To: Council
From: Steven Bettles and Lorraine Palmer
Date: 17 July 2019
Paper: C19/027

Review of Registration Assessments and consultation

Classification	Public
Purpose	For decision
Issue	To report on the outcome of the consultation in relation to the review of registration assessment processes to reflect the updated Osteopathic Practice Standards and modify the process.
Recommendations	1. To note the outcome of the consultation. 2. To agree the updated registration assessment process and documentation for implementation from 1 September 2019.
Financial and resourcing implications	This is managed within existing budgets for registration assessment and assessor training. Consultation planned for 2019 was managed in-house.
Equality and diversity implications	In terms of the process and documentation consulted upon, this was felt to be broadly clear and easy to understand. the provision of further support and/or resources for applicants as identified in the paper, may contribute to enhancing clarity and accessibility further for applicants, and reducing barriers.
Communications implications	The updated documentation will be available on our website and will be communicated to stakeholders through our usual channels.
Annexes	A. Updated Further Evidence of Practice form B. Updated Further Evidence of Practice Guidance for Applicants and Assessors C. Updated ACP evaluation form D. Updated Guidance for ACP Assessors and Applicants

E. Comparison tables of current Osteopathic Practice Standards assessed in the Current FEP and ACP processes, with the updated OPS assessed in the updated FEP and ACP processes.

Background

1. As was reported to Council at its meeting of 6 February 2019, applicants to the register with a UK qualification have had their qualification quality assured by the General Osteopathic Council to ensure that only students meeting the Osteopathic Practice Standards are awarded a 'recognised qualification'. We do not, however, go through a process of assuring the quality of international qualifications. We therefore assess whether internationally qualified applicants meet our requirements in a different way.

2. For internationally qualified applicants, the assessment process typically involves:

   a. Assessment of qualification

   b. Completion of further evidence of practice questionnaire (FEPQ)

   c. Completion of an Assessment of Clinical Performance (ACP).

3. As was reported in February, and is still the case now, a more streamlined process is in place for those with EU rights. This position may change if and when the UK leaves the EU. Current guidance for both applicants and assessors is published on the GOsC website[1].

4. The updating of the Osteopathic Practice Standards (OPS) and their implementation from 1 September 2019 means that the FEPQ and ACP documentation required updating, as these are grounded in demonstrating adherence to the OPS on the applicant's part.

5. Rather than just retain the documentation as it is, but with revised OPS references, we took the opportunity to conduct a broader review, based on feedback received from registration assessors, applicants, and from the executive's own reflections on the process. Initial feedback on updated documentation was sought from Registration Assessors in at training sessions in October 2018.

6. These early draft documents formed the basis of discussions with registration assessors at two training sessions in October 2018, to seek feedback to help us develop the drafts further, and to consider how best the assessments could be structured to provide assurance that applicants meet the standards but also to consider how they might embody those standards in practice.

7. At its meeting of 6 February 2019, Council raised a query regarding the reference to 'osteopathic techniques' within the draft ACP assessment form. It was asked whether the term 'osteopathic techniques' was well understood. it was explained that there were techniques typically devised and used by

[1] https://www.osteopathy.org.uk/news-and-resources/document-library/registration/further-evidence-of-practice-questionnaire-guidelines-for/

osteopaths which come under the nomenclature but could be used by any manual therapists: the term itself had no legal protection. Within the context of osteopathic education and assessment it was understood what the term denotes. That said, in the final consultation version of the ACP evaluation form, the relevant criteria within the 'working diagnosis, management/treatment plan' section of was amended to: *'Be able to adapt techniques and approaches in response to the patient's needs/clinical findings. (C1)'*, rather than referring to *'osteopathic techniques and approaches'.*

8. Council went on to agree the proposed documentation, consultation strategy, and the timetable set out below,

October 2018	Registration assessor training days to include workshop discussions on the draft documentation
October 2018	Consideration by the Policy Advisory Committee
October to December 2018	Rework drafts in light of feedback received and to develop policy options in relation to 'gaps'.
January 2019	Report to Council with updated documentation to agree for consultation
Early 2019	Further engagement with registration assessors and other stakeholders.
February to May 2019	Formal consultation and opportunity for assessors and others to provide further formal feedback.
July 2019	Final documents reported to Council
September 2019	All FEP and ACP assessments will be against updated OPS using revised documentation.

