General Osteopathic Council

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Policy Advisory Committee
16 June 2016
CPD scheme implementation – governance, finance and risk

Classification	Public
Purpose	For discussion
Issue	An update on the implementation of the CPD scheme incorporating consideration of the finance, risk and governance implications of the implementation of the CPD Scheme.
Recommendations	1. To note the progress of the implementation of the CPD scheme. 2. To consider the budget for the implementation of the CPD scheme. 3. To consider the risk matrix. 4. To note the progress of the planned evaluation of the implementation of the CPD scheme.
Financial and resourcing implications	An indicative budget for the implementation of the CPD scheme has been outlined in this paper.
Equality and diversity implications	None from this paper.
Communications implications	Communications about the implementation of the new CPD scheme are ongoing.
Annexes	A. High level Project Plan Summary for the Policy Advisory Committee for the implementation of the CPD Scheme to March 2017.Terms of Reference for the CPD Partnership Board B. Risk Log for the Implementation of the CPD Scheme C. Scoping the State of CPD Evaluation report – Osteopathic Practice Committee Paper – March 2015 D. Updated timeline for the State of CPD Evaluation report.
Author	Fiona Browne

Background

1. Our Corporate Strategy 2016-19 contains the following strategic objectives:

    - 'To promote public and patient safety through patient-centred, proportionate, targeted and effective regulatory activity
    - To encourage and facilitate continuous improvement in the quality of osteopathic healthcare
    - To use our resources efficiently and effectively, while adapting and responding to change in the external environment.'

2. The Corporate Strategy also provides that 'Partnership is at the heart of delivering our objectives; a regulator is not synonymous with the profession it regulates and we believe strongly that, where appropriate, we should work with others to achieve them.

3. Key goals outlined in the Corporate Strategy include:

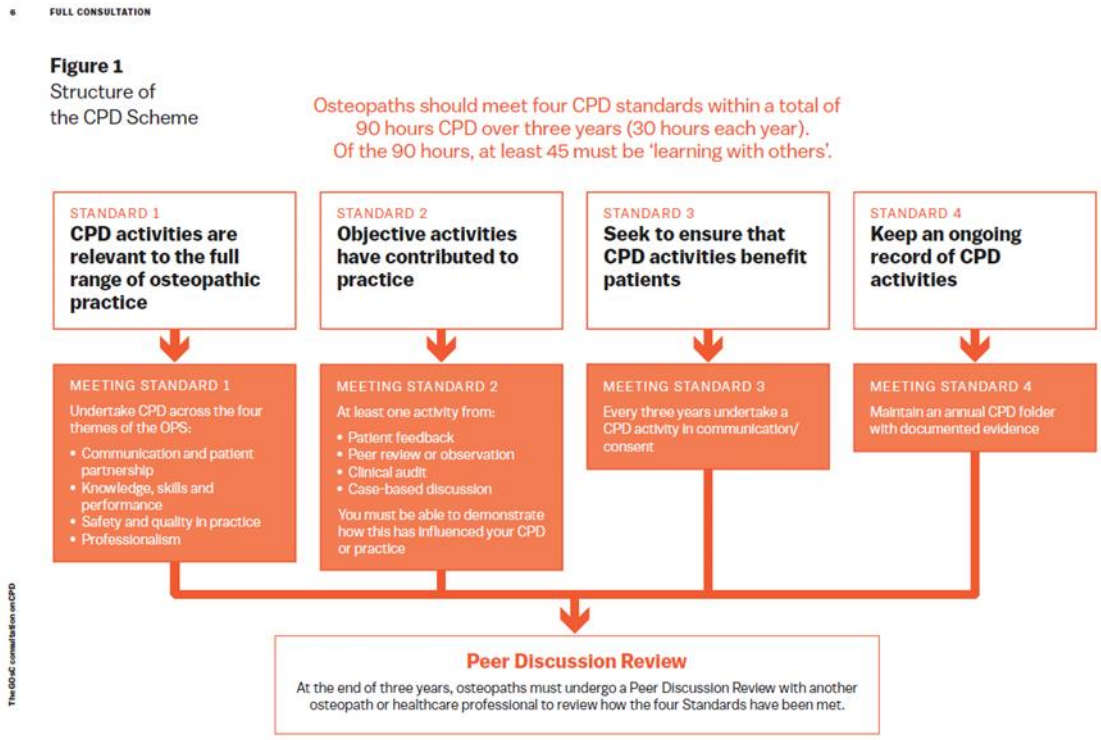
    - 'To ensure that osteopaths keep their knowledge and skills up to date, and continually enhance and improve their practice.' We state that we will do this by implementing a new CPD scheme that supports and encourages practitioner reflection, peer learning and peer review and that we will provide resources to support learning in key areas such as communication and consent. We also commit to monitoring implementation and impact of our new CPD scheme using a proportionate and risk-based approach.
    - 'To put patients, patient-centred regulation and patient-centred healthcare at the heart of our work'. We state that we will do this by encouraging the use of patient feedback by osteopaths within our new CPD scheme
    - 'To ensure that the osteopathic profession continues to develop its capacity to improve patient experience and high quality care'. We state that we will do this by working with the Institute of Osteopathy (and others) to support capacity building within local osteopathic groups to contribute to the development of the profession and the new CPD scheme.

