CPD Discussion Document
Consultation Analysis
Final Report

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Introduction

In autumn 2012, using a comprehensive discussion document, the osteopathic profession and other key stakeholders were consulted about the purpose and structure of the General Osteopathic Council's (GOsC) Continuing Professional Development (CPD) scheme. Osteopaths and other interested parties were invited to express their views using an online questionnaire and/or at regional events and meetings by completing a proforma and voicing their opinions. Abi Masterson Consulting Ltd. was commissioned to produce:

1. A narrative analysis of the qualitative data
2. A quantitative analysis of the narrative data on a question by question basis.

to inform Council's decision-making.

Methodology

Data collection

Data were collected in a variety of ways using several different formats and approaches. An online questionnaire published on the GOsC website, with a full set of questions, generated 84 responses. The remaining responses were collected through meetings and presentations. A member of GOsC staff presented the CPD Discussion Document and a summary of some of the options and arguments within the Document and encouraged attendees to write down their responses to the questions to contribute to the consultation responses. 333 responses (of a possible 834) were collected on a proforma at six regional conferences, 10 responses were collected using bespoke proforma with a more limited range of questions at regional network meetings and an additional 14 responses were generated from meetings with other professional and regulatory bodies and educational institutions, again with a more limited range of questions.

This approach generated a wealth of rich data from a variety of individuals and organisations – some osteopath specific and others not. A full list of organisations is included as appendix 1.

Data cleaning

Data cleaning involved checking the data had been entered correctly in the various databases, removing duplicates, and correcting misspellings/stray spaces and characters etc which would have an impact on the analysis.

Responses were received from four Osteopathic Educational Institutions (OEIs) and ten other stakeholder groups. These responses varied in format and the extent to which these were truly organisational responses or an individual response. Some organisations completed the online form but in most cases responses related to points of principle or issues the

organisation responding was grappling with too, rather than the specific GOsC consultation questions.

Data analysis

The purpose of the analysis is to support GOsC in its decision-making with regard to future CPD arrangements in the context of revalidation and demonstrating that registrants continue to be up to date and fit to practise.

As noted above, data were collected in a variety of ways using several different formats and approaches; Davies (2009) notes, while in principle having multiple versions of a consultation questionnaire/proforma and approach is a good idea because it helps maximise contributions from diverse stakeholders and provides some cross-validation and/or complementary understandings, it does however also pose some dilemmas about how best to handle the various different data sets[1]. To ensure we stayed true to the data we took the decision to analyse each data set individually first and then only to aggregate data when it was appropriate.

Part of the purpose of the consultation was to understand the arguments around the potential different options as well as how many people were in favour or against each option. Qualitative methods, as adopted in this consultation process, are ideal for this. Simple descriptive statistics have been produced where possible in relation to yes and no responses on particular questions. The frequency of particular responses has also been captured. This indicates where there are strong opinions. As Davies (2009) explains consultation responses of this type cannot be weighted. The relative priority to give to different views is always a matter of judgement and the aim is to make the sources clear in order to assist with decision-making. It is important to note that not every respondent answered every question.

The consultation process clearly enabled respondents to articulate their concerns and explain their rationale for responding in the way they did.

Representativeness

The majority of responses across all data sources are from osteopaths. Given that the prime purpose of the GOsC is public protection it is perhaps disappointing that only one response was received from an osteopathic patient, a member of the GOsC Patient Forum. Responses were received from a number of other regulators of health professions including the Health and Care Professions Council and the General Chiropractic Council as well as non health professional and regulatory bodies such as Chartered Insurance Institute and the Society of

[1] http://www.gmc-uk.org/Audit_of_GMC_Confidentiality_Guidance_Consultation.pdf_38718427.pdf

Trust and Estate Practitioners. A self-described academic, non-osteopath 'expert in CPD' also responded.

Those who attended the various GOsC hosted meetings also had an opportunity to contribute to the online consultation and so it is important to note that individuals may be represented in more than one data source eg online and conference, member of a society or special interest association and online and conference, and so on. Consequently where appropriate, the respective proportions of responses have been identified to indicate the strength of feeling around particular issues.

Rigour and robustness

The analysis process has been robust and rigorous with the intention of producing a fair and balanced interpretation of the consultation data to assist GOsC in its decision-making. The 2012 Cabinet Office 'Consultation principles' informed our analytical approach outlined below[2].

Where respondents used the online process this automatically generated its own database. Responses from the various conferences and meetings were entered into separate databases. For each data source, the analysis of the qualitative data involved identifying themes in the data, devising a coding framework and then coding the data according to those themes to identify patterns. The themes from the different sources were then compared in order to identify similarities and differences. The conference data included six events held in different parts of the country. On first reading, the tone of the discussions at some of these events seemed to vary and so an analysis was done of the responses by conference venue to see if there were significant differences between the different parts of the country. The pattern of the responses to the particular questions was however found to be very consistent.

This report presents the overall results and a supporting narrative illustrating the kinds of comments and strength of feeling expressed on each of the issues. For the yes/no online questionnaire responses percentages are presented and where possible and appropriate, frequency counts and proportions have been generated from the qualitative data. Competing perspectives and opposing views have been clearly identified alongwith the sources of these views.

[2] http://www.cabinetoffice.gov.uk/sites/default/files/resources/Consultation-Principles.pdf

Findings

The sections in the consultation document have been used to structure the findings.

Aims

The aims of CPD and the CPD scheme outlined in the consultation document (paragraphs 25 & 26) are:

CPD

- *To keep up to date with osteopathic/healthcare practice, embed knowledge and maintain skills within the changing context of patient and societal expectations.*
- *To strive to continually improve standards.*
- *To learn new things.*

CPD Scheme

- *To encourage osteopaths to undertake CPD to support enhancement of practice and patient care.*
- *To encourage a critical and reflective approach to practice and to support understanding of the limits of competence.*
- *To contribute to the enhancement of professional relationships between osteopaths*
- *for the benefit of practice and patient care.*
- *To support access to good quality CPD activities for all osteopaths.*
- *To encourage a diversity of CPD activities.*

80 of the 84 who completed the online questionnaire responded to the question 'Are these the right aims for CPD and the GOsC CPD scheme?' and **80%** of those responding (n=64) felt the aims outlined above were the correct ones. Please note there was some overlap in the responses to this question and the responses to questions about the benefits of CPD and the effectiveness of CPD in practice which are presented later in this report.

Additional aims suggested in the conference/meeting responses included *"Stimulating to energise practice"* (C-113); to "*foster an ongoing interest in CPD"* (C-8), to support practitioners in developing a special interest *"A CPD scheme should encourage/facilitate in-depth knowledge/skills/clinical performance in specialised areas of practice for those who wish to pursue a special interest"* (C-34) and encouraging sole practitioners to get together: *"To encourage sole practitioners to gather with other sole practitioners Ref: Dr Shipman case!!"* (C-62).

