Education Committee
16 November 2012
Continuing fitness to practise update

Classification	Public
Purpose	For noting
Issues	This paper provides an update on our progress with the revalidation pilot and the responses to the CPD Discussion Document, an update on the recently published CHRE Report, '*An approach to continuing fitness to practise based on right-touch regulation principles'* , and our next steps.
Recommendation	To note the continuing fitness to practise update.
Financial and resourcing Implications	None arising from this paper.
Equality and diversity Implications	None arising from this paper.
Annexes	Annex A – 'An approach to Continuing Fitness to Practise' CHRE, November 2012
Communications implications	None arising from this paper.
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Background

1. In June 2012, the Committee received an update about our work in relation to continuing fitness to practise along with a summary of the statements in the relevant White Papers and Command Papers and the expectations of stakeholders.

2. In October 2012, the Council received an update about the progress of the revalidation pilot and the responses to the CPD Discussion Document. This paper is available on request from Joy Bolt (jbolt@osteopathy.org.uk).

3. This paper reports an update on our revalidation pilot and the CPD Discussion Document responses, an update about the recent publication of the CHRE report '*An approach to continuing fitness to practise based on right-touch regulatory principles'*, an exploration of the potential impact of the report on our work and the next steps in developing our own proposals for continuing fitness to practise.

Discussion

Progress with the Revalidation Pilot and CPD Discussion Document Consultation Analysis

4. In October 2012, we received 264 completed revalidation portfolios for analysis which represents 72% of those remaining in the pilot at July 2012 (364) and is around 56% of those who started the pilot back in September 2011 (473). The number of portfolios received also means that just under 6% of the whole profession completed and submitted a revalidation portfolio for this pilot.

5. Most leavers, who have told us that they have left the pilot, are indicating that they are leaving for personal reasons, e.g. changes of roles or taking on additional work or life events throughout the year preventing them from completing the required amount of evidence. However, a small number have indicated frustration with the pilot in terms of the amount of work required or perceived to be required. The number of leavers has increased significantly from 66 in July 2012 to 109 confirmed leavers on 3 October 2012. The remaining participants who had not submitted a leaver form to KPMG or a portfolio to GOsC were sent a letter inviting them to submit confidential information to KPMG about their reasons for leaving the pilot to ensure that this information is captured in the KPMG independent evaluation and impact assessment.

6. All portfolios were sent to the pilot assessors during October. Each pilot assessor received eight or nine portfolios to mark. All assessors were then invited to attend a moderation meeting where they spent time reading portfolios and assessment grids from other assessors and providing feedback, presenting examples of good portfolios, portfolios with gaps and portfolios they were unsure about and discussing issues such as:
   - Providing constructive and supportive and perhaps reassuring feedback.

- The challenges of providing constructive feedback on excellent portfolios.
- Using the right tone and content of language to be useful and mindful that this is a pilot process
- Responding to gaps in evidence which could impact on clinical safety and feeding this back to the participant in a constructive way with further advice.

7. There was some consensus about the characteristics of a good portfolio which included:
   - Logical
   - Fully completed mapping grid
   - Detailed – not descriptive but discussion of evidence, why it was chosen and impact, if any, on practice.
   - Analysis of data including method, results, analysis, exploration of strengths and areas for development (if any) and next steps (not just questionnaires provided without any analysis)
   - Triangulation of data – ie demonstrating themes with more than one piece of evidence
   - Demonstration of good, safe practice. Evidence of consideration of red and yellow flags (in relation to criterion 2.4 – Determine the boundaries of safe osteopathic practice)
   - Good informative self assessment, reflective and analytical, demonstrating a process of learning about practice (perhaps also including the personal development needs analysis and the action plan templates) and even identifying particular CPD to take forward
   - The portfolio as a whole demonstrated a clear rationale, process and outcome
   - Clearly structured including contents lists and page numbers so that the pilot assessor could navigate the portfolio effectively and see what the participant was submitted for each criterion.

8. The assessors also provided feedback on the process and this will be taken into account in the KPMG analysis. Such feedback included:
   - The background evidence that would support the portfolio should be submitted, for example case histories were helpful
   - Patient questionnaires were helpful to see to support the patient questionnaire analysis.
   - Particularly difficult criteria to evidence included: 4.5 – Care for and manage your patients in a manner that abides by the Osteopathic Practice Standards, 3.6 – Ensure that the environment is safe. Adhere to data collection guidelines and ensure full, accurate and timely patient records and data collection are maintained in line with contemporary legal requirements and 3.7 – Avoids minimises and controls difficult situations. Also criteria that some found more difficult to evidence included: 1.3 Gain informed consent, as appropriate, in a manner that is understandable to the patient, carer or parent and that is in accordance with legal requirements for consent and the GOsC's Osteopathic Practice Standards and 3.5 Apply appropriate solutions in practice, to issues surrounding patient modesty within current norms for assessment or healthcare.