4. The Business Plan for 2016-17 has a range of activities outlined in relation to the implementation of the CPD scheme as follows:

    - Establish a strategy for the further development and implementation of a revised CPD scheme for osteopaths, working in partnership with all osteopathic stakeholders while ensuring appropriate governance oversight.
    - Recruit registrants and groups willing to work as 'early adopters' to test and refine the CPD scheme and its resources.
    - Update and publish learning resources that support the new CPD scheme – particularly in relation to communication and consent.
    - Review progress and legislative requirements, and consider timescales for introduction of compulsory elements of the CPD scheme.
    - Publish new CPD Guidance and related resources.

- Scope and undertake osteopathic continuing professional development evaluation to feed into 'State of Osteopathic Continuing Professional Development' report.
- Conduct communications and engagement activities to support and promote the implementation of a new CPD scheme for osteopaths.

5. At its meeting on 4 February 2016, Council agreed the CPD model to be implemented as outlined at Figure 1 below.



6. Council also agreed a staged approach to implementation and they agreed an outline timetable recognising that this will be reviewed at regular stages as part of the implementation plan.

7. The outline timetable agreed by Council is set out below:

Activity	**Timeline**
Agree CPD model for introduction .	February 2016
Establish governance structure, including Delivery Board, to oversee the further development and implementation of the CPD scheme.	April 2016
Update and publish resources to support learning – particularly in the area of communication and consent.	September 2016

Introduce scheme for those interested in early adoption.	November 2016
Review scheme and decide on introduction of mandatory elements for all.	March 2017
Publish updated CPD Guidance and resources.	March 2017
Communications and engagement activities to support and promote the implementation of a new CPD scheme for osteopaths.	All year 2016-2017
Ensure a robust, web-based infrastructure that can support the CPD scheme.	All year 2017

5. In May 2016, Council considered and agreed the governance structure for oversight of the implementation of the new scheme which included
   - the terms of reference for the SMT Task Group
   - the terms of reference for the CPD Partnership Board
   - the table summarising advice and decision making within the project work streams
   - the flow chart describing the CPD Project Governance Structure.

6. Council were also reminded that they had previously allocated up to £100,000 from reserves in order to support the implementation of the CPD scheme.

7. This paper provides a general update on the implementation of the CPD scheme within the various project streams and also provides more detail about the indicative budget, the risk matrix and the evaluation framework. To assist the Committee to consider the matters outlined in this paper, we have prepared a high level summary of key milestones for the Policy Advisory Committee over the course of the year, including key Committee decisions at Annex A for information.

Discussion

Update on the implementation of the CPD scheme

Guidance and resources

8. The CPD Guidelines, Peer Discussion Review Guidelines and Case studies and resources continue to be shared with stakeholders and updated. We are planning to consolidate all our resources within a dedicated page on our website for ease of access.

9. On 26 May 2016, we met with an osteopath who works within the NHS in two different areas to discuss the implementation of the CPD scheme and the way

that it fits with the NHS appraisal system. We have shared documentation and are working together to develop resources and case studies specifically for osteopaths within the NHS to avoid unnecessary duplication. These resources will also be available to osteopaths who do not work in the NHS should they wish to use them.

10. On 23 May 2016, we held a GOsC/OEI meeting and discussed the development of further resources and case studies for those working in education.

11. On 18 May 2016, we met with the Institute of Osteopathy (iO) to discuss a range of CPD-related issues, including the peer discussion review process. The iO indicated that peer discussion review is one of the areas about which they receive the most questions from osteopaths. We are looking to work together to develop dedicated resources that support osteopaths to undertake peer review. These include a 'matching' service to enable osteopaths to identify peer reviewers at an early stage in the CPD cycle so that they can develop their collaborative peer support at the earliest opportunity. We also plan to work together on video and other resources to show what a good peer discussion review looks like.

12. The resources and case studies continue to be updated and we will provide a further update at the next meeting of the Committee.

Communications and engagement

13. We are ensuring a regular flow of information regarding the development of the new CPD scheme in GOsC and iO print media and e-bulletins, to maintain a high level of awareness and engagement.

14. Our partner organisations are key to the effective implementation of the CPD scheme, and to this end we have been engaging closely with the Council of Osteopathic Educational Institutions, the Institute of Osteopathy, the Osteopathic Alliance, the National Council of Osteopathic Research and local CPD groups. An article in the June/July 2016 issue of *the osteopath* magazine demonstrates these organisations' common commitment the delivery of the new scheme and to the general ethos of engagement, support and community that underpins the scheme.

15. The Institute of Osteopathy is working with the GOsC to encourage osteopaths to sign up as early adopters of the scheme, promoting this opportunity to members in the July edition of *Osteopathy Today*.