One of the Regional Network respondents said *"I think the aims are admirable and aspirational – A well thought out set of aims."* (RN-3)

Another aim suggested for inclusion, which appeared more than once in all data sources, was to encourage collaborative working with other professions and agencies. For example:

"[Aims] *Should be broadened to ensure it includes a reference to enhance relationships with other healthcare professionals and not just other osteopaths which is far too limiting* "(BOA-S-1)
And
"...I feel that it is important to build/enhance relationships between osteo & other professions." (RN-7)

One of the Osteopathic Educational Institutions suggested that the aims *"... should have an emphasis on research"* (OEI-1)

The non-osteopath expert in CPD suggested an alternative conceptualisation of CPD "*Professionals as action researchers of their own practice"* (N=S-5)

However one conference respondent concluded *"Aims are too complicated and would be better framed as: ensuring osteopaths have the skills and knowledge they need to practice safely and effectively"* (C-327)

Principles

The principles outlined in the consultation document (paragraph 27) were taken from the Council for Healthcare Regulatory Excellence (CHRE) document 'Right touch Regulation'[3] (CHRE, 2010) and are that regulation, and therefore CPD in this instance, should be:

- *Proportionate*
- *Consistent*
- *Targeted*
- *Transparent*
- *Accountable*
- *Agility*

78 of the 84 who completed the online questionnaire responded to the question 'Are our principles appropriate to inform our thinking about the CPD scheme?' 76.9% of those responding (n=60) felt these principles were the correct ones as did three of the four stakeholders who addressed this particular question. The Conference proforma did not explicitly ask a question about the principles.

Another principle suggested for inclusion was:
"A further principle should be added: The CPD scheme should be appropriate such that any requirements are consistent with the nature of osteopathy" (OA-S-10)

[3] http://chre.org.uk/_img/pics/library/100809_RTR_FINAL.pdf

In addition several respondents suggested that the 'Osteopathic principles' should be central to CPD.

"Although, arguably, these are not principles, the scheme should explicitly recognise osteopathic principles and concepts as a fundamental and unique underpinning of the profession, and also to explicitly require a commitment to reflective practice." (C-34)

Issues with the current CPD scheme

The KPMG work on revalidation, internal review of CPD folders and summary forms, insights from fitness to practice cases and patient expectations research suggest several potential issues with the current CPD scheme. These were outlined in paragraph 29 of the consultation document and can be summarised thus:

- *Most osteopaths undertake around double the required 30 hours of CPD and do not record all the CPD they did because this was too time consuming*
- *There was a feeling that most CPD courses were in London and that desired CPD had to be balanced with available, accessible and affordable courses*
- *Most osteopaths do not appear to record feedback about practice because they don't have the templates to evaluate it*
- *The current CPD scheme requires osteopaths to evidence what they have done rather than what they plan to do*
- *Less than 5% of personal development folders audited on an annual basis show good evidence of a learning cycle having been undertaken*
- *CPD is sometimes concentrated on the same narrow area of practice year after year*
- *One of the most represented areas in fitness to practise procedures and patient expectations research is communication skills yet very little CPD appears to be undertaken in relation to communication skills*
- *Feedback from some osteopaths has indicated that they are not clear about the nature and purpose of CPD. CPD becomes focussed on ticking boxes rather than activities of value in developing and enhancing practice*
- *Some CPD activities are difficult to verify*
- *Approximately 5-8% of registrants are not able to complete the required number of hours due to extenuating personal circumstances*
- *Osteopaths sometimes report unsatisfactory CPD courses*
- *Few osteopaths appear to have structured methods for identifying aspects of practice that would benefit from further development*
- *The scheme encourages reporting on activity that has already happened rather than encouraging planned activity into the next year*
- *it is no longer acceptable for professionals to simply affirm that they are continuing to learn and are up to date*

76 people responded to the question 'Do you agree with these observations in paragraph 29?'. **52.6%** (n=40) of whom said they did agree. The Conference proforma did not ask an explicit question about these potential issues.

There were differences of opinion about the value or not of learning with others. CAIPE a body who's raison d'etre is encouraging inter-professional learning and working suggested that *"putting a figure on the numbers of hours of learning with others is too restrictive"* (CAIPE-S-6)

Respondents to the online questionnaire expressed concern that the 'hours' system results in people attending free lectures rather than meeting their particular learning needs. The non-osteopath CPD expert said that the *"Literature suggests that it is engagement not hours that is key"* (N=S-5)

It was noted by one of the regulatory body respondents that these issues are *"Common to many professions"* (GCC-S-4)

Only 25 osteopaths responded to the question 'what evidence can you refer to which demonstrates the issues in the CPD scheme?' and their comments, which were grounded in their own experience and discussions with colleagues, centered on the lack of availability of courses in areas such as communication skills and reflective practice as well as time and cost constraints. There was also a suggestion that the GOsC CPD portfolio should be designed to encourage reflection rather than content notes.

Learning cycles

71 osteopaths **(84.5%)** responded to the question 'how do you identify your learning needs?' in the online survey and 299 **(89.9%)** at the conferences. Their responses are presented in Table 1 below. Most listed more than one way they identified their learning needs as these quotes illustrate:

"I identify my CPD 'needs' in several ways, which I outlined in question 3, but repeat here briefly. 1. MOST IMPORTANT - through things that come up with my patients. I constantly reflect, research & decide on actions depending on patient interactions e.g. if I see patients with certain conditions, I may research those on the internet to refresh my knowledge of them & update my understanding of the current conventional treatment options. If I notice a pattern e.g. I've seen a few people with shoulder problems, I might book to go on a course about the shoulder (osteopathic or orthopaedic) in order to see if there are new ways of approaching things that I can try out or discuss with patients. If there are patterns that come e.g. I notice I'm a bit rusty on certain areas, I'll look for a course to refresh them. 2. I have a few keys areas of interest - I'll tend to research & update those regularly, say once a year, looking for ways to build on & extend my knowledge (no point doing the same stuff over - boring & a waste of my money). 3. I like to stretch, challenge & develop myself, so I might try something completely new, something that extends my skills - for example, I did the

BSO postgrad (now masters) in Osteopathy in the Cranial field 5 years ago, I did a course in Animal osteopathy last year. I can only do these things every 5 years or so because they require a lot of commitment in terms of time and finance, I don't earn a lot (less than £25k per annum), so major cost severely impacts on my ability to meet my personal finance obligations." (O-8)

"Challenging patients. Articles from other magazines (as well as GOsC and BOA's) lead interest. Always need to keep up to date with techniques" (C- 326)

Table 1 Identifying learning needs

Activity	Online (n=71)	Conferences (n=299)	Regional Network Meeting (n=8)
What I encounter in my practice	27	91	3
Reflection/self evaluation	16	44	2
Don't know/find this difficult/would like guidance	6	35	1
What's available/local to me	7	31	2
Personal interest/recommended to me	7	30	1
Becoming aware of a gap in my knowledge and skills	2	24	2
Conversations with other osteopaths/health professionals	11	23	2
Being aware of areas of weakness in my practice	9	19	1
Reading journals, literature and research	5	11	1
Keeping up to date/learning new skills	2	10	-
Cost/what's available for free	2	7	1
By attending CPD	-	6	1
Learning cycles	1	3	1
Audit	1	2	-
Participation in the revalidation pilot	7	1	-
OPS	-	1	-

One of the respondents from an OEI said that *"student feedback can also contribute to the learning needs identified"* (OEI-1).

