General Osteopathic Council

Policy Advisory Committee

Minutes of the 9th meeting of the Policy Advisory Committee – Public (and also the 89th statutory Education Committee) held on Thursday 18 October 2018, at the Society and College of Radiographers, 207 Providence Square, Mill Street, London, SE1 2EW

Unconfirmed

Chair:	Dr Bill Gunnyeon
Present:	Dr Marvelle Brown John Chaffey Bob Davies Elizabeth Elander Professor Raymond Playford (from Item 5) Alison White Nick Woodhead
Observers with speaking rights:	Professor Dawn Carnes, Director, National Council for Osteopathic Research (NCOR) Maurice Cheng, Chief Executive, the Institute of Osteopathy (iO) Amberin Fur, Osteopathic Alliance (OA) Fiona Hamilton, Council for Osteopathic Education Institutions (COEI)
In attendance:	Steven Bettles, Professional Standards, Policy Manager Christine Bevan, the Quality Assurance Agency (QAA) (from Item 4) Fiona Browne, Director of Education, Standards and Development Hannah Doherty, Regulation Manager Liz Niman, Head of Communications and Engagement Matthew Redford, Director of Registration and Resources Marcia Scott, Council and Executive Support Officer Tim Walker, Chief Executive and Registrar
Observer:	Deborah Smith, Registrant member of Council

Item 1: Welcome and apologies

1. The Chair welcomed all to the meeting. A special welcome was extended to Hannah Doherty, Regulation Manager, and Deborah Smith, a registrant member of Council and observer for this meeting.

2. Apologies were received from Dr Joan Martin, Dr Kerstin Rolfe, Chair of COEI, Sheleen McCormack, Director of Fitness to Practise and Dr Stacey Clift, Policy Officer.

3. Participants were reminded that they must declare any interest for any relevant agenda items requiring a decision or noting. Where an item required a decision, participants/observers would normally be asked to leave proceedings for the duration of the discussion to be recalled at the discussion's conclusion if there was a conflict. Where an item was for noting members and observers would also need to declare their interest, although conflicts were less likely in this case.

4. Observers were asked to note that where items relating to the statutory duties of the Committee, usually relating to osteopathic education institutions (OEIs), were to be discussed or noted these items were reserved and observers would not take part.

Item 2: Minutes and matters arising

5. The minutes of the eighth meeting of the Policy Advisory Committee, were agreed as a correct record subject to the following corrections:

    a. Item 6 – recommendation 1 (pg. 8):
    Agreed: The Committee agreed to the removal of expiry dates for new provisions and the approach of publication of 'conditions'.

    b. Page 9, paragraph 25i:
    How is touch communicated and received by both patient and health care professional (HCP) in the context of touch based therapies?

Matters arising

6. There were no matters arising

Item 3: CPD Scheme implementation

7. The Director of Education, Standards and Development introduced the item which considered the content of the third CPD evaluation survey 2019 questions and timeline.

8. The following points were highlighted:

    a. The CPD evaluation survey is a data source which contributes to the provision of assurance about the how the CPD Scheme is being implemented progressively. Other routes to providing assurance will include annual registration renewal data, an analysis of the communications and responses to communications.

    b. A presentation on the Risk Log for the CPD scheme and its relationship to the CPD evaluation survey 2019 was given to aid members' discussion in mapping the CPD survey questions to particular area of risks. This aided the

identification, mapping and the mitigation of risk. It was identified that further consideration to questions about the realisation of the intended benefits of the scheme would need to be given as we move beyond baseline into implementation.

9. In discussion the following points were made and responded to:

   a. It was confirmed that there are approximately 150 registrants who for a number of reasons are currently non-practising, but all are still required to meet CPD requirements to maintain registration.

   b. It was acknowledged that the survey questionnaire was lengthy taking approximately thirty minutes to complete but response rates, as shown from previous surveys, remained relatively high at approximately 10% of the register. It was confirmed that a sample of around 50 people had been approached to take part in a telephone survey and the outcomes recorded in respect of current respondents reflected the same results although numbers were small. It was confirmed that the exercise would be repeated in the future.

