



Results of consultation on child and adolescent health in osteopathy, conducted September to November 2015

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Terminology

1. To ensure that all readers understand the use of terminology in this document, to follow is a list of the key terms, and their meaning in relation to this analysis.

<i>Extended scope of practice</i>	A term used by the Council to describe a scope of practice that limits performance of tasks to practitioners who are registered in that scope of practice (e.g., WMA).
<i>Recertification</i>	A term used by the Council to describe the gathering of the required number of CPD credits each year and the coincident process of applying to renew a practising certificate.
<i>Recertification programme</i>	The statutory process (section 41 HPCAA) an RA may implement “for the purpose of ensuring that health practitioners are competent to practise within the scopes of practice in respect of which they are registered.”
<i>Renewal (APC)</i>	The requirement to renew a practising certificate on an annual basis, as set out in sections 26-30 of the HPCAA.
<i>Specialist scope of practice</i>	The term used in this document to describe either or both of the proposed “advanced” scopes of practice – extended and vocational.
<i>Vocational scope of practice</i>	A term used by the Council to describe a scope of practice that recognises an advanced level of skill and training in an area of practice in which practitioners in the general scope of practice may also practise (e.g., gerontology).

Introduction

2. This document provides an analysis of submissions received in relation to the Council's consultation on child and adolescent health in osteopathy, conducted between September and November 2015.
3. The Council asked a number of questions of stakeholders during consultation. Stakeholders can [click here](#) to refer back to the consultation document and refresh themselves on the complete background.
4. This document divides the various questions into Parts, analyses the responses to each question separately within each Part, and provides a brief summary of key points raised at the end of each Part. Key points, generally, cover views expressed by multiple respondents and suggestions made that were deemed useful in terms of considering options on how to proceed.
5. The Council received 180 submissions through its SurveyMonkey platform. It received one additional submission from the Osteopathy Board of Australia, which provided general comments on trans-Tasman issues.
6. The results of this consultation were discussed at the Council meeting on 22 February 2016, and again at a teleconference on 13 April 2016.

Analysis

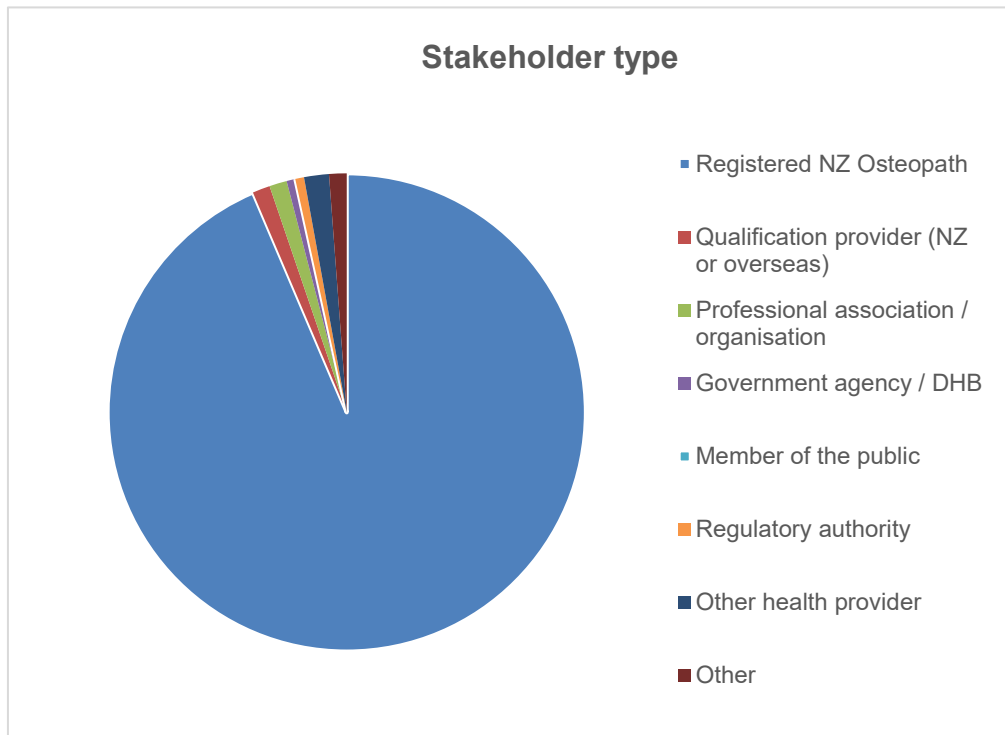
Part 1 – demographics of respondents

[Question 1 relates to personal and contact details of the respondent]

Question 2: In what capacity are you making this submission?

7. 173 respondents answered this question and 7 skipped it. Of those who answered, 164 (94.8%) were registered New Zealand osteopaths. The remaining 9 responses were from a combination of educators, professional associations, other health providers, a regulatory authority, a government agency or DHB, and two “other” who will not be identified here in order to protect privacy.
8. No respondent identified themselves as a member of the public.

Chart 1



Question 3: Do you give your permission for your submission to be published online, and do you give permission for your name to be listed in any published summary of feedback?

9. 64 respondents skipped this question. 26.7% (31) of the 116 who did answer did not give permission for their submission to be published online. 73% (85) did not give permission for their name to be listed in any published summary of feedback.
10. Given 85 of 180 respondents (47%) withheld consent (either explicitly by providing a negative response, or implicitly by skipping the question) to their submission being published online, the Council agreed that it would be a pointless exercise to publish only the remaining 53% of responses. This would not provide stakeholders with a complete picture of the consultation responses.

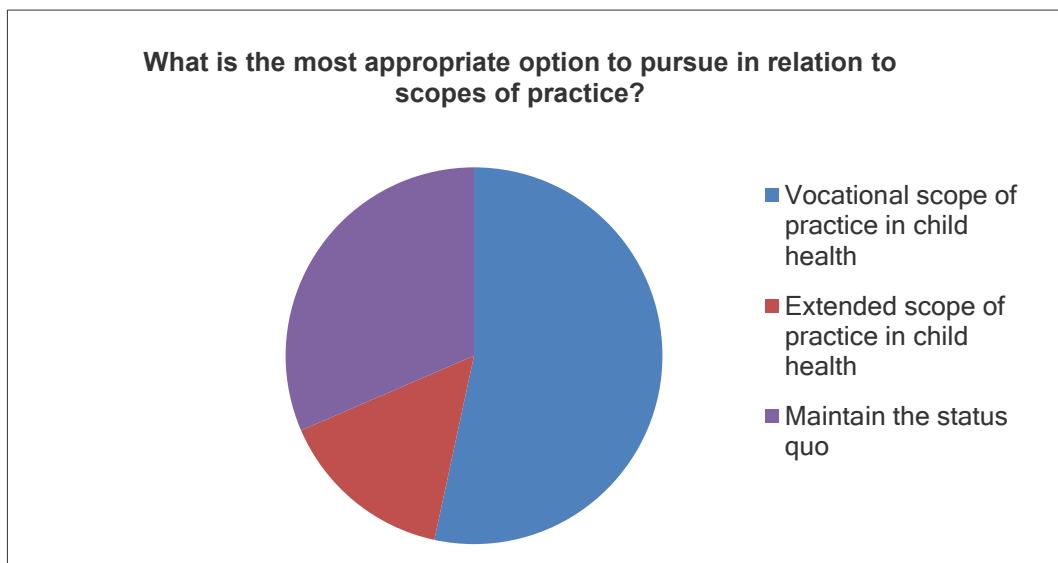
Part 2 – Specialist scope of practice

Question 4: What is the most appropriate option to pursue in relation to scopes of practice?

