General Osteopathic Council



**Osteopathic Practice Committee**
**25 June 2014**
**State of CPD Report**

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| **Classification** | Public |
| **Purpose** | For discussion |
| **Issue** | Scoping the State of Continuing Professional Development (CPD) report. |
| **Recommendation** | To consider the broad scope of the State of CPD Report. |
| **Financial and resourcing implications** | It is planned that the audit and the survey will be undertaken in-house and so costs will mainly comprise staff time. |
| **Equality and diversity implications** | Equality and diversity considerations are being taken into account as part of the scoping work. |
| **Communications implications** | We will publish information about this report in *the osteopath* and through other relevant channels. |
| **Annex** | Continuing fitness to practise model. |
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## Background

1. Our Corporate Plan 2013 to 2016 states that we will 'ensure through an appropriate process registrants are able to demonstrate their continuing ability to meet the *Osteopathic Practice Standards*.' This includes publishing 'proposals for a proportionate framework for continuing fitness to practise ... and a commitment to 'consult on and implement a new approach to continuing fitness to practise.'

2. Our Business Plan 2014 to 2015 states that we will

   - Design an osteopathic continuing professional development evaluation to feed into report of 'State of Osteopathic continuing professional development' (June 2014)

   - Conduct the continuing professional development evaluation (July to September 2014)

   - Publish a report about the 'State of Osteopathic continuing professional development (January 2015)

3. The purpose of the evaluation is to establish a current picture of osteopathic CPD under the existing scheme. Establishing such a baseline in 2014 to 2015 will help us to understand how (if at all), our new continuing fitness to practise model has altered patterns of CPD over time. As a part of our evaluation of that framework it will aid our understanding of how CPD makes a contribution to safe practice and continuing enhancement of the quality of care. The draft continuing fitness to practise model will be consulted on towards the end of 2014 with a view to working towards early implementation towards the end of 2015.

4. The new continuing fitness to practise model comprises a three year cycle, incorporating 90 hours of CPD and 45 hours learning with others. There are three mandatory elements which are:

   - CPD in all the four themes of the *Osteopathic Practice Standards*

   - CPD in communication and consent

   - an objective activity feeding into CPD and practice (for example patient feedback, peer observation, clinical audit or case based discussion).

   The osteopath moves into the next CPD cycle by successfully completing a Peer Discussion Review – discussing their CPD and their practice with a colleague and demonstrating that they comply with the scheme – meeting our CPD Standards. A more detailed outline of the draft model is provided at the Annex.

5. In relation to evaluation of continuing fitness to practise schemes, in this case, the GMC Revalidation Scheme, the Parliamentary Health Committee published their Annual Scrutiny Report of the General Medical Council on 25 March 2014.

The transcript of the evidence provided by the GMC at their hearing in December 2013 shows that the Health Committee was particularly interested in the effect of the implementation of revalidation. This is reflected in the published Committee report which states:

6. 'Revalidation has only been in operation for a little over 12 months and as yet the data does not exist to explain whether it is a fundamentally better process to identify and address failings in professional practice than the previous system which relied solely on employer led appraisals. From the perspective of employers, this process should be about more than simply helping their staff navigate revalidation and should **embrace ongoing appraisal and the management of poor performance**. Una Lane's comments in this regard are encouraging, but at our next accountability hearing the Committee would like to see **a formal assessment of the evidence relating to revalidation to ensure that it is making a significant contribution to the improved practice of doctors.**'

7. The comments provided by Una Lane, GMC Director of Registration and Revalidation, were that the introduction of revalidation had changed the way in which health providers managed their clinical staff by:

    - More doctors being subject to appraisal than was previously the case

    - More organisations having policies in place to identify poor performance at an earlier point in the process including reskilling, rehabilitation and remediation.

8. While clearly osteopaths tend not to work in managed environments, the principles are still relevant to frame our own thinking about how we demonstrate that our continuing fitness to practise model will make a difference – that is with a particular focus on the discussion of practice (strengths, areas of development, CPD) and the identification of poor performance.

9. We are considering this evaluation at an early stage – we have not yet finalised our new continuing fitness to practise scheme and therefore our direction of travel for the evaluation may yet still change. Nevertheless, we learned from our *Osteopathic Practice Standards* Evaluation, that we should consider evaluation at the earliest opportunity to ensure that that we get the best quality data to inform it.

10. The purpose of this paper is to seek the views of the Committee to the initial broad scoping of this report taking into account the information provided above.

**Discussion**

11. Our 'State of CPD' report will want to do two things. It will want to provide a picture of the existing patterns of CPD so that we can see how they change as we implement a new model of continuing fitness to practise. However, we will also want to consider carefully our draft scheme and the changes we would like

to see, so that we can get an explicit baseline in relation to these matters both currently and in the future.

