48)

*“...given the fact that you have made CPD so useful to all of us and have basically made it such that we are all doing CPD regularly and now you’re wanting to make it a part of this, how exactly are you going to keep it all the same for everybody if all of us are doing completely different CPD and you don’t really strictly speaking say, ‘You should be doing this, you should be doing that’, it’s left open to us. So if every single one of us is doing completely different sort of style CPD, how are you going to then knit it into this to make it basically valid for all of us?” (Stansted, Question 5)*

*“There is scope to restructure the CPD documentation so that it matches the revalidation documentation in the four sections making it easier for practitioners to take information from the CPD and easily incorporate it into the revalidation portfolio. “ (Respondent 211)*

*“I have thought since the beginning of CPD that GOsC might provide courses in the elements of our practice which is considers non-negotiable. e.g. First Aid, Neurological testing, Abdominal screening, Red flags etc. Not sexy, but I would imagine osteopaths would welcome the opportunity to partake....” (Respondent 338)*

*“...core topics and CPD, surely wouldn’t that be sufficient, mandatory core topics, key core topics like Pathology, Orthopaedics, Neurology, differential diagnosis, pros and cons of cervical adjustments and so on an open door basis, each Osteopath required to do some core topics, a certain amount of hours per year and so on, is that the way to do it? “ (Glasgow, Question 8)*

*“The GOSC need to find a way to validate post-grad courses so that they are of a standard fit to be used for CPD purposes. Otherwise the whole exercise has no meaning” (Respondent 7)*

*“If CPD is going to be so tantamount to the revalidation, is the General Osteopathic Council going to take more responsibility for validating CPD courses in the future so that people aren’t wasting their time attending courses that the General Osteopathic Council will then deem unnecessary? “ (Gatwick, Question 20)*

*“CPD should include a minimum number of patient contact hours if an osteopath wishes to be registered as “practising”. Ongoing practical experience is a better gauge of competence than completing educational requirements. “ (Respondent 123)*

## ***Refining and improving the proposed revalidation process***

Suggestions varied from a desire to reject the process in its entirety to details such as the colour of the written materials and the impact on those who are colour blind and recommendations for standardisation across all professions, some concern about the need to undertake clinical audit, anxiety about plagiarism, and a desire for the assessment criteria to be published:

*“More emphasis should be put on providing evidence from actual cases with case history forms and patient management rather than clinical audits which many of us don't have.”* (Respondent 118)

*“The original PPP took place over 3 years there were allegations of later applicants copying PPPs of earlier successful applicants = can you prevent this?”* (Respondent 10)

*“Provide applicants with your assessment criteria – standard practise.”*  
(Respondent 130)

*“...I'm interested to know, will the assessment criteria be made clear, because for us as osteopaths that's the most important thing in being able to provide the kind of feedback that will be appropriate? We need to know how we are being assessed.”* (Gatwick, Question 1)

### Cost

Concerns about the impact on the cost of registration were present in the written responses and emerged as a particular issue in questions at the consultation meetings:

*“Could I just ask, is there going to be any financial cost to us as osteopaths to go through the revalidation procedure?”*  
(Gatwick, Question 21)

*“Looking at the GMC, their fees quadrupled when they realised that revalidation was going to happen. I mean, are our fees going to increase significantly as well?”* (Taunton, Question 6)

*“I've been qualified fifteen years and if the revalidation process had been there and the CPD had been there when we first started, I'd have done 30 hours CPD a year, I'd have done three revalidations already, and I'd be having to buy new storage for my notes. I'd be doing clinical audit and governance... you know, the bottom line is that patients ring up and they want to know how much it's going to cost*

*and how quickly they can be seen. All of the things that you're introducing now are going to ... the bottom line is, I'm going to have to charge my patients. You know, osteopaths are dropping out of the profession, why is that, and some of it is well, 'It's costing too much to be an osteopath and it's taking too much time to do the paperwork'. It's not really a question, it's a statement really."* (Stansted, Question 27)

