General Osteopathic Council

**10**

**Council**
**17 October 2013**
**Continuing fitness to practise**

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| **Classification** | Public. |
| **Purpose** | For decision |
| **Issue** | To agree a draft Continuing Fitness to Practise Framework, for discussion with key stakeholders, ahead of consultation during 2014. |
| **Recommendations** | 1. To agree the draft framework for further discussion with key groups.<br>2. To agree that the draft framework and more detailed guidance should be subject to consultation during 2014. |
| **Financial and resourcing implications** | The operation of any Continuing Fitness to Practise Scheme must take place within current resources. However, Council has already agreed that the set up costs may be funded from reserves. |
| **Equality and diversity implications** | Equality and diversity issues have been taken account of as part of our revalidation pilot and equality impact assessment. We will continue to inform and update the equality impact assessment as we develop the framework and guidance with stakeholders. |
| **Communications implications** | We will continue to develop the draft framework for continuing fitness to practise outlined in this paper in partnership with our stakeholders ahead of a more formal consultation. |
| **Annexes** | Annex A – Environmental factors from the Professional Standards Authority Report.<br><br>Annex B – Draft Continuing fitness to practise Framework. |
| **Author** | Fiona Browne and Tim Walker |

**Background**

1. The Corporate Plan sets three core strategic objectives for 2013 to 2016 which provide a helpful structure for considering our draft framework for continuing fitness to practise. These objectives are:

    - To promote public and patient safety through 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. Goals include:

    - To ensure that through an appropriate process, registrants are able to demonstrate their continuing ability to meet the *Osteopathic Practice Standards.*

    - To ensure that through an appropriate process, registrants are encouraged continually to enhance and improve their practice.

3. Our Business Plan 2013-2014 states that we will:

    - Devise a communication and consultation strategy to encourage a breadth and depth of responses to the continuing fitness to practise consultation.

    - Approve and publish proposals for the regulation of continuing fitness to practise.

4. Our Continuing Fitness to Practise Framework should enable us to describe how we ensure that registrants practise in accordance with our standards to all our audiences including: patients and the public; osteopaths; other health professionals; and other organisations.

5. The development of our Continuing Fitness to Practise Framework has been based on an extensive collection of evidence and analysis as well as discussion with a range of stakeholders.

6. On 20 March 2013, Council considered and noted an extensive report of the findings from the evidence and analysis including:

    - The CPD Discussion Document and consultation analysis available on our website at: http://www.osteopathy.org.uk/practice/Continuing-professional-development/

- The Revalidation Pilot evaluation and impact assessment, available on our website at: http://www.osteopathy.org.uk/practice/Revalidation/Research/

- The publication and implications of the Professional Standards Authority Report in November 2012, *An approach to assuring continuing fitness to practise based on right-touch regulation principles* at: http://www.professionalstandards.org.uk/docs/psa-library/november-2012---right-touch-continuing-fitness-to-practise.pdf?sfvrsn=0

7. Since then, our thinking has also been shared with and influenced by a variety of individuals and groups including:

   - A seminar on 15 March 2013 involving regional group leads, the British Osteopathic Association (BOA), the Council for Osteopathic Educational Institutions (COEI), National Council for Osteopathic Research (NCOR) and the Osteopathic Alliance (OA).

   - A seminar on 18 July 2013 involving osteopathic representatives from educational institutions, special interest societies, patients and lay and osteopathic members of Council.

   - A discussion item with the other health regulators, the Professional Standards Authority and the Department of Health at the revalidation inter-regulatory meeting on 12 August 2013.

   - A Council Strategy Day on 10 September 2013.

   - As well as a number of discussions at one to one meetings with registrants, educational institutions, the BOA, other organisations and regulators both within the UK and international regulators and others.

8. This paper explores the current context, the findings, a draft framework and next steps.

**Discussion**

*Purpose*

9. The overarching outcome of any scheme must be public protection. In other words, the Scheme should enable safer and more effective practice and should not encourage any behaviour that could put public protection at risk (for example, gaming).

10. The foundation for our framework must be based on demonstrating that standards are met as well as the enhancement of practice. This is clear both from our own commitment to these objectives within our Corporate Plan and also from the Professional Standards Authority report.

*Context*

11. Achieving that outcome of public protection must be placed in the context of the osteopathic profession. This is important both in terms of what osteopaths do and also the environment within which they work.

