General Osteopathic Council



**Policy Advisory Committee**
**18 October 2018**
**Review of Registration Assessment**

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| **Classification** | Public |
| **Purpose** | For decision |
| **Issue** | The review of registration assessment processes to reflect the updated Osteopathic Practice Standards, and changes to documentation to reflect feedback received from assessors and applicants. |
| **Recommendations** | 1. To agree the proposed timetable for development, consultation and implementation of updated FEP and ACP documentation.<br>2. To consider the approach to assessment of internationally qualified applicants. |
| **Financial and resourcing implications** | This is managed within existing budgets for registration assessment and assessor training. Consultation planned for 2019 will be managed in-house, with no added resource implications. |
| **Equality and diversity implications** | Issues of diversity and equality may impact on accessibility to the application and assessment process, and will be taken into account in the proposed consultation when seeking feedback. |
| **Communications implications** | There will be a consultation process in 2019 which will have communications implications to be managed in-house, and the final agreed documentation will be communicated to stakeholders through our usual channels. |
| **Annexes** | A. Draft Further Evidence of Practice form<br>B. Draft Further Evidence of Practice Guidance for Applicants and Assessors<br>C. Draft ACP evaluation form<br>D. Draft table highlighting OPS assessed, and not assessed within the process. |
| **Author** | Steven Bettles and Fiona Browne |

## Background

1. 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'.

2. We do not 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.

3. For internationally qualified applicants, the process of applying to join the register for an osteopath who trained abroad differs between those who trained in the EU or Switzerland1, and those who trained outside the EU2. This position may change 'post Brexit'.

4. The process for those trained outside the EU or Switzerland includes an assessment of training, qualifications and experience. If a 'substantial difference' is found between our Osteopathic Practice Standards and the applicants' 'training, qualifications and experience' then the applicant must choose a period of adaptation or an aptitude test which includes a Further Evidence of Practice Questionnaire (FEPQ)3. Assessors of the FEPQ may recommend that the applicant is able then to progress to an Assessment of Clinical Practice4 (ACP) involving a practical assessment with two actual patients in a clinical setting. Successful passing of the ACP entitles the applicant to apply for registration.

5. Current guidance for both applicants and assessors is published on the GOsC website.5

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

7. Rather than just retain the documentation as it is, but with revised OPS references, we have taken this opportunity to conduct a broader review, based on feedback received from registration assessors, applicants, and from the executive's own reflections on the process.

8. Based on this feedback and reflection, we developed an initial updated draft of:

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[1] See GOsC website: https://www.osteopathy.org.uk/training-and-registering/how-to-register-with-the-gosc/i-trained-in-the-eueea-or-switzerland/
[2] See GOsC website: https://www.osteopathy.org.uk/training-and-registering/how-to-register-with-the-gosc/i-trained-outside-the-eueea-and-switzerland/
[3] Available here: https://www.osteopathy.org.uk/news-and-resources/document-library/registration/further-evidence-of-practice-questionnaire/
[4] Details here: https://www.osteopathy.org.uk/news-and-resources/document-library/registration/applying-for-registration-from-outside-the-eueea-or-switzerland/
[5] Available here: https://www.osteopathy.org.uk/news-and-resources/document-library/registration/further-evidence-of-practice-questionnaire-guidelines-for/

a. Further Evidence of Practice form (Annex A)

b. Further Evidence of Practice Guidance for Applicants and Assessors (Annex B)

c. ACP evaluation form (Annex C)

d. Table highlighting OPS assessed, and not assessed within the process as currently drafted.

9. These early draft documents formed the basis of discussions with registration assessors at two training sessions on 2 and 4 October, to seek feedback to help us develop the drafts further, and to consider how best the assessments can be structured to provide assurance that applicants meet the standards but also to consider how they might embody those standards in practice.

10. This paper explains the suggested proposals, and seeks input from the Committee and agreement to the proposed consultation and implementation plan.

**Discussion**

11. Initial feedback on the existing FEP and ACP process was given by applicants and registration assessors through assessment feedback, and also from registration assessors through appraisal and also through webinars held in Spring/Summer 2018, and included the following:

| Feedback | Response |
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| Generally the process of examining the qualification, written assessment and practical assessments were all felt to be important components | Although there were comments as to how the assessments might be improved, the consensus was that the broad structure was fit for purpose, and this has therefore been retained in our draft modifications. |
| Is there more opportunity to tailor the process? | This related to a greater individualisation of assessments to individuals rather than a one process fits all approach, |
| Areas of concern typically, communication and consent and demonstration of clinical reasoning | We have tried to emphasise these areas within the revised documentation for the applicants to demonstrate. |
| Follow up questions prior to judgement being made (qualification and FEP) | Some suggest broadening the scope of assessment by including an interview (maybe online) with the applicant to help verify their application, and explore any queries. We haven not included this within the process at |

