Academy of PHYSICAL MEDICINE

Transcript

CPD Changes and Planning

Cast List

Steven Bruce	S
Jos Drew	J
Ruth Tarry	R

S: What do we have to run tonight? If you were watching the last broadcast, then you'll remember that I was talking there about the change to osteopathic CPD standards, and I stupidly said that those change in a year's time. That's not what changes in a year's time. It's actually osteopathic practice standards, which change in a year's time. The osteopathic CPD standards have changed as of this month, which means they come into effect in December. December, January.

Chiropractic standards haven't changed, and we have a little bit to say about those as well, because it was interesting in our last broadcast to see how the chiropractic counseling, General Osteopathic Councils, differed in their approach to the complaints process. Of course, they are differing slightly in their approach to CPD as well. I think what we discuss this evening will be relevant.

We're going to talk about what is now in the rules, regulations for CPD, how it effects you, how we at APM can help you, what other resources there are to help you. To help me with that, I'm joined by Jos Drew. Jos has driven all the way out from Petersfield to join us in the studio here. She is the lady behind PONG: Petersfield Osteopathic Networking Group, I believe, and is an experienced osteopath. Ruth, you are ... Tell me, now.

R: Tarry.

S: Ruth Tarry. It's hard not to call you Walker, I'm afraid.

R: I know.

S: Ruth Tarry, who is an osteopath from my own clinic in Higham Ferrers. Both very experienced in what they do, but also able to give their perspective on how the CPD standards, and all those other things we've been talking about over the last few weeks and month, are going to effect all of us as practitioners. To remind you of those significant topics, I think there's still a lot of ground to be covered with advertising standards, with fitness to practice and the complaints process, because we've had lots of communication about that since the last broadcast with the CPD standards. And, well, you name it. All those other things which are in the back of your mind every time you put your hands on a patient.

You've got questions? Send them in. Doesn't matter what the topic is, we're going to cover anything that crops up this evening. We might even get around to a little bit of case-based discussion later on, because poor old Jos is suffering from frozen shoulder, so we might talk through some of the options for that and what's happened to her. There you are. We're going to hit all those aspects of the CPD standards.

Enough of me. Ruth, I'm going to turn to you as I promised, first of all, because I spend a lot of time looking at osteopathic standards and what the General Osteopathic Council is up to. Dare I say, I probably get more than my fair share of time on the phone or email with Tim Walker. It's easy for me not to see what it's like from the osteopathic coal face. How does the change in standards seem to you at the moment?

R: Well, it's quite daunting in general. There's an awful lot of technical jargon to get your head around. The osteopathic standards I didn't find particularly difficult. We got it, nice glossy copy in the post. Light bedtime reading. I haven't read it all the way through yet, but-

S: When was the last time you read the current osteopathic standards?

R: Probably when I was at university about four years ago?

S: Yeah, exactly. It's not something that's on our day-to-day reading list, is it? It's on mine. It's on my desk, because every time we do a certificate, I write down which specific standard the CPD relates to, but-

R: I would have to go-

S: Most people would never look at it.

R: Yeah. I'd have to go and actually look through to find out which standard my particular bit of CPD related to. At least I have a copy-

S: You've got a nice, shiny book in your hands and you're happy that can go and gather dust on a shelf now.

R: Pretty much. Yes. The CPD, I've sort of been aware of it, but I have to say I'm probably guilty as charged in that I haven't really got my head around it. I have this last week, because when I was told I should be doing this I had to. I have a little bit more of an idea about it now, but I was quite relaxed about it and thought, "Well, I'll get my head around it when I have to." I'm assuming that a lot of people are quite similar. I hope that I was more relaxed about it because of APM.

S: I hope so, too.

R: And knowing that you'll cover those four sections that we have to make sure that we tick off.

S: Yeah.

R: It's the extra bits, like the case-based discussions and the clinical audit and the peer review, that's the big scary one, which having read up on it, I don't think it is as scary as-

S: Well, we touched on it.

R: We first think.

S: We had Steven Bettles on a Zoom conference call-type broadcast some months back. This was in the early stages of it being introduced. He was keen to say, "Look, it's not that scary," but of course we all think change is scary, don't we? When you look through it, a lot of it is much the same dressed up in slightly different clothes. The bits that are new are actually not that scary at all, I don't think. What's your perspective, Jos?

J: No, I think what it's done with our group in Petersfield is it's actually brought us together, and we're going to do it together. Hold each other's hands and make it less scary.

S: You've got quite an active group in Petersfield, don't you?

J: We have.

S: How many members?

J: Ooh, crikey. Members-wise, could be up to 25, 30. We meet quarterly at the moment. Firstly, I'd say I can't take credit for it. It's my lovely associate Emily.

She took us all in hand about 18 months ago. A few of us had said we wanted to meet regularly, but just never made it happen. Emily just set it up, contacted us. She's the one that keeps us all in the loop. I would say quarterly, 15 regularly turn up. But on our actual emailing group, there could be anything, 25, 30 people.

S: Yeah. I suspect ... We discussed this earlier on. The osteopathic networking groups and the chiropractic equivalent, I expect they're really underused in terms of the overall profession. The problem we've got here is we're kind of preaching to people who are already using a networking group, because they're part of APM. Of course, they're part of a huge audience now, listening to this discussion. They've got all the resources they need for their CPD, so they're not that necessarily inclined to go and join an additional group. Except for the fact ... Well, go on. You're shaking your head for probably the reasons I was about to come onto.

J: Yeah. I think the regional groups ... I've lived not all over the country, but in a few different parts of the country where you've got-

S: You've lived all over the countries of the world!

J: Yes. I can't take regional groups to far flung places, although I've only been the only osteopath in where I've been. Previously with the big regional groups, that's been quite different to what we've done in the sense that ... And I was chatting this through with Emily the other day, just to get her thoughts behind how she set it up, how she's running it, and what's happening as it grows and becomes established. What did you ask me?

S: You were going to tell me why networking groups were useful to something like this.

J: Comparing with Petersfield, yeah. Petersfield has actually brought us, in a very small geographical area, together, which I think is going to keep it cozy and friendly and less intimidating. I don't know. Some people might think the bigger regional groups are intimidating. I don't know. We've got a lot of experience in Petersfield, all ages and specialisms. It just feels like we can use our own resources in a nice, manageable way.

S: I think the nice thing about the networking groups, or the osteopathic/chiropractic groups around the country, is that when it comes to this change in CPD regulations, actually there are things in there which, if our members want us to, we will try to do. But if you want to do peer review or peer observation, actually a networking group like that is the ideal place to do it.

J: Yeah.

S: If you know everybody there, it's probably a little less intimidating. I've said before on these programs. I once did a small tour of various parts of the country, just visiting other people's practice to ask what they felt about what we were doing at APM. How could we make it better, whether it was what they needed, that sort of stuff. It's really useful to go and see what other people do in their practices. The easiest thing, of course, is for an associate to shadow another associate in their own practice, but sometimes it might be really useful to go to someone else's clinic and see how they do stuff. You can learn so much. I was staggered. I thought, "Obviously, I feel my clinic is the best in the country, and we do everything perfectly." Saw some great things going on in other clinics, really good stuff.

J: I think another ... Sorry.

R: You go. No, no. You go.

J: Also in preparation for this, because the people who know me well knew how nervous I was going to be about this, we were just sort of talking about what do people want? What are they scared of? What are they scared of? What don't they don't, and what do they want?

S: Scared of in the new CPD requirements?

J: Yeah. With one particular colleague, because I'm taking a step out of clinical practice because of my shoulder, I can be that person, like you say, to go into other people's clinics if they want me to. Be nonjudgmental, be supportive. It's not a principal/associate relationship, either. I would've said this networking group has enabled me to get to know more people better, and if I can be of help, then I will.

S: There's a really good chance that the peer observation part of this process is going to reduce the likelihood of complaints as well, because a fresh set of eyes on how you conduct your case history taking, patient handling, communication is going to probably have a very positive impact on the likelihood of a patient misunderstanding what's going on, which is one of the common areas of complaint.

Should we outline what the changes actually are? Because A, the chiropractors watching may not be aware of what the osteopaths are up to. I'd be very surprised if they are. Why would they care? There may be some osteopaths living in the remotest parts of somewhere who haven't really, tell them what is. The GOSC have published a lovely little guideline in the latest of their magazines.

Am I right in thinking this has got all suddenly really nice and glossy, hasn't it? Very smart and-

R: It's got incredibly shiny month.

S: All the CPD guidelines are in there, although I think there's still some clarification needed of what's said in there. Talking it through is helpful.