   c. It was confirmed that there was continuous engagement with the profession through meetings with regional groups and societies to raise awareness and discuss CPD. Although it would be a challenge to undertake face to face engagement with the whole profession across the timeframe of the survey it would be possible to see some groups.

   d. It was suggested that as an incentive for completing the survey a link to certification or other form of recognition or award could be created. It was suggested that individuals should be able to claim up to one hour of CPD for completion of the survey (rather than just 30 minutes as at present) which might explain the high response rate to the survey. It was also explained that the issue of awarding individuals was that only those who were engaged and responsive to the survey would be captured in the analysis. It was, therefore, important to keep the process as open as possible to all to ensure inclusivity and that complete picture could be developed of how the profession was responding.

   e. It was explained that the Risk Log relates to the implementation of the whole CPD scheme not only the evaluation survey. The Risk Log was designed to identify the risks including non-delivery of the intended benefits in the implementation of the scheme. The CPD evaluation survey was one of the tools being implemented to provide data on the management of risk. Gaps in the data collected about implementation had been identified and the importance of collecting data to evaluate the impact on practise and the benefits of the scheme on patient care were acknowledged.

   f. It was agreed that the analysis had been thorough but was it a complete picture of CPD evaluation being presented by sole use of a Risk Log? It was

suggested that the collection of more quantitative data would provide further assurance about the scheme. Was there an opportunity to encourage the profession towards better use of technology and to subsequently use the quantitative data for evaluation of the scheme? In response it was explained that there were initiatives in place including registrants being required to keep an on-line CPD diary hosted by the regulator but who did not have access to the data. It was emphasised that access to quantitative data would be available through the annual registration renewal process which would ask registrants how they are maintaining CPD compliance once they become part of the three year scheme. It was also explained that the registrants would not be requested to declare their reflections as there would be some reluctance to do so but it was expected that over time peer review, reflecting and recording would be seen as helpful and positive.

g. It was explained that the first collection of data (completion of year 1) from all registrants from the annual renewal registration process would not be until October 2020. Registrants would make self-declarations on activities undertaken against each of the four themes of the Osteopathic Practise Standards, whether they have undertaken an objective activity, whether they have undertaken an activity relating to communication/consent and whether they have identified their peer. Many of the forms would be completed on-line but there was provision for the few returns in hard-copy format. The data provided will set out particular themes and trends identifying action/s that may be required. There would also be an assurance and verification process where random samples of declarations would be selected for discussion with individuals about particular activities which would also be required to be evidenced.

h. The Committee were informed that that there was also data, including soft data, being collected by other means, for example, through interactions with focus groups, regional groups and societies, feedback forms and on-line data analytics from the GOsC website.

i. It was confirmed that under the new CPD Scheme registrants are required to complete ninety hours of CPD over three years. It was also explained that reflective accounts are included as part of CPD but the GOsC in line with most other (health) regulators do not require the detail of all registrants' reflections due to registrant concerns relating to possibility of fitness to practise investigations.

j. It was suggested that CPD providers could have a check list of the courses undertaken which match specific osteopathic standards. This would also encourage engagement with the scheme and registrant buy-in. It was agreed that this was a positive step and CPD Provider Guidance had been published which encourages the providers to promote the scheme in their promotion of their own CPD provision. It was also reassuring to see, for example, the Institute of Osteopathy convention sessions linked to aspects

of the CPD scheme including objective activity and the themes of the Osteopathic Practice Standards.

Survey Timeline

k. The Director of Education, Standards and Development explained that it was expected that the survey would be finalised in early 2019 and would take into account the Committee's reflections as discussed. The survey would be launched on 1 March 2019. The reason for the time period set out is that most of the register will have begun the new scheme on 1 March 2019 and by the time of June 2019 majority of the register would be on the new scheme.

l. There was some discussion about whether the timeframe for the survey was too short within the proposed timeline of implementation of the scheme. It was suggested that one year might be a more realistic proposal. It was suggested that the timeline may be too early in that some respondents would be commencing the new scheme and some may not. It was explained that the issue was that full population data for completion of year 1 was not available until October 2020 which was two years from now and this gap could represent a risk in terms of the understanding the implementation of the CPD scheme. The CPD Evaluation survey provides an opportunity to get a picture of the implementation of the CPD scheme from a smaller sample in this interim period and to use this comparative data over time to provide a longitudinal picture of implementation. There were benefits and challenges in undertaking the survey in March compared to later in 2019. It was suggested that it was important that evaluation data should be available for Council in order to provide assurances on the progress of the scheme and that evaluation of the scheme should be undertaken at touch points in the timeline.