11. 155 respondents answered this question, of which 34 also made comments. 25 skipped the question. Respondents were given the following options to choose from:

- (a) Vocational scope of practice in child and adolescent health: favoured by 88 (56.8%)
- (b) Extended scope of practice in child and adolescent health: favoured by 25 (16.1%)
- (c) Maintain the status quo: favoured by 52 (33.5%).

Chart 2:



12. To follow is an outline of key messages submitted in relation to this question:

- (a) A higher degree of training is required for treatment of younger children (suggested age ranges captured by this varied from 0-1 years, to 0-5 years). Some respondents supported an extended scope for this younger age group; others felt that a vocational scope would be appropriate.
- (b) The Council should rely on individual osteopaths to recognise the limits of their knowledge and refer to either a more experienced osteopath, or to another health professional.
- (c) All osteopaths should be expected at some point to demonstrate their competence in treatment of children, perhaps through CPD. The Council should be responsible for providing the means for practitioners to undertake that training.

- (d) The Council's priority should be to ensure that every osteopath can, to a specified level of care, deal with a child who shows up at their practice, (such as taking a case history and conducting some screening tests). A vocational scope of practice would be appropriate for those osteopaths with the skills to treat children beyond that level.
- (e) Imposing additional requirements (and costs) on osteopaths to undertake training would not be fair on those practitioners not interested in treating children. The Council should incentivise practitioners to undertake advanced training through (for example) reduced APC fees in recognition of their higher and more recent training.
- (f) Extended scope of practice is not justified given the information available at this time.

Question 5: If the Council were to introduce a scope of practice (either vocational or extended), do you have any comments on the suitability of the qualifications that have been identified at this point?

- 13. 38 of the 180 respondents skipped this question. A further 96 had no comments to make. 46 (26% of all respondents) made comments.
- 14. The qualitative feedback provided in relation to this question suggests that some respondents may have confused the purpose of this question (i.e., an appropriate qualification for an optional specialist scope of practice) with other parts of the consultation dealing with questions about whether the general profession should be required to upskill, and with the general need for basic CPD refresher skills in areas relevant to practice. For example: *"I personally would welcome a postgraduate course to brush up on paediatric skills, ensuring that we are all up to standard"*, and *"...there will be many suitably skilled osteopaths who would not wish to undertake further study for qualifications related to this matter. However for newly qualified osteopaths and students adding relevant papers and study to the course would be invaluable."*
- 15. Bearing in mind that some responses may have been given in the belief that all practising osteopaths would be required to complete the identified formal qualifications as a minimum standard, to follow is an outline of key messages submitted in relation to this question:
 - (a) Some felt that the PGDip in Child Health offered by AUT may be too generic to add value, because it is not specific to osteopathy. Others felt that the qualification looked appropriate.
 - (b) Several respondents felt that osteopaths with significant experience (i.e., not formal qualifications) in treating children should be grandfathered into any specialist scope of practice in child and adolescent health.

- (c) There was a request from several respondents that courses be available outside of Auckland.
 - (d) There were varying views on the form and content that should be included in an appropriate qualification, including:
 - (i) The need for a practical component, and
 - (ii) Opposing views on the place of cranial osteopathy in any course content.
16. Generally, of the respondents who provided comment – which amounted to a quarter of all respondents - there were few who supported the identified qualification(s) as appropriate. However it should be borne in mind that the majority of respondents did not have any comments to make on the identified qualifications. This means that the Council has a very limited amount of input from stakeholders on this particular point.

Question 6: Do you have any suggestions for alternative / additional qualifications the Council should investigate?

17. 40 respondents skipped this question. 104 answered the question by advising that they had no comments to make. 36 (20% of all respondents) made comments. As with the previous question, it is noted that some respondents appear to have confused the question of a formal qualification for a specialist scope of practice with the issue of whether the general profession should be upskilled through CPD.
18. Key messages and suggestions submitted were:
- (a) Alternative formal qualifications could be considered, including:
 - (i) A course run at Victoria University in Melbourne called “Neonatal and Infant Paediatric Manual Therapy.”
 - (ii) A Massey University course, which can be designed for specific professions and run extra-murally.
 - (iii) A UK based 2 year paediatric programme. The programme name and provider was not given.
 - (iv) Create a course to train practitioners who will then become a teaching team to deliver core competency courses to other practitioners.
 - (v) Look into possible postgraduate certificates in child and adolescent health, or Sutherland courses in paediatrics.

- (vi) Respondents provided details of names and courses that they considered the Council should endorse (e.g., those provided by Jamie Taylor, Jill Hedifen), and suggested consultation with a medical school's paediatric department to define what should and should not fall into any specialist scope of practice.
- (b) Several respondents considered the best way forward to be an improvement in the undergraduate curriculum, and the creation of a range of CPD activities that existing registrants could do. This is a common theme throughout the consultation.

Question 7: Is there other information that you think the Council should gather on the question of scopes of practice before making a decision?

- 19. 54 respondents skipped this question, while 87 answered the question but had no comments to make. 39 (22% of all respondents) made comments. Of those 39, 32 (18% of all respondents) answered that they felt the Council needed to gather more information.
- 20. In the comments provided, a number of respondents indicated that they felt the Council's investigations had been thorough. However, suggestions for further information to be gathered included:
 - (a) Obtaining feedback from parents whose children have been treated [by an osteopath].
 - (b) Undertaking a financial analysis to determine cost implications for the public if only a limited number of practitioners are able to treat children.
 - (c) Researching the risk presented by osteopathic practice in relation to this age group. One respondent indicated that studies already published have found that the risks presented by osteopathic intervention in neonates and young children is "extremely limited or non-existent."
 - (d) Obtaining multi-disciplinary input (including chiropractic, midwifery, physiotherapy and paediatrics) to determine best practice in child and adolescent screening and assessment.
 - (e) Reviewing teaching available through other relevant disciplines (as identified above).
- 21. One respondent considered that creating a specialist scope was not the priority and suggested that instead the Council should focus on improving the undergraduate curriculum and upskilling the general profession.