R: That is a good at-a-glance overview of it there. It was the first time that I realized that there was a section which included clinical audit, peer review ... Not the peer review. No, the peer observation all the objective activities basically.

S: Basically case based discussion, clinical audit, patient feedback and the other thing you said.

R: Observation. But that was separate from the peer review and also I had thought that the peer review included or was the observation and then a discussion about it afterwards. So that's actually clarified for me that the peer review is about your CPD, it's not about you as an osteopath treating, it is very much about how you've put together and gone about your CPD.

S: There's an element of cynic about me that says that the whole business of handing over the review of everyone's CPD to other osteopath's is actually going to relieve the GOSC of a lot of work, having to do it themselves but actually they're probably still going to audit the same number anyway so it won't change things that much.

R: Something else that I noticed somewhere in a bit of reading this week is we still have to upload our hours each year from what I could see. So there's going to be an amount of keeping tabs on how much you're doing. I don't know if GOSC are going to track that.

S: You've got the edge on me there because I thought I'd mastered this and up until for the benefit of the chiropractors, rather like chiropractors we've had to upload our CPD to a log on the it's called the Ozone, and we record the number of hours of learning with others or learning by oneself, where it was, what it was and what was the relevance of that study. In the detailed guidance I read that you don't have to do that anymore you simply have to keep a register of it so that when it comes to the peer discussion review you can show it to your reviewer who can check that you've done what was required, met all the content, you have reflected adequately, I hate that word, reflected adequately on the CPD that you've done. But the changes we'll come back to that, might have to look it up because I thought I had it right.

R: I might have got it wrong.

S: Okay but if we will clarify after this broadcast if necessary but the changes are it's now a three year cycle with 90 hours of CPD. So effectively the same as before of which half has to be learning with others and you have to do something from both communication and consent which is theme three and theme two which is objective activity. So the other one is osteopathic

standards, you can do anything you like from osteopathic standards but you have to do something in that 90 hour cycle from the other two themes. The fourth theme is keeping a record of your CPD which kind of-

R: We do anyway don't we.

S: Got to do it anyway. And then after that you've got the peer discussion review which is towards the end of the three year cycle which is then as I said template for that, that you can go through, what your reviewer goes through. And it's meant to be a friendly process, it's not meant to be hostile and I can only imagine that two osteopaths getting together to do this are going to be relatively supportive about it because we're not out to crucify each other are we.

R: That was something that I've picked up in my reading this week is the whole idea behind the change is to bring osteopaths together and to try and create more local groups like yours so that we're there to support each other because it must be for people who are sole traders or work from home or in a clinic on their own it's quite an isolating job.

S: That is the justification for making us do learning with others because we are a very isolated profession and in many cases even if you are with others they're generally other osteopaths or very often other osteopaths, so they want us to get out and do CPD with other healthcare professionals and even other osteopaths are better than none.

R: Just at this point there's quite a good question come in, it's from anonymous so don't forget to give us your name, do we have to complete the planning your CPD form? If we get pulled up by the GOSC will they want to see our planning?

S: It's never been a compulsory part of our CPD I don't think has it. So I mean chiropractors do have to do planning. They have to show their, you know why they're doing what they're doing over the next 12 months and I know that a lot of them find that really onerous because it's a pig of a task isn't it. What do you say, I want to do CPD that improves my safety and my communication ability and my practical skills. I mean that's what I want from my CPD and it's where you know I'm going to blow APM's trumpet because I'm going to do on many occasions this evening probably but it's why we do things the way we do because we're doing two bite size chunks every month of a huge variety of different topics, all of which are relevant to practice and all of which count towards your CPD with dare I admit the sole exception of the chiropractors I now know can't claim anything which is about business building. I gather the general chiropractic council has got a bit wary of some of the business building lectures that are out there.

R: That's another good point though because I also found out that if you run a clinic part of your CPD can be to do with managing and running a clinic, it doesn't have to be all solely osteopathically based which I wasn't aware of.

S: That's always been the case I mean the actual CPD you can do in theme one, the osteopathic standards hasn't changed. You can still do stuff which is business marketing and other matters related to running your practice and I think where you'll fall foul of the system is at the end of your three year cycle and you go for your peer discussion review and they say well hang on all your CPD has been marketing, then you might find that your reviewer is a little bit more questioning of what you've done.

R: Well obviously.

S: Yeah and I don't know what they would do about you know because there's nothing in the book that says you can't do that or if you had to do the other two themes-

R: As long as you've covered the other themes.

S: But how much do you think you have to do, how much communication and consent do you think you have to do?

R: I think it's a minimum of three hours isn't it? I think I've read somewhere that it's a minimum of three hours.

S: I don't think there's actual minimums set.

R: Is there not?

S: Because how can you define a minimum time spent on that? If virtually everything we do has an element of communication and consent in it, how can you define how much time is spent on that? It's a strange one.

R: Bit ambiguous at times.

S: It is ambiguous yeah. Anything else to that question you just asked?

R: No that was the whole of that question and we do have another one again from anonymous that says can you help us with the peer support?

S: Yeah well we can. I assume they're asking if APM can help. Obviously all the networking groups will be really good for that. At APM we have got limited manpower so in extremes, yeah and we're supporting a number of our members at the moment, people who are developing new practices and people who are going through the fitness to practice process so we're supporting in all sorts of ways. But if we have you know the whole of the osteopathic profession turn to us and said you can do our peer observation,

do our peer reviews, we just couldn't do that. But what we can do is help to put people in contact with other people who can do it. And I know the Institute of Osteopathy will do that as well or they'll help out with that and so will the networking groups, the osteopathic groups around the country, regional groups that's the expression I'm looking for.

R: I've just had a sad thing come through apparently we're not allowed to claim for driving lessons or riding lessons, that has been tried in the past and didn't get through.

S: It's astonishing though because I'll bet that you could justify some of those things.

R: I could because I'ma equine osteopath, I could.

S: Yeah but your equine osteopathy has to relate to human osteopathy to count to your COD doesn't it. What I was going to say is the first discussion we had with Tim Walker when we did our broadcast actually from osteopathy house, one of our questioners was sort of haranguing him about claiming CPD for martial arts training. Now you can see the logic behind that because if you go on Laurie Hartman's manipulation course he will talk about how karate has really helped him in developing targeted short distance but very high velocity thrust and it's improved his tactile senses and all the rest of that stuff. So karate was really, really useful. And Tim Walker said yeah it's fine, you can claim it, you just can't claim every time you go to karate lessons being CPD. So you can't have two hours a week just because you went off to learn karate. There's got to be something, it must reflect on how it has effected your practice and how it was different each time. Excuse me if there was a little bit of cynicism in my voice every time I use the word reflect.

R: So reflection is a word that comes up a lot in this whole new CPD thing as well. Is that just the fact that we're keeping records? How can we sort of evidence the fact that we're being reflective?

S: Oh I wish I could be open and honest when I answer questions like this because ... all right in the old CPD requirements it was not necessary to reflect on your CPD and I made this point to Tim Walker when we had quite a lively discussion by email and phone about something we were doing at APM. I said to him it's not a requirement to be reflective and he said "Ah but it's going to be in the new regulations." I said all right so now we've got to reflect.

All it says in the new regulations that you must reflect on how what you have learned has affected your practice. And the example that they have given in one of the forms and I don't want this form up just yet but I'll show you the form in a minute, you've got copies here, the sentence in here is, I have reflected since on my own communication skills and reviewed my use of

some medical terms with patients, which some may find off putting, also considered how best to explore with patient values and what matters to them. Now I don't know about you but I mean that's just to me that's just putting what I would normally have said about what the CPD was in a slightly different framework. I've thought about what was said and I've reflected on how it's effects my new patients, my current patients, and so really that's all it is.

R: It's writing down what you're probably doing anyway isn't it?

S: Yes absolutely. That's what makes me so annoyed about the whole topic is ... somebody in educational bureaucracy is going to complain about this but I just think it's what we do, we just don't physically write down I am reflecting. If I go on a bit of CPD and it's let's say Laurie Hartman, Laurie Hartman teaches you how to do a cervical neck manipulation, I don't write down I have reflected on this and I may alter the way which I do my cervical neck, of course I'm going to do that. Or if I go to a communications and consent lecture or run one here, well of course I'm going to take on board what they've said and apply it to my patients. But you need to say that's what you're doing and that's all you need to do. If you put in the word reflect somewhere in the comments then that will satisfy the General Osteopathic Council. I'm going to digress, can I

R: Yeah, no that's fine, go.