Most respondents used what they encountered in practice as the trigger for their learning needs, as this conference participant explains:

"I identify my learning needs based on what I encounter in my practice ie earlier this year a lot of babies presented with anxious mums wanting to know all answers and immediate

results. In reflection it made me want to broaden my knowledge. I did craniosacral therapy TT and miserable baby CPD. Now I am more confident and able to manage such clients" (C-17)

Many reported using a combination of approaches:

"My CPD is identified when I find gaps in my knowledge that I consider useful or necessary. These gaps occur when I am in clinic from my patients, reading articles in 'The Osteopath', talking with colleagues at work or on CPD courses, and from students in my capacity as clinic tutor for [name of OEI]*."* (RN-9).

"Reading o zone Listening to my colleagues/patients From side effects and adverse reactions Attending conferences – seriously important – asking – searching" (C- 189)

Several said they would like guidance. One respondent from the regional network meetings noted that *"...Hard to identify what one doesn't know (unconscious incompetence)."* (RN-4)

A conference participant said:
"Not sure how I identify learning needs, CPD is done where and when it is available – rather than to fill a hole in learning. More guidance needed" (C-88)

The regulatory bodies were asked a slightly different question in their proforma namely: How do your members and registrants identify their learning needs? This produced a diverse list of issues and approaches. First of all a challenge to the assumption that the individual registrant should necessarily have responsibility for identifying their own learning needs rather than the regulatory body or employer as part of appraisal processes or business needs etc. The contribution of diagnostic tools and competency frameworks to assist this process was also advocated:
"HR Profession Map (an in depth version of a competence framework) – which has a member only 'My HR map tool' – diagnostic through self analysis against the content of the HR Profession map" (CIPD).

"Competency frameworks ie as an audit manager these are the skills required of you." (ACCA)

"We feel more people would comply with CPD requirements if they saw the personal benefit and also were given the tools to plan, record and evaluate their CPD and to highlight any gaps in their learning so that they are able to close these gaps." (STEP)

Some regulatory bodies said they did not ask their registrants to identify their learning needs.

Advantages and disadvantages of being required to demonstrate the learning cycle to the GOsC

The Consultation Document explained what the term learning cycle means in paragraph 34:
" A learning cycle means:

- *Identifying learning needs*
- *Planning activities to meet learning needs*
- *Doing the activities*
- *Reflecting on the activities and learning gained."*

However it seems clear from some of the responses that some osteopaths may not understand what a learning cycle is and its implications as the following quotes illustrate:

"Every osteopath is individual and different in their approach meaning it can be difficult to have a one stop learning cycle" (O-13)

"... Not sure what learning cycles involve...sorry. I have advantages / disadvantages of something I know nothing about" (C-59)

"Learning cycle I don't know what this terminology means. I have action plans for my CPD and planning, not sure how I would provide evidence for learning cycles. Would an action plan and summary suffice?" (C-145)

Nevertheless there was limited active and positive support for learning cycles in general and having to demonstrate their use to GOsC in particular. The benefits identified were that it makes the process more conscious; GOsC and others can monitor practitioners and that it helps ensure that osteopaths complete some CPD annually.

The disadvantages identified were:

- Too much form filling
- Too narrow/boxed in
- Who's going to read it
- Time wasting
- Will be 'gamed'

Osteopaths resented the time taken to record the learning cycles:
"When I did learning cycles for the first 3-4 years and gained very little benefit, I begrudged the time I had spent (identifying needs, reflecting). Some osteopaths working full time already struggle to do the 30 hours, without all this extra bureaucracy. I don't think the cost merits the claimed benefits." (O-7)

The BOA suggested that learning cycles are *"too academic and complex"* (BOA-S-1). Concerns echoed by the Osteopathic Alliance who saw them as being *"too prescriptive and burdensome"* (OA-S-10). The GCC pointed out that *"opportunistic learning can be as valuable as activities planned well in advance"* (GCC-S-4).

Some thought that a CPD system based on 'hours' was easier to manage than an outcomes based system as this quote from an osteopath responding to the online survey illustrates:

" [a] move away from an 'hours' based CPD scheme towards an outcomes based scheme would be more difficult to administer and monitor, both by providers of CPD and by the Council, and therefore have adverse cost implications, which could in turn lead to CPD actually becoming less effective than the current scheme." (O-2)

Mandatory learning cycles

There was a high level of resistance to having mandatory learning cycles. Resistance was linked to concerns about cost, the lack of evidence that it would benefit practice, that learning cycles are prone to gaming, mandating the implementation of learning cycles doesn't fit with 'right touch regulation' and GOsC would have to provide good quality CPD courses to meet this need. There were concerns that implementing mandatory learning cycles would result in osteopaths being put off engaging in CPD, increased cost of courses, a need for more online courses and ultimately increases in registration fees. Issues related to cost were raised by 27 of the 64 who responded to this question in the online survey. Questions on mandatory learning cycles were not included on the conference proforma.

"Anything 'mandatory' is hardly likely to encourage learning, or enthusiasm for participation. And ensuring 'compliance' always involves cost." (O-8)

"I would not object if I felt that it would improve patient care. But I really do not think it would. Osteopaths are professionals and should be treated as such. It feels as if the GOSC need to further their reach every year. Is there evidence bad practice is increasing? If not why is there every increasing checks and regulations?" (O-67)

The Sutherland Society said that "*the current CPD scheme was hard fought for to maintain the right to pursue personal interest and not be forced into the learning cycle mentality"* (SS-S-8)

There seemed to be some support for an advisory not compulsory approach as the following quotes illustrate:

"We should be encouraged not required" (O-11)

"Could be used. There would be a need for the profession to be trained in this process. I'd like to see the option of using this learning cycle." (C-43)

"Think learning cycles are useful but should be on an advisory level for the osteopath to note areas down to help them. Not to be assessed by GOsC at the end of the period as courses may not be able to attend within the correct time frame. Both due to being busy/family commitments/financial" (C-296)

Core CPD content

74 Osteopaths (88%) responded to the question in the online questionnaire 'Would core CPD contribute to the enhancement of standards of practice?'. Only 29 (39.2%) of those responding to this question thought that core CPD would contribute to the enhancement of standards of practice. Some said this would depend upon the content of the core. Opinions also differed about the desirability or otherwise of this being mandatory or whether guidance regarding useful topics would be more appropriate. For the OEIs, one said there should not be core CPD and three said they were ambivalent. Respondents from other regulators were also ambivalent.