10. The Chair summarised that the discussion had highlighted a number of issues which should be taken into account by the Executive in relation to the timeline. It was noted there were advantages and disadvantages relating to the proposed timeline and the Executive were asked to reflect on the Committee's comments and proceed as was seen appropriate to Council.

Noted: the Committee noted the timeline for the CPD Survey and the considerations relating to the timeline.

Item 4: OPS Implementation: Revision of registration assessments

11. The Policy Manager introduced the item which concerned the review of registration assessment processes to reflect the updated Osteopathic Practice Standards (OPS) and changes to documentation to reflect feedback received from assessors and applicants.

12. The following points were highlighted:

a. Two training days were held with Assessors to assist in giving further feedback of the drafts.

b. Issues around gaps in assessor standards and what gaps could be tolerated.

c. Whether the Further Evidence of Practice (FEP) process adequately assesses the standards or could some of the requirements be removed.

d. It is planned that the timeline for implementation in will run in conjunction with the implementation of the Osteopathic Practice Standards in the autumn of 2019.

13. In discussion the following points were made and responded to:

a. It was commented that it is difficult to assess techniques on paper and that perhaps using more technology such as video to demonstrate proficiency and competence could be considered.

b. It was noted that the FEP questionnaire was much more concise and would be helpful to both assessors and applicants. It was suggested that FEP should be available to assessors on the day of assessment when practical tests are undertaken to check for and address 'gaps' in the evidence provided as well as time set aside for short interviews to establish a more rounded sense of an applicants proficiency.

c. It was explained that the evidence of good character does not form part the FEP and ACP processes but is undertaken during the registration application procedure. This check comprises the completion of a character reference, the enhanced check of regulated activity – CRB check and/or an overseas police check. Under the current pathway an individual would also be required to supply evidence of qualification/s, lifelong learning, CPD and supporting evidence statements from individuals but these do not form part of the character statements.

d. Clarification was sought on the procedure for applicants who have been out of practice for an extended period as the questions reference a one year period. It was explained that an (UK) applicant who has previously been on the register would undergo a return to practice process which involves the completion of a questionnaire and a discussion with two Registration Assessors as to what may be required in terms of support for return to practise. It was pointed out that there were no legislative powers to compel an individual to undergo the return to practice process therefore if a person refused to undertake this process their application would still have to be considered. In the case of an overseas applicant returning to practise the individual would be given the opportunity to put forward hypothetical scenarios and this was outlined in the FEP documentation.

e. Members asked if there was a need for further evidence to be presented and more thought given specifically to the evidence requested to fill the gaps as described at Annex D and taking into account cultural approaches.

f. It was explained that there had been no specific work undertaken on an appeals process for applications and that appeals were rare. There had only been one appeal relating to a decision to deny an Assessment of Clinical Performance and feedback had been received relating to this.

g. In summary it was agreed that the comments put forward by the Committee were helpful and reflected the issues highlighted by the assessors attending the training days. It was pointed out there were no applicants/registrants undertaking the FEP/ACP process who had been required to go through fitness to practise proceedings and therefore currently these applicants presented a low risk (although numbers were small). Although the ideas suggested for supporting evidence were helpful there was also a need for the process to be proportionate, affordable and realistic.

h. It was confirmed that there would be mechanisms in place giving assessors the opportunity to comment and feedback throughout the consultation period by means of webinars and other media.

i. It was confirmed that there would be no further changes to the document once it had been presented to Council for agreement on the consultation in January 2019

Agreed: the Committee agreed the proposed timetable for development, consultation and implementation of the updated Further Evidence of Practise (FEP) and Assessment of Clinical Practice (ACP) documentation.

Item 5: Changes to the risk assessment process for fitness to practise cases

14. The Regulation Manager introduced the item which concerned revising the risk assessment process used during fitness to practise investigations.