S: It's not strictly a digression because it's about that last question. The discussion I had with Tim Walker well actually he called me and said stop it Steven basically, was over APM uploading osteopath CPD to the Ozone for them. So when you do, anything you do with APM if you've asked us to do it we upload it to your form, it's all there for you at the end of every month to two whatever it is we tell you what we've uploaded and towards the end of the year we tell you if you're falling short or whatever else so you don't have to think about it. And on every certificate that I produce there is a statement of relevance, it's not there immediately because of course I don't know what were going to talk about with my guests or with you two immediately. So afterwards I write it, but it automatically changes on the website, so you don't have to think about it, you just change it. So I was putting that in and he's said, "Well you can't do this because ..." Can I?

R: Yeah go.

S: "You can't do this because first of all you've got to have access to their login details and that means you have the potential to alter statutory information." And I was thinking well okay, that is true but why would I change your name or status or whatever else?

And then he said, "But also they're supposed to reflect on how this works to urge the suppliers to their own practice, and so you can't write for them the statement that says that they're reflecting." And I said, "A-ha." I said, "But there's nothing in the rules that says they have to reflect." And he said, "Yes but it's going to, so stop it."

So that's why I have had to stop uploading CPD because I have been told not to do it. I would argue the justification but it doesn't matter because the rules have now changed. And now I don't have to access the osteopathic ozone in order to upload CPD because you don't have to upload it, you just have to keep a record. So now I can do it for you, and what we will continue to do is provide that statement of how it's affected me in my practice. And I would argue, I certainly wouldn't advocate that anyone does this, of course not. But I would argue that if how it affects me in my practice is exactly how you feel it affects you in your practice then you can use the statement that I am using.

So this is where I want to show people this form, and I know you're itching to say something Ruth.

R: It's okay, no go for it.

Steven: This form is the CPD summary record template, it's just one of two options which are proposals given as examples by the GOSC on how to record your CPD under the new arrangements. It's got a number of columns. People with a full screen should be able to see this. What was the activity, the type, the subject that they knew, the hours claimed learning by oneself, learning with others, evaluation and impact on practice, which is the way you say I've reflected, and then the osteopathic practice standard themes at the end, which we always put on our certificates anyway. In fact we put the detail, we put which bit of those practice standards it reflects.

I've added another column at the bottom which is additional notes, and we will also add another column in here because we will be putting in not just the OPS themes but the CPD standards. So there will be a column that says you actually hit an objective activity or a communications and consent activity in here. So you can look through this and say, "Well there's a dozen things that I've done this year or over the last three years which hit the communications and consent." How you can save three hours, because no ... You're gonna be pushed to do three hours on communications and consent, I mean what is there to say? But you'll have all this record that you've done the mandatory things under the osteopathic practice standards. So don't need that anymore.

R: No, but on that point, there's a question just come in, and again unfortunately from anonymous, so good evening. Please forgive me, I'm one of those that relied on getting much of my information from APM, but I'm finding it difficult to get my head around despite the updates in the

magazines. My question is whether we have to do a report of the CPD we've done as opposed to just recording it as this person does now. My other concern is how time consuming this process sounds. Also, is it specified as to whether you need to complete hours with others or alone in each theme? Which we are sort of covering aren't we?

S: Well first of all, if we can put this form back up on the screen again, guys in the production room, in the column which is marked evaluation and impact on practice, that's where you've got to write the report of what the stuff was all about, which if you're with APM we'll do it ... if you ask us to we'll do it for you.

We're going to do this with every single certificate. So in fact we won't have to upload anything it will just be sitting there in people's profile on APM. Every certificate you've got will have this form and it will say what the what does CPD entails. It will have a statement which says, "I've reflected on this and it's made me think this this this and this about my practice." Which everyone's entitled to accept or refute or change edit or whatever, and there's another box at the bottom where they can add their own comments if that's what they want to do. Or just sign it and say, "Yeah that sounds right to me." So that's done.

The next part of that question was-

R: So that sort of covers the recording of it. Well it's how time consuming?

S: Well obviously it's not time consuming if we're doing it for people.

R: Also is it specified as to whether you need to complete hours with others or own on each theme? Actually that is a good point.

S: That's a really good question, yeah. No you don't. Because let's say you could go on a weekend course, again I'll pick Laurie Harper, and I'm not advertising his course in two weeks time because there's no space left on it now as far as I'm aware.

R: There was one available this afternoon I think.

S: I think Claire got rid of that one.

R: Oh did she? Oh, sorry.

S: Anyway. If you go on that course, in one weekend you'll get all of our learning with others. So you don't need any more of it, you just need to hit those other topics. So you could just go and read about communications and consent. You could watch one of the recordings on our website. We've got one interview which was purely about informed consent, actually two. One with an educator and one with Laurence Butler, who was talking about

Medicare legal issues and informed consent. Anyway, that would easily cover those topics.

So it doesn't have to be learning with others to do that, as far as I understand. Actually no, that makes it sound as though I'm not sure. I'm bloody sure that you don't have to do it as learning with others.

R: We're starting to get some questions about the peer review, so shall we have a chat about that to get that out of the way?

S: Okay.

R: Basically the first one is, "I'm married to another osteopath, are we allowed to peer review each other?"

S: Yeah as far as I know you are. I think they made some exceptions. It can be any other healthcare professional. There was one or two exceptions, I think when they say healthcare professional they mean established healthcare professions. So anyone who was in one of the registered professions would be acceptable.

R: So if I got on well with my dentist I could ask them or something like that?

S: Yeah you could, but if it happened to be your massage therapist down the beauty salon that probably wouldn't count because technically ... well they're not a registered-

R: I'm glad you said that because another question is, "Can we as osteopaths work with osteomyologists for peer review?" So is an osteomyologist seen as an appropriate professional?

S: Do you know I will ask that question of Tim Walker, because I suspect the answer would be no, because they're not a registered healthcare professional, because they're not registered. The Osteopathic practice standard, or sorry the CPD standards don't say registered I don't think, they say another professional healthcare practitioner. So I'd be interested to note, because of course almost all of those people will be either chiropractors or osteopaths or will have been technically, so they know their stuff.

But I will find the answer to that question, that is a really good question. I'll find that one out.

R: Okay. Jos, there's one here for you, and it's a little bit ... "Can you tell us about what your group are planning to do with regard to the peer review? Have you discussed it yet?"

J: No.

S: Well and one of the reasons you might not is because we've got three years to think about this haven't we?

J: Yeah and I think what I'm picking up on, even as we speak, is the difference between the peer review and the peer observation. I think I had thought those were one and the same, or I hadn't really unpicked that.

S: A peer discussion, PDR, peer discussion review is a formal process towards the end of the three years. That is the equivalent of submitting your CPD. It's another person reviewing all the CPD you've done and getting assurances that you've hit all the targets and that you've reflected on it properly and it's influenced your practice. And there is, there's a set template for the discussion, which is relatively easy to follow-

J: But that's different-

S: ... whereas a pure observation is going and having a chat with somebody in a clinic and say, "Well, I saw that. That was brilliant. Great. Why do you do it that way," or, "I might've done this slightly differently myself. What do you think?" It's a chat between practitioners, really.

J: Yeah.

S: A professional chat.

J: So we haven't formalized anything, other than, I think, all our friendships are growing and building so that we choose somebody that we feel comfortable doing with it.

R: And I would imagine that's half the battle, isn't it? Being in a group where you're all osteopaths together and you're getting to know each other. If it's a daunting task, knowing somebody who is going to support you through it, that's going to make it less daunting-

J: Yeah.

R: ... than something that you're going to look-

S: Excuse me.

R: ... forward to more than if you were meeting somebody from, I don't know, across the country that you'd never had any communication with before.

S: But wouldn't it be great, though, to do a peer observation, even, with someone like a GP.

R: Mm-hmm (affirmative).

S: Then there are plenty of GPs around who are quite amenable to this, especially for GPs as patients. I mean, you can't actually have the peer discussion review or the peer observation while you're treating the patient, really. I think it would be a really interesting bit of feedback if you sort of just doubled the length of the appointment and said, "Look, after I've treated you, can we have a discussion about how you thought it went?" And that could go for the dentist as well or whoever else. You could meld it into one thing and just log it as ... they would log it as CPD as well, probably.

J: Is there an ethical implication there that you've merged a treatment-

S: I don't think so.

J: ... with a professional conversation.

S: No, I don't think so. It's a professional conversation. If I treat another osteopath, I'm more than happy, and actually quite willing, to hear what they think of the way I treated them, or to explain why I did what I did. If I were to treat you, Ruth, and you said, "Well, I've never had that said to me before. I wish you'd told me what you were going to do in advance," that would be really good feedback to me. I'd be thinking, "Yeah." I keep forgetting that patients aren't expecting all the things we do. Sometimes they get quite shocked by them.