16. Osteopathic stakeholder organisations are working with the GOsC to develop and disseminate a variety of communications to osteopaths to encourage the recruitment of early adopters with a view to launching a recruitment drive in summer 2016.

17. On 18 March 2016 the GOsC convened a meeting of the Regional Communications Network (RCN), which provided an opportunity for regional

osteopathic leads to explore how to work together to support osteopaths to meet the requirements of the CPD scheme. The programme included workshops enabling participants to design their own CPD session and to explore the *Osteopathic Practice Standards*. Regional Communication Network leads were asked to encourage their members to become early adopters. Feedback on the event was very positive and the RCN leads were keen to continue to work with us on the further development of bespoke materials and sessions that help regional leads and their members implement the CPD scheme.

18. We are working, over the summer, on a programme to support regional group members plan, develop and implement CPD activities and sessions for their members and colleagues.

Process

19. We are currently working across teams to develop an appropriate process ensuring links between the early adopters and the existing CPD scheme to ensure a streamlined approach.

20. We are also working alongside the Institute of Osteopathy (iO) on the potential piloting of an electronic CPD portfolio. We have explored the use by other professions of online learning/CPD portfolios to develop a specification that might meet the needs of osteopaths. Potentially this could be a resource which the IO might wish to further develop for the profession.

21. Meetings of the SMT Task Group took place in March 2016. The next meeting is planned for June 2016. These meetings have been supplemented with regular staff updates and cross-departmental discussion to progress the project.

22. The invitations to the members of the CPD Partnership Board and Reference Group have been sent out along with project updates about the recruitment of the early adopters and opportunities to supplement the Resources and Case studies booklets ahead of the early adopters It is hoped that the first meetings of these groups will take place very shortly.

Early adopters

23. We are using the GOsC media – magazine and e-bulletins – partner organisations, and the Regional Communications Network to encourage osteopaths to sign up as 'early adopters' of the CPD scheme. This will be further reinforced by a direct email invitation to all registrants over the summer.

Legislation

24. Potential changes to legislation have been discussed with the SMT Task Group and also at a very preliminary stage with the Department of Health to assess appetite for change. A report is being prepared about options for change to our legislation for consideration at the next SMT Task Group and this will be brought to the Policy Advisory Committee for consideration in due course.

Equality and diversity

25. The equality impact assessment is in place and will continue to be updated during the early adopter phase.

Evaluation and impact assessment, finance and risk

26. The Committee is invited to consider substantive matters below.

Finance

27. In February 2016, the Council designated up to £100,000 from reserves for the implementation of the CPD scheme over a three year period. At its last meeting in May 2016, the Committee asked for a more detailed budget to be prepared for consideration.

28. To assist Council to monitor projected budgets and costs, we have outlined our narrative and assumptions below.

29. The implementation period is a time for kick starting the scheme for all osteopaths. We have agreed a staged approach to implementation which will commence with early adopters, and will conclude with the implementation of the scheme for all (although different elements of the scheme may be mandated for all osteopaths at different times). At the conclusion of the implementation period, there will continue to be ongoing costs from the scheme which will need to be met from the expenditure budget. Examples of these are outlined below.

30. It is important to highlight at the outset, that some of our costs – particularly those falling towards the end of the three year implementation period will be uncertain at this stage of development and indeed the ongoing costs of the scheme following the implementation period. For example, the costs of developing online resources are uncertain at this stage and will, to a degree, depend on the level of external expertise required to secure the desired deliverables which we are in the process of scoping out. Further, at the end of the implementation period as we move to the implementation of the scheme for all, there will necessarily be ongoing costs that will need to feature in the expenditure budget. An example of this is ongoing work to keep resources and case studies updated, the need for updated guidance should, for example the consent and communication requirement under 'CPD benefits patients' be changed to, for example, something on boundaries, the need for training and appraising GOsC assessors to undertake GOsC Peer Discussion Reviews for those that select or are required to undertake a peer discussion review with the GOsC rather than another colleague or the funding of the auditing process.

31. Nevertheless, to assist Council to monitor projected budget and costs in the context of the risk to the organisation as outlined at the risk log at Annex B, we have outlined an indicative budget below along with an indication of the anticipated phasing.

Item	Cost	Notes
Engagement (including recruitment of early adopters)	£33,000	Recruitment of early adopters and ongoing engagement is planned to commence during Autumn 2016. Expenditure will commence at this point and is not expected to exceed £31,000 before the end of year 2 of the implementation period.
Development of resources (for early adopters and mandatory implementation)	£31,000	Resources are currently being developed in house. Over time, we plan to develop online case resources which will require a degree of IT expertise. These costs are expected to fall towards the end of the implementation period. We are also considering piloting an online e-learning portfolio to support dissemination of CPD resources and materials which would be included within this overall figure.
Process development	£10,000	The costs of process development will fall as elements of the scheme are implemented for all. Therefore these costs are likely to fall towards the end of the implementation period.
Evaluation and impact assessment	£25,000	Expenditure on setting the baseline for the evaluation will commence shortly and is expected to be consistent throughout the implementation period.