- Requiring a particular type of case history might be helpful.
- Notable consistency in what assessors were saying in response to portfolios.
- More but streamlined guidance needed for participants in the process.
- Participants should submit supplementary evidence if this helped to meet criteria.

9. The Pilot assessor feedback to GOsC and to KPMG will be used to inform proposals for continuing fitness to practise moving forward.

Progress on Evaluation and Impact Assessment

10. The evaluation and impact assessment is progressing well. Participant survey data and assessor survey data is being analysed by KPMG. This is supplemented with a variety of Focus Groups which have included pilot participants, non-pilot participants, insurers, patients, pilot assessors as well as discussions with some other regulators.

11. The final report is due for submission at the end of 2012.

12. The CPD Discussion Document consultation ran alongside the revalidation pilot from 1 September 2011 to 30 September 2012. In total, we have received around 450 written responses including responses from individuals or organisations in the following groups:
    a. Patients
    b. Other lay people including educationalists and people with expertise in inter-professional learning and leadership
    c. Other regulators
    d. Other membership bodies – both within and outside the health sector.
    e. Osteopaths
    f. Osteopathic Educational Institutions
    g. British Osteopathic Association
    h. Osteopathic special interest groups.

13. During the consultation period we also met with a diversity of individuals and organisations to inform our thinking including:
    a. Health Departments in January 2012
    b. Osteopaths at Regional Network Meetings in March 2012
    c. Osteopathic Educational Institutions in March 2012
    d. A conference workshop in March 2012
    e. Meeting with the NHS Leadership Academy and health regulators
    f. Osteopaths at all the Regional Conferences from April to July 2012
    g. Osteopaths at local group meetings throughout the consultation period
    h. Meetings with osteopathic special interest associations during March to May 2012
    i. Meeting with the Osteopathic Alliance in May 2012
    j. Osteopathic Insurers in July 2012
    k. Council for Healthcare Regulatory Excellence in July 2012

l. Other health regulators at the Inter-regulatory revalidation meeting in September 2012
m. Other regulators and professional bodies at the UK Inter-professional CPD Group meetings in September 2012.

14. In our July 2012 Council paper we provided a very high level snapshot of the findings is set out below to give Council a feel for the types of responses we are getting to the key issues which are:
    a. The aims of CPD
    b. The learning cycle
    c. Core CPD
    d. The length of the CPD period
    e. Quality Assured CPD
    f. Effectiveness
    g. How could osteopaths best show that they are up to date and fit to practise (a copy of this high level snapshot is available on request from Joy Bolt at jbolt@osteopathy.org.uk).

15. We are currently collating an analysis of the data received which is both quantitative and qualitative in nature with a view to providing Council with a detailed consultation analysis in due course.

An approach to assuring continuing fitness to practise based on right touch regulation principles[1]

16. An approach to assuring continuing fitness to practise based on right touch regulation (the CHRE Report) was developed following discussions with all the regulators about their thinking and progress in relation to continuing fitness to practise.

17. It clarifies CHRE thinking on some important issues including the following:
    - The outcome of revalidation or equivalent schemes should be that registrants could demonstrate they were safe and fit to practise.
    - Regulators should be able to provide assurances of the continuing fitness to practise its registrants.[2]
    - The primary role of continuing fitness to practise should be that of affirming that registrants continue to meet the regulator's core standards.[3]
    - Quality improvement can likely be achieved through considered and intelligent use of quality control mechanisms: using their various regulatory levers, professional regulators can support and encourage quality improvement.

[1] CHRE, An approach to assuring continuing fitness to practise based on right-touch regulation principles, 2012, available at http://www.chre.org.uk/_img/pics/library/121102_Right_Touch_CFtP_-_FINAL_1.pdf and accessed on 16 November 2012.
[2] See para 3.3, p5 above.
[3] See para 1.2, p1 above.

However, professional regulators remain the guardians of minimum standard of conduct and competence, and have a duty to protect the public.[4]

- Compliance with continuing professional development requirements, while it may be a helpful measure to some extent, is not in itself a demonstration of continuing fitness to practise.[5]
- 'Other regulatory functions can help support the outcomes of the dedicated continuing fitness to practise function. Registration, fitness to practise and education can all contribute in different ways.'[6]
- 'Developing ways of assuring continuing fitness to practise that are proportionate and effective at mitigating risks will require a clear understanding of what professionals do and the context in which they do it.'[7]
- 'When considering risks, we should take a broad view, to encompass factors relating both to context and practise, and conduct as well as competence.'[8] 'There are a broad range of factors that regulators might wish to consider when determining how much resource to put into continuing fitness to practise and how to design the continuing fitness to practise mechanism.' The factors include:
  - Effectiveness of clinical governance mechansisms
  - Effectiveness of qualifying training
  - Frequency of practice
  - Level of autonomy
  - Level of isolation
  - Level of support
  - Practice context
  - Time since qualification
  - Workload
  - Complexity of task
  - Emotional and psychological engagement
  - Level of responsibility for service user safety
  - Liklihood and severity of treatment side effects
  - Medical invasiveness
  - Rate and evolution of techniques
  - Sexual invasiveness
- 'The severity and prevalence of any risks relating to continuing fitness to practice should guide decision-making about the regulatory force that is needed to address them.' Levels of assurance about reliability of assessment will be higher for higher risk assessments of risk.
- Effectiveness and proportionality – 'Regulators of lower risk professions on the other hand may not need to have such high levels of confidence in their continuing fitness to practise decisions.'[9] It appears from the CHRE document that a self-assessment based approach perhaps triangulated with external