J: Yeah, that's a good point. I've, yeah, experienced a lot of that recently as being the patient and seeing how other medical professionals, when they look at their consent and then it's variable.

S: Yeah, you'll get me going on my trousers-down story in a minute. I've told that before on air and maybe I shouldn't tell it again.

J: Oh, I don't know.

S: If there seems to be popular interest in my trousers-down story, then I will tell it.

R: Okay, right. Whilst we're on a slightly lighter moment, we do have somebody here who said, "We once did a brewery tour for CPD group of osteos, chiros and physios. Went on a brewery tour to assess ergonomics and ended up risk assessing the results of consumption." Three hours were claimed! Brilliant.

S: And it got through.

R: They haven't actually commented on that, but it looks like they did claim it.

S: It might just have been that they weren't audited on that one.

R: Possibly.

S: But let's be honest. I mean, there aren't many activities where you couldn't genuinely apply your osteopathical/chiropractic thoughts to, "How might we have done better? What might it do if it's a repetitive strain injury, lifting pints of beer, whatever it might be?" You could get away with it once, provided it wasn't too tongue in cheek and you'd genuinely gone into it with a view to ergonomic assessment.

R: And you've reflected well on it, I'm sure.

S: And you've reflected very well on it. But, you know, the thing about the driving lessons, earlier on ... I can remember, there was a lot of discussion when I was at college, and quite a bit since that I've been aware of, about what is the angle of the pedals in relation to the steering wheel. Well, okay, you might not say that the driving lesson itself is CPD, but you could say, "Well, I've done a discussion with the instructor about how does he find the fact that he or she is sitting in this position all day, every day in a car and I don't know ...

R: Yeah, or just-

S: There are aspects.

R: ... driving position ergonomics.

J: Mm-hmm (affirmative).

S: Yeah.

R: Just as a note from somebody here asking how the Merlot is. I've just tried it and it's very good. They're drinking pinot grigio and they're saying thank you very much to all three of us. It's been very helpful. So we're allowed to keep talking.

S: So no trousers-down yet.

J: No trousers-down, yeah.

R: But I do have a question here which says, "Does Ruth, as an associate, know what associates need to do for a clinical audit? Do associates have to do it as well? If so, how?" That comes from Sarah, with a small gin. Hopefully it's now a second small gin.

S: Right, and so the first ... You're going to hopefully better help us answer that question, aren't you, Jos, but the first thing is, none of us has to do a clinical audit. There are four options under ... what's it called? ... objective activity. Only one of them is clinical audit. One of the others is case-based discussions, which we do every other week online, at lunchtime, in APM, and which we've also ... the discussion we had with Nick Burch's group recently was with an

hour and a half of case-based discussions with MRIs and everything else. It was brilliant.

That's actually quite a easy one to do and there's no reason why all of your objective activity couldn't be cased-based discussion, because there's nothing in the rules that says it can't be, so you don't have to do clinical audit. But clinical audit, we were discussing it earlier on, and you're going to tell me, off the top of your head, what the nine stages are of the clinical audit, aren't you?

R: Oh, you're cruel.

S: Neither of us can remember what the bloody nine stages are, but I'm going to read some of them out in a minute. Here we are. There's a lovely little diagram. This is all taken from the GOsC's website. "Select a meaningful topic." Well, that's a good start. "Review the literature and identify best practice." Now, already, my eyes are starting to glaze. And then, "Agreed criteria and standards," and by now, I'm reaching for the second bottle of Merlot because I just think, "Oh, this sounds like writing a research paper." So tell me, is it easier than that?

J: I hope so.

S: You've got some expertise in this, haven't you? Because you've been looking at-

J: Only because ... Yeah. I think it was one of the things that put most fear in me, but I also wanted to find a way of being able to balance out the restrictions that the ASA have put on us. And I've seen other practices on their websites using audit data to present the types of patients that we see, the types of conditions that we see, and I don't know whether it will tighten up if we all start doing this, but is that a-

S: So what do you mean by that? other people are advertising things that we're not allowed to, or ...

J: Well, it's not advertising. So this is something to check who knows the answer.

S: Ooh, this is a good one. Go on.

J: Yeah. Because you have audited ... Say, in a month you've seen x number of low back pains, treated indigestion, irritable bowel, could you start categorizing the presenting symptoms purely as data, and is that going to help us be able to show what we can really do?

S: Here's the Steven Bruce answer to that question.

J: No.

S: No, not at all. No, I am absolutely as ballsy as it comes when it comes to the ASA and things like that. And we might discuss what's gone recently with one of our osteopathic colleagues, Philip Hartman over his practice in Hereford. And I don't want to get into detail of that, but to answer specifically what you were saying and then we want to have it relate to what went on with Philip, if you have got a bunch of data from your practice and you think that that data are sufficient to justify continuing a treatment, I would stick it on my website and say, "Yeah, this is what I do, and this is why I do it." And you will not be held to account by anybody until someone complains.

Now, the Good Thinking Society are all over osteopathic and chiropractic websites, complaining about things we're not supposed to advertise. However, as an osteopath ... This doesn't apply to chiropractors. As an osteopath, if they complain, they've got to go to the Advertising Standards Agency, and the Advertising Standards Agency will say to you, "Why are you saying this?" and you'll say, "Well, look, I've got this data. I've collected this data and these are the outcome measures." And the chances are, they will say, "Well, hang on, we want to see four randomized trials on this, so we don't accept your data. Stop doing it." And you say, "Okay, I'll stop doing it." And that's always going to happen. Not if you're a chiropractor.

J: But if enough of us start doing it-

S: Yes, and then we end up with some meaningful data. That will change things, yeah. And I notice ... Dawn Carnes, I think it is, in The Osteopath magazine, has just started collecting some data on treating infants.

J: Yes.

S: And you know, that's great because that's the big bone of contention, particularly with the Good Thinking Society. The more people that get involved with that and start sending NCOR their data, the more chance there is that we're going to be allowed to say to parents and others, "This is what we can do to help children." And it's-

J: That would really excite-

S: ... criminal that we can't tell people what we can do to help their kids at the moment.

J: And I think if we can do that, that would really excite me as a ... I know, as a professional, and, I'd hope, excite others that are feeling perhaps a bit restrained or constrained.

S: Is it slightly different from an audit, if we're collecting data?

J: That's how I've interpreted an audit, or a different type of ...

S: Yeah, and what does it say we're ... What are we allowed to audit? It's probably in here. Structure process outcome or patient satisfaction. So if you're auditing outcomes, that would fall into this category and you could say, "Well, I've done a number of audits on outcomes for this condition, this condition, this condition." And it may not fall into the precise category of randomized controlled study, but at least it's meaningful data.

And, of course, NCOR can help you structure that data and get it in a format where it's compatible with everyone else's data so that overall, we get a huge body of information which can help to influence things.

J: So I don't know whether it's Dawn and Carol-

S: Carol Fawkes, yeah.

J: But Carol ... They're doing a pediatric one, too.

S: Yes.

J: I think it's in a pilot form at the moment.

S: Right, it may be Carol.

J: I don't-

S: I was reading some stuff from Dawn and Carol in the magazine, so.

R: Do we know how we get in contact with Dawn if we want to share our data?

S: Yeah, it's in the magazine. It's in the iO magazine, which is on the website, and we'll put it as a link underneath our broadcast afterwards. Talk amongst yourselves and I'll look it up. It'll be very easy to find.

It was Carol Fawkes, expensive pediatrics, and in here we will have her contact details which are terribly easy. So ncore's site is ncore.org.uk, and we'll post that because it's a long link, but you can get in touch with them.

J: So if we've got ncore behind us, who regularly publish their data, and enough of us, I don't know what the uptake is from ncore at the moment, for providing outcome measures.

S: I get the impression they struggle because people aren't enthusiastic enough to want to go through this process. It is a bit of extra effort after all.

J: But if my plea to everybody, if enough of us, were sort of hopefully weren't in fear of it, and manage to get to grips with it, what a difference that could make. Especially to the cranial osteopaths.

S: And I know we asked this question, it with during the ASA broadcast, so the detail would be on that broadcast, where there was a chiropractic organization run by Jonathan Field, who was our guest from the Royal College of Chiropractic. They're doing similar stuff. And he's got a big interest, I think, himself in outcome measures. And I would like to think those organizations talk to each other. Because did you know, it's relatively recent that chiropractors can now treat sciatica. Who would have guessed? When we did the ASA broadcast, they were not allowed to say they could treat sciatica, but what's the different in evidence between chiropractic and osteopathy. I mean, it's the same treatment techniques, isn't it? Which are very similar to-

J: That seems-

S: Physiotherapy techniques and to others. But they weren't allowed to advertise it. Until recently. But they now are, congratulations. Well done, the chiropractors. I genuinely mean that, because you know, there's such a cross over between our professions.