*"Accepting that revalidation was not a scheme thought of by ourselves, but a scheme sent down by this super efficient government of ours in order to restore public confidence in Osteopathy, which I don't think too many people have noticed it being missing, but what hasn't been mentioned anywhere so far, and I think this is going to because no offence to government bodies but they are self perpetuating and they grow and they grow and they grow, has anyone costed this? The General Medical Council revalidation scheme, when it comes into practice will presumably be funded by government; our scheme presumably will not be funded by government, it will be funded by ourselves but in effect that doesn't mean funded by ourselves, it means funded by our patients. In a time of economic stress it looks like we will probably have to up our fees in order to pay for whatever it is we're going to have to do and by doing that, that in itself will have a defeating purpose by turning patients away because they're going to have to pay more for something that really they're not interested in despite the fact that we've got to do it. There's no mention of costs here or of ongoing predictions of costs, can you maybe give us some follow up on that?"* (Glasgow, Question 3)

## ***The consultation process***

Only a few comments have been made about the consultation process itself and the majority of these relate to a preference to have been supplied with a return envelope, preserving anonymity and/or the role of the GOsC vis a vis government. Being consulted in general and the regional meetings in particular were positively commented on by many respondents. There was a general acknowledgment that the consultation process itself has been handled well although some scepticism was also expressed about whether the responses would really make a difference:

*"Thank you for actually consulting."* (Respondent 186)

*"Great to be able to do it online"* (Respondent 204)

*"The general meetings are very informative and a positive way of obtaining information/feedback. I'm afraid there will be a long*

*process of 'drafts' occurring, but that's the only way to refinement."*  
(Respondent 156)

*"I found the consultation meeting to be very helpful and constructive and not the usual them and us battles between the council and practitioners which can so often overshadow these events..."*  
(Respondent 211)

*"I think the consultation process is a good idea but I think you are only asking questions that you are interested in – and I feel that the decisions have already been made."*(Respondent 142)

*"It would be nice to think this was not a done deal already as the questions make it difficult to whole heartedly agree or disagree a choice of models would be nice!"*(Respondent 122)

*"The consultation process outwardly has seemed open and listening, yet the documents reflect that certain agendas are being pursued. It is difficult to reconcile the content and the context. One must adopt a cautious attitude. Will we be heard?"*(Respondent 353)

*"...How much of this is actually now cast in stone, because all the talking has been quite generalised and I'm a bit confused still as to what exactly is going to be required?..."* (Stansted, Question 29)

### Equality and diversity

Very many concerns were expressed about the equality and diversity information requested in the questionnaire and its relevance:

*"I fail to see how topics such as gender and religion should affect ones ability to be an osteopath and why such consideration of discrimination is needed! I strongly feel that positive discrimination is wrong and discrimination in it's own right!"* (Respondent 39)

*"The section 2. is intrusive & not relevant in my view."* (Respondent 133)

*"I think it is entirely inappropriate & v. unusual to have to provide personal data on a form like this – including equal opps data."*  
(Respondent 131)

## Issues for implementation

The consultation responses indicate there is a high level of anxiety amongst osteopaths to get revalidation right and an understandable fear of failure. This would appear to indicate the need for clear guidance to osteopaths about what is required for revalidation the importance of active support for implementation including GOsC and others developing templates for policies and procedures and giving advice on audits etc:

*“Will the GOsC be looking for a percentage of failures?” (Stansted, Question 7)*

*“A respondent’s self-assessment form may be misinterpreted. Clever individuals who are good at “working the system” and form filling and communicating what they do on a paper will have no problem where as someone who is a competent and safe practitioner may fail to successfully communicate this on paper.” (Respondent 314)*

*“It would be extremely helpful if the GOsC could provide a written example so that osteopaths can see exactly what is required. Also, workshops would be beneficial to give osteopaths the opportunity to discuss any queries or difficulties which they may have.” (Respondent 248)*

*“Much guidance is needed on eg patient information leaflets, audits, written practice procedures, external feedback to discover what is acceptable to re-validation.” (Respondent 310)*

*“Increase guidance material eg. downloads available for complaints procedures, health and safety, data protection so we can be sure to meet the legal requirements as well as those relating to revalidation. This would mitigate the increased paperwork burden.” (Respondent 189)*

The consultation responses indicate that some up-skilling of the profession in particular areas such as clinical audit may be required in order that they can meet the requirements.