12. This context is informed through a variety of research, evidence and analysis and supports an understanding of the level of risk that we are seeking to mitigate through our draft Continuing Fitness to Practise Framework.

13. Relevant context to individual practice:

- The Clinical Risk Osteopathy and Management research study suggested that osteopathy can be described as a 'low risk intervention' although 'major events are rare, but do occur'.[1]

- The number of fitness to practise cases per registrant appears consistently to be lower for osteopaths than for General Chiropractic Council, General Medical Council and General Optical Council registrants, but higher than for General Pharmaceutical Council and Health and Care Professions Council registrants.[2]

- The Osteopathic Patient Expectations research study showed a high rate of satisfaction from osteopathic patients with over 96% of respondents reporting being satisfied or very satisfied with their osteopathic care with their expectations largely met.[3]

- Complaints to the regulator and to the insurers are on a 'wide variety of issues' including clinical, communication and conduct issues.[4]

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[1] See Vogel S. et al, *Clinical Risk Osteopathy and Management Summary Report, (the CROaM study)* 2012, p25, available at http://www.osteopathy.org.uk/uploads/croam_summary_report_final.pdf and accessed on 30 September 2013.

[2] See for example the CHRE/PSA Performance Review Reports for 2011/2012 and 2012/2013 available at: http://www.professionalstandards.org.uk/docs/scrutiny-quality/chre-performance-review-report-2011-12.pdf?sfvrsn=0 and http://www.professionalstandards.org.uk/docs/scrutiny-quality/performance-review-report-2012-13.pdf?sfvrsn=0 and accessed on 1 October 2013.

[3] See Leach J. et al, *The OPEn project, investigating patients' expectations of osteopathic care Summary Report*, (the Patient Expectations Study), 2011, available at: http://www.osteopathy.org.uk/uploads/open_summary_report%20_public.pdf and accessed on 30 September 2013

[4] See Leach J et al, *Complaints and claims against osteopaths: a baseline study of the frequency of complaints 2004–2008 and a qualitative exploration of patients' complaints*, 2011, p54, available at: http://www.osteopathy.org.uk/uploads/complaints_and_claims_against_osteopaths_2004-2008_public.pdf and accessed on 30 September 2013. Typically, complaints relating to 'adverse events' were directed to the insurers and complaints about conduct and communications were directed to GOsC. The insurers and GOsC are continuing to collect data related to complaints using a common classification system to enable this research to be updated and clarified during 2014 providing a more accurate picture of the complaints and claims made by patients against osteopaths. It is also worth noting findings from the Patient Expectations study which show that a number of unmet patient expectations related to communication (for example, not realising undressing would be required and information about side effects).

- 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.[5]

- In 2009, KPMG noted that 'Formal performance appraisal is rare, and … very little documented reflection on performance or feedback from patients exists.'[6] 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.'[7]

- Using the 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 development and reflections with the statutory regulator and perhaps more likely to share these reflections in a 'safer space'[8]. KPMG suggested 'there was often no evidence within the portfolio to demonstrate that they had actively considered what the feedback meant and how they had reconsidered their practice. In these instances, it is difficult to see the impact that revalidation would have on registrant practice without further feedback and support to these osteopaths.[9]

- The approach used within the Revalidation Pilot was too complex and burdensome and would need to be simplified.[10]

14. The Professional Standards Authority report discussed environmental risk factors. A list of these factors is attached at Annex A. These include lack of clinical governance, levels of autonomy and isolation, levels of support provided (or not), emotional and psychological engagement. The context for the osteopathic profession demonstrates the following:

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

[6] 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.

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

[8] Indeed on this, the GOsC has recently commissioned some research by Professor Gerry McGivern et al to explore this theory in relation to the osteopathic profession.

[9] See KPMG, Final Report (above), p5.

[10] See KPMG, Final Report (above), p5

- 'The unsupervised nature of osteopathy also means that responsibility for patient safety rests firmly with individual osteopaths.' Even in group practices, osteopaths consult with patients on their own.[11]

- 'More than half of osteopaths normally practise alone, meaning they are frequently alone with patients; and circa 20% of practising osteopaths spend more than 50% of their time practising in their own home.'[12]

- No more than 15% of osteopaths regularly practise in managed environments such as hospitals or clinics which may be subject to NHS standards of clinical governance.[13]

- The nature of osteopathic practice is such that boundaries can be readily miscommunicated and misunderstood.