Benefits of a core CPD content approach articulated by respondents to the online survey were:

- Common standards
- GOsC could ensure 'causes for concern are covered
- Simple and easy to understand
- Administratively efficient
- Cheap
- Increase patient safety
- Encourage the reluctant

One of the education providers suggested that it would ensure a framework and that there was a need for *"... some form of stick to drive osteopaths in this area"* (OEI-3). The Osteopathic Alliance said it "*Could be advantageous if it concentrated on communication and professionalism only* [and] *should constitute no more than 5-10% of the CPD requirement ..."* (OA-S-10) One of the other regulators said *"Yes it means the registrants can maintain minimum standards of safe and effective practice."* (HCPC-1).

Some regulators do make prescriptions about the content and focus of CPD:

"50% of the 35 hour requirement currently must be in trust and estate related work. The other 50% can be anything related to their professional role. We want to introduce a core area in the future which will be Ethics as this area would relate to all our members in their everyday practice." (STEP)

But most regulatory bodies and professional associations reported that their diverse membership needs would make setting a core difficult:

"We don't prescribe areas for CPD. What are core for some is not for others. May not need to cover each area every year." (LI)

"We do not prescribe that CPD should focus on a particular area, our membership is so broad based, such members are in a wide range of roles. Members must confirm that they have considered professional ethics." (ACCA)

Disadvantages of a core CPD content approach identified by those responding to the online questionnaire were:

- Draconian
- Access and cost
- Too prescriptive
- Limits development
- Rebellion
- Who defines core

"It limits the scope and range of CPD taken up by osteopaths and therefore the future development of the profession" (SCC-S-11). The non osteopath CPD expert warned that core CPD *"... would engage with the lowest common pattern of needs, to minimal standards ... it doesn't cater for varying needs in respect of levels, prior ability and particular skills"* (N=S-5) CAIPE were concerned that it "...*might inadvertently marginalise shared and contextual learning"* (CAIPE-S-6)

52 Osteopaths responding to the online questionnaire, 130 completing the conference proforma and 13 of those responding either at a regional network meeting or as an OEI or other stakeholder group made suggestions regarding areas and topics to be included as core CPD. The areas and topics suggested for inclusion in core CPD are listed in Table 2 below. Most of those who suggested topics suggested more than one.

Table 2 Areas/Topics for Core CPD

Area/topic	Online (n=52)	Conferences (n=130)	Other[4] (n=13)
First aid	8	18	4
Communication	9	13	1
Refreshers/updates of Clinical skills/techniques/methods	16	13	4
Legal issues	4	6	1
Evidence based practice	4	5	-
Neurology	1	5	-
Anatomy & physiology	1	4	-
Documentation/record keeping	4	4	2
Health & Safety	1	4	1
Orthopaedics	1	4	-
Business skills	2	3	1
Differential diagnosis	4	3	-
History taking & Clinical examination	3	3	2

[4] Regional network meetings, OEIs, stakeholder and group responses

Area/topic	Online (n=52)	Conferences (n=130)	Other[4] (n=13)
Osteopathic Practice Standards	6	3	2
Pathology	–	3	–
Philosophy of osteopathy	1	3	–
Risk assessment	1	3	–
Health policy/topical professional issues	2	2	–
Medical/surgery updates	3	2	–
Promoting the osteopaths own health & fitness	1	2	–
Red & yellow flags	3	2	–
Reflective practice/identifying learning needs	–	2	–
Areas of high complaint to GOsC	1	1	–
Audit	3	1	–
Critical appraisal skills	2	1	–
Fire	–	1	–
Infection control	–	1	–
Interprofessional learning & working	–	1	1
Management of complaints	1	1	–
Clinician/Patient relationships	1	–	–
Consent	2	–	1
Mentorship/supporting learners	–	–	1
Patient safety	2	–	–
Pharmacology	1	–	–
Practice policies	1	–	–
Professionalism	1	–	1
Referral to other professions	2	–	–
Revalidation	1	–	–
Self awareness	1	–	–

Resource and other implications of implementing a core CPD content approach

Concerns raised regarding the resource and other implications of implementing a core content CPD approach were in four main areas: expense, time, how to ensure access and quality assurance.

Expense

It was suggested that core CPD would turn into a money-making scheme for those providing the courses.

"We would end up being forced to spend out precious time and money on courses and study that would simply be jumping through hoops and take resources from what we (as responsible, motivated professionals) are truly interested in." (C-294)

"*Is this a money making venture for GOSC. Currently all I see is GOSC building a castle for itself at practitioners' expense."* (O-19)

Time

Some suggested that requiring osteopaths to spend time on the core might prevent them being able to undertake other more appropriate learning and development opportunities:
"Need to ensure the opportunities exist ... might be an additional burden to those doing postgraduate study "(OEI-2)

"We will do the core and have less time to focus on career interests or end up doing a huge excess of CPD at a cost of time and money" (C-311)

"How often would this have to be repeated – every 6 years... benefits – could help osteopaths keep up to date and allow refreshment of knowledge for safe practice. Disadvantages – doesn't fit with a reflective model of identifying weakness and becomes a box ticking exercise again. ... if decided on will generate courses, market led" (SCC-S-11)

Access

Ensuring equitable access was thought to be essential. Consequently implementation was said to require regionally based courses and/or online provision. There were differences of opinion about where responsibility for ensuring access lay – with the individual osteopath or GOsC.

"I am not totally against core CPD but it MUST be very affordable (FREE?), well delivered and easy for EVERYONE to access it for it to be fair and to avoid a lot of complaints basically." (O-12)

"Difficult to provide core CPD accessible to all osteopaths without them travelling a long distance which is unacceptable" (C-240)

Quality assurance

If the core CPD was fundamental to registration then many respondents said that GOsC would need to quality assure programmes.

Some other regulatory bodies have core CPD:

"RIBA have a core CPD model and you have to cover everything once every 3/5(?) years ... Ethics/ H&S are "safe" to be core topics." (LI) Although they also made a point about it being very difficult to monitor.

The nature and purpose of CPD

The online questionnaire asked the following questions with regard to the nature and purpose of CPD: 'What are the benefits of undertaking CPD in your practice?' and 'How can

we further develop and integrate values of accountability and quality enhancement into osteopathic CPD and practice?'. These questions were not asked explicitly on the conference proforma or on those used with the other regulators, regional network meetings and other stakeholder groups. There is however a significant degree of overlap with the online responses to the above questions and conference and other responses to the questions on effectiveness of CPD and practice and how osteopaths could best show they are up to date and fit to practice which are presented later on in this report.

