General Osteopathic Council

Regional Communications Network meeting

Osteopathy House, Friday 15 March 2013

Continuing fitness to practise

Purpose

1. This paper aims to:
   a. Support greater awareness of the findings of the revalidation pilot and the CPD Discussion Document consultation.
   b. Encourage debate and discussion about how osteopaths can demonstrate that they are up to date and fit to practise in a way that is useful to osteopaths, patients, the public and the regulator, building on those findings.
   c. Gain commitment from regional network representatives to host a local consultation meeting during November 2013 to February 2014 to discuss revised proposals with the GOsC.

Why did the GOsC undertake a revalidation pilot and why did the GOsC consult on possible options for change to the CPD scheme?

2. In its Command Paper *Enabling Excellence* (February 2011), the Government has asked the GOsC to continue to develop the evidence base for revalidation.

3. There are also other reasons and external expectations to ensure that the Register means that osteopaths on it are up to date and continue to be fit to practise and not simply that the osteopath qualified x number of years ago and has not been subject to fitness to practise proceedings. These reasons include:
   - Public confidence and expectations
   - Reducing incidence of adverse events to patients.
   - Fitness to practise cases – very few ending up as erasure – should cases that don't end up in erasure be picked up earlier or evidenced in a different way to better enhance patient care?
   - Supporting professionals to continually enhance patient care because that is where problems are best managed – locally?

- Expectations of the Parliamentary Health Select Committee
- Expectations of the Professional Standards Authority

4. The Professional Standards Authority 'An approach to continuing fitness to practise' (2012) (the PSA report) sets out more detailed and contemporary expectations of registrants and regulators. Our initial analysis of this paper and how it might help us to develop a proportionate scheme are set out in the next steps section below.

The revalidation pilot

5. The revalidation pilot took place from September 2011 to 2012. Participants were asked to inform a self-assessment of their practice through the use of templates such as patient feedback, clinical audit, structured reflection and case based discussion.

6. Pilot participants are being provided with developmental feedback on their submissions to inform future CPD should they wish it to do so.

7. The pilot was independently evaluated by KPMG. They explored the benefits and costs of the revalidation pilot from the perspective of the participants, the assessors, non-participants, patients, other osteopathic organistions and they sought the views of other regulators.

8. The full reports of the evaluation and the impact assessment are published on the GOsC website at: http://www.osteopathy.org.uk/practice/Revalidation/Research/Final-evaluation-and-impact-assessment/

9. Findings included the following:
   - Three quarters of participants reflected more on areas of their clinical practice
   - 40% of participants reported that their participation in the pilot has benefitted their patients
   - 79% of participants considered 'purposeful review' of the *Osteopathic Practice Standards* had been beneficial
   - Many osteopaths will continue to use the tools in the future
   - 'Complex and administratively burdensome' reported by 89%
   - Challenges for some participants to demonstrate both analysis and reflection
   - Differences in the perceptions of assessors and participants about the demonstration of criteria

- The need for considerable support to help osteopaths to comply with a scheme.

Findings from the CPD Discussion Document Consultation

10. The CPD Discussion Document consultation was published for consultation alongside the Revalidation pilot from September 2011 to September 2012. The aim of the document was to promote discussion and gain views about the ways in which the CPD scheme could be enhanced.

11. A total of 441 responses were received including 333 from the 2012 regional conferences, and responses from osteopathic educational institutions, osteopathic specialist organisations, other regulators, other professional bodies and associations and lay respondents. An independent analysis was undertaken by Abi Masterson Consulting Ltd.

12. The full analysis report is currently available in the papers (Annex C of Item 14) for the Council meeting of 20 March 2013 at: http://www.osteopathy.org.uk/about/the-organisation/meetings/

13. A summary of the findings is set out below:

Aims and principles

14. The aims and principles proposed in the CPD Discussion Document were broadly supported although making them both more specific to osteopathy and osteopathy principles and also to be broadened to enhance relationships with other health professions featured in responses.

Learning cycles

15. The questions about learning cycles generated a high level of responses. Many responses indicated that they did not know what a learning cycle was.

16. There was limited support for learning cycles and a 'high level of resistance' to mandatory learning cycles although limited support for advisory learning cycles.

17. Benefits of learning cycles included:

- Makes the process [of CPD] more conscious.
- Supports osteopaths to undertake CPD annually.
- '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.'

