The new GOsC Continuing Profession Development (CPD) scheme:

A background booklet

December 2014

Introduction

1. This booklet explains why the General Osteopathic Council are publishing proposals for a new continuing professional development (CPD) scheme ('the CPD scheme') summarising a six year programme of work with osteopaths.

2. You are invited to take part in a consultation on the new CPD scheme from January 2015 to May 2015 published on the GOsC website at www.osteopathy.org.uk

3. The consultation will be supplemented by small listening meetings within regional groups, osteopathic educational institutions, CPD providers and others. Please keep an eye on the osteopathic press or get in touch with your local regional group to find out how you can get involved.

4. These proposals replace what we were calling 'revalidation'. We do not now use the term 'revalidation'.

5. The new CPD scheme is designed to provide the public with assurance that osteopaths practise in accordance with the *Osteopathic Practice Standards*, our core standards for registration (assurance of continuing fitness to practise).

6. Initially, this work programme was driven by government expectations and also through a report of the Professional Standards Authority, the body overseeing all health professional regulators in the UK.

7. However, by working closely with osteopaths, we developed a better CPD scheme both for osteopaths and patients. Our proposals build on what most osteopaths are already doing, enhancing the role of colleagues within the learning process focussing on the development of a respectful learning community supporting continual enhancement of practice.

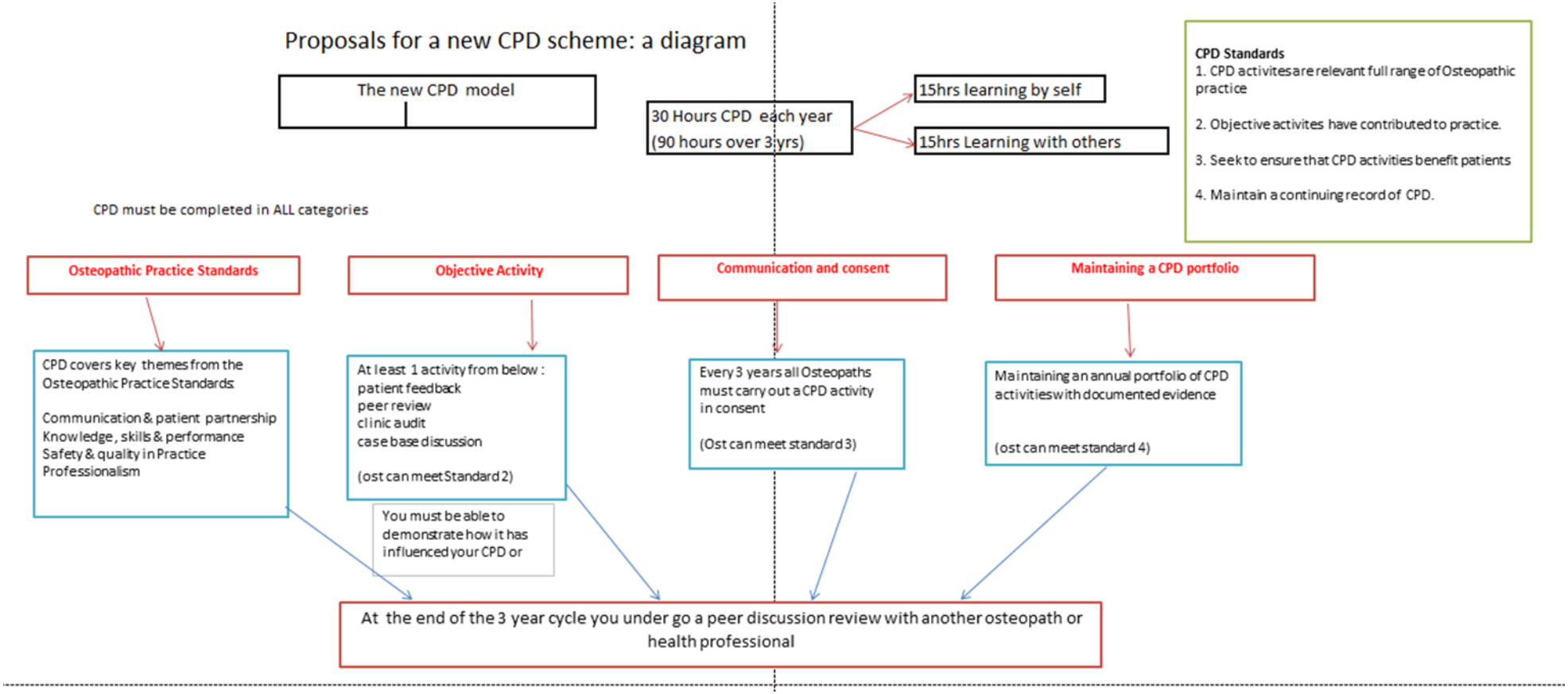
What is the new CPD scheme that you are consulting on?