The benefits of undertaking CPD for practice

Only one osteopath in responding to the online question 'What are the benefits of undertaking CPD in your practice?' reported no benefit. Others said:

- Staying up to date
- Broadening and deepening skills
- Collaborative working and learning
- Developing new skills
- Improving service to patients
- Personal and professional growth

Integrating accountability and quality

Respondents to the online questionnaire suggested that further developing and integrating the values of accountability and quality enhancement into osteopathic CPD and practice could be achieved by:

- Random sampling of portfolios
- Guidance on core subjects
- Quality assuring courses

Changes to the CPD cycle

The data on changing the CPD cycle or not appears to slightly contradictory but this may be an artefact of the different way the question was asked in the different data sources. In the online questionnaire 81 Osteopaths answered the question 'Do you feel the current CPD cycle of a 12 month period to be appropriate?' and slightly over half of them **(55.6%)** said that they felt the current CPD cycle of a 12 month period was appropriate. A slightly different question was asked of the conference participants – 'Should the 12 month CPD period be extended? And why?'. 162 **(48.6%)** of the conference participants responded to this question with 49 **(30%)** saying "yes" it should be extended, 111 **(68.5%)** saying "no", one saying they "didn't mind" and one suggesting that *"12 months or off set hours in one year to the next".* (C-40)

In all data sources the arguments made for increasing the length of the CPD cycle were the possibility of carrying over hours, leaving more flexibility for managing the impact of life

events such as maternity leave and making in-depth study such as higher degrees more worthwhile as the following quotes illustrate.

"We all have limited time and money available for CPD. There may be several courses that an individual wishes to take in their CPD year that goes above the minimum hours but few the following year. Under the existing system. 30 hours is needed to be spent the 2nd year just to satisfy the current requirements, and may not be of the best quality as the motivation behind it is wrong." (O-34)

"Life challenges such as maternity leave, illness of practitioner and the family can severely limit free time available to pursue CPD whilst running a practice, keeping an income stream coming in. Particularly the 'learning with others' part of CPD" (C-115)

"There should be room for individual learning plans to take shape over a number of years. E.g. I'm planning to undertake a PhD (in osteopathy) – that's going to take me 6 years." (O-20)

Those who felt 12 months was still an appropriate length of time mainly saw this period as being the right length of time to keep CPD in the forefront of practitioners' minds.

"12 months suits me fine. If it were a longer period I would find it harder to meet the requirements. I can plan a year – harder to be any longer." (C-125)

"I really believe that if the period is longer it will be put off by many practitioners leading to a flurry of hours at the last minute which are not in any way related to a learning cycle." (O-27)

Extending the cycle

43.7% of the online survey respondents (n=31) said extending the cycle would be preferable (42.3% said no, and 14.1% chose 'other'). **66.7%** of the conference participants said no (27.8% yes, 5.6% other) but only just under half (48.6% opted to answer this question).

For the online respondents three years (56.1%) was thought to be better than six (4.9%) which was felt to be too long however once again fewer than half of the online respondents chose to answer this particular question. Only 17 conference participants expressed a view, four of whom preferred three years. Three years was seen to be long enough for the acquisition of advanced/higher degrees. Some felt that there should be a mix of core and compulsory CPD with different time periods for each.

"yes and no; there should be an annual "optional" hours and a three year "core/compulsory" hours" (O-45)

The three OEI's (of four) who offered responses to this question suggested that 2-3 years would be more appropriate.

In the 'other' category, 2 years was the most popular.

"Should consider offering a 'carry forward' CPD as an option for when someone completes over 30 hours in a year, precedent has already been set under the revalidation arrangements". (REB-S-9)

"We agree with a longer learning cycle ... prompts would be needed to keep people on track" (SCC-S-11)

Minimum number of hours required

80 osteopaths responded to the online question 'Do you feel the minimum number of hours required is set at an appropriate level'. **80%** of these (n=64) said that the current minimum number of hours was appropriate. This question was not explicitly asked of the conference participants however 99 referred to the 'hours' requirement in their answers to other questions and their views reflected those of the online respondents as illustrated in the quotes below.

"Yes, definitely. I think that if the osteopath chooses their CPD activities well enough, then the 30 hours minimum is certainly adequate. In part the CPD process exists to demonstrate to the public an osteopath's commitment to continuing learning. The process should not be made so all-consuming so that it becomes impractical for all osteopaths to comply." (O-3)

"30 hours in 12 months is nothing anyway. Carry over of learning with others could be useful esp with long expensive courses" (C-253)

Some indicated that they did far more CPD than the minimum.

"I do a lot more, but it is such a hassle to complete the portfolio I only "declare" the minimum amount." (O-14)

And that the hours requirement might discourage osteopaths from undertaking in-depth study:

"30 hrs in 1 year encourages superficial CPD. a longer time frame with more hours would encourage and reward more indepth study, e.g MSc" (C-75)

Some respondents suggested that the 'hours' requirement could result in osteopaths undertaking courses to get the hours rather than to meet a particular learning need.

"My aims of my CPD - is to adhere to regulations which is done 1 yr to the next varies considerably and my means and ability to adhere to the hours. Some years there is nothing I

have addressed that I can go to so you end up doing anything just to get hours. This personally is disheartening." (C-65)

Increasing flexibility by enabling hours to be carried over was advocated by some:

"If there was more flexibility say 60 hours over a 2 year period you could then choose to do 40/20 or 50/10 depending on your own schedule that year" (C-139)

Other issues raised in the comments were concerns about quality and the cost of formal courses which many felt were essential to meeting the 'learning with others' criterion.

"Time is irrelevant; quality is the only important criterion." (O-20)

"15 hours working with others can mean at least 3 PG day courses [approx £375] and or belonging to a regional society, not easy if one is not near. Less hours could still be made up by one's own efforts if there were more online opportunities." (O-21)

"...a lot of courses are in 6-12 hour blocks. I am discouraged due to cost from attending some courses at the end of my CPD year - and would be 'waste' of CPD hours. Have to do 'filler' courses at the end of the year." (C-106)

Quality assured CPD

Across all of the data sources opinions were divided as to the need or not for CPD to be quality assured. Some thought only core CPD should be quality assured others wanted everything quality assured and still others either thought it unnecessary or were vehemently opposed to the idea.

"I don't think it is. I'm perfectly capable of deciding whether I got what I needed from a course in relation to the standards I work to, whether I need to do more (by myself, another course), what provider to chose in the first place (again it depends what I'm trying to achieve from that piece of CPD)" (O-8)

The numbers who expressed a clear preference regarding the need for quality assurance in the online and conference responses are captured in the table below.