*Purpose and aims of the continuing fitness to practise scheme*

12. The purpose of our continuing fitness to practise model is to ensure public protection, safer and more effective practice. It should not encourage behaviour that puts public protection at risk.

13. The aims of our continuing fitness to practise model are:

    - To ensure that osteopaths are up to date and practising in accordance with the *Osteopathic Practice Standards*?

    - To enable osteopaths to have access to communities and individuals where they can discuss areas of development and remediate if required and support the continuing enhancement of their practice.

*To ensure that osteopaths are up to date and practising in accordance with the Osteopathic Practice Standards?*

14. The current CPD scheme enables osteopaths to select their own CPD. Back in 2011, when we published our CPD Discussion Document we observed that most CPD was in the area of knowledge, skills and performance. It is therefore difficult to demonstrate that osteopaths on the register are keeping up to date across the breadth of the *Osteopathic Practice Standards*.

15. So our first question might be – how much CPD is undertaken in the Osteopathic Practice Standards under the current scheme in 2014-15?

| **Requirement** | **Method of testing** |
|---|---|
| Is CPD undertaken in all areas of the *Osteopathic Practice Standards*? | Check random selection of annual summary forms over 2014 and 2015 to test whether:<br>a. Majority of CPD is in Knowledge, skills and performance<br>b. Whether other domains of the OPS are mentioned, e.g. Communication and patient partnership, safety and quality in practice or professionalism. (This includes documented CPD but will not necessarily include undocumented CPD that the osteopath may undertake)<br><br>Include survey question exploring whether osteopaths review the Osteopathic Practice Standards and incorporate CPD in relation to each of the themes? (This question may include both documented and undocumented CPD). |

16. We know that 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.[1] This is not to say that communication and consent is an area of concern for all osteopaths. However, communication and consent is an area highlighted more frequently than other areas from a range of sources, sufficient for us to pay attention to this area in our scheme for the profession as a whole.

17. So our second question might be – how much CPD is undertaken in the area of communication and consent under the current scheme in 2014-15.

| **Requirement** | **Method of testing** |
|---|---|
| Is CPD undertaken in the area of consent and communication? | Check random selection of annual summary forms over 2014 and 2015 to test whether CPD is undertaken in communication and consent. (This includes documented CPD but not necessarily undocumented CPD).<br><br>Include survey question exploring whether osteopaths review the Osteopathic Practice Standards and incorporate CPD in relation to each of the themes? (This question may include both documented and undocumented CPD). |

18. We know that our current CPD scheme does not require objective feedback on practice. CPD and learning is primarily self-directed. In 2009, as part of their 'how osteopaths practice report' providing a baseline for the revalidation pilot, KPMG noted that 'Formal performance appraisal is rare, and … very little documented reflection on performance or feedback from patients exists.'[2] However, in 2013, KPMG noted that 'engagement in the pilot and using pilot tools had enabled participants to document their practice.' And that 'in

[1] 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.

[2] 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.

discussions with registrants many indicated that they would continue to use the tools to develop their practice in the future.'[3]

19. There is some evidence that learning with peers or learning from feedback can improve the quality of learning.[4] And that self-assessment on its own can be flawed.[5]

20. Using the revalidation 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'[6].

21. For these reasons, the continuing fitness to practise model contains two elements of feedback and discussion. The first requires the osteopath to collect feedback from an external source about their practice and reflect on it. The second element is part of the Peer Discussion Review which requires the osteopath to discuss their practice and the CPD with another osteopath.

22. There are a couple of questions that the osteopath that we may wish to explore arising from this. The first is: are osteopaths collecting feedback about their practice from external sources? The second is: are osteopaths discussing their practice and CPD with others to support their practice? The second is are osteopaths

| **Requirement** | **Method of testing** |
|---|---|
| Are osteopaths collecting feedback about their practice from external sources? | Check random selection of annual summary forms over 2014 and 2015 to test whether the collection (and / or analysis or reflection from external sources is documented).<br><br>Check random selection of CPD Folders over 2014 and 2015 to test whether the collection (and / or analysis or reflection from external sources is documented)<br><br>Include survey question exploring whether osteopaths collect and review information or data from external sources to inform their practice. |

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

[4] See for example, Sargeant JM, Mann KV, Van de Vleuten CPD, Metsemakers JF, Reflection: a lnik between receiving and using assessment feedback, *Adv. Health. Sci, Educ. Theory Practice*, 2009, 14. 399 - 410

[5] See for example, Tracey J, Arroll D, Barham P, Richmond D, The validity of general practitioners' self-assessment of knowledge: cross sectional study, *BMJ, 1997; 315: 1426.* (Similar findings were reported in the KPMG revalidation pilot.) See KPMG Final Report, p5

[6] 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.