8. The draft CPD scheme is outlined in the diagram at Table 1 below.

9. As now, it comprises 30 hours of CPD (including 15 hours of learning with others) but over 3 years making a total of 90 hours of CPD (including 45 hours learning with others). As now, CPD is primarily self-directed, but must also include the following:

    a. CPD in each of the themes of the *Osteopathic Practice Standards*
    b. A CPD activity in communication and consent
    c. An objective activity (e.g. case based discussion, peer observation and feedback, patient feedback or clinical audit)
    d. The three year CPD cycle is completed by a Peer Discussion Review with a colleague to discuss CPD and practice demonstrating engagement with the CPD scheme.

Table 1 – Diagram describing the CPD Scheme



How can I undertake this CPD scheme?

10. The new CPD Guidelines have a pack of resources, examples and case studies alongside them to help you to undertake the CPD requirements and to check that the scheme will work for you.

Why does the CPD scheme have to change?

11. The current CPD scheme does not help us to show public and patients how we keep up to date in accordance with our standards in the way that they expect. It is time to create a better scheme. We have worked closely with osteopaths across the UK to build on what we do already and make it fit the osteopathic profession.

12. The remainder of this booklet describes the research, engagement, consultation and piloting used to inform the development of the new CPD scheme.

Do I have to read this booklet to take part in the consultation?

13. No it is not necessary to read this background document to participate in the consultation. However, you may find it helpful to answer any questions about how the new CPD scheme was developed.

What happens next?

Date	Activity
January 2015 to May 2015	Consultation on new CPD scheme – how can we make it work for you?
2015	Infrastructure design Early adopters
2016-17	Scheme fully implemented

How can I find out more and get involved in the consultation?

14. Contact your local regional group, osteopathic educational institution or society of the Institute of Osteopathy and book a place at one of the local consultation events taking place throughout the consultation.

15. Alternatively, discuss the scheme with a colleague – how can you make it work for you. There are materials to support your discussion available on the GOsC website.

16. You can also contact the GOsC by contacting cpdconsultation@osteopathy.org.uk or by telephoning 020 7357 6655 x235.

How the new CPD scheme was developed

Purpose of the new CPD scheme

17. The overarching outcome of any scheme, providing assurance of continuing fitness to practise for regulated health professionals, must be public protection. The scheme should enable safer and more effective practice.

18. The scheme should enable us to respond to the question '*how can I know that the professional looking after me is up to date and fit to practise?*' The scheme should support a culture of continuous learning and improvement.[1]

19. The scheme should not encourage behaviour that could put public protection at risk (for example, unintended incentives not to discuss and improve areas of development because one is trying to pass an assessment demonstrating practice in accordance with standards).

20. The foundation for our scheme must be based on practising in accordance with the *Osteopathic Practice Standards* and enhancement of practice and demonstrating this but in a way which supports genuine enhancement of practice and engagement.[2]

[1] See p3, Council for Healthcare Regulatory Excellence (now the Professional Standards Authority), 2012, An approach to assuring continuing fitness to practise based on right touch regulation principles, available at http://www.professionalstandards.org.uk/docs/psa-library/november-2012---right-touch-continuing-fitness-to-practise.pdf and accessed on 1 September 2014.
[2] See pp 6 and 7, Council for Healthcare Regulatory Excellence (now the Professional Standards Authority), 2012, An approach to assuring continuing fitness to practise based on right touch regulation principles, available at http://www.professionalstandards.org.uk/docs/psa-library/november-2012---right-touch-continuing-fitness-to-practise.pdf and accessed on 1 September 2014.

