General Osteopathic Council

Council of Osteopathic Educational Institutions
Promoting Osteopathic Excellence

British Osteopathic Association

Joint response from the British Osteopathic Association, Council of Osteopathic Educational Institutions and the General Osteopathic Council to Liberating the NHS: Developing the Healthcare Workforce

Consultation Responses
Workforce Education Policy Team
Department of Health
Room 2N12, Quarry House
Quarry Hill
Leeds LS2 7UE

25 March 2011

Dear Sir / Madam,

Thank you for the opportunity to respond to the *Liberating the NHS: Developing the Healthcare Workforce consultation*. This submission represents the collective response from the British Osteopathic Association – the profession's representative association, the Council of Osteopathic Educational Institutions – representing all accredited osteopathic training providers in the UK, and the General Osteopathic Council – the UK statutory regulator for the osteopathic profession.

In summary, we wish to emphasise the following:

- Osteopathy, as a statutorily regulated profession, wishes to be included in the further development of the *Liberating the NHS: Developing the Healthcare Workforce* proposals as we believe osteopathy has an effective contribution to make to patient-centred healthcare.
- It is important for the government to engage effectively with smaller professions, like osteopathy, providing healthcare to the general public. This will help to achieve the aims of this paper and the wider aims of the *Liberating the NHS* White Paper of a patient-centred healthcare system where patients and their carers are in charge of making decisions about their health and wellbeing.
- It is important for smaller professions to be represented effectively at a national level in order to support the aims of the *Liberating the NHS* White Paper. With an increased focus on self care and personal responsibility, private healthcare provision and capacity should be viewed alongside the NHS to ensure that services are available to reduce the pressure within the NHS. It will be important that provision and capacity is not merely left to market forces but has some input from a planned approach.

We have set out some background about the General Osteopathic Council (GOsC), osteopathy and osteopathic education as an annex to provide you with a context for our response.

Question 1 – Are these the right high level objectives? If not, why not?
The General Osteopathic Council (GOsC) has a statutory responsibility of 'promoting high standards of education and training in osteopathy and keeping the provision made for that training under review' under Section 11 of the Osteopaths Act 1993. We therefore welcome the objective of 'High quality education and training that supports safe, high quality care and greater flexibility'.

Question 2 – Are these the right design principles? If not, why not?
Additional principles may be required to support the objective 'High quality education and training that support safe, high quality care and greater flexibility'. This could be achieved through additional principles perhaps as follows:

- 'To ensure alignment with the wider system design for the provision of high quality education and training in both the public and private sectors.'
- 'Clinical pathways should be developed by multi-disciplinary teams that include statutorily regulated professions not currently trained in the NHS.'

Question 3 – In developing the new system, what are the key strengths of the existing arrangements that we need to build on?
Osteopathy has not been involved in existing NHS arrangements linking workforce planning and education. Please note that osteopathy is already provided in pockets of the NHS in areas such as Essex, East Sussex, parts of London, Nottingham and Plymouth. However all undergraduate education and training is currently provided in teaching clinics situated mainly in the Osteopathic Educational Institutions (OEIs) or at charitable outreach centres. Postgraduate education and training is predominantly self directed and self-funded by individual osteopaths and takes place in a variety of settings.

There are areas of strength outside the current NHS system, which could also be taken into consideration in developing a new structure. It is important to involve all aspects of good patient care both in the NHS, and in the private and charity sectors in order to achieve the aims of this paper and the *Liberating the NHS* White Paper.

Question 4 – What are the key opportunities in developing a new approach?
The GOsC has a statutory duty to 'develop and regulate the profession of osteopathy'. It is a small but growing profession.

As part of the GOsC's remit to develop the profession we would like to ensure that osteopathy is taken into account in a revised multi-professional approach to the structure for education and training for the benefit of patients. We support involvement in the multi-professional approach to the structure of education and training. This would also support the link between the delivery of healthcare both within and outside the NHS envisaged by the White Paper *Liberating the NHS* and associated consultation papers.

Osteopathy has been recognised by NICE in the *Guidelines on Low Back Pain*. The osteopathic professional organisation, the British Osteopathic Association (BOA) can provide more information about the benefits of osteopathy and how increased provision of osteopathy may assist in implementing the NICE guidelines in a variety of areas for the benefit of patients.

The key opportunities of developing a new approach will be realised only by involving all statutorily regulated healthcare professions (not just those currently trained within the NHS) in the development of effective patient pathways. This will enable a better appreciation of the knowledge and skills of different healthcare professions, improving referral and therefore effective and patient centred pathways. In turn this knowledge could also help to improve the efficient commissioning of services if a fully multi-disciplinary team is involved.

Question 5 – Should all healthcare providers have a duty to consult patients, local communities, staff and commissioners of services about how they plan to develop the healthcare workforce?