*“It seems unfair to require us to do things that we have no idea how to do – such as practice audits & and giving info regarding roles of treatment, since no statistics are available.” (Respondent 320)*

*“Hi. Would you, or the BOA for that matter, consider running regional clinical audit workshops prior to the first pilot in 2010, because if you*

*hold our hands before the scheme, maybe you won't need to hold our hands afterwards.”(Manchester, question 19)*

There are also some very practical suggestions regarding the availability and presentation of materials:

*“All information that is relevant to the practice of Osteopathy and is part of the revalidation/registration process for Osteopaths should be collated and made easily available on the GOsC website, rather than each osteopath having to track down the same bits of information...”*  
(Respondent 172)

*“The two colour split green/blue was difficult for me to differentiate as a colour blind individual – suggest you use boxes/other differentiation model.”*(Respondent 89)

At the consultation meetings in particular the importance of carefully communicating to the public the purpose of revalidation was emphasised as was ensuring other health professionals were aware that osteopaths were subject to revalidation processes too:

*“...the public might when they see revalidation and they think of Shipman, they think of weeding out bad apples. I just want you to clarify that it's mainly about nurturing and encouraging the good apples and there may be one or two bad ones that needed to be weeded out. But I think the public need to be reassured that that's the main purpose of revalidation....”*(Taunton, Question 3)

*“I'd be interested to know to what degree the medical profession is in the know about osteopaths going through the revalidation process and whether one would expect for that, if it is known about, to filter down to ones GPs?”*(Taunton, Question 4)

## Discussion

The response rate was significantly lower than for previous consultations undertaken by the GOsC. This may be because over 1000 osteopaths attended the regional events and used this as a way of expressing their views, the profession has accepted that revalidation is a necessity and have relatively few concerns about the process as proposed or it may have been the result of 'consultation fatigue' as there were three major consultations taking place during this period.

Concern about the potential for confusion was also expressed about running several consultations simultaneously:

*“The decision to have the revalidation proposals and osteopathic practice framework at the same time has led to confusion both within the GOsC documents and osteopaths themselves. Clarification could be improved by first running the revalidation consultation and when this was completed moving on to the osteopathic practice framework”.*  
(Respondent 290)

The weighting of responses is always a challenge in consultations. However only one organisation response was received and as recommended by the Government’s 2008 Code of Practice on Consultation, the response form asked the respondent to identify whether they are making the response as an individual, or on behalf of an organisation or group, and if on behalf of a group to explain the process used to generate the response thus allowing a judgment to be made about representativeness.

In consultations of this type the options available to the regulator are by necessity affected by statutory requirements and resources as well as respondents’ views.

## Conclusions

The purpose of the consultation was to enable GOsC to elicit and understand the views of stakeholders on its proposals for the revalidation of osteopaths. 360 written responses were received and over 1000 practitioners attended regional meetings where there was an opportunity to discuss the proposals. Overall, the proposals were well received and most of the proposals received widespread support.

The main issues raised which are likely to have an impact on implementation are that:

- there may be an in-built bias in the types of evidence required such as complaints policies and audits etc against those who are associates rather than principals, those who are sole practitioners, and locums;
- there may be challenges for those involved in full-time education and/or research in sufficiently demonstrating their clinical skills;
- there may be challenges for those not in clinical practice for example those on maternity leave or sick leave etc;
- those who work very part time e.g. fewer than 8 hours a week may find it difficult to generate the evidence required;