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|---|---|
| Are osteopaths discussing their practice and CPD with others to support their practice | Check random selection of annual summary forms over 2014 and 2015 to test whether osteopaths are documenting the discussion of their practice with others to support their practice.<br><br>Include a survey question exploring whether osteopaths collect and review information or data from external sources to inform their practice. |

23. Concerns about practice are another key area that we will need to consider as part of the continuing fitness to practise model.

24. An important focus of our continuing fitness to practise model and particularly as part of the peer discussion review, is the creation of a supportive and constructive environment which is built on trust and relies on osteopaths (both reviewers and those being reviewed) to genuinely participate and show interest in activities, and helping colleagues feel valued. Both parties use skills of listening carefully and of giving and receiving constructive and helpful feedback to maintain the continuing enhancement of practice and patient safety.

25. However, a focus on reporting concerns could bring a tension to the peer discussion review process. In many ways, this tension could be similar to that which exists in a regulator. On the one hand, we want to provide support and guidance to osteopaths to enable them to discuss things that have gone wrong or might go wrong and take actions to put them right locally. A level of trust is necessary because only by providing a space for osteopaths to honestly discuss practice can we achieve patient safety. It is inevitable that things will go wrong in any form of clinical practice and it is important to discuss these and learn from them to achieve patient safety. Yet, on the other hand, where patient safety is at risk, it is important that concerns are reported to us and acted upon. However, an unintended consequence of this is that osteopaths will feel concerned about being 'reported' and may be fearful about discussing areas of development (with its consequent impact on patient safety).

26. It is also worth noting here both the overlap and distinction between 'concerns' and 'areas for development'. 'Areas of development' do not necessarily mean 'concerns' or 'deficiencies in practice' and so caution must be applied to using areas of development as a direct proxy for concerns.

27. We have therefore provided some draft guidance in our Peer Discussion Review Form to further elaborate when concerns are appropriate to be managed locally and when concerns may need to be reported.

28. It is difficult to know what success looks like in this scenario. It might be described as more osteopaths able to identify and remedy concerns in practice at an earlier stage. But what would the indicators of this be? It could be an increase in referrals to fitness to practise (perhaps suggesting that more cases

were being reported rather than ignored). It could be a decrease in fitness to practise cases (perhaps suggesting that more cases were being identified and managed at a local level). It could be an increase in the number of 'incomplete' Peer Discussion Reviews over time, suggesting that areas of development are being identified more explicitly and monitored over time.

29. Perhaps, therefore, we need to ask for information from osteopaths themselves and monitor the above trends over time so that they can be interpreted alongside any qualitative explanation. It is likely that we will need to use areas of development as well as 'concerns' to explore this requirement. This is because 'concerns' that are discussed between two osteopaths and where there is insight into the area of concern, then becomes an area of development.

| **Requirement** | **Method of testing** |
|---|---|
| Are concerns about practice being managed appropriately? | Monitor existing CPD forms to explore whether areas of development or concerns are being identified.<br><br>Monitor numbers and trends in fitness to practise cases.<br><br>Monitor numbers of completed Peer Discussion Review forms.<br><br>Monitor samples of Peer Discussion Review forms to see if areas for development are being identified and appropriate CPD followed up.<br><br>Survey to osteopaths asking how they manage concerns with others. (Perhaps mirroring the questions asked in the 2012 registrant survey) |

*To enable osteopaths to have access to communities and individuals where they can discuss areas of development and remediate if required and support the continuing enhancement of their practice*

30. Access to communities or individuals to discuss practice is important to support peer discussion about practice and enhanced learning and patient safety through an environment in which areas for development can be discussed. Osteopathic healthcare is primarily delivered within a commercial context outside teams or employers. Therefore understanding whether such a community or groups of individuals is accessible is very important.

31. Our 2012 Registrant survey showed us that just under 50% of osteopaths were members of regional or other local groups of osteopaths and just over 50% were not.[7] Osteopaths who had been qualified for longer, were more likely to be

[7] See GOsC Registrant Survey, 2012, q56 available at: http://www.osteopathy.org.uk/uploads/osteopaths_opinion_survey_2012_findings_website.pdf

members of regional groups. However, some respondents felt that they had sufficient contact with osteopaths outside of local groups. Equally, some felt that they did not have access to such local groups.

32. A measurement of some form about the level of professional 'connectedness' or conversely and understanding of the level of expressed professional isolation is important to help us to understand whether there is an available community for osteopaths to discuss their practice and areas of development.