Table 3 Preferences for Quality Assuring CPD

Data source	Clear preference Yes	Clear preference No
Conference	36	54
Online responses	12	21

Those who were supportive of the need for CPD to be quality assured often defended their view by highlighting the benefits of quality assuring CPD as they saw them. Those who saw benefits mainly listed more than one. The benefits of quality assuring CPD in both the online and the conference responses were seen to be:

- Ensuring standards/consistency
- Offering reassurance
- Enabling better Value for Money (VfM)

And the frequency with which these were suggested in the online survey and conference participant data is presented in Table 4 below.

Table 4 Benefits of Quality Assuring CPD

	Online (n=12)[5]	Conference (n=36)
Ensuring standards/consistency	15	33
Offering reassurance	8	26
Enabling better VfM	7	6

18 of the 21 online respondents and 22 of the 54 conference respondents did not want CPD to be quality assured and made explicit objections. These were that quality assuring CPD:

- Was likely to reduce diversity and choice
- Would increase cost
- Was too difficult to administer
- Would reduce the numbers of osteopaths attending courses run by other professions

And that it was unclear who could do it.

CPD activities that could/should be quality assured

Those who advocated some quality assurance of CPD in both the online and conference responses again differed with regard to the sorts of CPD that should be quality assured ie any/all of it, some of it or just the core. Although the numbers who ventured an opinion were very small indeed.

Who should quality assure CPD?

Only **26.1%** of those responding online thought that GOsC should quality assure CPD and **55.1%** said that it shouldn't. Few (n=9) of these respondents gave a rationale for their decision whether pro the GOsC having a role or anti. Concerns expressed about GOsC quality assuring CPD were that it would become a money making venture, it might be 'South East Centric' and that it should be open to others. One of the OEIs (of the two that answered this question) suggested OEIs could and should quality assure CPD.

Conference participants weren't asked explicitly whether they wanted the GOsC to quality assure CPD just who should quality assure CPD.

In both the online survey and in the conference/meeting responses respondents could cite as many organisations as they liked and many did. The responses this generated are

[5] Please note there are more responses than the numbers of those who expressed a strong preference for quality assuring CPD because some respondents did not support the quality assuring of CPD but still identified potential benefits if it was.

presented in Table 5 below. They were quite contradictory and polarised with several saying quite explicitly 'not the GOsC' yet the GOsC received most mentions overall.

Table 5 Who should quality assure CPD

Body	Online	Conference/meeting responses
GOsC	29	36
BOA	37	30
OEIs	37	22
Others	59	36

Within the 'others' category in the online questionnaire responses were: CPD providers (n=15); NCOR (n=2); Specialist Interest Societies (n=24); Regional Societies (n=2); any professional body including non-osteopathic ones (n=3); universities (n=1); any organisation with competence and experience in educational quality assurance (n=1); the market (n=1); QAA (n=1) and osteopaths themselves (n=2).

Within the 'others' category in the conference/meeting responses were: any professional body including non-osteopathic ones (n=4), an alternative independent authority (n=3), Osteopathic Alliance (n=1), any education provider including non-osteopathic ones (n=5), Regional Societies (n=3), Specialist Interest Societies (n=2); NCOR (n=2), NHS (n=1), QAA (n=1) and OEF (n=1) and osteopaths themselves (n=1).

Many respondents from all groups, when the data from all of the various questions related to quality assuring CPD was reviewed, said that the osteopath themselves should be the judge of quality:

"Nobody. It is up to each individual osteopath to find good quality training." (O-14)

"I think that osteos should assess osteopathic courses" (C-4)

"quality should be judged by the practitioner" (N-S-5)

How could CPD be quality assured?

Embedded in the qualitative data related to quality assurance of CPD were some suggestions about how CPD could be quality assured. Suggestions were mainly focused on making some form of quality assurance necessary before courses could be advertised in The Osteopath and developing some sort of Amazon or Tripadvisor approach (either linked to GOsC or separate) for osteopaths to rate courses they had attended. It was also suggested that OEI's could do more to assure the profession of the quality of their courses.

"*OEIs can choose to publish their client satisfaction surveys and this will give transparency in how useful and helpful a course is ...*"(SCC-S-11)

Regulatory bodies and professional associations were asked how they quality assured CPD or ensured the quality of CPD undertaken. Most undertook a paper-based audit of a random sample of registrants/members:

"CPD standards, linked to registration. Each time a professional renews registration, each professional must confirm they meet our CPD standards. We randomly select 2.5% of the profession for audit, and ask those registrants to submit a profile setting out how they meet the standards in detail." (HCPC).

All except one did not quality assure CPD because of fears of being held to account for the quality of provision, or being seen to favour a particular provider. Some had set up partnership arrangements with providers:

"...we enter into partnerships with CPD providers. In these instances we get internal assessors to review material and we go through a formal procurement. In some instances we do signpost and don't assure." (ACCA)

The majority of regulatory bodies and professional associations concluded that it was really down to the practitioner to make the decision:

"Ultimately it is up to the individual to decide if the course/experience is any good – for them." (Anon – 2)

More feedback to Osteopaths

67 Osteopaths responded to the question in the online survey 'Would you like to see more feedback to osteopaths about the content of Annual Summary Forms or folders?'. **62.7%** of those responding (n=42) would like to see more feedback and 17.9% (n=12) said they wouldn't. Those who didn't want feedback when they offered a reason said either that it would be too resource intensive (n=1), that it wouldn't be of interest to them (n=1), that they wouldn't want it from GOsC (n=1), or they couldn't see how it could be done:

"possibly but without them actually attending how could they vet it unless it was obviously not relevant to osteopathy" (O-73)

Four respondents reported finding this question difficult to understand.

"I don't understand the question – feedback from whom?" (O-45)

Only two of the conference participants addressed this point explicitly. Both said they would not want more feedback. As one of them explained:

"We do not see this to be necessary if the above proposals for quality assurance are established. More feedback on individual registrants' CPD returns is seen as being unnecessarily resource intensive and would have substantial cost implications." (C-34)

Measuring the effectiveness of practice and CPD

Measuring the effectiveness of practice

The responses to the question 'how do you measure the effectiveness of your practice?' are presented in table 6 below. Most respondents suggested more than one approach. Seeking patient feedback (28%) and reviewing patient outcomes (17%) were the most frequently cited but "don't know" or "I don't" was the third most frequent response (16%) amongst conference participants. The numbers are so much smaller for the online responses that percentages are likely to be misleading but patient feedback and referrals/recommendations were most often mentioned.