Background

21. The proposals for our new CPD scheme have been developed following a six year programme of work looking at revalidation as well as the context within which the osteopathic profession works. The programme has been informed by consultation on our existing CPD scheme, consultation on an earlier scheme of revalidation, a revalidation pilot and also research with patients and osteopaths. This background work is outlined in detail below.

The revalidation scheme – 2009 to 2012

22. In 2008 and 2009, the General Osteopathic Council worked with a small group of osteopaths to develop a revalidation scheme based on assessment against standards.

23. This revalidation scheme which involved four stages:

    - Stage 1 – self assessment against standards.
    - Stage 2 – further evidence of practise
    - Stage 3 – a bespoke assessment of practice
    - Stage 4 – an assessment of clinical performance

24. In 2009, a consultation took place and in broad terms, the consultation supported the scheme with 77% of respondents agreeing that the scheme appeared feasible and appeared to meet the needs of patients and osteopaths. However, much of the detail still needed to be worked through, so issues such as assessment criteria and quality assurance needed to be clearer. [3]

25. In 2011 and 2012, the General Osteopathic Council undertook a year long pilot, just of stage 1 of the process which was completed by more than 1 in 18 of the whole osteopathic profession.

26. The pilot involved osteopaths undertaking *four* activities (choosing from activities such as patient feedback and analysis, case based discussions, case presentations, clinical audit or significant event analysis) over *one* year to demonstrate that they met each of the *Osteopathic Practise Standards* through explicit and defined assessment criteria. Pilot Assessors assessed and provided feedback on each completed submission.

27. Osteopaths taking part in the pilot answered questions at three monthly intervals about the benefits and costs of undertaking each activity. Other stakeholders were also asked for their views. The information was collated as part of an

[3] See p1, Masterson A. Revalidation for Osteopaths Report, 2009 available at http://www.osteopathy.org.uk/uploads/revalidation_consultation_analysis_report_2009.pdf and accessed on 15 October 2014.

independent expert evaluation of the pilot by KPMG. Full reports are available at: http://www.osteopathy.org.uk/practice/Revalidation/Research/

28. There were many benefits outlined to the pilot including

    - Increased review of the standards and
    - Reported enhancement of patient care.

29. However, the pilot was found to be even more complex and costly than the scheme of revalidation put in place for doctors by the General Medical Council. These original proposals were therefore considered disproportionate.

30. While the pilot was being undertaken, the General Osteopathic Council also published a CPD Discussion Document. Key findings from this document included:

    - limited support for learning cycles;
    - slightly more support for core CPD (with further guidance about what was needed);
    - support for feedback to osteopaths about their CPD;
    - considerable support for retaining the current system of CPD, although also of note is that many more osteopaths are now using patient feedback and other similar mechanisms to inform themselves about the effectiveness of their practice.

31. A full report of the analysis of the responses to the CPD Discussion Document as well as the original document can be found at: http://www.osteopathy.org.uk/practice/Continuing-professional-development/

The osteopathic context

32. Achieving the outcome of public protection must also 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.

33. Building a scheme around the context and community within which osteopathy is practised will help to ensure that implementation of the scheme ensures safer and more effective practice. This was clear from the feedback of osteopaths through the revalidation pilot and also through the CPD Discussion Document consultation but also other commissioned research as outlined below:

    - The Clinical Risk Osteopathy and Management research study (2012) suggested that osteopathy can be described as a 'low risk intervention' although 'major events are rare, but do occur'.[4]

[4] 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.

- 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.[5]

- The Osteopathic Patient Expectations research study (2011) 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.[6]

- Complaints to the regulator and to the insurers are on a 'wide variety of issues' including both clinical as well as communication and conduct issues.[7]

- 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.[8] It is interesting that clear

[5] 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.

[6] 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

[7] 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).