Risk

32. The purpose of the implementation of the CPD scheme is to support safe and effective patient care, practice in accordance with the *Osteopathic Practice Standards* and to support the development of learning communities that enable osteopaths to share and develop their practice safely and effectively. Anything which could impede this aim is potentially a risk.

33. The current risk log for the implementation of the CPD scheme is attached at Annex B. The risk log is presented for regular consideration by all parts of the

governance structure. This is because implementation of the CPD scheme is a major project not just for ourselves – but also for our stakeholder partners and the goals that it seeks to achieve go to the very heart of the purpose of regulation. It is therefore important that time is spent considering the consequences and any unintended consequences of the project to ensure that at all times our focus is on outcomes.

34. The risks have been considered by the SMT Task Group and are presented to the Policy Advisory Committee for consideration. The Committee is invited to consider risks to the implementation of the scheme from the following perspectives:

    - Patients
    - Osteopaths
    - Osteopathic stakeholder organisations (including the osteopathic educational institutions, the Institute of Osteopathy, the Osteopathic Alliance, the regional groups, the National Council of Osteopathic Research)
    - The General Osteopathic Council.

35. The Committee is invited to consider the following questions:

    a. What are the key risks of implementation of the CPD scheme to our core goals of ensuring patient safety and the quality of care?
    b. What mechanisms should we be taking to mitigate these risks.
    c. How are we monitoring impact?
    d. What other actions should we be taking?

Evaluation

36. The Committee considered the proposed evaluation of the current CPD patterns at a meeting of the Osteopathic Practice Committee in March 2015. This paper is attached at Annex C for information.

37. An updated timeline is attached at Annex D.

38. It is planned that the evaluation process confirming a baseline for the evaluation of the implementation of the CPD scheme will commence after the Policy Advisory Committee meeting.

Recommendations:

1. To note the progress of the implementation of the CPD scheme.

2. To consider the budget for the implementation of the CPD scheme.

3. To consider the risk matrix.

4. To note the progress of the planned evaluation of the implementation of the CPD scheme.

High level Project Plan Summary for the Policy Advisory Committee for the implementation of the CPD Scheme to March 2017

(Please note that a more detailed project plan sits underneath this high level summary for the Committee and this is monitored by the SMT Task Group).

Committee decisions are highlighted in bold italics.

Date	**1 – Guidance and resources**	**2 – Communica-tions and engagement**	**3 – Process**	**4 – Early adopters**	**5 – Legislation**	**6 – Equality and diversity**	**7 – Evaluation and impact assessment (including finance)**
	Outcome: To finalise CPD Guidance, Peer Discussion Review Guidance and resources and case studies for the early adopters.	Outcome: To ensure that GOsC and stakeholders work together in successful delivery of the scheme for the early adopters.	Outcomes: To ensure that appropriate governance arrangements are in place to oversee the CPD scheme. To develop appropriate CPD process for the early adopters.	Outcomes: To recruit early adopters to participate in the early implementation of the CPD scheme. To provide support to early adopters to participate in the CPD scheme.	Outcome: To report on changes needed to our current legislative framework to enable the CPD scheme to be implemented for all osteopaths.	Outcome: To ensure that the equality impact assessment document is updated throughout the pilot to ensure that all equality issues are identified and managed.	Outcomes: To secure a baseline for implementation of the CPD scheme. To continue to evaluate the impact of the CPD scheme (including costs and benefits) through the early adopters to inform phased implementation.

Date	**1 – Guidance and resources**	**2 – Communica-tions and engagement**	**3 – Process**	**4 – Early adopters**	**5 – Legislation**	**6 – Equality and diversity**	**7 – Evaluation and impact assessment (including finance)**
							To monitor the budget.
June 2016		Establish CPD Partnership Board and reference group and contact all osteopathic stakeholders to populate. ***PAC to:*** ***Note update on communica-tions and engagement***	***PAC to:*** ***Note update on governance arrangements***	Recruit early adopters ***PAC to:*** ***Note update on strategy for recruitment***	To develop report on the legislative changes required for implementation of the scheme.		***PAC to:*** ***Agree specification for the 'State' of CPD Report' and method of evaluating initial impact of the CPD scheme.*** ***Agree indicative budget for the CPD scheme. Consider the risk matrix for monitoring the implement-ation of the CPD scheme.***

August 2016				Recruit early adopters			
Sept 2016	Complete update of Continuing Professional Development Guidance, Peer Discussion Review Guidance and Resources and Case studies for early adopters. NB: Resources and case studies guidelines will be continually updated throughout the early adopter phase			Recruit early adopters	To consider report on legislative changes required for phased implementation of the scheme.		
October 2016	***PAC to:*** ***Note updated CPD Guidance, Peer Discussion Review Guidance and updated Resources and***		***PAC to:*** ***Note update on process for early adopters.***	Recruit early adopters ***PAC to:*** ***Consider specification for early adopters***.	***PAC to:*** ***Consider report on changes required to legislation.***	***PAC to:*** ***Consider updated equality impact assessment ahead of the start of the implement-***	***PAC to:*** ***Consider progress of the evaluation reports, finance and risk matrix.***