33. It is also important to ask osteopaths if they feel that they have access to a people with whom they can discuss practice.

| **Requirement** | **Method of testing** |
|---|---|
| Do osteopaths have access to people with whom they can discuss their practice (including areas of strength and development)? | Use of planning forms in CPD Folders.<br><br>Review of CPD Annual Summary forms to explore how many have discussed areas of development and practice with colleagues.<br><br>Survey – Ask osteopaths 'do you have access to people with whom you can discuss your practice (including areas of strength and areas of development) and explore barriers to this. |

*A description of the CPD people are currently doing?*

34. In addition to these specific questions focussing on the aims of the CPD process, it is also helpful to have a clear description of the CPD that people are currently undertaking. Understanding the pattern of CPD now may help us to understand whether there are any intended or indeed any unintended consequences from the introduction of a new scheme in due course.

35. In responding to these questions, it will be helpful to stratify our samples to include practising and non-practising osteopaths, years in practice, UK or non UK qualified as well as looking at protected characteristics such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Exploring protected characteristics will help us to understand whether or not there are any unintended consequences related to protected characteristics and will ensure that we apply legislation and respect and implement good practice.

36. Specific aspects could include:

a. Compliance – how we monitor CPD, how it comes in and when it is submits. Is there a correlation between submitting late and complying with our Guidelines?

b. Content

- Where is CPD undertaken?
- How much is planned/unplanned?
- Is it a range of CPD across all the domains of the OPS? Or is it concentrated in particular areas?
- Is there evidence of planning CPD?
- How much learning with others?
- How much learning by oneself?

c. CPD Course Provision – has there been a change in the courses offered (that we advertise on the website?) E.g. Are they primarily technique focussed or do they offer explicitly elements of communication and patient partnership, safety and quality or professionalism.

d. Relationship to practice? Do osteopaths feel that their CPD enhances their practice? What is their reason for undertaking CPD (e.g. to meet identified areas of development? To meet regulatory requirements to complete CPD before the year end?)

37. This information can be gathered from CPD Annual Summary forms and CPD folder audits, perhaps with some supplementary questions in a survey to osteopaths.

**Next steps**

38. Changes to current staff resources mean that it would be prudent to slightly delay the original planned timetable for this work. A revised timetable is set out below. The timetable below still allows us to collect baseline data ahead of the implementation of a revised continuing fitness to practise process towards the end of 2015.

| **Date** | **Activity** |
|---|---|
| June 2014 | Agree broad scope of the report |
| Autumn/Winter 2014-15 | Design and undertake audit and survey |

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| Spring/Summer 2015 | Analyse data |
| Summer 2015 | Publish report |

**Recommendation:** to consider the broad scope of the State of CPD Report

## Continuing fitness to practise model

The continuing fitness to practise model comprises a three year cycle (30 hours of CPD each year and a minimum of 15 hours learning with others), of this there are four key activities which must be undertaken as part of the CPD cycle:

*Osteopathic Practice Standards*

- CPD must be undertaken and recorded in all themes of Osteopathic Practice Standards:
  - communication and patient partnership,
  - knowledge, skills and performance,
  - safety and quality in practice and
  - professionalism.

- CPD should also support all areas of osteopathic professional practice (clinical practice, education, research and management).

Completion of these activities will enable the osteopath to demonstrate CPD Standard 1.

*Objective activity*

- At least one objective activity must be undertaken. This might include:
  - Patient feedback
  - Peer observation or feedback (involving two or more people)
  - Clinical Audit
  - Case based discussion (involving two or more people)

- The objective activity should be recorded to include:
  - a note of the method used,
  - the data or feedback gathered, and
  - how that data has fed into CPD and practice (this will usually include analysis, reflection and an action plan).

Completion of these activities will enable the osteopath to demonstrate CPD Standard 2.

*Communication and consent*

- CPD must be undertaken in communication and consent. There are a range of resources to enable the osteopath to undertake this CPD either through self study, through a course, or through e-learning, or through group discussion. A suggested guideline is around 3 hours.

This will enable the osteopath to demonstrate CPD Standard 3.

*Peer Discussion Review*

A Peer Discussion Review is undertaken towards the end of the three year cycle. Discussion and review of the CPD Folder as part of the discussion will enable the osteopath to meet CPD Standard 4.

GOsC will automatically audit the required number of hours and so this does not need to form a part of the Peer Discussion Review.

Completion of these activities will enable the osteopath to demonstrate CPD Standard 4.

*CPD Standards*

The CPD Standards explain to others how we know that registrants are keeping up to date and meeting standards. Genuinely engaging with and completing the continuing fitness to practise activities below will enable osteopaths to show that they are meeting the CPD Standards and therefore be 'signed off' during a Peer Discussion Review.

The CPD Standards are:

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| CPD Standard 1 – Range of practice | Demonstrate that activities are relevant to the full range of osteopathic practice. |
| CPD Standard 2 – Quality of care | Demonstrate that objective activities have contributed to practice and the quality of care. |
| CPD Standard 3 – Patients | The registrant has sought to ensure that CPD benefits patients. |
| CPD Standard 4 – Portfolio | Maintain a continuing record of CPD |