R: Okay, we got a little... Hi, Jos from Sam Craig Wood, so hopefully you know who that is.

J: Hi Sam, whichever camera's on. That one. Hi Sam.

R: We've got a question here, that says what happens if we don't pass the audit on our CPD? Or an audit on our CPD.

J: Is there a pass and a fail?

R: Well I suppose they're saying-

S: Well, it says at the moment, 20% of all CPD records are-

J: Oh, sorry, that audit.

S: I've given an audit by GRSC and of that 20%, 20% are then more detailed audit. So I think it's 20% to see that you've done what you have supposed to have done, and 20% then to see well, did you really do, tick all the right boxes and say the right things. It wasn't really relevant. So under the new system, I'm sure they will be auditing it, but of course what they'll be auditing is whether you've been fairly evaluated by your peer discussion reviewer. Because they're the one who's checking that your CPD record is appropriate. And I don't know the answer to the question, and it's good one, which we will ask them.

R: Well just from a-

S: Steven Bettles will be a good one to ask that question.

R: Just from a clarifying point of view as well, we no longer log the CPD. So I guess that comes back to that thing that I thought that we had to put the hours on.

S: That's right, just keep a record. Which-

R: Yeah. We maintain and store a record to be produced in the event we're audited.

S: Yeah. And that record can be on paper or it can be in the cloud, so therefore, keeping it on your profile in APM where we keep it, and our database is backed up every 12 hours. So at the worst, you might lose one or two bits of CPD if the world crashed around our ears. So you know, this is a perfectly legitimate way of doing in. And of course, we send up things every two months or three months we send everyone an updated what they've got on their records so far, so.

R: That's helpful. This is another point, here. Ncore run a scheme that gains feedback directly from new patients. So if you sign up to that scheme, you can just pass on the information and they contact the patient, as far as I'm aware. And that will fulfill the requirement of a clinical audit.

J: Yeah. You have to get codes to sort of set all that up.

S: But ncore'd help with that.

J: Yeah, it's very simple, you just email Carol, say you want to do it, and she sends you the codes. I got started and then it all stopped. So I think some of it might sort of feel a bit clunky, but I'm hoping that with a bit more time, I will finally get to grips with it. But there is a process that you have to get first, to get a code to give to the new patient. But there's also an app that that first interaction with the patient starts. You can start the interaction with the app. But you still need a code, I think, beforehand.

R: So do you have the app, or does the patient have the app?

J: Good question. I have downloaded it. I haven't opened it, yet.

R: So probably we all need to go into a bit more... research on that one.

J: I don't know. So the patient gets an email. I don't know.

R: I'm sure we'll get a bit of clarification-

J: It's one of those things, I think, that until you do it, a few times, it is onerous. But, once you get going, then you're off.

S: And when we were looking at the CPD, at the audit cycle and the terminology used there, it can be really intimidating until you've tried it and with guidance from ncore and apps. And presumably, the Royal College of Chiropractic in chiropractor's case actually becomes able to use it.

J: It's getting started. Yeah.

S: It would be nice if the chiropractors, there's no requirement for them to do any of this stuff at the moment. And I have been in conversation with the GCC, as you might know, we had Niru Uddin, the head of Fitness to Practice on our last broadcast. And she was very helpful in what's happening in terms of changes to chiropractic professional conduct complaints processes. But she also put me in tough with Jamie Button, the man in charge of the CPD processes. I had a long discussion with him and it boils down to the same thing as changing the Fitness to Practice process. There was no money around for Parliament or Parliamentary time to adjust this and to change the way that chiropractors do their CPD, has to have Parliamentary approval. It's not just simply a question of changing the rules. As came out in that discussion last time. So it's probably going to be two years at lease before there are any changes to the way the GCC goes about its regulation of both CPD and Fitness to Practice.

But it will come, because I know they've been sounding out what people would like to see and what they think would be appropriate. And the back channel word that I got was that it's likely to be something similar to what the Osteopathic Council is doing. I don't know for sure, but that's what I heard. From an authoritative source.

R: Okay. You've got a little bit of support, here, Steven. Surely driving lessons of CPD, if you want to expand your business into being a mobile osteopath and you cannot currently drive, the comment is from Vlad to support what you're saying.

S: I'm very pleased to hear that. Jos, you were talking about using Clinico to do was it data gathering, or was it clinical audit or was it-

J: It was a sort of exploration into how to do it. So I had simplified my sort of view on an audit, initially, and just said what question do I want to ask. Do you want to say how many of your patients that month had low back pain, or you were treating low back pain or headaches. So I contacted Clinico, and said was there something in the sort of back end that did that already. They said no, but, if you go to the data export bit... you don't use Clinico, do you?

S: No, we use PPS, Rushcliffs software.

J: So I then went and looked at how you do that, 'cause I've had to work it out for my loss of earning for while I'm not working. I realized just how much data you can collect and present and stuff.

S: A lot depends on what you put in in the first place, presumably. What box do you tick?

J: Yes. So just by default, I sort of thought, I went to do this export and realized what columns were in a standard one, and then you can manipulate. It gives you drop-down menus to manipulate what columns you do want in it, and what columns you don't. And then, the bit that made me excited 'cause I'm not an IT whiz at all, is that you can add your own questions in. So you can, in your case history, you can add whatever you want, you then record it, and then when you export that data, it's there in a nice spreadsheet. Telling you what-

S: So you're saying with each patient, you could have a drop-down list which says, low back pain, shoulder pain, neck pain, just tick that whichever one's appropriate, and then you can call up how many people did I see over this period where this box was ticked.

J: Yeah.

S: Yeah. I'm pretty sure that we can do that in PPS. And I can't speak for TM4, or whatever it's called at the moment, or the other software stuff. Maybe if there's someone out there who's watching who uses those systems so you can comment in more detail, that would be really helpful. Because it sounds like a really easy way of doing clinic audit. And there's nothing in the rules that says that the clinic audit has to be to any particular standard. It could just be just auditing what's going on in my practice and maybe reflection would be what I'm seeing an awfully high proportion of people with this condition, therefore, I'm gonna do some more research into that particular condition.

You need to do that reflective bit. Trying to say it without sounding cynical.

J: Somebody a few years ago had given me an exercise to about, so who do you think your typical patient is? Or who is your ideal, who's your perfect patient I think is the question that often that sort of business mentors ask you. And I had assumed it was a young mum, or, you know, a baby. At that time that I was thinking about. So she made me, sort of, and at this point I was still in a paper diary, ticking off who I'd seen, and in that week, it wasn't.

It was, you know, 40-something male. And I thought, that's not who I think I attract, but it just so happened in that week, and her lesson to me then was don't ignore the 40-year-old male patient which used to come and see you. So there is all sorts of reflection.

S: Yeah.

R: But that's a good way to then steer your marketing if you are finding you are wanting attract your pregnant ladies or babies, but you happen to be attracting your 40-year-old males, you need to change your marketing to attract the people you want to see.

S: You might feel you have a particular skill in treating that particular demographic, and as you say, you might be think, cricky I have been missing a trick here, I think I'm treating all these people, but actually I am wasting some of the training I've had. Yeah. Go on Ruth.

R: Somebody who obviously has some experience with using the Encore first New Patient PROM Form, so that the problem with that is that we were already talking and there was so much to say to the new patient on that first appointment. It's all just too much and can be a bit overwhelming for them.

J: It's not just me.

S: No, and you probably remember this Ruth, but when we had an NSH contract at the client we had to do patient outcome measures from that and we used a modified version of the Born-With questionnaire which is a well known patient outcome measure form, which I modified because the NSH didn't say they needed, so I just made this up. So I looked for the Born-With questionnaire and it's hugely complicated and the questions I thought were so confusing that the patient would have sit down for over half an hour with guidance after to be able to answer them properly. So we tried to simply them while trying to get the same information out.

And I think because this is a valid questionnaire which has been approved through various studies and so on, I think it's something like that the Encore are using and I sympathize with whoever said that, because it has got to be reasonable.

And what they suggest on the General Osteopathic Counsel's website, we have got an example here, there is a simple six question form which is really easy, I could read them, they are so simple. How thoroughly did they ask you about why you came? Did you feel they listened to what you had to say? How well did they put you at ease? How well did they explain the problem? How well did they engage with you? Did you feel they demonstrated concern for your welfare? Do you have any other comments?