[8] 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.

communication was an important factor for patients in our recent patient focus groups along with explicit consent to treatment.[9]

- In 2009, KPMG noted that 'Formal performance appraisal is rare, and … very little documented reflection on performance or feedback from patients exists.'[10] 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.'[11]

- 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'[12]. 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.'[13]

- The approach used within the Revalidation Pilot was too complex and burdensome and would need to be simplified.[14]

34. The Professional Standards Authority report, *An Approach to Continuing Fitness to Practise*, (2012) discussed environmental risk factors. These include lack of clinical governance, levels of autonomy and isolation, levels of support provided (or not) and emotional and psychological engagement. Using these principles, the context for the osteopathic profession demonstrates the following:

    - '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.[15]

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[9] See Community Research, (2014), *Public and patient perceptions of osteopaths and osteopathy*, p22, 28 and 29, available at http://www.osteopathy.org.uk/uploads/public_and_patient_perceptions_of_osteopaths_and_osteopathy_2014.pdf and accessed on 1 September 2014.
[10] 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.
[11] See KPMG, Final Report, 2013 (above), p4
[12] 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.
[13] See KPMG, Final Report (above), p5.
[14] See KPMG, Final Report (above), p5
[15] 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

- '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.'[16]

- 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.[17]

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

35. 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. It is also of note, that patient focus groups closely link the levels of supervision found in the NHS, to levels of trust.[18]

36. The context above explored through a variety of research, evidence and analysis supports an evidence informed understanding of the level of risk that we are seeking to mitigate through our draft continuing fitness to practise scheme.

How these findings informed our new proposals

37. 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:

    a. 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.

    b. 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.

    c. Peer review and patient feedback are important. (Although our patient focus group (2014) felt that patient feedback was less important than peer feedback.)

[16] As above.
[17] As above.
[18] See Community Research, (2014), *Public and patient perceptions of osteopaths and osteopathy*, p10, available at http://www.osteopathy.org.uk/uploads/public_and_patient_perceptions_of_osteopaths_and_osteopathy_2014.pdf and accessed on 1 September 2014.

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

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

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

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

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

38. 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.

39. 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.

40. 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.

How was the new proposed CPD scheme developed?

41. The General Osteopathic Council agreed the draft scheme outlined in our consultation document in October 2013 based on the research above and engagement with osteopaths and others through stakeholder events which took place during spring and summer 2013.

42. Since October 2014, we have been working closely with four regional pathfinder groups (comprising representatives across the UK), educational institutions and postgraduate CPD providers and the Institute of Osteopathy, to develop the scheme. Over fifty osteopaths have been involved in this process which involved a series of focus groups and discussions, and the development, testing and writing up of case studies by all involved to give examples of how the scheme might work in different contexts. Their immense work is reflected in both the *Continuing Professional Development Guidelines* (and associated resources, examples and case studies) and the *Peer Discussion Review Guidelines*.

43. We also undertook a day long patient focus group to test out our emerging thinking with members of the public. A full report of this group is available at: http://www.osteopathy.org.uk/uploads/public_and_patient_perceptions_of_oste

opaths_and_osteopathy_2014.pdf. Key findings from this focus group suggested that:

- Initial reactions to the draft continuing FTP scheme were positive and appropriate to the context of the profession.
- Peer Discussion Reviews should be undertaken by someone qualified and independent.
- Mandatory requirements for training and development were felt to be positive.

44. The GOsC have now published:
    - Consultation documents – both a full version and also a shorter simplified version.
    - New CPD Guidelines
    - Case studies and resources to help osteopaths access help in completing the mandatory requirements
    - New Peer Discussion Review Guidelines along with walk through templates and frequently asked questions.
    - A website with a range of resources to help you to navigate through the consultation including:
        - Videos from osteopaths describing the scheme.
        - Specific sections on each of the consultation issues
        - Discussion Guides to support you to discuss the consultation with a colleague or as part of a group.
        - A list of local meetings, where members of the GOsC staff team will be attending to listen to your feedback.

Next steps

45. The draft CPD scheme is being consulted on from January 2015 to May 2015. Further information is provided on the GOsC website at www.osteopathy.org.uk