These points illustrate that the layers of employer regulation and team-based regulation that might be present in other healthcare contexts, to support the objective of public protection and continued enhancement of quality of care, are not usually present in osteopathy.

15. In discussing revised proposals for continuing fitness to practise based on the osteopathic context, and the key findings from the Revalidation Pilot and the CPD Discussion Document as well as other research, points for consideration have included:

    - Osteopathy is low risk not no risk, and thus we must focus on ensuring that our message about how the public is protected is clear.

    - We must address the issue of how we can support genuine reflection and feedback in a profession practising primarily independently – we think that the involvement of the regulator alone will not necessarily achieve this and therefore presents challenges as to how to demonstrate standards and enhanced quality of care.

    - Peer review and patient feedback are important.

    - A single scheme (rather than separate CPD and revalidation schemes) could be a proportionate way of ensuring continuing fitness to practise.

    - We must ensure that the whole breadth and depth of practice is covered as part of the requirement to demonstrate standards.

    - We must understand and demonstrate how we will know when people are not complying.

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[11] See How do Osteopaths Practice?, KPMG, 2011, available at: http://www.osteopathy.org.uk/uploads/how_do_osteopaths_practise_kpmg_reporta_ozone.pdf and accessed on 27 September 2013, p3

[12] As above.

[13] As above.

- Audit must focus on the quality of activities and not just the quantity.

- There is potential for partnership working as part of the Scheme, but appropriate mechanisms for governance and quality assurance must be in place.

*Timing*

16. Given the context of the development of the osteopathic profession and infrastructure within it, it may not be possible to meet all the Scheme's objectives at the outset.

17. The evolution of the Scheme will require capacity building within the osteopathic profession – among individuals and professional groups – to support learning, to support safe practice and continued enhancement of practice.

18. As these networks are strengthened and professional isolation is reduced, we will be in a position to build on the Scheme, ensuring always that it achieves our desired outcome of patient safety and enhanced quality of care.

**The draft Continuing Fitness to Practise Framework**

19. A draft Continuing Fitness to Practise Framework is attached at Annex B. The framework has sought to take on board the evidence, data and information from the CPD Discussion Document and Revalidation Pilot and also includes feedback from the interested parties as outlined above.

20. The framework is based on the following propositions:

    a. A single Scheme should enable the demonstration of the *Osteopathic Practice Standards* and the enhancement of quality of care, covering the full breadth and depth of individual practice.

    b. The Scheme should remain primarily self-directed by the osteopath, as it is now, but with some additional elements planned in over a period of three years to strengthen links to the *Osteopathic Practice Standards*.

    c. The Scheme should encourage feedback to individuals to support both the demonstration of standards and the enhancement of the quality of care.

    d. The peer review discussion element could be delivered by people, groups or organisations outside of the GOsC supported by appropriate governance and quality assurance arrangements.

    e. The Scheme should include a specific focus on consent and communication.

    f. There should be fair and appropriate mechanisms for people who are not engaging with the process to be removed administratively, as there are now in the existing CPD scheme.

21. The framework comprises the following sections:

    a. Purpose of the framework

    b. Principles

    c. Summary of the process

    d. Standards for continuing fitness to practise.

**Next steps**

22. The early engagement and active involvement of our other stakeholders is crucial to develop and implement a proportionate process which genuinely delivers our objective of public protection and the continued enhancement of quality of care.

23. Council is asked to agree the draft framework in principle to enable us to work more closely with stakeholders and organisations such as the regional communication network groups, the special interest groups, educational institutions, CPD providers and the British Osteopathic Association to explore the roles that they might take in such a framework and to explore matters such as quality assurance and support.