Council decisions in relation to this Part

22. The Council considered the feedback with reference to its overarching goal of protecting the health and safety of the public. It noted that, based on comments made in submissions, it appeared that some respondents had confused the question on development of a specialist qualification in child and adolescent health with the separate question of whether there was a need to upskill the general profession in core competencies in child and adolescent health.
23. The Council agreed that it was necessary to ensure in future communications with the profession that there was clarity around the separation of the two issues, and to ensure that general registrants understood that they would not be compelled to undertake a post-graduate diploma in child and adolescent health in order to keep practising.
24. It was agreed that introducing an extended scope of practice (that is, a scope of practice that limits performance of tasks to practitioners who are registered in that scope of practice) would not address public health and safety needs. In particular:
 - (a) Although there are concerns about the current state of skills and knowledge amongst the general profession in this area, the Council has an obligation to apply the least regulatory force necessary to achieve safety. The evidence available at the moment does not indicate that there is a need to stop all osteopaths who do not have specialist training in child and adolescent health from treating children; and
 - (b) There are risks that limiting the treatment of children only to osteopaths with advanced (i.e. postgraduate) training in child and adolescent health would reduce access to osteopathic care for child and adolescent patients to an unacceptably small number of practitioners. Over time, such a move would result in lack of exposure of osteopaths registered in the general profession to child and adolescent patients, and this in turn would erode the skills and knowledge already held by these osteopaths in this area. In the long term, this would likely prove detrimental both to the profession and the public.
25. The Council preferred an approach that would foster continued development and learning, as well as intra-professional liaison between practitioners with advanced training and those without. With this in mind, the Council agreed, in principle, that any specialist scope of practice developed should be a vocational scope of practice, not an extended scope of practice.
26. Having formed this view, the Council agreed that there was likely to be benefit to the public in having access to osteopaths recognised as having specialist skills in child and adolescent health, and that it appeared to be worth pursuing the development of a vocational scope of practice in child and adolescent health.

27. The Council then considered the question of the qualification(s) required for registration in such a scope of practice. It had consulted with stakeholders on this question, together with a request for feedback on two suggestions – both postgraduate diploma – that the Council considered may be appropriate qualifications. It noted feedback which included:
- a) Views that perhaps a PGDip in child and adolescent health may be too generic to add value, as it is not specific to osteopathy
 - b) Views that the qualifications identified appeared appropriate
 - c) Views that there would be a need for a significant practical component in any specialist training.
28. The Council also noted details of other courses that might be suitable, including:
- a) the Neonatal and Infant Paediatric Manual Therapy course run by Victoria University in Melbourne
 - b) an unnamed UK based 2 year paediatric programme
 - c) a course developed by Massey University
 - d) A course developed by CPIT
 - e) A course developed by Unitec
 - f) A suggestion that osteopaths with significant experience in child and adolescent health should be grandfathered into a specialist scope of practice.
29. The Council considered the new suggestions and agreed that recognition of previous experience, without formal qualifications, would not be a suitable approach. First, it would not be consistent with already approved vocational scopes for the Council to introduce a process of evaluating individual portfolios of experience for the purposes of determining whether a practitioner has sufficient background to qualify as a “specialist” in child and adolescent health. Second, it is important, in terms of public confidence, that the Council, and individual practitioners, can demonstrate to the public that those practising in a “specialist” scope of practice hold formal and recognised qualifications that have undergone appropriate accreditation processes. It was noted, however, that when considering applications for enrolment in their programmes, training institutions may recognise prior learning as part of the application process. This would be a matter for the individual training institution; it would not be appropriate for the Council to interfere in those enrolment processes.
30. The Council also agreed that some of the formal qualifications suggested by respondents should be investigated further before any decisions were made in relation to the development of a vocational scope of practice in child and adolescent health, noting that a critical question still to be answered was whether there was one or more qualifications that appeared to be appropriate for registration in that scope of practice.

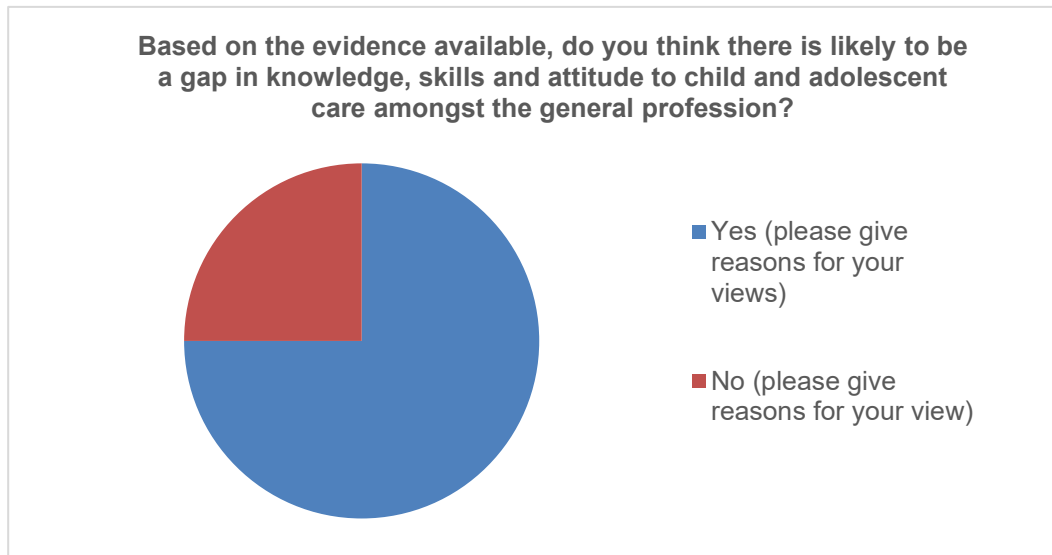
31. The Council therefore decided that further information is required before it can make a decision on whether to introduce a vocational scope of practice in child and adolescent health, including:
- (a) Gathering details of courses suggested by respondents (Victoria University of Melbourne, Unitec and CPIT), to determine whether they would be appropriate for a specialist scope of practice; and
 - (b) Obtaining feedback from the profession on the likely interest in studying towards a specialist scope of practice in child and adolescent health.

Part 3 – skill level of the general profession

Question 8: Based on the evidence available, do you think there is likely to be a gap in knowledge, skills and attitude to child and adolescent care amongst the general profession?

32. 64 respondents skipped this question. 103 made comments. Of the 116 who answered the question, 87(75%) thought that there was likely to be a gap in knowledge in this area of practice amongst the general profession (48.3% of all respondents).