	Case studies for the early adopters.			This will include who the early adopters are, what they are doing and how we will gather information to inform implementation of the scheme for all.		***ation of the CPD scheme for the early adopters.***	
November 2016				Launch early adopters with kick off meetings			
December 2016				Early adopter sessions incorporating patient feedback, case based discussion, communication and consent and Osteopathic Practice Standards			
January 2017				Early adopter sessions incorporating			

				patient feedback, case based discussion, communication and consent and Osteopathic Practice Standards			
February 2017				Early adopter sessions incorporating patient feedback, case based discussion, communication and consent and Osteopathic Practice Standards		Continue to update equality impact assessment following feedback from early adopters	Continue to collect information to inform evaluation, costs and benefits.

March 2017	***PAC to:*** ***Consider update CPD Guidelines, Peer Discussion Review Guidelines and Resources and Case Studies for roll out to all osteopaths***	***PAC to:*** ***Note update on communications and engagement***	***PAC to:*** ***Consider process arrangements in place for all osteopaths and timeline for implement-ation.***	Early adopter sessions incorporating patient feedback, case based discussion, communication and consent and Osteopathic Practice Standards ***PAC to:*** ***Note progress of early adopters.***	***PAC to:*** ***Consider timeline for phased implementation of the CPD scheme for all.***	***PAC to:*** ***Consider updated equality impact assessment***	***PAC to:*** ***Consider progress of the evaluation reports, finance and risk matrix.***

Risk Log for the Implementation of the CPD Scheme

Aim: To support safe patient care and the continual enhancement of the quality of care. To support the development of learning communities in osteopathy. To support practice in accordance with the *Osteopathic Practice Standards*.

Issue	**Impact (1 is low and 3 is high)**	**Liklihood (1 is low and 3 is high)**	**Mitigating Actions**	**Residual Risk (Low, Medium or High)**	**Are we prepared to tolerate risk**
Failure to recruit osteopaths to be early adopters	Early adopters are important because having a core of people who are comfortable with the scheme, understand how it works and gain real benefits from it will help us to more successfully roll out the scheme to others. It is important to have the diversity of osteopathic practice represented in order that any unintended consequences arising from implementation can be identified and managed. 3	2	Working with osteopathic partners. Oversight and responsibility for recruiting early adopters through CPD Partnership Board and regular communications with all osteopathic stakeholders and engagement with regional communications network and other osteopathic networks. Our early attempts to recruit early adopters have been successful and we have around 70 (as at 8 June 2016). A sustained campaign launched by all our osteopathic stakeholders should deliver a good diversity of osteopaths to help us to explore the impact of the implementation of the scheme. Information will be collected from early adopters to help us to ensure that they reflect the diversity of osteopathic practice.	Low	Yes

Issue	**Impact (1 is low and 3 is high)**	**Liklihood (1 is low and 3 is high)**	**Mitigating Actions**	**Residual Risk** **(Low, Medium or High)**	**Are we prepared to tolerate risk**
Peer Discussion Reviews are undertaken badly (thus osteopaths do not share areas of development and consequent impact on patient safety)	Peer Discussion Reviews are important because they should create a 'safe space' within which practice can be discussed. Development areas can be identified and supported thus enhancing patient care and practice – supporting both professional and personal development. However, feedback given in a way that is not constructive has been shown to damage confidence and may lead to osteopaths becoming uncomfortable discussing areas of development thus impacting on the purpose of the scheme. 3	3	Resources to support osteopaths to undertake the role of reviewer and participant will need to be developed. These will include setting ground rules and expectations, encouraging osteopaths to identify a peer discussion reviewer at the earliest opportunity to encourage ongoing discussion (all of which counts towards CPD). Guidance about how to manage disagreements and concerns will need to be enhanced following the consultation. Working with osteopathic partners to support the development of a core of trained peer discussion reviewers. Working with registration assessors to support the development of a core of peer discussion reviewers. A help line to discuss with trained staff Peer Discussion Reviews that have 'gone wrong' should be developed to mitigate any unintended consequences to keep osteopaths on track with the development of the scheme.	Medium	Yes – but the impact needs to be closely monitored