24. This will enable us to prepare a refined framework and more detailed guidance for consultation during 2014.

**Recommendations:**

1. To agree the draft framework for further discussion with key groups.

2. To agree that the draft framework and more detailed guidance should be subject to consultation during 2014.

**Risk Factors associated with continuing fitness to practise from the Professional Standards Authority Report, *An approach to continuing fitness to practise*, 2012**

1. The following risk factors are outlined in the Professional Standards Authority (PSA) Report and relate to the context, or the environment of practice.

| **Risk Factor** | **CHRE description** |
|---|---|
| Effectiveness of clinical governance (or equivalent) mechanisms | What measures are in place to manage risk and learn from mistakes |
| Effectiveness of qualifying training | How well the course has taught skills of knowledge, and professionalism |
| Frequency of practice | If practitioner is well-versed in his/her field. e.g. returners to practice, practitioners in predominantly management roles |
| Level of autonomy | Extent to which practice is monitored and practitioners are able to practice independently |
| Level of isolation | Level of interaction with other practitioners (linked to practice context) |
| Level of support | Quantity and quality of appraisals, learning opportunities, etc. to which registrant has access |
| Practice context | Whether practising in private practice, NHS or non-NHS managed environments, or domiciliary |
| Time since qualification | Length of time since practitioner qualified (linked to age) |
| Workload | Pressure on practitioners to be more efficient; increased stress |

2. The following risk factors are also outlined in the PSA report and relate to the types of activities undertaken by the practitioners.

| **Risk Factor** | **CHRE Description** |
|---|---|
| Complexity of task | Complexity of diagnosis, procedure, or treatment; including the management of issues related to the service user such as compliance with treatment |
| Emotional and psychological engagement | Extent to which intervention poses an emotional and/or psychological risk to the service user |
| Level of responsibility for service user safety | Whether responsible for service user safety and how many responsible for; vulnerability and/or severity of condition |
| Likelihood and severity of treatment side effects | Extent to which practitioner manages negative side-effects |
| Medical invasiveness | Whether the intervention requires invasive medical treatment |
| Rate of evolution of techniques | Level of need for ongoing training and learning |
| Sexual invasiveness | Whether the intervention requires undressing and/or contact with intimate areas |

## Draft Continuing Fitness to Practise Framework

### Outline

1. The purpose of the Continuing Fitness to Practise Scheme is to:

    a. Protect the public and patients through ensuring that osteopaths practise in accordance with the *Osteopathic Practice Standards.*

    b. Help registrants demonstrate that they are practising in accordance with the *Osteopathic Practice Standards.*

    c. Support the continued enhancement of the quality of patient care.

### Principles

2. The following principles of the Scheme underpin its rationale. The Scheme should:

    a. Support safe care and improving standards of care.

    b. Develop the osteopathic professional community to support peer discussion amongst osteopaths about safety and quality of care.

    c. Encourage reflection, learning and development of practice.

    d. Encourage interprofessional relationships.

    e. Encourage awareness and integration of current research.

    f. Focus on current and planned practice.

    g. Be based on CPD and reflection linked to the *Osteopathic Practice Standards* and areas of personal interest.

    h. Enable areas of concern identified through research or fitness to practise data) to be fed through to the CFtP Scheme to enhance compliance in these areas.

### Summary of the process

3. The Continuing Fitness to Practise Scheme comprises the following elements:

    a. Evidence of 30 hours of CPD and 15 hours learning with others to be declared annually. This will total 90 hours of CPD with at least 45 hours learning with others over the proposed three year cycle of the Scheme.

    b. The majority of CPD will continue to be self-directed. However, as part of the total 90 hours, at the end of each three year cycle, CPD activities must

have been completed in each of the following areas of the *Osteopathic Practice Standards*:

- Communication and patient partnership
- Knowledge, skills and performance
- Safety and quality in practice
- Professionalism.

c. All osteopaths will need to undertake at least one defined activity that focuses on consent and communication.

d. At the start of each three year cycle, osteopaths should undertake at least one of the following:

- Peer discussion (including patient notes) and analysis
- Patient feedback and analysis
- Clinical audit and analysis
- Case based discussion (including patient notes) and analysis.

e. Peer Discussion Review – at the end of each three year cycle, there must be a peer discussion involving a review of the registrant's CPD Record. It is expected that the CPD Record would demonstrate the standards for CPD (see Appendix 1).

The peer discussion review must be documented (see below) and take account of the registrant's:

- current level of knowledge, skill, area of practice and experience
- any learning that they have completed
- the registrant's analysis of their own learning needs which may lead to future action.