Now a patient can answer that in five minutes at the end of a consultation and then you got have the first bit of a clinic audit, or this itself counts as an objective activity because this is a patient feedback, so.

R: Well it has just occurred to me I know in your client, our client, we do a follow up call two days after a first appointment. Would it be appropriate at

that point in time to ask the patient if we could email them some follow up form or something for them to-

S: Yeah. I think if you were doing this scientifically people would want to know, a patient presenting form, as we were, so how did you feel before you had any treatment, how did you feel after the first treatment, how do you feel after six weeks and how do you feel six months after you had your last treatment?

The problem is it's very hard to know when the last treatment is isn't it, because it's not-

R: I'm pretty sure with the Encore one, they get follow up form is it six weeks later?

J: Yeah.

S: After what though? After-

R: After that first one.

J: After that first one.

S: Yeah, okay.

R: So there is some sort of form of follow up but it's only six weeks.

S: Which is meaningful, but I suppose the degree of meaning that you attach to it depends on how long did the consultation process, how long does the treatment process last, because if your treatment process is still going on after six weeks it's not as meaningful as if you had three appointments in two weeks and they are out the door and they are fixed.

R: But all of this information is really important information for us to have as a profession, so I suppose together we need to work out a way to get it to our patients and get them filling in it.

S: Which is good point, isn't it, because on the one hand we have got people wanting to tick the CPD boxes and just get it out of the way, on the other hand there is a useful side to this that we can improve, not only our own skills, but we can improve our communication with potential patients and patients. Because we can tell them, yes, we can treat these problems, provided we have the data to back it up.

R: Okay. Oh, this is a very good question. It takes us back a bit to the peer review, but do we have to have the same, or do we have to have a different peer reviewer in every three year cycle, or can it be the same one?

S: There is nothing to say that has to happen. I don't think they thought that through that far.

R: So if I happen to be married to an osteopath and we peer review each other we can just continue doing that?

S: Yeah.

R: It's all right for you and Claire.

S: I think part of the review process by the General Counsel, the audit process would be well, how well do they regard the peer reviewer, because if they do audit it they will expect to see a meaningful review. If they look through your CPD record and say well, how on earth did the reviewer come to this conclusion, from what I have read in these notes here, then they might have both of you, well they wouldn't call you in front of the PPC but they might question both of you on the validity of the review. But yeah of course, yeah you can do that.

R: And while we are on that topic, I have just been asked for clarification that is it possible to have a peer reviewer from a different profession?

S: Yes.

R: Like podiatry, or as we mentioned dentistry early on?

S: Yeah. It specifically says that you can use another health care professional and I don't think health care professional is defined further than that, but I think they do mean one of the established professions or the registered professions.

R: That's what I read, it was health care professional.

S: Yeah.

R: Okay. We have been asked for a training course on reflection, because surely that will take up at least three hours.

S: We can do that, in fact I can tell you what we can do, and it's one of the things that we do throw in every so often, we have done two 90-minute broadcasts on effective and informed consent, as I said earlier on, but actually we could easily add in something on reflection in those, because it wouldn't be difficult to do and I suspect there is a certain tongue-in-check to the rest of that question.

R: I think so.

S: And if anyone needs any guidance as to what constitutes reflection, we can probably cover that if I didn't do it earlier on.

R For sure we will. Another question here from Kevin in Surry, thank you very much, can the peer review and observational review be at any time within the three years or just at the end?

S: Peer observation can be any time, and you can do that as often as you like, and whenever you like, but the peer discussion review has to happen towards the end of the three year cycle, because the reviewer has to be able to assess your CPD record over the three years.

R: What I gathered from reading about it was that you probably didn't want to do it in the last two months in case there is anything that your reviewer picks up that perhaps needs more work, or adjusting.

S: Yeah. And you are absolutely right, it would make sense to leave yourself some time to address any shortfall.

R: Okay.

S: One of the interesting things about the new rules, is 90 hours CPD over three years, so in theory you could get it all done in a weekend, or 10 days or something, in the first week of your CPD period, but it does say in the notes that it should be carried out at regular intervals. It doesn't say whether those regular intervals have to be every month or every day or every year or whatever else, but the implication is that you should spread it throughout the three years and you can't just get it done. The guideline is it should be 30 hours per year, funny old thing, pretty much what we are doing now.

R: This is a really good question from Ian at Fenland Osteopaths, he works very hard to encourage patients to post their review and ratings on Google, Google Reviews, do these reviews contribute to CPD?

S: Well, they don't contribute to CPD because they have done the review, it might contribute to CPD if you were keeping a record of all of those reviews, and there was something more meaningful than just three, four five stars. If there was something that he could reflect on and practice. I know but seriously. I got 10 reviews and they were all five stars. These are certain amounts of patient feedback. There's not much to reflect on in that is there? So, you can't really say how it's effected your practice. I suppose you could say, "Well, I'll just carry on doing what I'm doing then." But you kind of need more information to be able to demonstrate that it has been impactful. But well done him for getting the Google reviews, because it's so important.

R: It is important, and it's not easy either. How long do we have to keep a record of the CPD?

S: I don't know.

R: It made me go "Oo" when I saw that as well.

S: We'll definitely find that one out, because it's not like patient records, so it's not going to be a seven year job. But yeah, I'll find that out. I really don't know.

R: That's one for later then.

S: I'm hearing from the production team that it's three years, but again, we will look at it. That's the CPD process. Maybe we just have to keep it for one further cycle.

R: Surely there has to be a period of time for GOSC to decide they want to order to you, and if you've thrown it away the minute you've seen your peer review work, that doesn't really solve that problem does it?

I heard somebody is on their second Guinness already, so it's an alcohol infused evening.

S: What's the point of doing a CPD this way? So you can sit down in the comfort of your home or pub, and watch this on your own device.

R: Can we assist in creating group orders to combine data?

S: Can we APM assist?

R: Yeah. Can you?

S: I bet we can. I haven't thought about that, but I'm really please if anyone can give us a new idea of how we can make life easier for people. So, who was that? Was that Ian?

R: Anonymous.

S: Oh, it was anonymous, right. Well anonymous, if anonymous would like to get in touch with us over more precisely what he has in mind, yeah, we'll certainly set something up. That'd be great.

R: Okay.

S: I can see my team holding their heads, "Oh no, not more work."

J: Well it could be something I can do.

S: Yes, exactly. We will call on other people to help us with it. We aren't going to be able to do all this ourselves, but if we can help facilitate it, then I think that'd be great.

R: Okay, Matthew sent in a big question. Does CPD-

S: If this is the Matthew I'm thinking of, Matthew does always send in big question.

R: I'm sure it is. Does CPD as enforced by the GOSC, with all the stress uncertainties threaten a waste of time, actually improve the practice of osteopathy for the individual, or benefit the wider profession? It feels to me like it is narrowing and downgrading the way we work.

S: We like a little bit of philosophy don't we?

J: Do you know what? It's made me feel more confident in running a business. So, in the last few cycles I've ... I was a paper diary, so I then went on to clinic co. And initially it was just for invoicing, just to keep a tab on that better. Then understanding what the diary could do, the online bookings, I don't want to advertise clinic co. too much, but it just made me then develop a more professional business presence and confidence. I used a lot of that and reflected for the last few years. So, I was reassured when you said just now that we can still use that, because chiropractors did you say can't?

S: They can't use business training as I understand it because the counsel of GCC has not clamped down on it, because it was being overdone. I think they found that some chiropractors, and the chiropractors will know which particular branch it is that probably was doing this. We're using all our CPD was effectively marketing training, which is hardly what they had in mind of CPD as a whole. That's what I understand, and I don't want to malign chiropractors at all. So, we... I just wanted to go back on something you said there. Remind me what that last point was? Matthew saying that ... yeah.

I suspect, I mean I've come across very few osteopaths who think that CPD as a whole, as a concept, is a waste of time. But I know there are some. I haven't come across any chiropractors who have said that to me, but I bet there are just as many of them as there are osteopaths who believe the same thing. But, I really can't accept that we're all perfect at what we do. That's just not conceivable that we're all perfect, and I don't believe it narrows our thought, because the osteopath has 27 osteopathic practice standards, and you can do your CPD in any one of those, and being asked to do a little bit now on objective activity case based discussion. What's wrong with case based discussion? You can't help but learn from case based discussion, and communication and consent, yeah, you can probably argue that there's only so much that you can learn about communication and consent, but it is the biggest cause of complaints.