Issue	**Impact (1 is low and 3 is high)**	**Liklihood (1 is low and 3 is high)**	**Mitigating Actions**	**Residual Risk (Low, Medium or High)**	**Are we prepared to tolerate risk**
Implementation of scheme does not achieve intended benefits of development of learning community and practice in accordance with Osteopathic Practice Standards	If the benefits of the scheme are not identified and recorded, the benefits will not be realised. 3	2	The evaluation and impact assessment will explore the benefits of the scheme activities to the early adopters. All the Resources and Case Studies developed explore the benefits and costs of undertaking the relevant activities from the point of view of those undertaking them thus focussing not on compliance – but upon how the scheme can deliver its purpose and the 'what's in it for me' for the participant.	Medium	Yes – but this needs to be closely monitored
Underestimating resources required of GOsC and other stakeholders in order to support early adopters and wide scale implementation of the CPD Scheme.	If the scheme costs too much – and is therefore not implemented in practice, the intended benefits of the scheme won't be realised. If the budget for GOsC is not sufficient, this could put damage the financial health of GOsC as provision for the implementation of the	1	The idea is that the breadth of CPD has been widened to incorporate not simply clinical CPD, but CPD across the range of practice – including education, research, leadership and management. This means that osteopaths should be able to claim CPD for all aspects of the implementation of the scheme – including being a mentor to another. Free resources to undertake the core elements of the CPD scheme will be available. It is therefore intended that across the CPD cycle of three years that there should be no additional costs for osteopaths. Indeed as the whole scheme should be able to be undertaken for free, it is intended that	Low	Yes

Issue	Impact (1 is low and 3 is high)	Liklihood (1 is low and 3 is high)	Mitigating Actions	Residual Risk (Low, Medium or High)	Are we prepared to tolerate risk
	scheme is identified from reserves. 3		the scheme could even be cheaper for some osteopaths who pay for all their CPD courses. All osteopathic stakeholders will be asked to ensure that they are represented in the early adopters. The early adopters will be asked to feedback about benefits and costs so that costs can be monitored. This risk log will be a standing item for all groups within the governance structure to ensure appropriate monitoring of costs. The budget for the implementation of the scheme will continue to be reviewed and monitored by Council and the Policy Advisory Committee.		
No buy in to the scheme from the osteopathic stakeholdedrs	We can only deliver the scheme in partnership with our osteopathic stakeholders. 3	1	Governance structure focussing on partnership. Regular and ongoing communications with all osteopathic stakeholder partners.	Low	Yes – but this risk needs to be continually monitored.

Project scope or clarity is lost	Good project management is essential to ensure that the scheme is rolled out effectively. 2	1	Governance structure has been agreed. Detailed project implementation document and project plans in place with arrangements for regular monitoring at SMT.	Low	Yes
IT difficulties	Lack of knowledge about developing effective online educational resources to support key aspects of the CPD scheme, for example consent and communication potentially threatens implementation of the scheme. Lack of knowledge to scope out changes necessary to CPD module to give effect to the CPD scheme. 3	3	Scoping paper about changes to IT necessary in preparation for consideration by SMT, Provision made in budget for external expertise as necessary. Internal expertise recruited to support content development of resources required. Partnership development may be able to ensure that wider IT expertise is available.	Medium	Yes – but this risk needs to be continually monitored

Osteopathic Practice Committee
12 March 2015
Scoping the State of CPD Evaluation report

Classification	Public.
Purpose	For decision
Issue	Scoping the state of continuing professional development (CPD) report
Recommendation	To agree the scope of the state of CPD report and next steps.
Financial and resourcing implications	It is planned that the audit and the survey will be undertaken in-house and so costs will mainly comprise of staff time
Equality and diversity implications	Equality and diversity considerations are being taken into account as part of the scoping work
Communications implications	We will publish information about this report in the osteopath and through other relevant channels
Annex	Continuing professional development: providing assurance of continuing fitness to practice model
Author	Stacey Clift

Background

1. Our Corporate Plan 2013 to 2016 states that we will 'ensure through an appropriate process registrants are able to demonstrate their continuing ability to meet the *Osteopathic Practice Standards*.' This includes publishing 'proposals for a proportionate framework for continuing fitness to practise ... and a commitment to 'consult on and implement a new approach to continuing fitness to practise.' We are now using the terminology continuing professional development: providing assurance of continuing fitness to practise to describe our new CPD proposals which are currently out for consultation (see the consultation website at http://cpd.osteopathy.org.uk for further information).

2. Our Business Plan 2014 to 2015 states that we will:

    a. Design an osteopathic continuing professional development evaluation to feed into report of 'State of Osteopathic continuing professional development'
    b. Conduct the continuing professional development evaluation
    c. Publish a report about the 'State of Osteopathic continuing professional development'.

3. The aims of our current continuing fitness to practise model are:

    a. To ensure that osteopaths are up to date and practising in accordance with the *Osteopathic Practice Standards*
    b. To enable osteopaths to have access to communities and individuals where they can discuss areas of development and remediate if required and support the continuing enhancement of their practice.

4. The current CPD scheme enables osteopaths to select their own CPD.

5. We know from our CPD Discussion Document (2011) that most CPD was undertaken in the area of knowledge, skills and performance. It is therefore difficult to demonstrate that osteopaths on the register are keeping up to date across the breadth of the *Osteopathic Practice Standards*.