The peer review may be undertaken:

i. By a professional colleague (either an osteopath or other healthcare professional)

ii. Within arrangements put in place by:

- A regional society or group
- A member of the Osteopathic Alliance or other postgraduate CPD provider

- Ann osteopathic educational institution
- An employer

iii. By the General Osteopathic Council (GOsC).

f. Standards – the peer review discussion would take place using the CPD standards. Examples of the standards that might be in place are attached at Appendix 1. An example of a cycle complying with the standards is attached at Appendix 2.

g. Quality Assurance – peer discussions that take place through organisations other than GOsC will be subject to quality assurance.

## Standards for Continuing Professional Development (CPD)[14]

These standards for CPD are based on the assumption that all practitioners will attempt to enhance their practice through genuine engagement with the process.

Standards for CPD would help to determine whether osteopaths are doing what is required in their CPD. If, after help and support, osteopaths refused to comply, they would be administratively removed – in much the same way that we do now for CPD.

The following are emerging examples of what the standards might look like:

Within each CPD cycle of three years, osteopaths must:

1. *Demonstrate that activities are relevant to the full range of osteopathic practice.*

   The breadth of the individual registrant's should be covered within the CPD cycle (for example, academic, research and clinical practice roles and mentoring or reviewing roles and should also include management roles). Demonstration of this standard will require osteopaths to describe their practice over a three year period and explain how CPD is relevant to it or to intended future practice. Osteopaths should also describe each CPD activity and its relevance to practice.

2. *Seek to ensure that activities have contributed to the quality of care through analysis and reflection and consideration of a range of types of evidence including objective evidence and discussion with peers*.

   This will be achieved by undertaking at least one 'objective' activity and then completing an analysis of the evidence arising from this activity. Examples of an objective activity include: patient feedback and analysis or clinical audit and analysis at the start of each three year cycle plus an analysis of any other evidence (for example feedback from a peer discussion review, or structured reflection) in order to prepare a plan of areas for development and an outline of any CPD activities to be undertaken to meet these needs.

   Although most CPD will continue to be self-directed, at the end of each three year cycle, CPD activities must have been completed in each of the following areas:

   - Communication and patient partnership
   - Knowledge, skills and performance
   - Safety and quality in practice
   - Professionalism

[14] These are very much drawn from the HCPC standards for CPD available at: http://www.hpc-uk.org/registrants/cpd/standards/ and accessed on 1 October 2013.

It will also be expected that all osteopaths undertake a CPD activity in relation to communication and consent.

A single activity may meet the requirements in relations to more than one of the activities above.

It will be expected that activities claimed as CPD should be mapped against the relevant theme of the *Osteopathic Practice Standards* in advance, and the documentation of these learning activities should include the intended learning objectives and an evaluation of whether learning objectives have been achieved.

We will discuss with CPD providers how they can support osteopaths with this mapping, and hope that over time, this will be included as part of the delivery of traditional CPD courses. For bespoke 1:1 activities, a focus on the *Osteopathic Practice Standards* at the outset will enhance awareness and improve learning.

A reflective statement must accompany each CPD activity and should include evidence that the osteopath has:

- considered their current level of knowledge, skill, area of practice and experience
- reviewed any learning that they have completed
- come to a considered view about their own needs, which may lead to future action.

The CPD hours claimed must include a minimum of one 'objective' activity to be undertaken every three years. This should be either:

i. Patient feedback and analysis

ii. Clinical audit and analysis

iii. Peer review and analysis

iv. Case based discussion and analysis.

In this context, analysis must include:

- Aim of activity
- Description of method used and discussion of why method was chosen
- Summary of results
- Conclusion, which must include a review of the method chosen, a summary of the strengths identified and a summary of the areas for development and
- An action plan about how those areas of development will be met.

3. *Seek to ensure that CPD benefits patients*.

   Within each CPD cycle of three years, osteopaths must:

   - Undertake CPD activities related to consent and communicating with patients.

   - As part of the peer discussion review, discuss the activities identified by the osteopath as potentially benefitting their patients and discuss activities that might be undertaken over the next three year CPD cycle.