15. The following points were highlighted:

a. The current model for assessing risk in fitness to practise cases is focused on whether an interim suspension order (ISO) is required but the risks within a case are broader and therefore the new model will take into account the wider risks and ensure they are being captured and prompt case workers when completing the risk assessment to identify what actions are required in response to the risks.

b. The new model will specifically require that case workers to account for their decisions which will lead to safer and more robust decision making.

c. The new model will be more user friendly, being less cumbersome and allowing users to respond to individual circumstances of a case more precisely.

d. Both risk assessment documents will be trialled in conjunction to ensure consistency and training will be provided for the Regulation team in the use of the new risk assessment document.

16. In discussion the following points were made and responded to:

a. It was confirmed the changes to the risk assessment process were not being implemented due to any issues regarding the fitness to practise and the risk assessment/decision making process. The changes being suggested were administrative with intention of making the assessment process more robust.

b. It was suggested that an amendment in the wording of the Risk Assessment Form, 1.4: Aggravating and mitigating factors, should be made to read:

…However, if the allegation is of a single incident of violent conduct, it being a single incident does not mitigate the seriousness of the risk.

c. It was confirmed that seeking further information for the new model of the risk assessment process would not slow response rates.

Item 6: Assuring applicant qualifications

17. The Director of Registration and Resources introduced the item which sought the Committee's early input as the Executive considers mechanisms to enhance how the GOsC is assured over the qualifications of applicants applying for registration from a) UK qualified applicants and b) internationally qualified applicants.

18. The following points were highlighted:

a. The significant increase in the number of bogus 'degree mills' being established.

b. The challenges presented to the OEIs and the GOsC in being assured that qualifications presented by applicants are genuine and using primary source verification screening for both UK and international applicants would give added security.

c. The cost of the verification scheme is c. £200-£250 per check which in the case of the OEIs and the GOsC would be borne by the individual making the application.

19. In discussion the following points were made and responded to:

a. It was confirmed that primary source verification would be different to the services provided by UK NARIC (which is the designated United Kingdom national agency for the recognition and comparison of international qualifications and skills).

b. It was highlighted that some proportionality would be required in order not to deter prospective applicants as the verification process could be onerous and time-consuming.

c. It was agreed that ensuring an applicants credentials were correct was at the core of the registration process and that assurances were critical. The importance of clear information and an understanding of how checks would be conducted was stressed. It was confirmed that this information would be made available as part of the process.

d. It was stated that the GOsC took into account that the OEIs may have their own verification systems in place but wanted to ensure that there were options available especially for the smaller institutions. The process being presented would be an additional tool in the provision of assurances and mitigation of risks.

e. It was agreed that the proposal was very helpful and a useful complement to UK NARIC in supporting the OEIs.

Item 7: Registration Assessor and Education Visitor – length of service

20. It was noted that Marvelle Browne, Bob Davies and Elizabeth Elander declared interests as either Registration Assessors or Education Visitors but remained in the meeting for the discussion as no decisions were being made in relation to this item.

21. The Director of Registration and Resources introduced the item which concerned the identification of potential policy gap in relation to GOsC appointed Registration Assessors and Education Visitors and specifically how long they can remain as an assessor or visitor.

22. The following points were highlighted:

    a. An anomaly had been identified in the contracts for Registration Assessors and Education Visitors which meant individuals' appointments could continually be renewed after four years in contrast to other members of the governance structure (Council and committee members) whose terms of office were limited to eight years.

    b. It was noted that there should be consistency in terms of governance but it would also be important to maintain the pool of assessors and visitors without loss of experience and skills within the pool.

