General Osteopathic Council

General Osteopathic Council

Note of Continuing Fitness to Practise Seminar

18 July 2013

International House, 1 St Katharine's Way, London, E1W 1UN

Present:
Miss Alison Brown, Sutherland Cranial College
Ms Fiona Browne, GOsC, Head of Professional Standards
Mr John Chaffey, GOsC Council Member (osteopath)
Mr Maurice Cheng, British Osteopathic Association, Chief Executive
Mr Kelston Chorley, Osteopathic Pelvic, Respiratory and Abdominal Association
Professor Colin Coulson-Thomas, GOsC Council Member (lay)
Mr Bob Davies, Swansea University
Ms Elizabeth Elander, College of Osteopaths
Ms Sarah Eldred, Communications Manager
Dr Jorge Esteves, GOsC Council Member (osteopath)
Mr Mark Foster, Surrey Institute of Osteopathic Medicine
Ms Sonia Gogia, London College of Osteopathic Medicine
Mr David Gomez, GOsC, Head of Regulation
Ms Helena Greenwood, Rollin E Becker Institute
Ms Fiona Hamilton, London School of Osteopathy
Mr Nick Handoll, Sutherland Cranial College
Ms Clare Hardy, Patient Partnership Group
Mr Jonathan Hearsey, GOsC Council Member (osteopath)
Miss Dustie Houchin, Society for Osteopaths in Animal Practice
Mr Charles Hunt, British School of Osteopathy
Miss Santosh Jassal, Institute of Classical Osteopathy
Mr Ben Katz, British Osteopathic Association Council Member
Mr Stuart Korth, Foundation for Paediatric Osteopathy
Ms Kim Lavely, GOsC Council Member (lay)
Mr Manoj Mehta, British College of Osteopathic Medicine
Mr Simeon Milton, Osteopathic Sports Care Association
Professor Renzo Molinari, Molinari Institute of Health
Mr Matthew Redford, GOsC, Head of Finance and Acting Head of Registration
Ms Julie Stone, GOsC Council Member (lay)
Ms Brigid Tucker, GOsC, Head of Policy and Communications
Ms Marina Urquhart-Pullen, British Osteopathic Association, President
Mr Tim Walker, GOsC, Chief Executive
Ms Elena Ward, National Council for Osteopathic Research
Ms Alison J White, GOsC, Chair of Council, (lay)
Miss Jenny White, GOsC, Council Member (lay)

Apologies: Mr Adrian Barnes, European School of Osteopathy
Ms Geraldine Campbell, GOsC, Council Member (lay)
Mr Stephen Castleton, Oxford Brookes University
Dr Ian Drysdale, British College of Osteopathic Medicine
Mr Brian McKenna, GOsC, Council Member (osteopath)
Mr Haidar Ramadan, GOsC, Council Member (osteopath)
Mr Mark Robson, Patient and Partnership Group
Dr Catherine Sanderson, Leeds Metropolitan University

Introductions and Purpose

1. Tim Walker welcomed everyone to the seminar including patients, lay members and members of leading osteopathic organisations and educational institutions. He explained that the purpose of the seminar was to:

    - Develop a common understanding of the changing political context around 'continuing fitness to practice'.
    - Share some key findings from the GOsC revalidation pilot and CPD consultation.
    - Hear the views of those present on emerging ideas based on the evidence gained from the pilot and the CPD Discussion Document.

Presentation

2. A copy of the presentation is attached at Annex A. Tim proceeded to start the presentation by explaining that he and Fiona Browne would be talking about:

    - The political context – explaining about the background to the requirement for continuing fitness to practice, summarising the findings from a number of public inquiries and government papers including *Trust, Assurance and Safety* and *Enabling Excellence* and concluding with the November 2012 paper about *Continuing Fitness to Practise* published by the Professional Standards Authority. It was clear that the political context had changed and that the development of the revalidation pilot proposals, the pilot itself and revised proposals today all took place during different contexts.
    - The method used for informing the GOsC proposals – a summary of the development and implementation of both the revalidation pilot and the CPD Discussion Document.
    - The findings from the Revalidation Pilot and emerging questions for consideration.
    - The findings from the CPD Discussion Document Analysis and emerging questions.
    - The examples of the possible elements of the scheme.
    - Next steps in the development of thinking.