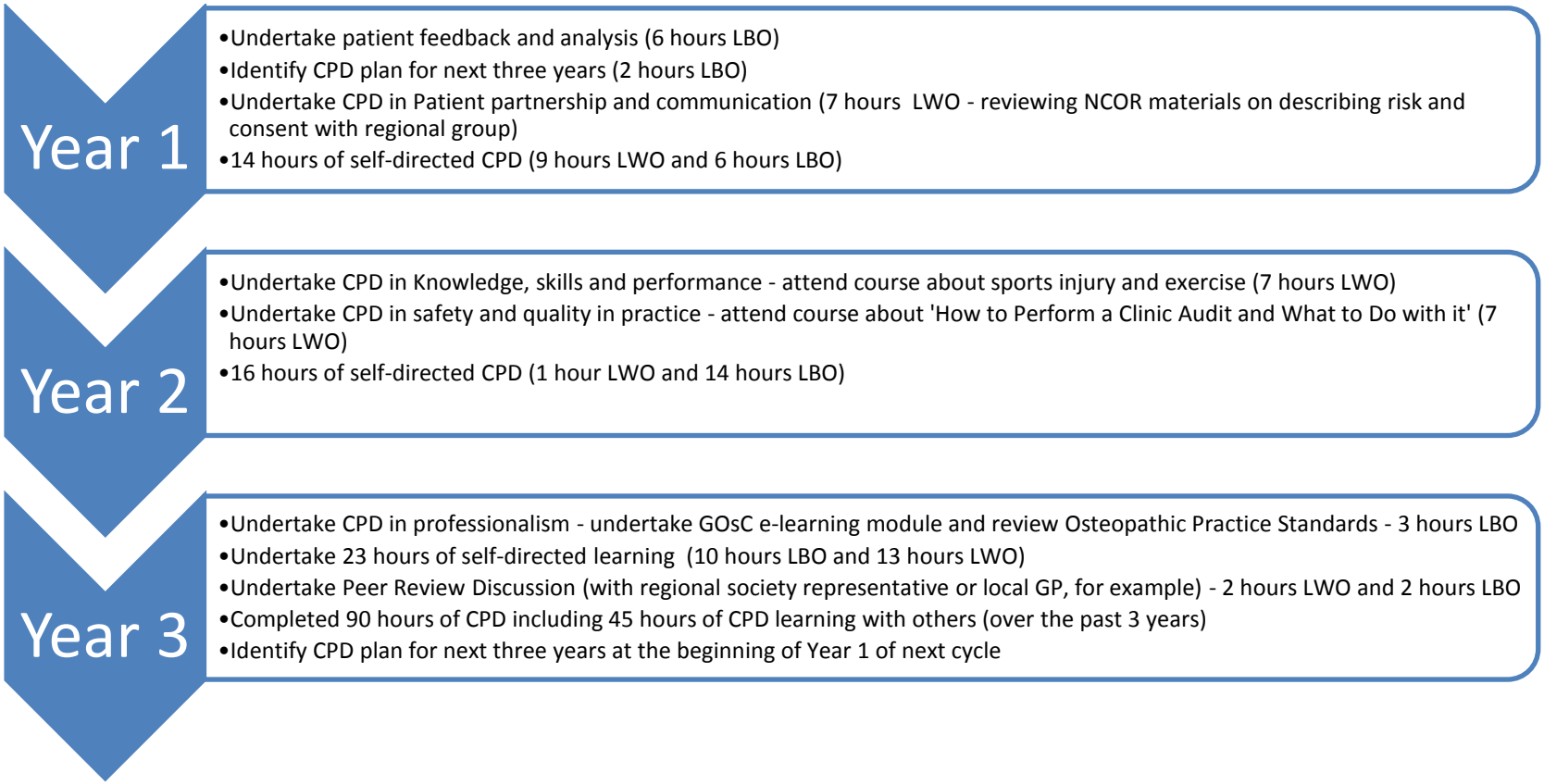
4. *Maintain a continuing record of CPD activities*

   The record should demonstrate that 30 hours of CPD have been completed each year, including 15 hours of learning with others, combining to make a total of 90 hours of CPD and 45 hours of learning with others over a three year cycle. It should also include evidence that CPD has been completed in the four themes of the *Osteopathic Practice Standards* and the area of consent and communicating with patients. It should include a reflective statement on each activity.

**Example of a continuing fitness to practise cycle**

**Name:** *A.N. Osteopath*

**Description of practice:** *Working 30 hours a week in a local sports centre seeing primarily patients from their teens to their 60s with sports injuries.*




Key: learning with others is 'LWO' and learning by oneself is 'LBO'