23. In discussion the following points were made and responded to:

a. It was suggested that there was no parallel between assessors and membership of Council and/or committee as assessors and education visitors were contracted. It was also suggested that increasing the pool of assessors should be considered as the number trained should have no increased cost implications.

b. It was pointed out that the role of assessors and visitors were of equal importance to those of Council and committee members as part of the GOsC's statutory duty in protection of patients and to take a different stance could be viewed as diminishing the roles.

c. It was suggested that the importance of the assessors and visitors was not in question but the comparison to members of the governance structure was not correct. In limiting the time an assessor/visitor could remain in a role there was a risk of losing skills and experience. It was suggested that to guard against this perhaps those assessors who had served a number years could move on to take training roles so as not to lose the experience gained by individuals. It was also suggested that a rotation system could be introduced so that assessors/visitors could have two years fallow and, if they chose, be reinstated into the pool after the two year period.

d. It was pointed out that the frequency of visits undertaken by assessors/visitors must be taken into consideration as it is possible that individual may have only completed two visits in the period of eight years.

e. It was suggested that a review of how to continually professionally develop and review assessors/visitors was required. There had to be a distinction between contractors and non-executives but care was needed as to how this was managed. It was pointed out that there had been some criticism and concerns raised with the GOsC about the diversity of the pool of assessors/visitors and actions had been taken to try address the concerns. It was agreed the issue needed to be addressed and that it was vital to maintain the skills and experience of the assessors/visitors.

24. It was noted that the comments had been helpful and would help develop a policy document for discussion by the Committee at its next meeting.

Item 8: Quality Assurance: Update on GOsC/QAA Handbooks

25. The Director of Education, Standards and Development introduced the item which requested the Committee to consider the current drafts of the GOsC/QAA Handbooks and agree the next steps prior to the removal of RQ expiry dates and publication of conditions.

26. The following points were highlighted:

a. The interim handbooks agreed in June 2018 were now in use for the current reviews of three institutions, the London School of Osteopathy, the London

College of Osteopathy and Swansea University which were currently underway.

b. The current approach to risk based quality assurance has been outlined in the QA policy which sets out what is currently undertaken while recognising that the Committee will consider this further in due course.

c. A number of clarifications were highlighted:

- the current approach to risk based quality assurance;
- clearer definition of 'conditions' for publication;
- publication of action plans;
- clarification of RQ expiry dates

d. The Committee's feedback would be welcome and if the members were so minded then further work would be undertaken on the handbook with input from Visitors and institutions. The Handbook would then be returned to the Committee along with new RQ orders without expiry dates during 2019.

e. Christine Bevan, QAA, added that the overarching rationale for the amendments were to consolidate and update the two existing handbooks, make the handbook more consistent and bring it into line with General Data Protection Regulation (GDPR). There were still improvements which could be made and a process of consultation was being undertaken with stakeholders.

27. In discussion the following points were made and responded to:

a. It was suggested that paragraph 62: Withdrawal from the visit team, should be made more robust so as to avoid any misunderstandings if it became necessary for a visit team to be withdrawn from an institution which was undergoing an evaluation. It was explained that the paragraph was designed for a single visitor who was unable to continue with a visit and that paragraph 66, which says a visit will always conclude with a report, took into account the unlikely scenario of a visit team being withdrawn but it was agreed that inserting wording based on the possible scenario would be considered.

b. It was explained that the process for giving feedback on Visits had been in place for sometime. It was confirmed that at the conclusion of a visit the team complete an electronic survey which is anonymised and sent to the QAA for analysis. It was suggested that the process be made clear in the handbook.

c. The criteria for appointing Visitors was confirmed and pointed out at pages 46 – 47. It was suggested that the specific requirements for appointment should be included for clarity.

Noted: the Committee noted that the interim Handbooks considered in June 2018 had been agreed with the providers as in force until the 'post RQ expiry date' Handbook comes into force.

Item 9: European School of Osteopathy (ESO) – Renewal of Recognised Qualifications RQ Report

28. John Chaffey, Bob Davies and Elizabeth Elander declared conflicts of interest and left the meeting for the duration of the discussion.

29. The Observers with speaking rights were requested to leave the meeting while the Committee took the decision on whether a discussion on issues relating to the ESO should continue in public due to a sensitivities relating to individuals in the institution.

30. The Committee agreed that the discussion should continue as set out on the agenda.

31. The Director of Education, Standards and Development introduced the item which concerned the European School of Osteopathy seeking renewal of its current Recognised Qualification for the:

    a. Master of Osteopathy – four years full-time
    b. Bachelor of Science (Hons) Osteopathy – four years full-time

32. An addendum to the paper was also introduced for the Committee's consideration which provided an analysis on the current information about progress with the proposed conditions at the ESO as at 17 October 2018.