If that's going to stop people having to face the PCC, and frankly, if we want to be health care professionals, we have to accept that we're going to be regulated, and that patients must have a legitimate way of complaining if something goes wrong, or we're just... If we're going to be professionals, we have to accept that that process is going to be there. I just don't think it limits, because there are so many things you could discuss. Are you perfect at every possible manipulation? Just go the course and do the things you think you might learn something on.

R: I know for me, whenever it's courses or even just a discussion with one of the other osteopaths in the clinic, quite often it sort of revitalized my enthusiasm, because it's possible to get a bit worn down by the daily grind.

J: Well you forget things.

R: You forget things and I know I've done a little bit of work with Georgia, and come back to work the next day, really excited about trying that out. That's what CPD is to me.

S: But also, I sort of put a different slant on it. It's not necessarily being worn down by the daily grind, it's getting yourself into a routine and a rut where sometimes your analytical processes just shut down a little bit, because you're so used to seeing people with lower back pain with this symptom. You stop thinking about the other things that it might be. You say, "Well, this is what I always do," and it happened again. One of the things he says in courses is one the big red flags is getting into a routine. Do not get into a routine. Always go through a good analytical process.

R: But that's where case based discussions can really help as well. After watching Nick Burch's one a couple of weeks ago, that made me go "Oo."

S: Yeah, thoracic pain.

R: Thoracic pain especially.

S: With sleeplessness and remitting, yeah.

R: But also, when you're doing things, it reinforces where you're good, and I always ask about night pain. And so, I know that I've covered that. It shows me that I've got that part of my process down. Another useful observation, again, I'm not sure who it's come from, every activity leads to who we see people. I go shopping to co-op, I look at people's posture. Can my shopping trip go down as CPD?

S: I guess you could, and I know it's tongue and cheek, but if you were really pushed for getting some CPD, you might get away with say 30 minutes if it was, but I need you to show how it's effected your practice. You couldn't say every time you go to Waitrose it's CPD, because manifestly then you say you

could learn from watching people pushing shopping trolleys. Actually, I'm sure other people have done this, but I've gone up to a lady with a walking stick in Waitrose and said, "Excuse me, but you're using the stick in the wrong hand," and had a discussion with her. She tried to justify to me why she had to use it in this hand because she was right handed, and couldn't pick the fruit up with her other hand. I said, "Hang on, you don't have to be dominant handed to pick fruit out of" ... we had this discussion, and you can argue that was patient evaluation in Waitrose and trying to help the public, and also learning about the reaction of a person who didn't want to be told that they were using their walking stick incorrectly which they were.

R: So more reflection.

S: Yeah, I've reflected on that a lot.

R: Good. We have a question or two from Liz, thank you very much, regarding the peer observation. Is there a formal way of recording that episode, and secondly, is there an idiots guide to the new CPD process?

S: Yeah, there's an idiots guide to the new CPD process. I think you will find the simple outline in the magazine, but the new cycle certainly is available on the GOSC's website. I'm holding this up to my camera. Again, we'll publish this. We'll put this up as an image on our own cite. It's not our document. We produced our own ages ago before it became formalized, but this is the formal one from GOSC, which simply shows you the different elements you've got to conduct, and it's divided into the osteopathic standards, the objective activity, communication and consent, and then it says here, keeping a record of peer discussion review, so those are the four standards, and then it's the peer discussion review. Like we said, keeping a record doesn't really seem too much of a standard to me, that's just an activity that goes with it. These three things at the top is the important bit.

It's really simple, and it's ... I don't know about you, I just think people are getting so tied up with the idea that they've got to do a clinical audit, or they've got to do a patient feedback or something like that, when it's just four options there. Actually, if you can think of another objective activity which is there to assess the quality of your practice, you can say, "Well, I didn't do any of those four, I did this one because it helps me assess the quality of my practice and that's why I've done it.

R: Well, we do have a question that sort of links in with that, and this is if you only need one objective activity, such as a case based discussion, is that every year or cycle, or will you at some point have to have another objective activity?

S: You have to do one objective activity in your three year cycle.

R But you might find that this cycle it's a case based discussion, and then would it be okay next cycle to do another case based discussion?

S: Yeah.

R: So you might find you might not have to go near an audit or a peer observation.

S: Of course. Absolutely, yeah. There's nothing to say ... those are examples of what counts as an objective activity, and any one of them or more of them is acceptable. You don't have to do all of them, you don't have to vary them, you do what's good. My view is that case based discussion is a lovely, easy way to get that particular box checked, and it's a really useful way to do it as well.

R: Now, I know I was looking this morning on the CPD website that GOSC has put together, and there is a form for completing the peer review. Is there a formal way of recording some of these sort of objective activities?

S: You know, I haven't seen one. I might have missed it, and I don't know about you, I find it sometimes quite hard to navigate around everything that is available on the GOSC website. I haven't seen it, but actually why make it complicated for yourself? You go in, you observe somebody, and you say, "Well I saw some good stuff, I saw some bad stuff. This is what it means to me in treating my future patients," and that's all you need to say. You can say, "I shadowed for an half an hour." That's 30 minutes of CPD with another osteopath, so that's learning with others, or with another chiropractor if you choose to go."

R: I suppose actually the template that you're putting together for everything that we do here at APM, that is pretty much a format for it isn't it?

S: Well, yes and no, because it's that long box with the comments in it, which is the bit that your question there is asking about. What am I supposed to look for? Well, if you're just observing a peer, what you're looking at is how do they go about communicating with their patient and treating their patient? Do they do all the things we're supposed to do? Informed consent, explaining the condition, explaining the options, dealing with patient modesty and things like that. You could think of any number of things that you could tick off on a list. Maybe we'll try to put one together. Why not? We can put together some sort of guideline for doing peer observation, but it doesn't really matter if you don't have a template, because you could just use common sense.

R: Okay, fine. Now, there's quite a long bit of-

S: Do you know I thought we'd run out of CPD co-questions.

R: From a chiropractor-

S: Excellent.

R: So we'll go through the first time. As a chiropractor, we have had to reflect on our CPD for a few years. It's not actually onerous, and only takes a few minutes. The planning in advance of our CPD is a little bit more complex. We have to identify an area of weakness in our knowledge or ability, then state how we tend to improve in this area of weakness, i.e. by taking a course. Then, we have to explained what we learned on the course, and finally reflect on how it has effected our clinical practice. Luckily we don't have to do the peer review.

S: Yet. Well, interesting to say that, because we've been uploading chiropractic CPD to the chiropractic GCC's website for people for quite a long time, they've asked us to do it. The only requirement that's been made of us is that we upload a certificate to show that they've done the CPD. As far as I know, it doesn't even ask for a statement of relevance. So, I wasn't aware that they have to do that reflection. Interesting to hear that, but also interesting to hear, I'd love to know who that chiropractor is. If you're prepared to share who you are, I'd really like to know, because I'd like to have a discussion with you about that, but I wasn't aware that there was that extra complication in addition to the planning, that you've then got to go back and reflect on each course, and say how it effected your practice.

R: But again, I suppose it comes down to just recording what we're probably doing anyway. So, it's just getting into the habit of writing down what we're thinking isn't it?

S: It is, yeah. As I've said, I've been told we must not spoon feed osteopaths with how it's effected their clinical practice. Well, I'm not going to spoon feed them. I'm going to write a statement on how it effects me, and if it happens to be what you think as well, then you're free to use it. There's nothing to say that we all couldn't think the same thing after these courses. Do you think that that is bad? Do you think that if I spoon feed this statement, is that detracting from the whole purpose of the CPD, then the individual practitioner no longer thinks what to reflect on this? We're all saying, well actually, we do reflect on it anyway.

J: We do, and sometimes I think we need a prompt. I know sometimes I've gone, what did I learn, and then trying to put it into practice. You know what you've learned-

S: Isn't it the hardest thing ever, writing something from scratch, rather than editing someone else's copy? If I write, I reflected on this, and I realize I've got to stop using medical terminology with my patients, you might think that's nonsense. That's not what I learned form it. What I learned from it was

that I need to expand on the medical consequences of ... it might be totally different from you, but at least you've got my format, which you could chop change and edit to your own satisfaction.

R: This is an interesting part, and hopefully I can help with it a bit. Amanda, thank you very much. There are repeated mentioning of computerized records or diaries. It changed my life. We're in the process of converting and we've all taken a few deep breaths, but it's not that hard at all. Is it coming that we will have to move from paper records to digital? That's Amanda's fear.

S: No, I don't think so at all. I think the chances are that it's going to be ... people are going to ... put bluntly, there's a generation of us who'll be dropping off our perches before to long, and another generation who have forgotten what pencils were ever for. So that change is just going to happen in sort of an evolutionary change in the way people have been brought up to deal with record keeping, but there's certainly nothing in the pipeline that I'm aware of that says we're ever going to compulsory make people move to computers. Not until the GOSC and GCC are prepared to pay for those computers I don't think, so it's not going to happen.