- the proposals are likely to have a greater impact on the earnings of those who work part time;
- the self assessment form needs to be succinct and focused and supported with very clear guidance as to expectations regarding content and length of responses;
- further consideration is required regarding what constitutes a special interest, whether having a special interest poses more or different types of risks with respect to revalidation, whether osteopaths with a special interest should always apportion part of their CPD to that interest and what the balance between specialist and generalist practice should be i.e. if a minimum number of hours should be spent in general osteopathic practice.
- where possible the structure of CPD forms and revalidation forms should be similar so that the systems enhance and support each other;
- further work needs to be undertaken to ensure that the requirements meet the needs of those with a disability;
- all materials need to be produced in disability friendly formats and consideration should be given to enabling responses to be produced in alternative formats e.g. audio-taped;
- consideration needs to be given as to how the model generally and particularly initial self assessment might be improved;
- more thought may need to be given to the feasibility of evidence collection for osteopaths and the impact on costs for patients.
- the assessment criteria should be published;
- careful selection of assessors will be important and assessors are likely to require reimbursement for undertaking this role;
- GOsC investment in making available particular types of CPD programmes related to clinical audit, first aid and clinical updates etc across the UK may reduce anxiety in the profession and smooth implementation;
- further thought needs to be given generally about how to ensure the process will aid the development of osteopaths and particularly about the availability of appropriate support for remediation;
- safeguards will need to be put in place to guard against plagiarism etc; and

- discussions should take place with the other regulators regarding the potential for mutual recognition of CPD and processes in place to meet the needs of those with dual registration for revalidation whilst ensuring the protection of the public;
- clarity is required about the costs and benefits of the process (with reference to the potential additional costs for patients);
- further thought needs to be given to the Quality Assurance of the revalidation process in its entirety as well as the quality of CPD courses and assessors.

# Appendix 1: Revalidation for Osteopaths Consultation Questions

## Your details

1. Are you responding as an individual? Or on behalf of an organisation?
2. (a) If you are responding as an individual, which of the following categories best describes you?
  - Osteopath
  - Patient
  - Member of the public
  - Other Health Professional (*please state profession/discipline*)
  - Other
2. (b) The GOsC is committed to equality and diversity. In order to reduce the possibility of discrimination occurring as a consequence of revalidation we would like to collect the following personal information from all respondents. The information you provide will be treated in the strictest confidence and will be used only for statistical monitoring by Abi Masterson Consulting Ltd.
3. If you are responding as a representative of an organisation, please
  - supply your full name and job title
  - confirm that your response represents your organisation's views;
  - explain how the views of your organisations members/staff/students were ascertained
  - Indicate which of the following categories best describes your organisation?
    - Osteopathic Education provider
    - Osteopathic Professional association
    - Other Professional association
    - Statutory regulatory body
    - Public/patient representative body
    - Other (*please give details*)

## The purpose of revalidation

4. Is the overall purpose of the revalidation proposals clear?
5. Do the proposals seem fair?

6. Are any of the proposals likely to unfairly discriminate directly or indirectly against individuals because of their gender, race, age, disability, religion, belief or sexual orientation?

7. Are any of the proposals likely to unfairly discriminate directly or indirectly against individuals because of their area of practice e.g. educator, researcher etc?

8. Are any of the proposals likely to unfairly discriminate directly or indirectly against individuals because they are on more than one professional register e.g. GOsC and General Medical Council, Health Professions Council, Nursing and Midwifery Council?

9. Are any of the proposals likely to unfairly discriminate directly or indirectly against individuals because they work part time?

10. Can you foresee any unintended consequences arising from implementation of these proposals?

## The Guidance Notes

11. The proposed revalidation process has four stages. Each osteopath will be required to submit a self-assessment every 5 years. Does the four stage model as outlined appear to offer a feasible process for the revalidation of osteopaths which is likely to meet the needs of both the profession and the public?

12. Are the guidance notes  
clear?  
sufficiently comprehensive?

13. From the guidance notes, is it clear what osteopaths will need to do?

## The self assessment form

14. The self assessment form is designed to assess whether an osteopath continues to be fit to practise. It contains sections on how the practitioner practises osteopathy, patient partnership, clinical practice, professionalism and continuing professional development. Is it

Clear?  
Comprehensive?  
Relevant?  
Appropriate?

15. Are the suggested examples of supporting evidence  
Relevant?  
Appropriate?

Sufficient?  
Feasible to collect?

## **Continuing Professional Development**

**16. The intention is that the GOsC's CPD scheme should integrate with and support the revalidation process. Should the GOsC therefore amend any particular elements of CPD to support revalidation?**

## **Additional comments**

**17. Please make any other comments you feel will help refine and improve the proposed revalidation process.**

**18. Please tell us if you have any comments on the consultation process.**