[4] See para 311, p7 above.
[5] See para 3.22, p8 above.
[6] See para 1.4, p1 above
[7] See para 4.2, p10 above
[8] See para 6.5, p19 above
[9] Para 5.14, page 18 above

evidence such as patient assessment could be appropriate for a lower risk profession.[10]

18. The CHRE Report is a welcome document as it starts to flesh out some of the issues to consider when deciding whether a particular approach to demonstrating continuing fitness to practise is proportionate or not.

19. In our Revalidation Poster, 2010[11] we noted that:
    - The risks of osteopathic techniques and treatments are 'extremely low'.
    - Complaints to the regulator and to the insurers are on a 'wide variety of issues' including clinical, communication and conduct issues.
    - Unmet patient expectations forming the potential for complaints include: not realising undressing would be required; insufficient preparation for the forceful nature of the intervention; and the possible side effects after treatment.
    - Some osteopaths undertake techniques which are 'adjunct' to osteopathy, for example, acupuncture, homeopathy, nutrition therapy and for which they are not trained at pre-registration level.
    - Most osteopaths practiced independently without employers or teams.

20. However, we also recognised that
    - All osteopaths on the register have been through an assessment and that explicit standards and quality assured education has been in place since 1998.
    - Practitioners have been subject to a practitioner directed mandatory CPD scheme (involving learning with others) since 2012.

21. Since then we have had some additional research that we will wish to fully analyse and feed into our understanding of risk in the osteopathic profession for example:
    - The findings of the clinical risk and osteopathy management research study
    - The findings of the preparedness to practise research
    - The responses to our CPD Discussion Document
    - The results of our revalidation pilot and the impact and evaluation assessment due in December 2012.

22. We will need to carefully review the context and activity risk factors identified in the CHRE report and the impact on osteopathic practice in terms of the ways in which registrants should demonstrate that they meet our standards.

23. That said, the CHRE Report does allow us to critique our original four stage revalidation model proposed and consulted on in 2009 which could be regarded as highly reliable (i.e. it would produce a consistent result in terms of passing and failing) should an osteopath proceed to stage four – ACP. The paper encourages us to pose the question about whether such reliability is necessary if,

[10] See for example, paras 5.4 and 5.5, p16 above and para 6.6, p19 above.
[11] Browne F., Revalidation Poster, 2010 available at http://www.osteopathy.org.uk/uploads/revalidation_poster.pdf and accessed on 16 November 2012.

following our analysis of the additional data, the assessment of osteopathic activities remains 'low risk'.

24. On the other hand, the CHRE Report also gives us space to look at our input based CPD scheme and to explore whether the current scheme is really sufficient to enable us to confirm with confidence that registrants are indeed meeting our minimum standards – particularly when we consider the findings in our CPD Discussion Document about the lack of breadth in recorded CPD because most CPD is concentrated in the area of knowledge, skills and performance.

25. The CHRE Report also encourages us to think more broadly about ways in which we might build on activities at local level to support continuing fitness to practise, for example, if osteopaths were involved in considerable data collection and analysis in a local group, for example for patient reported outcome measures (PROMs), then the approach taken to these groups could be different than to those who are not so involved.

26. Given that the CHRE Report also indicates that high reliability is appropriate for high risk professions and that low reliability is appropriate for low risk professions, this could support us to perhaps to consider a single scheme, based on our CPD scheme, which is formative in nature and builds on identified benefits of the revalidation pilot.

27. Clearly we are unable to fully elaborate an appropriate position until we have received the KPMG report and we have published the analysis of our CPD Discussion Document responses, however, the CHRE Report provides some useful signposts for the ways in which we might further develop proposals in 2013.

Next steps

28. The next steps are as follows:

Date	Activity
October/ November 2012	Assessment of pilot folders. Feeding back to participants
December 2012	KPMG submit independent evaluation of the benefits and costs of the Revalidation Pilot.
Spring 2013	Publication of the KPMG Evaluation Publication of the CPD Discussion Document consultation analysis
Spring/ Summer 2013	Publication of revised proposals about regulating continuing fitness to practise.

Recommendation: to note the continuing fitness to practise update.