9. This paper provides a recap of the changes within the documentation, reports on the outcomes of the consultation on the Registration Assessment process and documentation, and presents final updated documentation for approval by Council.

Discussion

10. As was reported to Council at its February 2019 meeting, Initial feedback on the existing FEP and ACP process was given by applicants and registration assessors through assessment feedback, from registration assessors through their appraisal process, and also through webinars held in Spring/Summer 2018. This included:

    a. A general agreement that the overarching process, including both written and practical assessment, was fit for purpose.

b. Highlighting areas of concern around areas such as clinical reasoning, communication and consent.

c. The complexity of the documentation, and its accessibility, both for applicants and for assessors.

d. Clarity as to which OPS it is reasonable to assess in the FEP and ACP processes, respectively.

11. This feedback was borne in mind when developing initial drafts for consideration. Further feedback from the assessors and from the Policy Advisory Committee enabled us to develop the documents for consultation.

12. The issues raised in the consultation document, and upon which specific feedback was sought in the consultation are:

    a. Retaining the requirement for applicants to provide a patient profile as evidence of their practice for the FEP.

    b. Requiring FEP applicants to provide details of their professional development activities, including a reflection on how two cases from their patient profile have contributed to this.

    c. Changes to the number and types of case scenarios which the applicant is required to submit.

    d. Retention of the requirement that the applicant provides a summary of the osteopathic approaches with which they are familiar, and links this to their patient profile.

    e. Summary report from FEP to ACP assessors

    f. The inclusion of more specific criteria in the ACP assessment form.

    g. Options in relation to the gaps in terms of assessment of the OPS.

    h. Feedback on the general clarity and accessibility of all documentation, including the FEP and ACP assessments and their respective guidance documents.

Consultation process

13. There was an initial delay in commencing the consultation in February as originally planned, and it was launched instead on 11 April 2019, running until 6 June 2019. This was available on the GOsC website. We informed all of the Registration Assessors that the consultation had been launched, and invited them to attend lunchtime webinars on either 13 or 16 May. Other stakeholders were also informed.

14. The consultation was also publicised via:

- GOsC website home page
- GOsC Social media channels: Twitter, Linkedin and Facebook
- Monthly GOsC eBulletin
- The Osteopath Magazine

15. We outlined the consultation process to the Osteopathic Educational Institutions leads at our meeting with them on 29 April 2019, and asked that they raise awareness of this with their respective faculties.

16. We held webinars for Registration Assessors to provide feedback on the consultation process on 13 and 16 May 2019. Only one assessor was able to attend each of these, but both provided helpful feedback which will be reported later in this paper.

17. We held a focus group on 22 May 2019, at which participants comprised:

    - Two Registration Assessors

    - Two registrants who had been through the application process.

    - Two patient representatives

    - A representative of the Council for Osteopathic Educational Institutions.

18. The focus group was very helpful, and provided an opportunity to gain feedback both on the process and the documentation from a range of perspectives. Again, the outcomes of this will be considered further in this paper in relation to the specific areas raised within the consultation.

19. We received three written responses to the consultation - one of these was from a Registration Assessor who had also provided feedback within a webinar and the focus group. There was therefore some duplication within the responses. We also received a very helpful written response from the Professional Standards Authority, and a response online via the website.

20. This was not a consultation where we expected to receive many written responses, however, and we always considered that the richest feedback would come via direct contact, both with Registration Assessors, and in the focus group and it was for this reason that a number of engagement events were planned as part of the consultation method

21. In the following sections, we will consider the feedback received in relation to the issues raised in paragraph 11 above:

Retaining the requirement for applicants to provide a patient profile as evidence of their practice for the FEP.

22. In the current FEP application section 1 requires applicants to provide a profile of their patients seen for a three-month period within their last year of practice. A

table is provided for them to complete, and they are required to provide anonymised case notes as evidence of this. They are further asked to consider and briefly discuss how these patients have helped them to maintain their clinical and professional skills, and to indicate areas of practice which they might wish to strengthen. Also, to indicate any areas of special interest or clinical focus.

23. In section 1 of the updated FEP document, the request for an overview of their case load for a three-month period within their last year or practice has been maintained, together with details of any areas of special interest. The rationale for retaining this is that the applicant is given the opportunity to demonstrate the breadth of their osteopathic practice to help contextualise their application for registration. It also helps to assess their ability to gather and present data about their practice (OPS B4). We have, however, removed the requirement in this section for the applicant to reflect on the professional development opportunities afforded by their patient profile. This element is picked up in section 2.