Chart 3



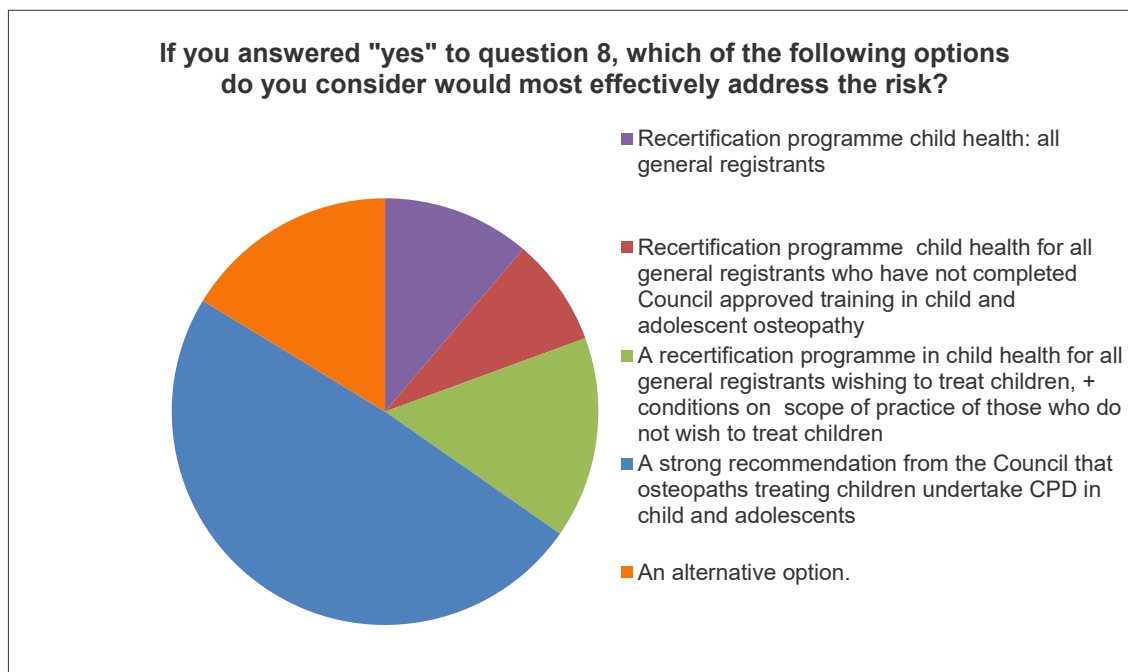
33. Key messages from respondents in relation to this question include:
- (a) There is likely to be a gap in knowledge given some students graduate with no clinical exposure to child and adolescent patients.
 - (b) Some recent graduates do not feel that they received sufficient training in this area.

- (c) Those who are interested in child and adolescent health are likely to have the relevant skills and choose appropriate CPD.
 - (d) General knowledge in the general profession is not up to standard in this area.
 - (e) There is likely to be a range of skills and gaps in knowledge in any sub-area of osteopathy (e.g., sports care, Maori health, etc). Why is the Council focusing specifically on child and adolescent health?
 - (f) Practitioners interested in child and adolescent health are largely self-taught. The public cannot rely on this as a safety measure.
 - (g) There should be more CPD available in this area so that practitioners can improve their knowledge if they choose to.
 - (h) The Council should try to take a holistic, big picture approach instead of creating specialities.
34. Based on the quantitative results of this question, it seems clear that the significant majority of practitioners believe there is a gap in knowledge in this area. A number of respondents seemed to consider that this risk was limited by practitioner self-awareness and choice to limit practice, while others thought that the main concern was recent graduates who did not have sufficient clinical exposure or experience.

Question 9: If you answered "yes" to question 8, which of the following options do you consider would most effectively address the risk? Please give reasons for your views.

35. 82 respondents skipped this question. Of the 98 who answered the question, almost half (49%) considered that the best option presented was a strong recommendation from Council that osteopaths treating children undertake CPD in child and adolescent health. The next most popular option was "an alternative option" with 16% support. This will be analysed further below, through the comments provided.
36. There was 15% support for a recertification programme in child and adolescent health for all general registrants wishing to treat children, combined with the inclusion of conditions on the scope of practice of those practitioners who did not wish to treat children.
37. There was 11% support for a recertification programme in child and adolescent health for all general registrants, and 8% support for a recertification programme in child and adolescent health for all general registrants who had not completed Council approved training in child and adolescent osteopathy.

Chart 4



38. As with responses made under Part Two, some respondents appear to have confused the suggestion of a recertification programme with “forced” postgraduate training. This should be borne in mind when reviewing some comments made.
39. Based on comments, the “alternative options” suggested included:
- (a) A recertification programme should focus on 0-5 age group.
 - (b) CPD courses should provide sufficient training for those who wish to upskill.
 - (c) A combination of Option 2 (a recertification programme) relating to 0-18 months, and Option 4 (CPD) relating to 18 months to 18 year old patients.
 - (d) The Council could obtain “statements of intent” from practitioners who wish to treat children, then allow a specified period of time for those practitioners to complete appropriate upskilling.
40. General messages included:
- (a) There is a need for a wider range of CPD in this area (this is reflected in responses to other questions as well).

- (b) The Council should leave practitioners to identify their own learning needs.
- (c) A basic, easy to complete (i.e online) assessment would work as a recertification programme (suggestions included an E-module/PebblePad with an open book test would likely provide an adequate “recertification” process).
- (d) There is a need for the entire profession to be able to demonstrate its competence in this area.
- (e) All osteopaths should be able to/allowed to treat the entire age range, without conditions.
- (f) Conditions limiting scope of practice may create a negative perception of the practitioner.
- (g) If a specialist scope of practice is introduced, this will provide clear signposting for the public towards the more qualified professionals, negating the need to ban others.

41. Of the options provided, the profession is most in favour of the Council simply recommending that practitioners undertake CPD in this area, and has indicated that more CPD activities are required. However, it is noted that a number of respondents understood the recertification process to be “punitive” and assumed that it would take the form of formal postgraduate training. It cannot be known to what extent this understanding affected those responses. In the comments provided, there was some support for a low-key yet robust form of assessment such as an e-module with testing.

42. Few comments specifically address the question of whether practitioners should be able to opt-out of recertification requirements with the inclusion of a condition on their scope of practice. Relevant considerations for the Council in relation to whether to allow an opt-out provision include:

- (a) The Council's ability to monitor compliance with any conditions, and
- (b) The impact on the reputation of a practitioner with such a condition (noting the increased sensitivity of the condition specifying that the practitioner does not treat children), and
- (c) The overall policy effect of such a decision, including whether it might extend to other vulnerable practice areas. There is a risk that introducing widespread ability to self-limit areas of practice in this way may dilute the general skill level across the profession in the long term, and
- (d) Whether the number of practitioners who might choose to opt out would impact on access for children to osteopathic care.

Question 10: If you answered "yes" to question 8, do you have other suggestions about how the Council might ensure that osteopaths are treating children and adolescents to a safe standard?

43. 84 respondents skipped this question. Of the 96 who answered, 51 provided comments.
44. Key relevant messages included:
- (a) What is the evidence that osteopaths are not treating children safely – e.g. complaint, adverse event, and treatment injury history?
 - (b) Ensure that registrants do child/adolescent CPD at least once every two years.
 - (c) There should be a compulsory core competence module for all.
 - (d) Leave it to the individual osteopath to decide what education they need.
 - (e) Education needs to be hands-on as well as theoretical.
45. The suggestions put forward in the response to this question are generally variations on previous comments made.