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| | this stage, but it can be discussed further. |
| Provide samples of good practice to improve the quality of documentation/evidence being submitted (qualification and FEP) | The suggestion here was to provide more examples of what a 'good' application looks like, to help support applicants and prevent the consideration of substandard applications. There is the risk, of course, that providing examples leads to a mirroring of these within applications, which are not representative of the applicant's actual work and do not test the desired components of the standards. |
| Time taken v payment | The guidelines suggested that the expectation of the time taking to undertake a FEP assessment was unrealistic, and we have removed mention of this and the fee for assessors was increased. |
| Complexity of documentation/ supporting candidate to map against relevant standards/reducing implicit judgements | In the current FEP documentation, the process of cross referencing against standards is quite complex. We have tried to address this in the updated draft by requiring the applicants to map their activities to the relevant standards, so they take more responsibility for this, and it is easier for the assessors to navigate and mark. |
| Clarity about purpose of FEP (e.g. cannot assess quality of techniques in FEP) | The FEP process requires applicants to outline their familiarity with and use of a range of osteopathic techniques and approaches. Some have felt that a written portfolio is not ideal for assessing technical knowledge. We have reduced the scope of this in the draft for discussion (removing reference to an 'appropriate' range, for example) though there is still scope for further amendment – some have suggested removing the patient profile or the technique section completely. |
| Review of aspects of OPS that can be assessed in clinical setting | Assessors are required, effectively, to judge the applicant's fitness to practise in terns of their ability to meet the OPS. It is acknowledged, though, that there are gaps in which standards can actually be assessed, both within the FEP and in the ACP processes. We have attempted to reflect this in the drafts, and are discussing this further to identify 'gaps' in the OPS in terms of the assessments. |

12. The feedback above was therefore borne in mind when developing initial drafts for consideration, in order to address particular areas of concern, or to enhance the process generally.

*Summary of initial suggested changes in draft FEP documentation*

13. The draft FEP (Annex A) includes the following changes for consideration:

    a. *Name:* we have suggested reference to this as a 'questionnaire', as it is far more complex than this.

    b. *Reporting to ACP assessors:* currently the FEP form states that a report from the evaluation will be submitted to the ACP assessors to assist them in their assessment of the applicant's management of two new patients in the clinical setting. We are suggesting that the FEP should be seen as a stand alone stage in the process, and that a report is not submitted to ACP assessors. The idea is to acknowledge that the FEP is a separate stage in the process which applicants either pass or not, and that if they pass, they should be given the chance of an ACP without any prejudgements being made. There are mixed feelings on this suggestion from the assessors with some approving the greater fairness to the applicants, but others feeling assured that they can pass on potential concerns from an FEP application to the ACP assessors to explore further when they see the applicant in practice. There are questions, therefore, as to whether these are two separate and distinct processes, or whether they form a composite assessment. There are arguments supporting both views and these could inform consultation questions in 2019.

    c. *Patient profile – question 1:* in the current version, there is some crossover between questions 1 and 2, so we have suggested making the first more of an audit – descriptive, but not reflective – to get a sense of the applicant's practice over a three month period. We have taken out the need to reflect on the profile in terms of its contribution to professional development, as this can be covered in the next question. Feedback from assessors was mixed about whether you needed a picture of the osteopath's practice in order to assess their approach to practice as outlined in the CPD section and the questions about approach to managing patients. Again, these views could inform consultation questions in due course.

    d. *Keeping professional skills up to date – question 3:* we have specified that applicants should indicate how they have kept their professional knowledge and skills up to date over the last two years, to give it a time period. We've also asked them to pick two cases from the profile given in response to Q1, and expand on how these helped them to enhance their professional and clinical skills. The guidance to the applicants has been modified accordingly. We have asked about CPD activities, but said that this might also include their general approaches to CPD – do they attend regular meetings with

colleagues, for example, or whether they undertake feedback or audit activities.

e. *Case presentations – question 3:* we have proposed amending this so that applicants are asked to supply four separate case scenarios. The list is:

   1 A neuro-musculoskeletal presentation

   2 A musculoskeletal presentation without nerve involvement

   3 A case where you concluded that the primary issue was non-musculoskeletal in origin

   4 A case where you referred the patient to another healthcare practitioner.

   5 A case where you felt that osteopathic intervention was contraindicated from the outset, or had been indicated, but becomes no longer appropriate

Applicants are asked to provide one case from categories I-III, then choose one from category 4 or 5. We have not included a visceral case or one where they are asked to specify their osteopathic management of a patient (current requirements), as the latter should apply to all of the cases, rather than being a separate issue. Applicants are also asked to state how they involved the patient in making an informed decision about their care, and also to state which of the OPS are demonstrated by the case. They are told that we are looking to see, over the four cases, how they've met OPS A1, A2, A3, A4, B1, B2, C1, C2, D10. We have also asked them to provide an overview of the techniques used in each case.