24. Feedback on this from the Registration Assessors who responded was positive. Both supported this as appropriate to retain as modified. Within the focus group, the registrants indicated that they had found this helpful in terms of helping them to reflect on their practice and to think about future CPD. It was generally considered that requiring applicants to provide a patient profile as set out in the FEP form, really gave them the opportunity to provide a flavour of their practice as an osteopath, and helped to put this in context for the assessors. The online response also supported this element of the FEP.

Requiring FEP applicants to provide details of their professional development activities, including a reflection on how two cases from their patient profile have contributed to this.

25. In section 2 of the current FEP, applicants are asked to discuss how they feel that they have kept their professional knowledge and skills up to date and what initiatives they have taken to enhance and monitor the quality of care they provide.

26. In the updated section 2, applicants are still asked to discuss how they have kept their knowledge and skills up to date (over the last two years this time) and what initiatives have they taken to enhance the quality of osteopathic care they provide. They are further asked, however, to pick two cases from the profile provided in response to section 1 and expand on how these particular cases have helped to enhance their professional and clinical skills. The rationale here is to focus this section on professional development, and to allow the applicant the opportunity to refer to two specific cases in this respect, rather than their full patient profile.

27. This change was supported by the Registration Assessors and by other participants in the focus group. Prompting applicants to consider their professional, as opposed to technical development was felt to be helpful. The

online response also supported this, citing that it will evidence professional development directly related to practice.

Changes to the number and types of case scenarios which the applicant is required to submit.

28. In the current FEP, applicants are asked to provide specific case studies in several areas:
    - Neuromusculoskeletal presentation
    - Visceral (non-musculoskeletal) presentation
    - Referral of a patient to another healthcare professional
    - Presentation where patient was considered unsuitable for osteopathic treatment
    - Two cases to demonstrate their osteopathic management of a patient

29. In section 3 of the updated FEP, we ask applicants to provide four case scenarios:

    - A neuromusculoskeletal presentation
    - A musculoskeletal presentation with or without nerve involvement
    - A case where they concluded that the primary issue was non-musculoskeletal, but mimics a musculoskeletal presentation

    And then a choice of:

    - A case where they referred the patient to another healthcare practitioner
    - A case where they felt osteopathic techniques or approaches were contraindicated from the outset or had been indicated but become no longer appropriate.

30. In each case, applicants are asked how they involved the patient in making an informed decision about their management and treatment, and which of the Osteopathic Practice Standards they have demonstrated. Over the four cases, they need to demonstrate compliance with at least standards A1, A2, A3, A4, B1, B2, C1, C2, D10.

31. The rationale, here, is to simplify the process to an extent, for both the applicant with fewer case examples required, and for assessors in terms of assessing adherence to standards. There is a greater focus for applicants, however, in judging for themselves which standards they have met in each case, which assessors can then review. In requesting details of how patients have been involved in the decision process, we have aimed to make the process more patient-centred and emphasise this aspect of the Osteopathic Practice Standards.

32. Feedback received on these changes was, again, very supportive from the Assessors who gave feedback, and from other participants within the focus group. The number and type of case scenarios requested was felt to be

appropriate. The online response was similarly supportive, stating that requiring applicants to explore the case scenarios in greater depth should allow a better evidence of incorporation of key elements of the OPS, though the point was made that clear guidance is essential to ensure applicants understand what it required of them.

Retention of the requirement that the applicant provides a summary of the osteopathic approaches with which their familiar, and links this to their patient profile.

33. In the current FEP application, applicants are required to complete a table outlining their familiarity with and use of a range of osteopathic techniques and approaches. Further they have to provide examples of contraindications for techniques that they do use, and indications as to when they might be used, mapped to the case scenarios which they have already provided.

34. This is reflected in section 4 of the updated FEP, where a slightly modified table is retained, and applicants are asked to complete this to outline their familiarity and use of particular osteopathic approaches, and to map ones they utilise to examples within their patient profile.