Council decisions in relation to this Part

46. The Council initially discussed this issue at its meeting on 22 February 2016, then obtained legal advice on some of the points that were discussed, before reconsidering at its teleconference on 13 April 2016.
47. When considering the question of the skill level of the general profession, the Council referred back to the issues set out in its consultation document, and also considered the feedback from stakeholders. In particular it noted that:
- (a) Undergraduate training in child and adolescent health in the three main jurisdictions that supply osteopaths in practice in New Zealand (Australia, the UK and New Zealand) does not appear to provide graduates with sufficient knowledge in child and adolescent health, at both theoretical and clinical training levels.
 - (b) Current knowledge of child and adolescent care ranges significantly across the profession, as evidenced in the Capabilities of Paediatric Osteopaths (COPO) report, July 2015, in which the following issues were identified:
 - i. Critical thinking;
 - ii. Case history-taking, information retrieval, tests and screening;
 - iii. Ethics in child health care;
 - iv. Basic health programme provision in New Zealand health care;
 - v. Child health systems and support networks;

- vi. Mental health issues for children;
 - vii. Management of the health needs of the under one-year olds across a wide spectrum of needs;
 - viii. Maori paediatric health care issues;
 - ix. Adolescent health issues;
 - x. Communication and interpersonal skills in an integrative health-care arena.
- (c) The Council's mandatory CPD provisions are relatively new and each individual osteopath chooses their own CPD. Practitioners who have had limited exposure to children in the course of their career are unlikely to have focused on this aspect of care in their CPD choices, and, combined with insufficient core training are likely to have eroded skills in this area of practice.
- (d) Feedback from stakeholders indicated that there was overwhelming agreement (75%) that, based on the evidence available, there is likely to be a gap in knowledge, skills and attitude to child and adolescent care amongst the general profession
- (e) Long-standing evidence that individual self-assessment of learning needs is not reliable. In 1997, the Goodfellow Unit in New Zealand reported on a study it had undertaken of 127 general practitioners who were asked to assess their level of knowledge in a given area.¹ The same doctors were then tested in that area. Correlation between the self-assessments and the test scores ranged between 0.19 and 0.21 (0 = no correlation, 1 = complete correlation). Another study, reported in the JAMA in 2006, reviewed the Goodfellow Unit's research and 12 other studies on the value of self-assessment, and reported similarly poor results.²

48. The Council considered the question of whether competence in child and adolescent health is an essential requirement for all registered osteopaths, and after discussion formally resolved that it is an essential requirement. It formed this view on the basis that the general scope of practice specifies that practitioners work across the age span, in recognition that osteopathy is firmly based within the primary healthcare setting which should be accessible to patients in every age demographic.

49. Given the range of concerns set out above, the Council is of the view that it is not appropriate to wait for a sentinel event involving osteopathic treatment of a child or adolescent patient before it acts. It is the Council's primary function to protect public health and safety by ensuring that osteopaths are fit and competent to practise, and the evidence

¹ J Tracey et al. "The validity of general practitioners' self-assessment of knowledge: cross sectional study" *BMJ* 1997;315:1426–8

² D Davis et al. "Accuracy of Physician Self-assessment Compared With Observed Measures of Competence" *JAMA* Vol 296 No 9, 1094-1102

available to the Council at this time is more than sufficient for it to form a reasonable view that there is a risk to this patient demographic that needs to be addressed.

50. The Council considered the options open to it, including:
 - (a) Requiring all osteopaths registered in the general scope of practice to complete a recertification programme of approved education in child and adolescent health; or
 - (b) Requiring all osteopaths registered in the general scope of practice either to complete a recertification programme of approved education in child and adolescent health, or to have conditions imposed on their scope of practice limiting them to treatment of adult patients; or
 - (c) Requiring all osteopaths registered in the general scope of practice to complete a recertification programme in child and adolescent health, unless they have already completed Council approved training in child and adolescent osteopathy; or
 - (d) Strongly recommending to the profession that osteopaths treating children undertake CPD in child and adolescent health; or
 - (e) Offering all osteopaths the option of voluntarily completing Council approved CPD in child and adolescent health over a period of perhaps three years, and including conditions on the scope of practice of osteopaths who had not done so at the end of that period.

51. The Council initially hoped that it would be able to offer an option that would allow practitioners to choose whether to upskill in child and adolescent health (i.e. option (e) above), but agreed that it needed to seek legal advice on whether this was a suitable approach, taking into account the other strands of this project – including the registration of overseas trained osteopaths in the present and future, and the likely change in core curriculum to increase focus on child and adolescent health at Unitec.

52. Upon consideration of the legal advice, the Council is of the view that the only viable pathway is a recertification programme (as described in section 41 of the HPCAA) which all osteopaths registered in the general scope would be required to complete over a reasonable period.

53. The Council acknowledged that some practitioners may not wish to complete the recertification programme, noting in particular those who may be intending to retire in the near future. Practitioners who had not completed recertification requirements by the due date (yet to be determined) would be referred to the Council which would consider whether to limit the practitioner's scope of practice under section 43 of the HPCAA.

54. The Council agreed that, if possible, the required training programme should be available entirely online to ensure that practitioners throughout New Zealand, as well as those overseas intending to practise in New Zealand, would be able to access it. The Council

noted however that it would need to seek advice from educationalists on whether this was achievable in light of the content that needed to be covered.

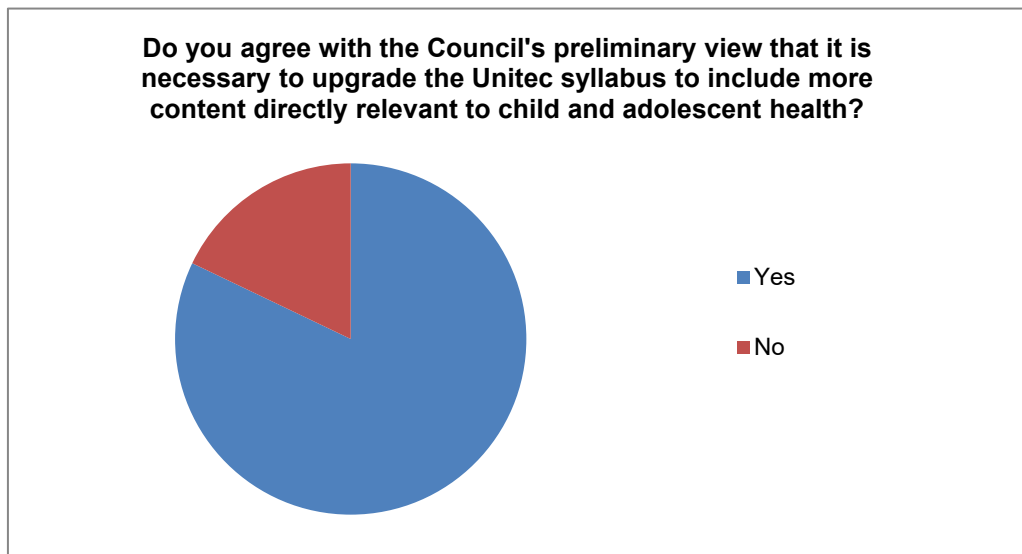
55. It was decided that, before it could make further decisions on the management of this process, the Council would need further information, including:
- (a) Details from training providers on whether they would be able to deliver a financially and practically accessible course for all osteopaths in New Zealand that would cover the issues of concern, and if so, the form that this training would take, and an indication of the likely costs involved for individual practitioners.
 - (b) An indication of how many practitioners would consider studying towards a vocational scope of practice in child and adolescent health, and if so, the likely timeframe for completion of study.
 - (c) An indication of how many osteopaths currently treat children, and if so, the average frequency that they do so.
 - (d) An indication of how many osteopaths would treat children if they felt more confident in their skills in this area.
 - (e) An indication of how many osteopaths would choose not to undertake a recertification programme in child and adolescent health, preferring to have their scope of practice limited.
56. The Council agreed that in the first instance it would obtain the necessary information from possible training providers about the likely format and content of the recertification programme before putting this information to the profession, so that individual practitioners could be fully informed when answering the questions above.