Patient input across the country is essential.

As currently drafted, the definition of 'healthcare service providers' on page 72 would appear to include small groups of practitioners and OEI clinics in private practice such as osteopathy. There may be more benefit to reconsidering the definition to consider how larger professional associations might provide a better overview of provision, or how organisations such as the Council of Osteopathic Educational Institutions (COEI) may provide a better overview of providers. The definition of healthcare service provider could be amended to the following (see italics) to perhaps deal with this point:

Revised definition of healthcare service provider: They are any organisation that provides healthcare services to the public and patients. The majority, but not all, are funded by the NHS. They include NHS providers, private and voluntary third sector providers which are wholly or partly funded by the NHS and independently funded private service providers. *Where services are provided by sole practitioners, or are provided in a small and discrete area of practice or aspect of the patient care pathway, a larger organisation such as a professional association may be able to take a better overview as the 'healthcare service provider' for that profession.* They are central to planning and developing the healthcare workforce. They are responsible for ensuring their workforce is equipped with the right skills in the long and short term. These decisions will inform education and training commissioning.

Question 6 – Should healthcare providers have a duty to provide data about their current workforce?

Please see comments for Q5 above.

The GOsC, although not a healthcare service provider, holds data about osteopaths in practice as part of the information we hold on our Statutory Register. We would be pleased to share this information to contribute to the collective data available about the osteopathic workforce within the constraints of data protection legislation.

The OEIs may be able to contribute data about the numbers of students going through training for the purposes of contributing to the general picture about future workforce.

It would be helpful to have a clearer picture of what is currently provided in the NHS environment.

Question 7 – Should healthcare providers have a duty to provide data on their future workforce needs?

See comments on Q5 and Q6 above.

Question 8 – Should healthcare providers have a duty to cooperate on planning the healthcare workforce and planning and providing professional education and training?

As part of the GOsC's statutory remit to 'develop and regulate' the profession of osteopathy, we agree that a duty on healthcare service providers (defined as we have suggested above) to co-operate on planning the healthcare workforce and professional education should support improved patient care pathways, as the knowledge and skills of professions become better known to each other.

Question 9 – Are there different functions that healthcare providers working together would need to provide?

We note the emphasis on management of postgraduate education and training. Osteopaths are trained and qualified as primary care practitioners at the point of registration. At this point they are able to provide a service without further postgraduate training. We therefore wonder if there should be provision for relevant undergraduate data too, to ensure appropriate links with GP commissioning.

There is no further regulated postgraduate training for osteopaths once they are registered. There are a growing number of academically accredited postgraduate programmes being completed by osteopaths, some of which are specific to osteopathy and are provided through the OEIs. A number of osteopaths also complete postgraduate education through multi-professional programmes such as MSc courses in sports medicine. In due course, it is envisaged that postgraduate training programmes may enhance further patient pathways in particular areas. As demand for these patient pathways grows, it will be appropriate for structures such as Colleges or Deaneries to oversee them and to be involved in the structures developed under the proposals in this paper.

Question 10 – Should all healthcare providers be expected to work within a local networking arrangement?

Yes. Working in local networking arrangements could be helpful to allow all healthcare providers to be aware of each other's knowledge, skills and practice to contribute to more efficient patient pathways – in turn informing decisions about commissioning of education.

It will be important to ensure that information about quality is shared effectively to ensure that providers are not subject to an unnecessarily heavier regulatory burden.

Question 11 – Do these duties provide the right foundation for healthcare providers to take on greater ownership and responsibility for planning and developing the healthcare workforce?

No comment.

Question 12 – Are there other incentives and ways in which we could ensure that there is an appropriate degree of cooperation, coherence and consultation in the system?

If new clinical pathways are developed by multi-disciplinary teams, there is an incentive to provide a service to satisfy the new clinical pathway. Local networks should also include employer groups, perhaps DWP representatives, and perhaps charities with knowledge of local areas so that the detailed health needs of the local area could be established.

Question 13 – Are these the right functions that should be assigned to the Health Education England Board?

The functions specified for the Healthcare Education England Board (HEEB) appear to be the right ones.

However, osteopaths are trained outside the NHS in OEIs. As indicated earlier in our response, osteopaths generally provide a service to patients outside the NHS framework with some working in small pockets within the NHS.

In order to achieve the broad policy objectives outlined in this paper, we believe that it will be important to include membership of *all* the statutorily regulated professions, even those that do not currently benefit from training in the NHS.

This will ensure a more efficient multi-professional approach (which includes those not currently trained in the NHS) to the development of patient care pathways which in turn will inform workforce planning data.