35. Some of the assessors questioned the usefulness of this section, pointing out that it is not really possible to assess application of techniques in a written application such as this, and query how can it be determined whether applicants genuinely are familiar with particular techniques and approaches? Others feel it is useful, however, as it does provide the applicant with a further opportunity to provide some context as to their osteopathic practice in relation to Osteopathic Practice Standards B1 and C1, which is evidenced by a linking to their patient profile. We have removed reference to an 'appropriate' range of techniques, as there is no consistency as to what this is. Osteopathy features many approaches, and osteopaths may engage with some or all of these, according to their clinical interests and experience.

36. Again, the retaining of this section as modified was supported. One Registration Assessor indicated that it gives applicants the chance to demonstrate their practice in more detail. Another said that asking applicants to outline their familiarity with particular approaches and techniques 'provides a good starting point for evaluation, provides insights into how the applicant is thinking and gives a context for their treatment perspectives'. It was acknowledged that techniques cannot, of course, be assessed on paper, but that wasn't the point of this section. Requiring applicants to link where they've used a technique or approach to an example from their patient profile, also enables this to be triangulated. The online response also supported this element of the FEP.

Summary report from FEP to ACP assessors

37. In the current FEP process, if an applicant is deemed able to progress to the Assessment of Clinical Practice element of their application for registration, a

summary of the FEP assessors' findings is provided to the ACP assessors. This enables them to highlight any areas where they feel particular attention should be made in terms of the applicant's clinical performance.

38. In reviewing the FEP process, it was considered whether it was appropriate for a report of FEP outcomes to be provided to ACP assessors. Some assessors felt that the two elements of the process should be separate, and that if an applicant passed the FEP process, they should be seen by ACP assessors without any pre-conceptions. Some ACP assessors wanted to be able to assess the applicant without any leading information from the FEP process.

39. Others felt that it was useful to be able to provide a summary, whether this was to give assurance to FEP assessors that they could raise any particular areas of concern, or to ACP assessors that they had a more rounded understanding of the applicant being assessed. We left the reporting requirement within the consultation draft FEP process as acknowledgement of the fact that both elements – the FEP and ACP – collectively generate the evidence needed to determine an applicant's adherence to the Osteopathic Practice Standards, and, on reflection, these are complementary rather than completely distinct.

40. This was strongly supported by the Registration Assessors who responded. The report was felt by them to be highly useful, and enabled FEP assessors to highlight any areas where they felt that the applicant might need to be questioned further to explore their knowledge or skills in a particular area. It was acknowledged that the ACP is determined, to an extent, by the patients who attend on the day, but even so, it was felt that it's helpful to have this information in order to inform a particular line of questioning. This was further supported within the focus group discussion. It was mentioned there that EU and international applicants may not always express themselves so well within the clinical writing required in the FEP, and that their application may not fully 'make sense' until it is combined with the full patient evaluation and treatment seen in the ACP. The ACP was perceived as being the final part of the assessment process, and that seeing applicants practise is fundamental. For this reason, any particular perceived or potential weakness should be reported to the ACP assessors so that the issue might be revisited, adding more evidence to the final decision. The online response also supported the provision of a report *'as any areas which appear slightly weaker or require further consideration or exploration should be made available to ACP assessors'*.

The inclusion of more specific criteria in the ACP assessment form.

41. The current assessment of clinical practice comprises an evaluation of the applicant with two actual patients. There are two examiners – one for each case, and a moderator. As with any clinical evaluation with a real patient, it is hard to predict how a patient will present, and whether or not they will be appropriate for osteopathic intervention. This can lead to a variable experience for those being assessed, with some patients presenting with fairly straightforward issues,

and others being much more complex. That said, the assessment of applicants in this way (which is carried out in the teaching clinic of an osteopathic educational institution) has high validity, as applicants are assessed with real patients in unpredictable scenarios, replicating real practice. Such assessments are typical within pre-registration osteopathic education, and it is not proposed to change the format of this assessment.

42. The current Assessment of Clinical Performance Evaluation Form divides the assessment into:

- Case Summary – looking at the taking and recording of a case history and communication in general.
- Differential diagnosis, clinical reasoning, knowledge base, biomedical science and osteopathic principles
- Clinical Examination/Osteopathic evaluation
- Formation of diagnostic conclusions/treatment and management plan

43. The updated Assessment of Clinical Performance evaluation form is set out as annex C to this document. This maintains the broad structure of the current evaluation form, with sections on:
    - Case summary
    - Differential diagnosis
    - Clinical examination/evaluation
    - Working diagnosis - management/treatment plan

44. The form is more structured, however, with criteria setting out what 'the applicant should' demonstrate in each case, which reflect the expectations of the relevant Osteopathic Practice Standards and aims to be more patient-centred. Some assessors indicated that they found some of the 'aide memoire' checklists from the current evaluation form helpful, and these have been incorporated into the updated evaluation form.