Part 4 – review of prescribed qualifications

Question 11: Do you agree with the Council's preliminary view that it is necessary to upgrade the Unitec syllabus to include more content directly relevant to child and adolescent health?

57. 68 respondents skipped this question. Of the 112 who responded, 92 (82%) agreed with the Council's preliminary view that the Unitec syllabus requires an upgrade in the area of child and adolescent health.

Chart 5

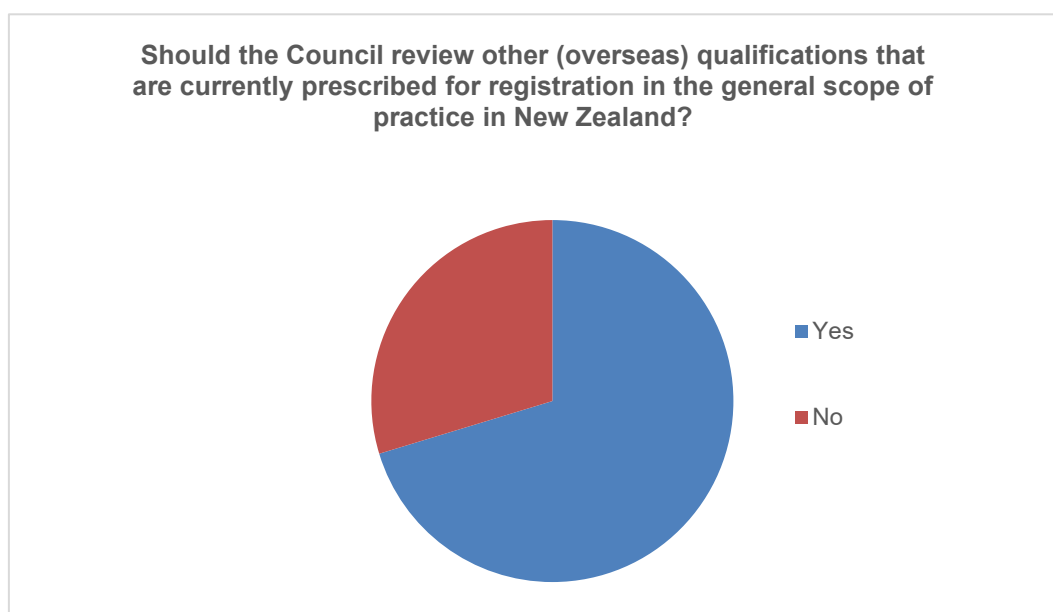


58. 89 respondents provided comment. Messages conveyed included:
- (a) Graduates of both UK and NZ qualifications considered that there was insufficient training in child and adolescent health during their undergraduate training.
 - (b) The Unitec syllabus may need upgrading in a range of areas, not just in child and adolescent health. Again the question was raised as to why this particular area of practice is under the spotlight.
 - (c) There were questions about what content would need to be removed from the Unitec qualification to make room for child and adolescent health, and at what cost to the graduate's core knowledge?
 - (d) While some respondents believe that the Knowledge, skills and attitudes (KSAs) required to treat adults are also relevant to treating children, others consider that specific skills and knowledge are required to treat children.
 - (e) One suggestion was to stream students wishing to focus on particular areas (e.g., children, geriatric, sports etc).
 - (f) A number of respondents replied that they were not sufficiently familiar with the course content to provide a view on the question.
59. Based on the quantitative results, it is clear that the profession overwhelmingly agrees with the Council's preliminary view that the syllabus should include more content directly related to child and adolescent health.

Question 12: If you answered "yes" to question 11, do you agree that it is also necessary for the Council to review other (overseas) qualifications that are currently prescribed for registration in the general scope of practice in New Zealand?

60. 79 respondents skipped this question. Of the 101 who answered, 71 (70%) agreed that it was necessary for the Council to review other qualifications for registration in the general scope of practice. 30 (30%) did not consider it necessary.