33. The following points were highlighted:

    a. Since the paper recommending renewal of the recognition of the RQ subject to the four conditions outlined by the Education Committee and the submission of the Action Plan in August 2018, there had been further changes to the governance structure in addition to those reported in the paper. Two days previously, it has been announced that the Dean of the ESO, who was the senior academic lead, had resigned. In light of this taking place very shortly before the Committee it had not been possible for a full response to be provided. As a result of this reported change, there was an impact on the action plan originally submitted by the ESO and therefore the evidence for the renewal of the Recognised Qualification at this meeting.

    b. An analysis of the current position had been prepared for the Committee's consideration relating to the conditions outlined in the RQ report which brought together progress against the original action plan, and further information from the Chair of the Board of the ESO.

    c. In reviewing the analysis the Committee could consider the following options:

Option 1: Renew recognition of the Recognised Qualification

Option 2: Request an updated Action Plan and evidence of compliance with the conditions including a plan in relation to the academic governance oversight (either renewing now or in March 2019 subject to agreement of the plan and evidence that it is being implemented effectively)

Option 3: Undertake a targeted monitoring visit as soon as possible.

34. In discussion the following points were made and responded to:

a. Governance was an important component to provide assurance that standards were delivered. The RQ report outlining the visit in April 2018 provided assurance that the governance in place complying with the conditions outlined would provide the necessary assurance about the delivery of the standards. This piece of assurance was now not clearly in place due to the changes to the board and the academic senior team since the report. The replacement of academic lead will take time and there is a risk in terms of the small pool of potential qualified individuals.

b. How could assurance be provided that students are currently meeting the required standards? A targeted review could do this but would be an additional burden to the institution. Further, it was not clear that significant change could be implemented within a realistic timescale that would give the Committee the assurances that the RQ could be renewed.

c. The challenge to the leadership could impact on the teaching staff and students therefore targeted monitoring would be a way of ensuring the quality of education and the student experience.

d. In terms of ongoing assurance about standards, it was suggested that with a new Chair, a relatively inexperienced Board and changes to the senior leadership team that the new Chair would need a reasonable period of time to produce a turnaround plan that identifies and deals with the issues arising. It was important that the institution should have in place sufficient executive and non-executive capacity so that the organisation can be managed through this period of change.

e. It was suggested and agreed that the new Chair should be given time to produce a turnaround plan to demonstrate that the organisation could and was being managed through this period. It was also suggested that other OEIs could, if viable and appropriate, provide qualified academic support to assist in demonstrating that standards were being met. It was suggested that the ESO should consider seeking or commissioning external support to provide assurance about standards.

f. A key challenge would be the timescale for assurance and approval of the RQ. It was suggested there were solutions to seeking approval of the RQ that would be challenging but not insurmountable and also working with the Department of Health and Privy Council to remain within the timeframe if necessary. It would be important for the Committee and the ESO to consider contingency plans in the event of any further slippage in the RQ renewal process.

35. In summary it was agreed that the ESO should produce a turnaround plan demonstrating governance and academic traction, and assurance that students by the time of their graduation will be able to meet the standards required by the OPS both currently and in the future. The Chair also asked the Committee to bear in mind that there was a possibility that if by March the issues remained without sufficient progress, that contingency plans would have to be considered.

Agreed: the Committee agreed that it did not have the evidence to make a recommendation to Council that it recognises the Master of Osteopathy and the Bachelor of Science (Hons) Osteopathy subject to the conditions outlined in paragraph 21 from 1 September 2019 to 31 August 2024 at this time.

Agreed: the Committee agreed that a turnaround plan demonstrating compliance with the conditions, including a plan to manage and maintain academic governance oversight and delivery of standards, and demonstrate current delivery of standards, should be presented to the Committee to provide the necessary assurance to enable it to have confidence that only students meeting the Osteopathic Practice Standards were awarded a 'recognised qualification'.

Item 10: Corporate Strategy development

36. It was agreed that the report on the development of the Corporate Strategy would be circulated by email for the Committee's consideration and comments.

Item 11: Any other business

37. There was no other business.

Date of the next meeting: Wednesday 13 March 2019 at 10.00