45. The Registration Assessors who gave feedback confirmed that they were happy with the format and contents of the updated ACP evaluation form. At the focus group, we explained the ACP process to ensure that all stakeholders understood they way the assessment is structured. Overall, this was felt by the group to be an appropriate way to assess applicants, and met the expectations of the patients attending the group in this regard.

46. The respondent in the online form queried whether the format of the revised evaluation form suited the collection of evidence unless this was recorded electronically allowing for the expansion of boxes. It could be argued, though, that this would apply to any evaluation form filled in on paper rather than electronically, including the current evaluation form. We would always evaluate

the forms in use, and seek feedback from assessors as to how these might best be completed.

ACP Guidance document for assessors and applicants

47. The focus group felt that the Guidance document for ACP Assessors and Applicants was clear and accessible. Both registrants, however, indicated that when they undertook their own ACPs, they were still unsure of what to expect from the assessment process. There was some discussion as to further means by which applicants might be supported in preparing for the ACP, including the provision of a short video or online tutorial, and the possibility of spending some time observing in the University College of Osteopathy clinic (where the assessments are currently carried out) to help them understand the process and expectations of patient management.

48. The respondent in the online form raised some points regarding the clarification of clinical responsibility within the ACP guidance, and the role of the moderator. In the consultation version of the guidance, we stated that the examining team including the moderator hold clinical responsibility, and the respondent felt that this should be limited to the examiner overseeing the assessment of each patient in the process. This is an area that has been the subject of much discussion with assessors in recent years, and it is our position and set out in the guidance that clinical responsibility is with the whole team. We have modified paragraph 12 of the guidance, however, to reference the 'exercise' of clinical responsibility, as follows:

   One member of the assessment team must be present to observe the applicant with the patients at all times in order to exercise clinical responsibility, and that responsibility must be clear to all parties.

49. This issue will be further explored in future Registration Assessor training events.

50. The consultation version of the guidance also stated in paragraph 19 that examiners would have one major opportunity to question applicants after the case history and clinical examination had taken place. The online respondent felt that this was, in fact, two opportunities, and we have amended paragraph 19 as follows:

   Assessors will have normally have two major opportunities to question the applicant during the clinical encounter with the patient, after the case history and after the clinical examination have been performed. However, if necessary, the assessors can reserve the right to modify this with the agreement of all parties.

Options in relation to the gaps in terms of assessment of the OPS.

51. The purpose of the Further Evidence of Practice and Assessment of Clinical Performance processes, is to assess whether the applicant has the knowledge and skills required to practice in accordance with the Osteopathic Practice Standards. In the current version of the practice standards, implemented from September 2012, there are thirty-seven standards. In the updated practice standards, to be implemented from 1 September 2019, there are twenty-nine. This has been achieved by reducing areas or repetition, combining some standards, and in some cases, moving a standard to 'guidance' within the document where this was felt to be appropriate.

52. In both the current Further Evidence of Practice and Assessment of Clinical Performance processes, and the proposed updates to these set out within this document, not all of the Osteopathic Practice Standards are assessed. Annex E compares the standards assessed in the current FEP process and ACP processes (tables 1 and 2 respectively) (in the left column), and those assessed within the proposed updated FEP and ACP processes (in the right column).

53. The only standard which is referenced in the current ACP assessment but not in the updated version is the current D12 – Take all necessary steps to control the spread of communicable diseases. In the updated OPS, this features within the guidance to updated C5 which states: '*You must ensure that your practice is safe, clean and hygienic and complies with health and safety legislation*'. In practice, this is hard to assess when the assessment is undertaken in a teaching clinic of an educational institution, as is the case here.

54. The standards which, in the current proposals, will continue to remain unassessed within the FEP and ACP processes are shown in the table below:

Gaps in assessment of OPS
A7 - You must make sure your beliefs and values do not prejudice your patients' care.
C5 - You must ensure that your practice is safe, clean and hygienic, and complies with health and safety legislation.
C6 - You must be aware of your wider role as a healthcare professional to contribute to enhancing the health and wellbeing of your patients.
D1 - You must act with honesty and integrity in your professional practice.
D3 - You must be open and honest with patients, fulfilling your duty of candour.
D4 - You must have a policy in place to manage patient complaints, and respond quickly and appropriately to any that arise.