3. Members of the audience were asked to note thoughts about the questions presented during the presentation for further consideration during the plenary discussion.

4. Some key questions included:

    - How could we continue to build awareness of the *Osteopathic Practice Standards*: communication and patient partnership, knowledge, skills and performance, safety and quality and professionalism?
    - How could we reduce the time spent on the requirements to demonstrate continued fitness to practice?
    - What roles could other organisations or groups play in the process to support honest reflection in practice?
    - Could more local or peer scrutiny work in the osteopathic context?
    - How could we work together to improve the patient's experience in relation to consent? How can we connect all osteopaths to the increasing resources available (for example through the National Council of Osteopathic Research) to support the consent process?
    - Are we content that the minimum requirements for CPD should remain 30 hours including 15 hours learning with others?
    - What more needs to be in place to meet PSA's expectations?
    - Would a longer cycle make it easier to include additional requirements?
    - How could we build (developmental) feedback into a revised scheme?
    - Should we consider the role of QA further as we develop the role of other organisations in the continuing fitness to practice framework?
    - How can we build what many osteopaths are already doing into a continued fitness to practice scheme?

5. At the end of the presentation, Tim Walker presented some potential components of proposals for a continuing fitness to practice scheme for discussion, while stressing that no decisions had been taken as to whether these were the right approach. These included:

    - Overall process – was there a need for two separate approaches (CPD + Revalidation) or were there benefits to combining those?
    - CPD – retain the requirement of 30 hours of CPD with 15 hours of learning with others with a lengthened three year scheme.
    - Osteopathic Practice Standards – during a three year cycle osteopaths would be expected to undertake CPD relevant to their own personal interests and professional development and CPD relevant to each of the themes of the Osteopathic Practice Standards including: communication and patient partnership, knowledge, skills and performance, safety and quality and professionalism.
    - Feedback on practice – once during a three year cycle, osteopaths would gain feedback on their practice through patient feedback and analysis or peer or student feedback and analysis, clinical audit and analysis, case based discussion with another and analysis.
    - Demonstrating reflection – once during a three year cycle, osteopaths would demonstrate reflection through their practice either through an appraisal or a local peer review (for example with peers or through a regional society) or to GOsC.

- Engagement – the key to the process was the expectation of 'engagement'. Osteopaths would not need to be subjected to a pass fail decision in the same way as with doctors because of the different risks posed. But osteopaths would be encouraged and supported to interact with others in a more structured and meaningful way demonstrating a positive response to feedback and demonstrating the development of their practice.

6. A key message from Tim was that emerging proposals suggested that this was not a process that would be 'done' to osteopaths by GOsC. There were opportunities, indeed, an essential need, for other organisations such as educational institutions, CPD providers, post-graduate institutions to play a role in the process of supporting osteopaths to demonstrate development and standards.

Discussion

7. The discussion was opened to the floor. Points made included the following:

Elements

- The idea that different approaches could fit osteopaths working in different contexts was supported.
- It was recognised that any proposals would be the first of many iterations and that we won't all get it right first time.
- The idea of one continuing fitness to practice scheme (rather than a separate CPD scheme plus revalidation) was welcomed.
- The existence of statutory regulation had put in place minimum standards, however, now the development work streams were considering the development of advanced practice – there was a whole undefined super-structure that needed to be put in place – to join up the different frameworks. It was felt that the development of the continuing fitness to practice framework and the advanced practice frameworks were interlinked.
- Some felt that there were two distinct elements – the maintenance of core competencies and the ability to reflect on learning, expanding horizons, interests etc., both should be included effectively.
- It was agreed that the starting point for the development of the scheme should be that everyone was competent rather than not-competent.
- It was recognised that interaction, the roles of others and the development of capacity were essential elements in the supporting of a revised continuing fitness to practice scheme (for example, not just CPD but supervision).
- More clarity about the formative/summative elements was required. For example peer review appeared more summative – even demonstrating and documenting becomes summative.
- Confidence and fear were important aspects to be aware of when developing proposals.
- Important to provide resources to help people.

The Revalidation Pilot

- Views varied about the revalidation pilot. Some felt that the isolated components and nature of the pilot did not fit well with the holistic nature of osteopathic practice.
- Others felt that they had learned a lot from the use of the pilot tools which had helped to identify strengths and areas of development and to remedy these – particularly strategies in complex cases.
- Not having a formal assessment should banish cheating and place the emphasis on development of practice.
- The reduction of the complexity of the pilot was welcomed – particularly the loss of the 3-D matrix structure.