6. We know that issues surrounding consent and communication form the basis of concerns as outlined by patients, insurers, osteopaths as well as participants and assessors within the Revalidation Pilot.[1] This is not to say that communication

[1] See for example, KPMG, *Final Report of the Evaluation of the General Osteopathic Council's Revalidation Pilot, 2012*, pp 5, 23, 29available at: http://www.osteopathy.org.uk/uploads/kpmg_revalidation_pilot_evaluation_report.pdf and accessed on 30 September 2013. See also Vogel et al, the CROaM study, 2012, p6 (see above). See also Leach et all, the Patient Expectations Study above, p10. See also information from the Annual Fitness to Practise Report presented to the Education and Registration Standards Committee and Osteopathic Practice Committee on 19 September 2013 which shows that failure to gain consent features highly both in complaints made and investigated as well as cases found proved alongside failure to maintain adequate records. (Although note numbers are small – see also above where further data is being collected on complaints across the aggregated complaints made to GOsC and insurers.) Finally also see Freeth et al, Preparedness to Practise Report, 2012, p20 available at:

and consent is an area of concern for all osteopaths. However, communication and consent is an area highlighted more frequently than other areas from a range of sources, sufficient for us to pay attention to this area in our scheme for the profession as a whole.

7. We know that our current CPD scheme does not require objective feedback on practice. CPD and learning is primarily self-directed. In 2009, as part of their 'how osteopaths practice report' providing a baseline for the revalidation pilot, KPMG noted that 'Formal performance appraisal is rare, and … very little documented reflection on performance or feedback from patients exists.'[2] However, in 2013, KPMG noted that 'engagement in the pilot and using pilot tools had enabled participants to document their practice.' And that 'in discussions with registrants many indicated that they would continue to use the tools to develop their practice in the future.'[3]

8. There is some evidence to suggest that learning with peers or learning from feedback can improve the quality of learning.[4] And that self-assessment on its own can be flawed.[5]

9. Our new continuing professional development proposals (providing assurance of continuing fitness to practise) comprise a three year cycle, incorporating 90 hours of CPD and 45 hours learning with others. There are three mandatory elements which are:

    a. CPD in all the four themes of the *Osteopathic Practice Standards*
    b. CPD in communication and consent
    c. an objective activity feeding into CPD and practice (for example patient feedback, peer observation, clinical audit or case based discussion).

    The osteopath moves into the next CPD cycle by successfully completing a Peer Discussion Review – discussing their CPD and their practice with a colleague and demonstrating that they comply with the scheme – meeting our CPD Standards. A more detailed outline of the draft model is provided at the Annex.

10. Using the revalidation pilot tools had supported osteopaths to document practice. However, evidence of reflection was variable. It has been suggested by commentators, that individuals are less likely to share analysis of areas for

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http://www.osteopathy.org.uk/uploads/new_graduates_preparedness_to_practise_report_2012.pdf and accessed on 1 October 2013.

[2] See *How do Osteopaths Practice?*, KPMG, 2009, p3 available at: http://www.osteopathy.org.uk/uploads/how_do_osteopaths_practise_kpmg_reporta_ozone.pdf and accessed on 27 September 2013.

[3] See KPMG, Final Report, 2013 (above), p4

[4] See for example, Sargeant JM, Mann KV, Van de Vleuten CPD, Metsemakers JF, Reflection: a link between receiving and using assessment feedback, *Adv. Health. Sci, Educ. Theory Practice*, 2009, 14. 399 - 410

[5] See for example, Tracey J, Arroll D, Barham P, Richmond D, The validity of general practitioners' self-assessment of knowledge: cross sectional study, *BMJ, 1997; 315: 1426.* (Similar findings were reported in the KPMG revalidation pilot.) See KPMG Final Report, p5

development and reflections with the statutory regulator and perhaps more likely to share these reflections in a 'safer space'. More recently this assumption has been evidenced through the research by Professor Gerry McGivern and colleagues exploring the factors that enable compliance with the *Osteopathic Practice Standards*.

11. For these reasons, the continuing professional development model contains two elements of feedback and discussion. The first requires the osteopath to collect feedback from an external source about their practice and reflect on it. The second element is part of the Peer Discussion Review which requires the osteopath to discuss their practice and the CPD with another osteopath.

12. An important focus of our continuing professional development model and particularly as part of the peer discussion review, is the creation of a supportive and constructive environment which is built on trust and relies on osteopaths (both reviewers and those being reviewed) to genuinely participate and show interest in activities, helping colleagues feel valued. Both parties use skills of listening carefully and of giving and receiving constructive and helpful feedback to maintain the continuing enhancement of practice and patient safety.

13. However, a focus on reporting concerns could bring a tension to the peer discussion review process. In many ways, this tension could be similar to that which exists in a regulator. On the one hand, we want to provide support and guidance to osteopaths to enable them to discuss things that have gone wrong or might go wrong and take actions to put them right locally. A level of trust is necessary because only by providing a space for osteopaths to honestly discuss practice can we achieve patient safety. It is inevitable that things will go wrong in any form of clinical practice and it is important to discuss these and learn from them to achieve patient safety. Yet, on the other hand, where patient safety is at risk, it is important that concerns are reported to us and acted upon. However, an unintended consequence of this is that osteopaths will feel concerned about being 'reported' and may be fearful about discussing areas of development (with its consequent impact on patient safety). Again, this tension was explored in the McGivern research where he suggested the need for the provision of further more detailed guidance about 'red card' issues that should be referred to the regulator and 'yellow card' issues that should be managed locally. The research also makes recommendations about the level of documentation required for a Peer Discussion Review.