D5 - You must respect your patients' rights to privacy and confidentiality, and maintain and protect patient information effectively.
D6 - You must treat patients fairly and recognise diversity and individual values. You must comply with equality and anti-discrimination law.
D7 - You must uphold the reputation of the profession at all times through your conduct, in and out of the workplace.
D8 - You must be honest and trustworthy in your professional and personal financial dealings.
D9 - You must support colleagues and cooperate with them to enhance patient care.
D11 - You must ensure that any problems with your own health do not affect your patients. You must not rely on your own assessment of the risk to patients.
D12 - You must inform the GOsC as soon as is practicable of any significant information regarding your conduct and competence, cooperate with any requests for information or investigation, and comply with all regulatory requirements.

55. Options for potentially managing these gaps in OPS assessment were discussed within the consultation. These included:
    - Option 1 - Acknowledge that it is not possible to expect assessors to form a judgement on each of the Osteopathic Practice Standards, though this does not mean that a clear breach of these would be ignored in the assessment process.
    - Option 2 - Require applicants to provide additional evidence, for example, an additional essay style explanation that which could cover such issues as:
        - How they would handle complaints
        - How they would deal with an issue where candour with a patient was needed regarding the outcomes of a particular treatment
        - Their approach to supporting colleagues
        - How they establish appropriate boundaries with patients.
    - Option 3 - Expand the FEP process to provide scenarios for the applicant to consider, which explore their thinking around some of the unassessed standards, for example, a case around candour or boundaries with patients.
    - Option 4 - In relation to practical assessment, ensure greater consistency of experience by using model patients, or structured clinical assessments, where each applicant performs a range of activities (evaluation and examination of patients and application of a range of techniques to achieve a given outcome – for example - 'demonstrate how you would test for mobility of the lumbar spine, and show two techniques for increasing range of movement in this area'.
    - Option 5 - Applicants to be asked to sign a declaration linked to the FEP to confirm that they had read the Osteopathic Practice Standards and had considered these in the context of their own practice. Resources could be

signposted to support the implementation of standards (for example, guidance pages on the GOsC website, the dedicated CPD and OPS microsites, and the Institute of Osteopathy resources). This was our suggested proposal, but we were keen to see what others felt about this.

56. There are, therefore, additional options that might be considered to broaden the scope of assessment of an applicant's ability to practise in accordance with the Osteopathic Practice Standards. Some are more achievable than others in the shorter term, but options 1-4 would add a further burden on the applicant and require additional assessment and costs.

57. Both Registration Assessors who responded, and the focus group together all felt that requiring applicants to self-certify that they had read the OPS and considered them in the context of their own practice, was an appropriate and proportionate way forward, which did not add further complexity, expense or barriers to the process, and supported this proposal.

58. In their feedback, the Professional Standards Authority raised some concerns about the unassessed standards:

'However, we are concerned about some of the OPS which the GOsC has identified remain outside of the assessment process, in particular the following standards: A7, D3, D5, D6' (these are set out in the table above).

They go on to acknowledge the challenge in assessing some of these standards: *'However, some of the above standards may have relevance for internationally qualified applicants: the professional duty of candour is specific to health professional practice in the UK; the others may be interpreted differently within the cultural norms of the country of qualification.'*

59. In relation to the options outlined above, and the point that some of these may lead to increased costs for the applicant, they do not consider that decisions on these should be based on costs, but on the consideration of the patient safety risks to be managed. They suggest that if we do proceed on the basis of self-certification of these, then we should consider alternative mechanisms to mitigate any risks arising. They cite the monitoring of a registrant's continuing fitness to practice, for example (which we would do via the new enhanced CPD scheme in any event), or through additional training or information for internationally qualified applicants, to improve their understanding of the context and specific requirements for health professionals in the UK. This is discussed further below.

60. The respondent in the online form queried whether the format of the ACP, with two new patients, was sufficient as a test of clinical abilities. This was due to the fact that it may limit the exploration of clinical testing, for example, depending on the presentation of the patients involved. The suggestion was to add another

thirty minute viva to explore these areas. The Registration Assessors who took part in the webinars and in the focus group, however, felt that there was opportunity within the current system to explore other potential areas of knowledge and skill, even if this strayed a little from the presentation of the patient concerned. For example, questions around neurological testing might be included, even when neurological testing was not necessarily indicated, in order to explore the applicant's knowledge further.