Self-assessment

- Self assessment was felt to be an important component, but supplemented with other activities and perhaps particularly peer review.
- It was recognised that self-assessment was vital for reflective practice; however, it did not capture unconscious incompetence. Something else was necessary.

Alternatives to self-assessment

- Some felt that a peer review of actual practice observing the day to day practice of another and feeding back – not to evaluate another's practice – but more to feedback about against norms to counter professional isolation. It was important that this was not regarded as a test to be passed, but as advice against norms.

Professionalism

- Professionalism is an important component. Trust, reliability, honesty are taught theorised and scrutinised in academic environments. However, these are much harder to capture in practice (e.g. how will GOsC assess accuracy of patient feedback?)
- One osteopath, who had experience of working within the NHS, told how regulation in healthcare was changing rapidly. It was important for osteopaths to promote professionalism and to demonstrate their role in healthcare. It was explained that one of the questions at interview for roles that he oversaw was how practitioners dealt with complaints. How practitioners dealt with complaints was a helpful way of exploring approaches to professionalism.

Reflection

- An important component – but who will take the view about whether reflection is sufficient or adequate?
- It made sense to move to a model which involved deciding what areas for improvement were needed, agree a method for meeting that with a peer

reviewer, undertaking an activity, and reflecting on the improvement process. It was important to position the CPD scheme as a scheme to support improvement rather than simply compliance.
- Reflection covers the need to demonstrate awareness of practice and change.
- Mentoring and peer review could play important roles in supporting reflection.
- Reflection about treatments provided rather than self had a role to play.
- This was now being taught at undergraduate level, however, it was challenging. Many students think therapists and the move to critical self-reflective health professional was challenging. Resources and capacity needs to be available to support registered osteopaths too.
- Identity – are osteopaths health professionals?
- The need for business skills was a gap for many newly qualified professionals.

Patient feedback

- Patients want safe and competent practice.
- Moving towards patient expectations and feedback is important but how will GOsC assess accuracy?
- Feedback from patients was felt to be important.
- Experience of using the patient questionnaire was helpful and positive.

Clinical audit

- It was felt that the driver for the continuing fitness to practice debate had been suggested as political pressure. However, it was felt that the main driver was about the fact that people choose to use osteopathic services. Demonstrating more about practice would be used as a promotional tool and to reassure patients and to provide a greater value to services offered. The group discussed the reviews on Google and noted that in the NHS some health professionals were starting to publish data about their practice. Patient's being able to access more information from practitioners was very important in terms of making decisions about what practitioners to see.
- Clinical audit was felt to be an important area of practice to demonstrate.
- Should clinical audit be mandatory? Some felt that it was an important marketing tool, that more data was being published in the health service and that it was only a matter of time before patients would expect such data to be published about osteopathic practice. A Trip Advisor for health would be commonplace in a year or two.
- Others felt that clinical audit could be a helpful tool to explore practice and to support changes and improvements in practice.
- Others referred to the Cochrane Review of Clinical Audit which demonstrated small to moderate benefits to practice. It was noted that the challenge in osteopathy was that the common standards against which to undertake clinical audit were not yet in place.
- It was noted that many audits were presented in the revalidation pilot, although most of these were not clinical audit.
- It was noted that clinical audit was one tool out of the clinical governance took box. Audits of patient experience could be very valuable too.

- Consumers expect to have access to data.
- It was felt that the working environment was an important aspect of osteopathic practice and that practice audits had a role. One osteopath made a comment about some of the unprofessional environments in which he had noted newly qualified osteopaths had set up practice.

Core elements of CPD

- It was felt that core elements of CPD should focus on areas of concern to patients, for example consent and confidentiality. Could an analysis of fitness to practice findings support the core elements of CPD?
- It was noted that research had been undertaken to consolidate the areas of concern from both fitness to practice cases, but also complaints and claims to insurers to provide a broader picture of formal patient complaints. A common classification system was being piloted this year and data from 2013 would be reviewed and considered during 2014.
- It was felt that the language used would be important. There had been a mismatch between 'regulatory language' and expectations. Perhaps providing clearer examples of what a new patient case might look like and other forms of evidence would be helpful.
- Aspects of communication and consent were felt to be important elements of Core CPD.
- Core CPD demonstrates the need to be aware of standards.
- It was felt that first aid certificates should be mandatory.
- CPD in the four themes of the Osteopathic Practice Standards was felt to be important – particularly for new graduates.
- Personal interests CPD – important – this could take in some of the postgraduate courses that people were interested to undertake.