Table 6 Measuring effectiveness of practice

Method	Online (n=63)	Conferences & Meetings (n=274)
Patient satisfaction/feedback	28	77
Clinical outcomes/Patients get better	8	47
Don't know/I don't	3	45
Patient numbers/ busyness of practice	9	40
Referrals/recommendations	16	38
Self evaluation/reflection	3	36
Audit	16	29
Patients don't drop out of treatment/come back again	4	24
Benchmarking/feedback from colleagues	2	14
Need support with this	-	10
Participating in revalidation pilot/NCOR research	1	6
Conferences/CPD	-	2

How do you judge the effectiveness of CPD?

There was a difference of opinion across all data sources about whether or not it was possible to judge the effectiveness of CPD and also even if this were possible, whose responsibility it then was.

"No evidence of effectiveness in the literature and perhaps looking for it is a holy grail "(GCC-S-4)

Two of the stakeholders thought the effectiveness of CPD was a question for GOsC to address and that it would be best to address this by looking at the impact on fitness to practice cases (SCC-S-11; BOA-S-1). The Sutherland Cranial College (SCC) went on to suggest the following:

- *Are you getting fewer disciplinary complaints?*
- *Has the incidence of collateral insufficiencies reduced eg note taking since CPD started?*
- *Has the public perceived this change?*
- *Have the other medical professions noted these changes?*
- *Has the media changed its tune against us?*
- *Has Professor Ernst recognised the change?* (SSC-S-11)

Evidence of effective CPD suggested in all data sources is presented in Table 7 below.

Table 7 Effectiveness of CPD

	Online questionnaire	Conferences	Others
Treatment outcomes	✓	✓	
Increased knowledge	✓		
Feedback from patients	✓	✓	
Increased skill set	✓		
Using things I've learned in practice	✓	✓	
Feedback from colleagues	✓		
Doing things differently		✓	
Increased confidence	✓	✓	
Improved technique		✓	
Enhanced practice			✓

How do you measure the effectiveness of your CPD?

The responses from the online survey, conferences and the regional network meetings to 'how do you measure the effectiveness of your CPD' are presented in table 8 below. Some of the respondents suggested several measures in combination.

Table 8 How do you measure the effectiveness of your CPD?

How	Online (n=51)	Conferences & meetings (n=105)	Regional network (n=10)
Can use it in my practice	13	26	–
Patient outcomes/audit	7	20	2
Enhances me as a person and a practitioner	2	17	–
I don't know/how could I	10	15	2
Reflection	3	8	2
Patient feedback	4	8	4
Increases my knowledge & improves my understanding	6	7	–
Met my learning goals	4	4	1
Relationships with colleagues/increasing networks	3	3	3
Growth of practice & increase in referrals	1	2	–
CPD folder/GOsC should test this	–	1	1

Responses from the online survey to the question 'what is effective CPD?' are presented in table 9 below. Please note this question was not asked explicitly at the conferences and meetings. Most of those who responded offered more than one suggestion.

Table 9 What is effective CPD?

What	Online survey (n=55)
Courses/lectures/seminars/workshops	9
Refreshing/broadening knowledge and skills	9
Something you can use in day to day practice	8
Stimulates, challenges and engages me	8
Reading/personal research/study	7
Being taught new techniques/treatment approaches	6
Informal discussions with other professionals	6
Meets my learning needs	6
Developing self	2
Improves my practice	2
Developing business	1

What	Online survey (n=55)
Meets my patients' needs	1
Mix of learning with others and by one self	1
Regional Society meetings	1
Something tailored to my learning style	1
Teaching others	1

Responses from the online survey to the question 'why is this effective CPD?' are presented in table 10 below. Please note this question was not asked explicitly at the conferences and meetings. Only a small proportion responded and several of the responses were 'It's obvious!'. Those who responded generally offered more than one suggestion.

Table 10 Why is this effective CPD?

Why	Online (n=48)
It benefits my patients	14
It helps me develop/stay up to date	9
It extends and advances my skills	5
I can use it	5
It improves my knowledge and confidence	5
It makes me safer and more effective	4
I enjoy it	2
I reflect	1

How could osteopaths best show they are up to date and fit to practice?

Responses from the online survey and conferences to the question 'how could osteopaths best show they are up to date and fit to practice?' are presented in table 11 below. Those who responded generally offered more than one suggestion.

Table 11 How could osteopaths show they are up to date and fit to practice?

How	Online (n=56)	Conferences (n=243)
Existing CPD process	18	101
Modified CPD system eg including a core and quality assurance and mapping to OPS	5	30
Completing revalidation	10	23
Test/exam	7	15
Contact with other osteopaths eg attending courses and meetings	2	15

How	Online (n=56)	Conferences (n=243)
Clinical audit	1	14
Patient feedback/satisfaction	2	13
I don't know/difficult to do	4	12
Reflection on practice	-	8
Peer assessment/review	1	7
Full patient list/thriving practice	1	6
Evidence of application of research in practice	1	6
Be observed in practice	5	6
Lack of complaints	2	4
Reading journals	1	3
Teaching others	-	1
Standard of surgery environment	-	1

There were a small minority who objected to the concept of 'being up to date'.

"What exactly is 'up to date!'. Another new idea reinventing the wheel of age and gradual chronicity in an ageing population." (O-63)

"I'm not sure 'being up to date' is the be all and end all - physiology, anatomy etc don't change. Techniques just work and are refined over the years of individual practice within the individual. What one does cannot be captured in its entirety, only as relatively trivial 'minimum requirements'." (C-127)

Broad support for the existing arrangements was indicated by responses to the question of how osteopaths could show they were up to date and fit to practice in the regional network proforma.

For three of the four OEIs who responded to this question revalidation was the answer:
"probably wrapped up with revalidation and evidence of CPD activity with evidence of why they choose to undertake certain activity and how they then reflect on these in terms of impact on practice" (OEI-2)

However revalidation and CPD can be seen as having different foci and purposes as this quote from one of the regulatory body responses indicates:

"Makes a distinction between CPD as a means of developing themselves and their practice and demonstrating fitness to practice which is the purpose of revalidation" (GCC-S-4)

For the other OEI some form of assessment was advocated.

The regulatory bodies and professional associations were asked how they know that registrants or members are up to date and fit to practice. Several reported that they didn't.

The majority relied on some form of self assessment backed up by an audit process and were frank about the limitations of such approaches:

"Our members self certify. They make that judgement it is difficult for us to fully know if members are up to date and fit to practice. We check their CPD records (those that are monitored) but as it is hours based at the moment we can't rule out the people that do irrelevant CPD merely to make up the required hours." (STEP)

"Audits check compliance rather than competence." (CIPD)

"The CPD audit process is monitored carefully, and gives is some reassurance that most registrants meet our CPD requirements – however, it's not an assessment of overall FTP" (HCPC – 2)

Fitness to Practice data, complaints and employability were suggested to be the ultimate tests.

Impact on equality and diversity

The groups who were regularly mentioned with regard to any changes to CPD having a disproportionate impact were those osteopaths living and working abroad, those on maternity leave and the cost to part time workers with young children. It was also suggested in all data sources that there may be implications for osteopaths with dyslexia.