14. We have therefore provided some draft guidance in our Peer Discussion Review Form to further elaborate when concerns are appropriate to be managed locally and when concerns may need to be reported. However, it is likely that further work will need to be undertaken in this area – following the findings in the McGivern research.

15. Access to communities or individuals to discuss practice is important to support peer discussion about practice and enhanced learning and patient safety through an environment in which areas for development can be discussed. Osteopathic healthcare is primarily delivered within a commercial context outside teams or

employers. Therefore understanding whether such a community or groups of individuals is accessible is very important.

16. Our 2012 Registrant survey showed us that just under 50% of osteopaths were members of regional or other local groups of osteopaths and just over 50% were not.[6] Osteopaths who had been qualified for longer, were more likely to be members of regional groups. However, some respondents felt that they had sufficient contact with osteopaths outside of local groups. Equally, some felt that they did not have access to such local groups.

17. The purpose of the proposed evaluation is to establish a current picture of osteopathic CPD under the existing scheme. Establishing such a baseline in 2015 will help us to understand how (if at all), our new continuing professional development model has altered patterns of CPD over time. As a part of our evaluation of that framework it will aid our understanding of how CPD makes a contribution to safe practice and continuing enhancement of the quality of care. The draft continuing professional development model is currently in its consultation phase with a view to working towards early implementation in 2016 and 2017.

18. The purpose of this paper is to seek the views of the Committee to the scoping of this report taking into account the information provided above.

Discussion

19. Our 'State of CPD' report will want to do two things. It will want to provide a picture of the existing patterns of CPD so that we can see how they change as we implement a new model of continuing fitness to practise. However, we will also want to consider carefully our draft scheme and the changes we would like to see, so that we can get an explicit baseline in relation to these matters both currently and in the future.

20. Our research questions might be:

    a. How much CPD is undertaken in all domains of the *Osteopathic Practice Standards* under the current scheme in 2014/15?

    b. What are the main reasons for selecting/undertaking CPD?

    c. How much CPD is undertaken which involves learning with other?

    d. How much CPD is undertaken which involves learning by oneself?

    e. How much CPD is planned or unplanned?

    f. How much CPD is undertaken in the areas of consent and communication?

[6] See GOsC Registrant Survey, 2012, q56 available at: http://www.osteopathy.org.uk/uploads/osteopaths_opinion_survey_2012_findings_website.pdf

g. Are osteopaths collecting feedback about their practice from external sources?

h. Are osteopaths discussing the practice of CPD with others to support their practice?

i. Are concerns about practice being managed appropriately?

j. Do osteopaths have access to people with whom they can discuss their practice (including areas of skill and development)?

k. Do osteopaths feel that their CPD enhances their practice?

21. Methodologically, this could involve a three stage process:

    a. A randomly selected 20% CPD Annual Summary Forms and 2% CPD Record Folders over the period 2014/15 to test whether there is a range of CPD across all the domains of the *Osteopathic Practice Standards;* that CPD is undertaken in communication and consent; reflection from external sources are documented; discussions of development and practice with colleagues to support practice are documented; that areas of development or concerns are being identified and whether CPD planning forms are being used in CPD Record Folders. This sample size has been selected as per our current CPD audit sampling processes, in order that such data collection can become an on-going and integral part of the overall CPD audit process in the future.

    b. Survey questionnaire covering the following broad areas for investigation: Selecting CPD activities in relation to the themes of the *Osteopathic Practice Standards*; use of data or information from external sources to inform osteopathic practice; managing concerns with others and having access to people to discuss practice.

    c. An analysis of CPD course provision advertised through the GOsC website and the Osteopath Magazine, so as to establish whether CPD courses are available in all areas of *the Osteopathic Practice Standards* e.g. knowledge skills and performance, communication and partnership, safety and quality, and professionalism.

22. In responding to these questions, it will be helpful to stratify our samples to include practising and non-practising osteopaths, years in practice, UK or non UK qualified as well as looking at protected characteristics such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Exploring protected characteristics, as far as possible within the current data held in accordance with the Data Protection Act 1998, will help us to understand whether or not there are any unintended consequences related to protected characteristics and will ensure that we apply legislation and respect and implement good practice.

Next steps

23. A timetable is set out below.

Date	**Activity**
March 2015	Agree scope of the report
Spring/summer 2015	Design and undertake audit and survey
Autumn/winter 2015	Analyse data
Winter 2015	Publish report

Recommendation: to agree scope of the State of CPD Report and next steps.

Updated timeline for the State of CPD Evaluation report

Date	**Activity**
March 2015	Agree scope of the report
July 2016	Establish baseline data from CPD audit
October 2016	Design and undertake survey
December 2016	Design and undertake qualitative semi-structured interviews and/or focus group (depending on findings from above research methodologies)
January 2017	Analyse complete data set
March 2017	Publish report