CPD cycle

- It was felt that the profession was more ready to move to the longer CPD cycle plus elements such as feedback and peer evaluation.
- However, some felt that the three year cycle would leave a flurry of activity at the end of the three years rather than annually as is the case currently. However, it was noted that some CPD activities take over a year, and that annual staging posts or self-declarations could be a helpful way of managing this concern.
- It was felt that the input based model of CPD was very old-fashioned compared to that in place in other professions – most of which now tended to use peer review and outcomes based CPD.

Peer evaluation

- It was recognised that perhaps as many as one in ten osteopaths worked part time in educational institutions and that many educational institutions were undertaking appraisal with their tutors and that even in some places appraisal included the review of feedback from colleagues, peers and students. An

approach which built on this kind of mechanism could work well and reduce the burden and duplication.

- It was also noted that GOsC Registration Assessors were now undertaking appraisals.
- It was felt that roles for regional societies to form a network of supportive peer reviewers of portfolios, rather than this function being undertaken solely by GOsC could also work well provided that key criteria were met, for example, appropriate training.
- Whilst the profession is potentially ready to move towards peer evaluation, such an approach would require capacity building. Osteopaths would need to know what to look for and would need to be provided with support. Such an approach would also support the development of a community of practice and more of a sense of community. It would be important to move away from the idea of competition and integrate the values of the importance of self-evaluation.
- Peer evaluation could also be undertaken by other health professionals to support integration with other health professionals.
- Perhaps a hybrid system of peer evaluation could be helpful. Formal Visitors to practice would be too expensive. However, a hybrid system could be created where osteopaths paired up with another or alternatively, paid an assessor who had been externally validated. Osteopaths could choose to use such reports as evidence or not.
- Others felt that the scope for peer evaluation or review needn't be resource intensive – people could partner up. It was felt that all osteopaths had the skills to communicate constructively and to be a critical friend.
- Peer review could also be undertaken remotely, for example, through Skype.
- One osteopath described a positive but not costly experience of being involved in the review of a doctor as part of a structured appraisal with simple questions to respond to.
- It was noted that the profession could not bear the burden of costly and expensive appraisals and the need for extensive and heavy training.
- Appraisal and assessment were felt to be key areas for consideration.
- One of the participants had significant experience of peer review outside of osteopathy. She felt that there was a lot of evidence to utilize outside osteopathy about how peer review works. She noted that distance was an important component for effective peer review to avoid competition. It would be important to try to involve others, for example GPs and also patients. Perhaps consider the idea of learning sets, undertaking common audits within groups with a non-competitive forum for discussion. Peer review and audit could also be mechanisms to promote practice to others.
- Peer evaluation of the ability to assess oneself was felt to be important.
- Mentoring systems were required to support supportive peer evaluation.
- Peer review should encourage reflection and not be an assessment of practice.
- Encouraging all osteopaths to be mentors was important.
- Peer review was helpful to combat and support practitioners working in isolation if this was the main concern about osteopathic practice.

Conclusion and next steps

8. Tim Walker thanked all those present for attending and for contributing to a lively debate. He explained that the next steps were:

Date	Activity
Spring/autumn 2013	Consideration of findings from KPMG Evaluation and Impact Assessment and CPD Discussion Document consultation to identify all issues and options.
Summer 2013	Discuss and listen to osteopaths, patients, osteopathic organisations and others as we develop revised proposals. Seminars.
Autumn 2013	Publish framework proposal about regulating continuing fitness to practice.
Winter 2013	Work with existing societies, providers, educational institutions and groups to develop resources to support osteopaths in the revised framework.
Spring/summer 2014	Publish more detailed guidance for consultation.

9. Attendees were invited to continue to send in thoughts and comments by email to Fiona Browne at fbrowne@osteopathy.org.uk or Tim Walker at twalker@osteopathy.org.uk