Chart 6

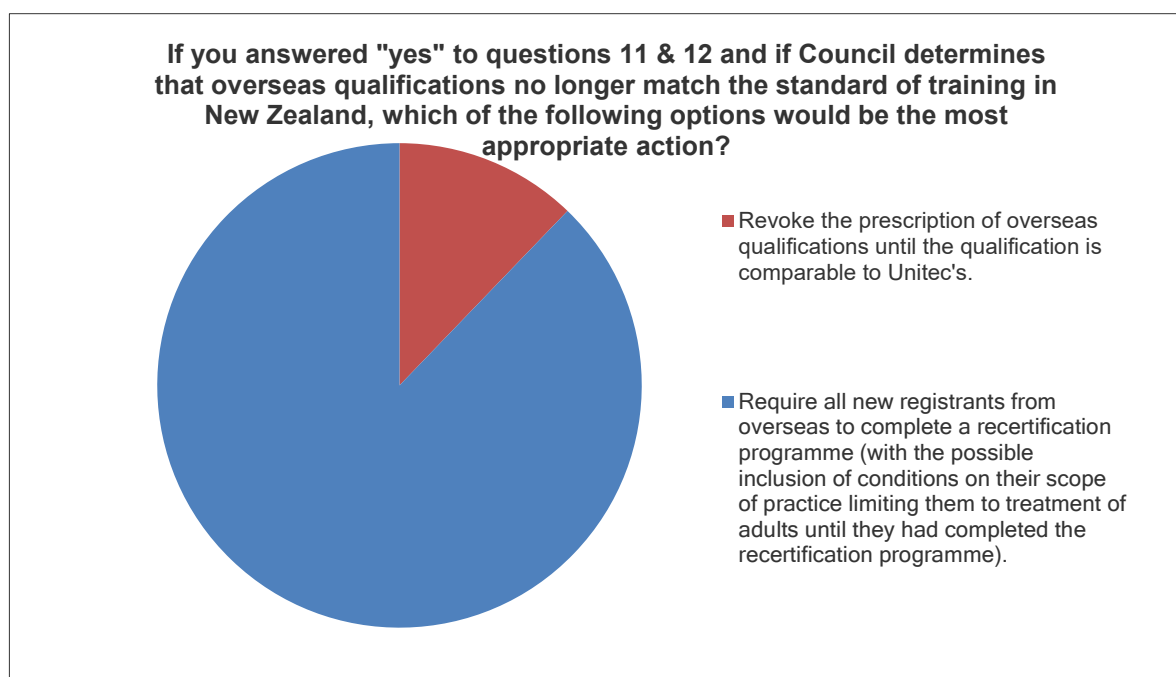


61. Comments on this question included:

- (a) The Council should not put barriers in place that might limit registration from overseas trained osteopaths.
- (b) NZ standards should be aligned with international guidelines/standards.
- (c) If the bar is going to be raised in NZ, then for consistency all practitioners coming in should be able to meet that standard (i.e., overseas qualifications need to be at least comparable to Unitec standards).
- (d) Upgrade of overseas trained practitioners can be achieved through recertification/CPD/peer group/pebble pad testing.
- (e) Opposing views on the adequacy of training in this area in the UK.

Question 13: If you answered "yes" to questions 11 & 12, in the event that the Council determines that overseas qualifications no longer match the standard of training in New Zealand, which of the following options do you consider the most appropriate action (giving reasons for your view)?

62. 106 respondents skipped this question. Of the 74 who answered, 65 (88%) considered that the Council should require new overseas registrants to complete a recertification programme within a specified period after registration (with the possible inclusion of conditions on the scope of practice limiting them to treatment of adults until they completed the recertification programme).
63. 9 (12%) considered that the Council should revoke the prescription of overseas qualifications until/unless they matched the revised Unitec qualification.



64. Responses to this question included:
- (a) If an overseas provider can demonstrate that its syllabus is comparable with the upgraded Unitec syllabus, there should be no reason for its graduates to have to complete a recertification programme.
 - (b) There is a varying degree of relevant training amongst UK training institutions – some are more advanced than Unitec, others are comparable.
 - (c) Requirements could be built into the preceptorship framework.

- (d) New overseas registrants could be required to complete the same e-modules/training etc that the general profession might be required to complete if the Council implements a recertification programme in this area.
- (e) Neither of the two options presented is appropriate.
- (f) This concern would be addressed through CPD.

Council decision in relation to this Part

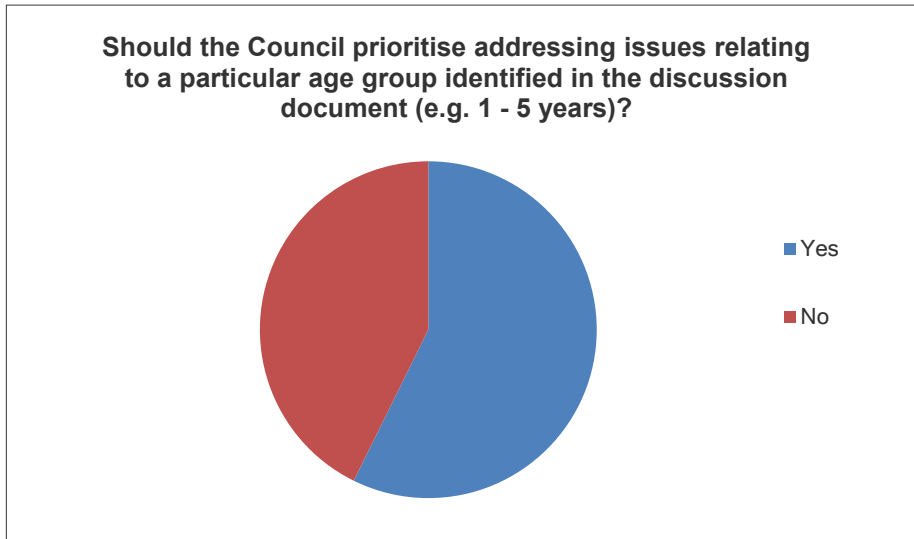
- 65. In the Council's view, the information before it indicated a clear need for revision of the Unitec curriculum. It understood Unitec was already aware of this need, and agreed to advise Unitec to begin work on amendments as soon as possible. The Council would provide Unitec with direction on the areas of concern that would need to be addressed in the course content. This would likely include the background and key issues of concern identified in the COPO report, and may also include relevant content from the Certificate of Proficiency in Child Health run by the University of Otago.
- 66. The Council noted that to date, it had relied on anecdotal information about child and adolescent content delivered in some overseas based training institutions. It agreed that before deciding how to proceed with the question of managing overseas prescribed qualifications, it needed to obtain concrete information from those training institutions on the child and adolescent health content currently delivered by them. Upon receipt of this information, the Council would consider next steps.

Part 5 – Prioritisation of age groups

Question 14: Generally speaking, do you believe that the Council should prioritise addressing issues relating to a particular age group identified in the discussion document (e.g. 1 - 5 years)?

- 67. 70 respondents skipped this question. Of the 110 who answered, 63 (57%) thought that the Council should prioritise a particular age group, while 47 (43%) did not think this should be done.
- 68. This question did not provide an option for comments to be provided, but of all the questions in the consultation, this is the one that has most evenly divided the profession.

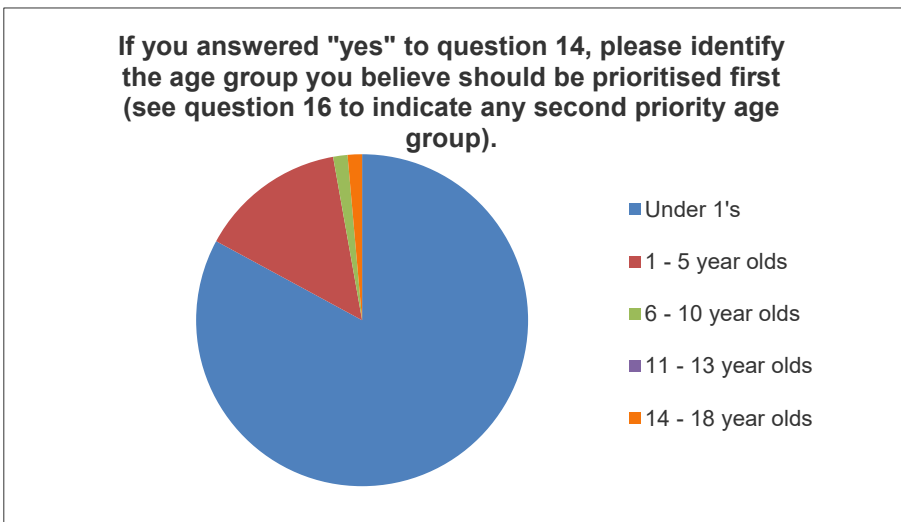
Chart 7



Question 15: If you answered "yes" to question 14, please identify the age group you believe should be prioritised first (see question 16 to indicate any second priority age group).