18. Disadvantages of learning cycles included:
    - Too much form filling
    - Too narrow/boxed in
    - *'Too academic and too complex'* BOA
    - *'Too prescriptive and burdensome'* OA
    - *'Anything mandatory is hardly likely to encourage learning or enthusiasm for participation'.*

Core CPD

19. There was limited support for this concept.

20. Arguments for core CPD included:
    - Common standards
    - Coverage of 'causes for concern'
    - Increased patient safety
    - *'Could be advantageous if concentrated on communication and professionalism only'.*

21. Arguments against core CPD included:
    - Draconian
    - Access and cost
    - Too prescriptive
    - Can be difficult to set core of members have diverse needs
    - *'It limits the scope and range of CPD taken up by osteopaths and therefore the future development of the profession.'*

Changes to the CPD cycle/minimum hours requirement

22. Changes to the CPD cycle were mixed. About half liked the annual cycle and others wanted a longer cycle.

23. Around 80% of online respondents suggested that the minimum number of hours was appropriate.

Quality Assured CPD

24. There was limited support for the GOsC undertaking quality assured CPD and mixed views about whether it was necessary.

25. Around 63% of those responding thought that individual feedback would be helpful. However, 18% thought that it would not be helpful mainly due to resource implications.

Measuring the effectiveness of practice

26. Respondents to the question 'how do you measure the effectiveness if your practice?' indicated the following ways including:

Method	**Online (n=63)**	**Conferences and 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

27. Although, perhaps in contrast, when looking at ways that osteopaths could best show that they are up to date and fit to practise, the responses included:

How could osteopaths best show that they are up to date and fit to practise?	**Online (n=56)**	**Conference (n=243)**
Existing CPD process	18	101
Modified CPD system (e.g. including a core and quality assurance and mapping to the Osteopathic Practice Standards)	5	30
Completing revalidation	10	23
Test/exam	7	15

How could osteopaths best show that they are up to date and fit to practise?	Online (n=56)	Conference (n=243)
Contact with other osteopaths eg attending courses and meetings	2	15
Clinical audit	1	14
Patient feedback/satisfaction	2	13
I don't know/difficult to do	4	12
Reflection on practice	0	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	0	1
Standard of surgery environment	0	1

Next steps

28. The PSA report 2012 clarifies PSA 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 of its registrants.
    - The primary role of continuing fitness to practise should be that of affirming that registrants continue to meet the regulator's core standards.
    - 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.
    - 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.
    - 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.'

29. It appears from the PSA document that a self-assessment based approach or a CPD based approach, perhaps supplemented with external evidence such as patient assessment, could be appropriate for a lower risk profession.

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

31. On the other hand, the PSA 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.

32. The PSA 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, such as patient reported outcome measures (PROMs), . , then the approach taken to these groups could be different to those who are not so involved.

33. Given that the PSA 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 perhaps to consider a single scheme, based on our CPD scheme, which is formative and developmental in nature and builds on identified benefits of the revalidation pilot but with much less complexity

34. The next steps taken in this area are extremely important. The emerging consistent themes, in terms of the development process, from both the Revalidation pilot and the CPD Discussion Document analysis are:

    a. Support is required to demonstrate the effectiveness of practice

    b. Concern about demonstrating areas of development to the regulator.

35. Both of these themes are important to explicitly identify and articulate because if we do not get these right, the new 'continuing fitness to practise' process will be 'gamed' and will not therefore achieve what we want it to – i.e. enhancement in patient safety and of quality of practice.

36. It will therefore be important for all to consider these findings fully both internally, but also in partnership with others, informed, for example by roles and projects within the development debate.

37. The proposed next steps are as follows:

Date	**Activity**
Spring 2013	Publication of the KPMG Evaluation and Impact Assessment Reports
Spring to Autumn 2013	Deeper reflection and consideration of the findings of both the KPMG evaluation and impact assessment and the CPD Discussion Document consultation to identify all emerging options and issues
Summer 2013	Engagement with osteopaths, patients, osteopathic organisations as we develop revised proposals. Council and Committee seminars to enable a full discussion about the findings and how they can be built on in a proportionate way
Autumn 2013	Publication of revised proposals about regulating continuing fitness to practise for consultation

The Consultation process

38. Regional Communication Network will form key components of the GOsC Consultation strategy facilitating local osteopaths to feed their views directly to GOsC in small groups.

Take Home Message

PLEASE CONSIDER INVITING A MEMBER OF THE GOC TEAM TO COME AND SPEAK AT YOUR LOCAL REGIONAL EVENT DURING NOVEMBER, DECEMBER, JANUARY OR FEBRUARY 2014 AND TO HEAR YOUR VIEWS ABOUT THE REVISED REVALIDATION PROPOSALS!