R: That's not going to happen. Okay, Matthew Davis. Is that the Matthew you were thinking of? That says, "all true Steven, obviously, but we are entirely dependent on what the GOSC find acceptable. There is real CPD, then there is GOSC CPD, not the same thing at all, and that is the problem."

S: It is a problem, but I think ... and thanks Matthew, because I kind of thought that question might have come from you. I think there is a spectrum of CPD, and in the middle, there's stuff which no one could possible object to. You go on an HVT course, you go on a course on neurological testing, and no one can object to that being CPD, particularly, you've got to reflect on how it effected your practice. There's stuff on the fringe here. Watching people with shopping trolleys in Waitros, and driving lessons are very differently on the outer fringes of what might be acceptable CPD, but I don't think it's hard to make ... 13 hours a year isn't an awful lot, and every single thing that we do in APM, all our live stuff, counts as learning with others for osteopaths, and I apologize to the chiropractors that your lot won't accept the business building stuff, but that's a very small percentage of what we do. There's miles more than you need in terms of annual CPD available for us.

J: I'm just wondering if whether some of that fear comes from when it's been a twelve month cycle, you do sometimes reach a point where you go, "Oh my god, I'm 10 months in and have I done enough?" And then you're trying to find stuff that's relevant.

S: I told that to Tim Walker, because actually the bigger danger is that you'll get to two years and 11 months, and think, "Shit, I've got to get 90 hours of CPD,"

because theoretically you don't have to do until that point. They're saying regular intervals, but I'm not sure how they're going to monitor regular intervals that you're doing it. How can they enforce it, because a regular interval is not a defined concept is it? Once every three years, or once every year. I'm not trying to dismiss your point. I do take the point that if you submit your CPD and the GOSC says it's not acceptable actually, it can be awkward because then they can say that the end of your cycle, "We'll, you're short so many hours of CPD," and then what are you going to do about it? There's not time left to do anything about it, and it's stressful.

R: Two things. We've got lots of questions still to be thrown at you both but brace yourselves, but before that-

S: We've got 10 minutes.

R: We've got 10 minutes. So, before that, it's Danielle, Dani from Edingborough, hi.

S: Danielle?

R: Danielle, or Dani.

S: Okay, Dani.

R: Just wondering-

S: There's a background to this because Dani, Dan, or Danielle, the number of times I've misspelled his name or called him the wrong thing, and I'll probably get stink for mentioning this now, but I just wanted to clarify that it's Danielle.

R: We'll go with Dani, it's easier to pronounce anyway. Just wondering, yes the new CPD is starting soon, but when does it actually start for each individual person? For example, their CPD year ends in March. Does that mean the current CPD will start after that year ends, or does it mean that everything they've done so far this year ends up being void, because did it start on the first of October? This I think needs clarifying.

S: The new CPD system comes into effect this month, so if your CPD year ends after this month, actually I think it's registration month, but there's a slight difference between ... If your CPD year ends after this month, you're on the old routine until you reach your next CPD end. Then, you go on to the new routine. There's a wonderfully unclear explanation in the magazine because they say "Well, what happens is when your registration date is due, your CPD starts three months before your registration date," and so therefore they explain it, and you think, "Hang on," and then I suddenly tell them actually yeah. My registration date is May, but actually my CPD year ends in February. So, it's not going to change for now, it's just that it doesn't start until your

current CPD, the CPD year that you were in in September. When that year ends, that's when the new one starts. So, most people have got three years and two or three months before they'll have to even think about peer review. Well, they've got to do it a bit before that.

R: Fine, okay let's have some quick fire questions-

S: I hope that was clear enough Danielle.

R: Right. So yes ... oh, I think I've just done something wrong.

S: Don't do that one, that wasn't a good one.

R: Yes, the other chiropractor is correct about the reflection. For what it's worth, I think it does force you to reflect on what you've spent your time and money on for CPD. Has it made you a better chiropractor?

Okay, so question. What about specific training? For example, can I claim piloti's class is a CPD, seeing as I often teach those rehab exercises to patients? A little bit tongue and cheek, but again, sort of true. Thanks for that.

S: Yeah. I would put that down as a very definite yes. You can't put down every piloti's training session as you go to as CPD, but I think if you go to piloti's and somebody says we're going to do the ... I don't know yoga, backward bending dogs or whatever they are, but this particular pose. Why are we doing that exercise? What's it doing? Which muscles is it effecting? How is it effecting your likelihood of getting back pain? Yeah, that's definitely CPD, but you can't claim it every time you go and do the same exercise, but if you learn something new and you reflect and say, "Well, how can I apply that to the patients that I'm trying to ..." yeah, definitely.

R: I know I use my exercises I pick up piloti's for my patients definitely.

S: And some of them get better.

R: Right. Some of them. Carrie has possibly a cynical attitude. She says, "I think it's a very cynical attitude that CPD is a waste of time. Take box exercise. I think that when you stop learning, it's time to retire, and maybe the problem is that people with such views are choosing the wrong CPD." Sorry Carrie, I thought you had the cynical attitude, not your point about it.

S: I think most people would agree with that, and I think probably even Matthew would agree with it, that actually learning is a good thing, and none of us know everything. I suspect that a lot of resentment is down to the fact that we're being told what we've got to do. The bottom line is that we're all human beings, and if we weren't told that we have to do it, we would probably just keep putting it off and not doing anything, and then people

start to fall into ruts, and Carrie absolutely is right. I don't think that CPD is a bad thing at all, I think it's a great thing.

R: There's a comment here, again, from somebody anonymous saying, "Doing CPD and using clinic management software, but has it made you a better clinician? And I would say yes. Having been to Laurie Hartman's course, my manipulations were definitely better having done that, and that was CPD.

S: What's the connection with the clinic software?

J: I think it's just something that we've been discussing, and also, how does it relate to actually being a better clinician.

J: You're more efficient.

S: Yes, and I think again, you have to put it in perspective. A certain amount of it is useful in building your practice, and I think it's fair that the general osteopathic counsel allows you do to some training, which helps build your practice, and not just make you a better manipulator. But I think if you did nothing but learning how to use your clinic software and claimed it all as CPD, that would be perhaps tearing the outside a little bit.

R: This is a very useful one from Robin. "Following Steven's suggestion that wine may be involved in this evening, I've jumped down from my usual seat on the wagon, and poured myself a small glass of Damsin wine, with the thought that we might lift a glass to the late, great, Leon Chaitow, and I think that is a very good point.

S: In fact, I think I need to pour myself some more wine for that purpose.

J: Has my hand stopped shaking yet.

S: This is to Leon Chaitow. It's such a sad loss. We've had him on the program a couple of occasions, and he is such a delightful man. The course we ran with him, did you have his course?

J: I didn't. No, I missed it.

S: I'm so sad that we aren't going to be able to do any more courses with Leon Chaitow. I think Laurie Hartman is brilliant, but Leon was brilliant in a completely different way. Ale Letterman who runs the CPD organization in London, he had the two of them in the same venue on the same weekend, and he put them head to head on manipulating a neck, or getting results from a neck. Both of them think the won, but I have good ... it's interesting to see the two approaches. Leon was being much more MET and soft tissue.

R: There is one actually I think important thing that we should just pick up from Kevin in Edinburgh. Any guidance to how the peer review ... sorry. Is there

any guidance to how the peer chosen should review? Is there a form to fill out when observing in case I'm asked to review my colleague?

S: There's not a form to fill out as far as I'm aware of for observing, and I said that I would check that, and if people wanted it we will create a check list to say these are the things you might look for, but there is definitely a template for the peer discussion review to make sure you've covered all the aspects of the GOSC want to have evaluated.

R: I saw that on the website this morning, and it looks quite easy.

S: I think they say you need to allow three hours for the review.

R: I thought an hour and a half?

S: Was it? Okay. There is an hour and a half reflection.

R: Afterwards. Linked to it actually, do clinical audits have to be completed and recorded digitally, or can they be on paper?

S: On the back of a fag packet if you want to, as long as you've got the information. As long as you've got the nine stages of the cycle, the last two of which are redo the audit, and then write the report aren't they, so actually they don't really count. So, that topic doesn't really count, but that goes without saying. So, there's only six bits to the cycle.

R: Oh it's easy, but don't forget you don't have to do it.

S: You don't have to do it, yeah.

We are about to go off air, but it's been our first broadcast from our new studio. Cheers, thank you for joining us. We'll see you again next time.

J: Cheers.