This approach reduces the number of cases that the applicant provides, but aims to make the information informing judgements more explicit by expressly requiring the applicants to explain their clinical reasoning among other areas.

The templates for each case are the same, for the applicants to complete (which differs from the current FEP form).

f. *Techniques – question 4*: we have retained this question from the current form, but modified it slightly. In this draft, applicants will still be required to complete a table, indicating their familiarity with particular techniques, and the frequency with which they use them, but we have taken out reference to 'an appropriate' range of techniques, as this is quite difficult to quantify. They still need to provide clinical examples to illustrate their use of a technique if this is not shown in the case scenarios in Q3. The technique chart for completion has been updated slightly – this is now in landscape format and we have taken out the need to cross reference to cases answered in response to Q3, as they now have to specify this more clearly in the case itself.

   As reported in the table above, some assessors' initial response to this has been that it is difficult to accurately assess a question about techniques and

approaches to treatment within a written format, and this might be better left for the practical assessment. The downside of this is that the techniques demonstrated within the practical assessment are dependent on the patient, and may reveal only a limited range, depending on the circumstances.

*FEP – Guidelines for Applicants and Assessors*

g. The guidelines have been amended to reflect the changes proposed in the FEP form outlined above. The evaluation forms in appendix 2 of the guidelines have been updated from the current version which just lists some standards in relation to the questions. For 1, 2 and 4, specific questions are asked for the assessors to consider. For 3 – the case scenarios – again, these have been updated to outline the key skills and knowledge that the applicant is required to demonstrate across the four cases, rather than just a list of standards. In meeting the criteria, then the standards should be met, in so far as this is possible to gauge from the application.

*ACP evaluation form*

14. In the updated ACP evaluation form, we have streamlined the mark sheet to reflect the separate stages of the process, and added criteria to each aspect, rather than just standards to consider. The thinking is that in demonstrating these criteria, the applicant will be meeting the standards.

*Gaps*

15. The gap analysis at Annex D shows that the areas of the OPS that are not currently assessed within the current framework. These areas are mostly in the theme of Professionalism and cover important areas, such as confidentiality and candour.

16. The registration assessors have helped us to identify this gap and we have discussed the issues and the policy options in high level terms. Feedback included:

- What is our approach to ensuring that internationally qualified applicants are aware of their obligations to fulfil all aspects of the OPS in practice and including the context of practice in the UK?

- Different mechanisms to fulfil this gap were identified including:

    - Providing specific resources in the area of professionalism which should form a part of the applicants CPD prior to registration. (Advantages – general resources can be made available to all osteopaths. Disadvantages – difficult to assess that the desired knowledge and skills have been developed by the osteopath)

    - Requiring some form of education in these areas prior to application to GOsC (perhaps e-learning, shadowing etc.) – (Advantages – some form

of assessment is required even if self-declaration. Disadvantages – It is not clear that we have powers to require formal education prior to completion of an assessment).

- Assessed as part of the registration assessment through either the FEP (the written assessment) or the ACP (through oral questioning). Advantages – assessment of candidate in important areas of the OPS. Disadvantages – time and resources to put into development of a question bank, model answers etc.)

- Assessment through a reflective portfolio from the applicant – Advantages – assessment of the candidate in important areas of the OPS. Disadvantages – assessment criteria and consistency may be more difficult to demonstrate.

- Finally, it is worth considering further should we, and if so how should we support internationally qualified applicants into practice. Numbers are currently small and it is worth noting that internationally qualified applicants are not represented in our fitness to practise processes. But as we move to exploring implementation of the OPS not just from the perspective of raising awareness and knowledge to embodying the Osteopathic Practice Standards and embedding these in practice, in this context, what steps should we be taking to support transition into practice for this group of registrants?

*General*

17. At the time of writing, the feedback sessions with registration assessors were completed but a full analysis and reflection on their comments has not yet taken place.

18. It is intended, though to work to the following proposed timetable for the review process:

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| 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. |

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| July 2019 | Final documents reported to Council |
| September 2019 | All FEP and ACP assessments will be against updated OPS using revised documentation. |

**For consideration**

19. We are keen to receive feedback and comment from the Committee to help us further develop the FEP and ACP documentation to report to Council with final consultation drafts in January 2019. In particular:

    a. Any comments regarding ensuring that the applicants sufficiently embody the OPS in their practice? There are standards which are impossible to assess, or which may not arise in every case – are we able to tolerate the gaps or develop the policy options here?

    b. In relation to FEP – does the proposed draft provide sufficient opportunity for assessors to make an informed judgement as to the applicant's demonstration of the stated standards?

        - How could this be enhanced?

        - Are there any aspects which might be removed from the FEP (for example, details of the applicant's familiarity and use of particular osteopathic techniques)?

**Recommendations:**

1. To agree the proposed timetable for development, consultation and implementation of updated FEP and ACP documentation.

2. To consider the approach to assessment of internationally qualified applicants.