69. 110 respondents skipped this question.

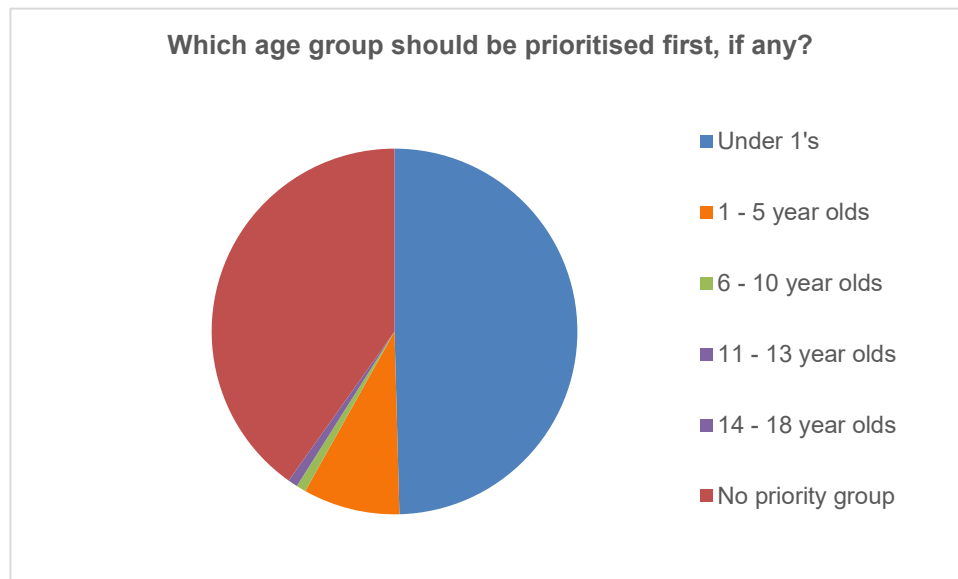
Chart 8



70. Of those who responded, the vast majority (58, or 82.9%) believed that improving competence in treating the under 1s should be prioritised. A further 10 (14.3%) believed that the highest priority group was 1-5 year olds. Combined, these two age groups accounted for 97.2% of responses.

71. It should be borne in mind when considering the result of this question that the answers above reflect the views of the respondents who felt that a particular age group should be prioritised. If we also factor in the 47 respondents who answered that there should be no prioritisation of a particular age group, the distribution changes quite substantially. A graph which includes representation of this group is provided below.

Chart 9

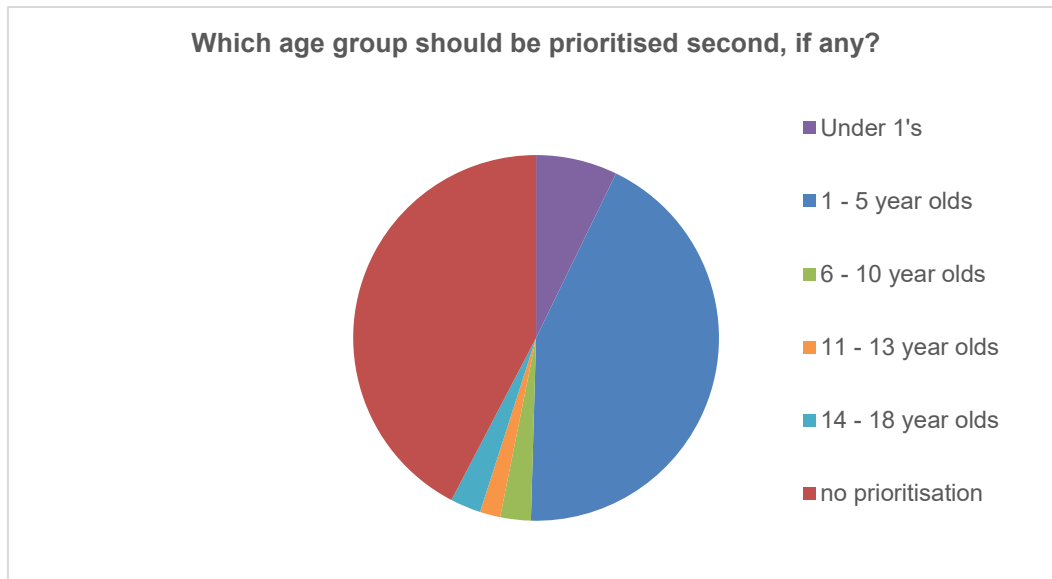


72. Comments provided in relation to this question were difficult to interpret as some did not clearly link to an identified age group. Key points included:
- The Ministry of Health statistics indicate that 0 -5 year olds have the highest representation in health issues.
 - Under 1s are the most vulnerable age group for a variety of reasons.
 - Babies' anatomies are different, requiring a different skillset.

Question 16: If you answered "yes" to question 14, please identify the age group you believe should be prioritised second, if any.

73. 116 skipped this question. Of the 64 who answered, 48 (75%) considered that 1-5 year olds should be the second priority age group. The next highest group was the under 1s, with 8 (12.5%).
74. As with question 15 above, the 47 respondents who did not support prioritisation should be considered in this question. They came in almost equal with those who prioritised the 1-5 year olds.

Chart 10



75. Comments provided in relation to this question included:

- (a) This age group is still vulnerable, with speed of growth and developmental change.
- (b) In support of a focus on an older age group (it is unclear which age group, but on the basis of the content is assumed to be 14-18 year olds), there was a view that teenagers are more at risk of sports injuries, accidents and suicide.
- (c) 0 – 5 year olds have the greatest amount of changes to deal with.
- (d) There are difficulties with communication and consent for younger age groups.

Council decisions in relation to this Part

76. The Council noted that, based on feedback from stakeholders, there was a very even split between those who considered that any particular age group should be prioritised, and those who did not.
77. It also noted that strong arguments were made during consultation in support of improved knowledge in treating age groups other than the 0-1 age group that had been identified in the COPO report as higher risk (for example, assessing Gillick competence in teens, and understanding mental health risks for that age group).
78. The Council agreed that, given the above, it was appropriate that training should cover 0 – 18 year olds.

Next steps

79. The Council appreciates the input provided by stakeholders through the first consultation, and believes that this feedback has helped it to work through the issues. As noted above, the Council needs to gather further information. Once it has done so, it will provide relevant information to the profession, together with a range of questions that it hopes will give it a clear picture of how individual practitioners might choose to proceed in relation to their own practice. Once the Council has gathered all of the necessary information, including further input from the profession, it will review the situation and make final decision on how to proceed.