61. At this stage, it is proposed that we proceed as suggested on the basis of self-certification rather than increasing the assessment process, subject to the development of further resources and support as outlined in paragraph 65 below which provide a way of ensuring patient safety in a proportionate way. The Professional Standards Authority is quite right in saying that cost should not be a factor here, and it is patient and public safety that features in our statutory objectives.

Feedback on the general clarity and accessibility of all documentation, including the FEP and ACP assessments and their respective guidance documents.

62. In general, the documentation was felt to be clear and accessible, and no specific issues were raised regarding the wording or presentation of these. One Registration Assessor did raise a query as to whether template examples might also be provided to applicants to indicate 'what good looked like', in terms of an FEP application, and perhaps, also, 'what good didn't look like'. The suggestion was that Assessors might be asked to prepare/peer review such examples to help guide applicants. At the focus group, and within the webinar, we discussed the potential risks of this, namely that applicants might just replicate the good example. The case was made, though, that this is an approach used regularly within education where examples of 'good' assignments might be provided, without this ever leading to plagiarism. The group agreed that this would be a useful resource to develop, and a Registration Assessor has been commissioned to develop this.

63. On the subject of plagiarism, one of the focus group participants asked whether applications were ever put through plagiarism detection software such as Turnitin. It was confirmed that this wasn't the case, but that the numbers are relatively low, and are processed by one member of staff who is likely to pick up similarities between applications.

64. The Professional Standards Authority commented overall that:

'Broadly the process appears clear and the guidance for assessors and relevant forms are clearly laid out and easy to understand.'

65. The online response queried whether it was clear enough where applicants provide copies of their anonymised case notes, though in practice, this has never been an issue, and case notes are provided adequately as directed with applications. The GOsC registration team also liaise with applicants personally

where necessary to ensure that they understand the process, and will point out if documents are not provided as required.

Next steps in developing further resources and support for applicants

66. The provision of additional support and resources for applicants, as has been mentioned above, was raised within the focus group feedback, and by the Professional Standards Authority. Since the consultation, we have already taken steps to develop and enhance the support offered to applicants. This includes:

    - Confirmation from University College of Osteopathy that applicants might observe 1-2 sessions in their teaching clinic to help familiarise them with the nature of UK practice and expectations and with the clinic itself (where the ACPs are undertaken).
    - Preparation of a webinar session to offer all applicants from September 2019, aimed at providing an overview of the application process, an introduction to the OPS and how these are assessed, and an overview of the key standards not explicitly assessed during the FEP/ACP process.
    - Commissioning of a Registration Assessor, as outlined in paragraph 61 above, to develop a template of an FEP application to demonstrate 'what good looks like', to be used as a supporting resource for applicants.

67. Further consideration will be given to the development of a short introductory video aimed at applicants and potential applicants, to explain the process in simple and straightforward term. This would be along the lines of the video we developed to explain the new CPD scheme[2].

68. Finally, we will give some further consideration as to whether there is any further need for incorporating the suggestions of the Professional Standards Authority as part of the development and implementation of the CPD verification and audit process for the CPD scheme. We are conscious that there is no evidence that international graduates pose more of a risk in these areas than UK graduates drawing on data from our fitness to practise processes, but it is important that this feedback is considered as part of that development process alongside other factors which may influence this process.

Final summary

69. The consultation, as was expected, did not receive a large number of responses, but those that we did receive within the mechanisms outlined in this paper were helpful. They were from a diverse perspective which provided assurance that the process and associated documentation largely met the expectations of various stakeholders.

70. The feedback regarding the provision of supportive resources, opportunities to observe in a teaching clinic, and the potential for direct engagement to help

[2] https://cpd.osteopathy.org.uk/about-the-cpd-scheme/overview-of-cpd-scheme/

contextualise the nature of UK osteopathic practice and regulatory requirements, was helpful and positive. These aspects will be further explored and developed.

71. In the meantime, feedback on the FEP and ACP updated process and documentation was positive, and Council is asked to approve this ready for implementation from 1 September 2019.

Recommendations:

1. To note the outcome of the consultation.
2. To agree the updated registration assessment process and documentation for implementation from 1 September 2019.