"As I live abroad, I could not continue undertaking CPD: this is discriminating against people living abroad. Do you want us to leave GOsC?" (O-14)

"Life challenges such as maternity leave, illness of practitioner and the family can severely limit free time available to pursue CPD whilst running a practice, keeping an income stream coming in. Particularly the 'learning with others' part of CPD" (C-115)

"Yes – mums with young children are impacted due to the high cost of registration and the cost of CPD as well as the time to do it. There needs to be better provision for those who are working part time and lower GOsC costs." (O-62)

"Dyslexic which is why I chose a practical hands on occupation such as Osteopathy it is a bit of a shock having to form fill etc so keep the audits simple please." (O-76)

Any other comments

Responses to the 'any other comments' sections fell into four main types:

- Fears about the future of osteopathy
- More detail about experiences with the current CPD process

- Support required to identify learning needs
- and some concerns about the consultation process itself.

The future of osteopathy

Several osteopath respondents seemed to be fearful about the future of osteopathy and how revalidation in particular might impact on this.

"As we saw from the show of hands at the Elstree meeting, the majority did not and do not believe there is a future for osteopathy in the next ten years. It is all about a few people running private Colleges who have the time and interest to keep pushing their agenda. Search for the financial records and they are all hidden away." (O-63)

"It is interesting to note that Chiropractors have chosen not to revalidate - do we know why? Does revalidation make a difference to the patient? Do they care? Will they in the future see chiropractors as less professional than osteopaths as they do not do revalidation? Probably not - they want cost-effective treatment" (C-150)

Current experiences of CPD

In general the existing CPD scheme was broadly supported as this quote from one of the specialist societies indicates:

"The general feeling is that there seems to be no case for altering the current CPD nature, content and length, and indeed there is considerable resistance to the idea of changes ... The CPD scheme should be left as a vehicle for individual professional development <u>outside</u> of more formal mandatory requirements [for revalidation] *allowing personal professional practice development to be left as it is, for the individual to work into their personal interest area"* (SS-S-8)

In the 'any other comments' section in the various data collection tools, comments related to osteopaths current experiences of CPD were often reinforcing comments they had made earlier on in the questionnaire or proforma such as their resistance to learning cycles, and the cost and lack of availability of courses etc. Additional comments included:

- A desire for a list of approved courses
- The GOsC CPD folder and reporting process forms etc need changing/updating
- There should be an appeals system for 'not allowed' CPD
- Could/should patient outcome data be included/expected as part of CPD
- The need for 'return to practise courses

Some suggestions were also made for tweaking or amending the existing system:

"GOsC to identify a theme annually informed eg by hearings which must be reflected in CPD activity" (OEI-4)

"[GOsC] to require needs analysis and action plan to be included in portfolio" (OEI-4)

"Initial waiver of CPD is not a good thing. Out of step with other health care professions. Graduates finish college and go straight into private isolated practice away from colleagues. Not having to do CPD for 10-22 months means they do not get off to the right start and it could be a downward spiral from there. CPD is actually more important at this stage and it would be more effective if it were guided for the first 2-3 years following graduation to ease the graduate into practice and developing reflection skills to be able to do this more autonomously later on. GOsC could set a specific core for these first few years even if it doesn't develop core for whole profession. ... senior students to trial online CPD submission ..." (COO-S-3)

Embrace all relevant learning, avoid too much emphasis on documentation, give more guidance as to explaining reflective practice and the content of CPD. Don't recommend any of the options on page 5. (GCC-S-4)

"Give more attention to peer review and self evaluation" (N-S-5)

"Value the explicit reference to learning with others but GOsC might advise who these others might be and the focus of that learning. Recommend continuing interprofessional development" (CAIPE-S-6)

"*Should also include non clinical skills like leadership behaviours"* (LA-S-7)

""we support the idea of an initiative to inform osteopaths about the nature and benefits of CPD" (OA-S-10)

"Can GOsC make arrangements with local hospitals to access the CPD provided for their staff, more affordable, regional and allow diversity in subject areas and build relationships" (SCC-S-11)

Support with identifying learning needs

Throughout the consultation responses there was a small but significant minority of osteopaths who reported how difficult they found identifying their own learning needs and indicated that they would appreciate support from GOsC with this. In particular it was suggested that there might be value in GOsC:

- undertaking a survey of the profession regarding their learning needs
- developing a tool to help osteopaths systematically identify their learning needs.
- setting up mentoring/buddying systems to help osteopaths with their learning needs.

The consultation process

Some concerns were expressed by a small number of osteopath respondents about the consultation process itself. These related to whether or not GOsC would listen to what the

profession had to say, that there should be a discussion with current CPD providers, and the length and content of survey and conduct of the consultation events.

Caveats and limitations

The questions asked varied across the data collection processes which made robust comparison between data sources difficult. Where this comparison has been possible because the questions asked were the same, there are sometimes contradictory responses. For example whereas 43.7% of the online survey respondents supported extending the CPD cycle only 27.8% of the conference participants did.

Even though the headline response rates seem reasonably high, often respondents did not answer all questions so the response rates for particular questions and sub questions are often much lower.

Nevertheless the consultation process clearly enabled those engaging with it whether by using the online questionnaire or attending a meeting, or participating in their professional association to articulate their concerns and explain their rationale for responding in the way they did.

Conclusions

Overall there seems to be strong support for the current system of CPD. There also seem to be some pretty universal development needs for the profession as a whole regarding support with undertaking clinical audit and ways of measuring the effectiveness of their practice. There seems to be a need too for further guidance on how to systematically identify learning needs and the detail of the CPD system itself and in particular what sorts of learning are appropriate.

Appendix 1: List of organisations

This is a complete list of organisational responses across the various data sources.

1. Anonymous (regulatory/professional body) (n=2)
2. Anonymous osteopathic professional association
3. Association of Chartered Certified Accountants
4. Anonymous (regulatory/professional body) (n=2)
5. British Osteopathic Association
6. British School of Osteopathy
7. Cambridge Professional Development Ltd
8. Centre for the Advancement of Interprofessional Education (n=2)
9. Chartered Institute of Personnel and Development
10. Chartered Insurance Institute
11. College of Osteopaths
12. General Chiropractic Council
13. General Pharmaceutical Council
14. Health and Care Professions Council (n=2)
15. Landscape institute
16. National Council for Osteopathic Research
17. NHS Leadership Academy
18. NCOR
19. Osteopathic Alliance
20. Rollin E Becker Institute
21. Society of Trust and Estate Practitioners
22. Sutherland Cranial College
23. The Sutherland Society

Four Education Institutions
One osteopathic patient from the GOsC Patient Forum
One academic with an expertise in CPD
Nicholas Woodhead on behalf of the Nottingham Osteopaths