Question 14 – How should the accountability framework between healthcare provider skills networks and HEE be developed?
Osteopathy is delivered in small pockets in the NHS locally. In order to ensure a strategic overview it will be important for it to be represented at national level as well as local level. The model proposed for small professions, such as the Health Scientists, would also be applicable to osteopaths whereby commissioning is nationally organised due to the small population size and number of accredited schools. It is likely that a national overview will need to be taken based on detailed local information.

Question 15 – How do we ensure the right checks and balances throughout all levels of the system?
No comment.

Question 16 – How should the governance of HEE be established so that it has the confidence of the public, professions, healthcare providers, commissioners ?
All those stakeholders noted should be represented at board level whether directly or indirectly. We believe that it will be appropriate for the General Osteopathic Council to be able to nominate representatives to be involved in HEE to ensure linkages between high quality education and training responsive to the changing needs of patients and local communities and to assist in national leadership on planning and developing the healthcare workforce. It would be possible to do this by ensuring that the board reflects constituencies of interest and for any nominee of the professional regulators to have a duty to represent all the professions.

HEE will need to have a clear engagement strategy for each profession, for example in osteopathy, working with GOsC, the BOA and OEIs. HEE will also need to engage effectively with organisations assuring the quality of educational provision to ensure that the regulatory burden is not increased.

Question 17 – How do we ensure that the Centre for Workforce Intelligence is effective in improving the evidence base for workforce planning and supports both local healthcare providers and HEE?
It will be important to collect a wide range of data, including from those professions that do not have a traditional focus in the NHS, to ensure that the whole variety of care available to patients can be taken into account in determining care pathways and the healthcare professions' requirements. This data should include information about patient outcomes. A cost benefit analysis may need to be undertaken to demonstrate the utility of this.

Question 18 – How should we ensure that sector wide education and training plans are responsive to strategic commissioning intentions of the NHS Commissioning Board?
There will be a need to ensure that workforce planning includes those healthcare professions which do not currently have undergraduate or postgraduate medical training in the NHS to ensure that all policy objectives are achieved.

Question 19 – Who should have responsibility for enforcing the duties on providers in relation to consultation, the provision of workforce information, and co-operation in planning the workforce and in the planning and provision of professional education and training.
The Care Quality Commission (CQC) and Monitor may be appropriate organisations to take this forward. There also may be a role for the GOsC.

Question 20: What support should Skills for Health offer healthcare providers during transition?
Identification of emerging best practice and the establishment of a mechanism to communicate this across the country would be very helpful.

Q21: What is the role for a sector skills council in the new framework?
No comment.

Q22: How can the healthcare provider skills networks and HEE best secure clinical leadership locally and nationally?
The professions quoted in the paper have rich 'firmaments'. For example, a statutory regulator, a strong professional association, strong Royal College type framework and strong and cohesive undergraduate education frameworks. There are gaps in some of these areas in the osteopathic 'firmament'. The GOsC provides support to the OEIs and to the National Council for Osteopathic Research (NCOR) as part of its role to 'develop' the profession. We believe that it would be appropriate for the GOsC to continue to support and develop the profession whilst it matures and develops an infrastructure to take these issues forward through organisations, such as a College or Postgraduate Deanery, in due course.

Question 23: In developing the new system, what are the responsibilities that need to be in place for the development of leadership and management skills amongst professionals?
No comment.

Question 24: Should HEE have responsibilities for the leadership development framework for managers as well as clinicians?
Such a responsibility may well provide an opportunity to cohesively develop a healthcare workforce which was united with common competences of leadership whilst also being more aware of the individual knowledge and skills of each of the different professions helping to bring together efficient and effective patient care pathways.

Question 25: What are the key opportunities for developing clinicians and managers in an integrated way both across health and social care and across undergraduate and postgraduate programmes?
As we have indicated in earlier responses, it will be very important to take into account the provision of education and training and workforce planning from undergraduate education onwards, particularly for professions like osteopathy, which do not have formal regulated postgraduate training pathways at present. We perceive there are common elements of undergraduate education that could be delivered in an integrated way and are aware of OEIs where this currently occurs.

A common leadership framework should develop the opportunities set out at question 24. There are opportunities to develop clear roles for those in clinical and / or managerial capacities.

Question 26: How should Public Health England, and its partners in public health delivery, be integrated within the new framework for planning and developing the healthcare workforce?
Full stakeholder identification, engagement and consultation is important.

Question 27: Should Local Authorities become members of the healthcare provider skills network arrangements, including their associated responsibilities; and what funding mechanisms should be employed with regard to the public health workforce?
No comment.

Question 28: What are the key issues that need to be addressed to enable a strategic, provider-led and multi-professional approach to funding education and training, which drives excellence, equity and value for money?
As stated earlier some professions, such as osteopathy, are not funded by the NHS for undergraduate or postgraduate training. Nevertheless, to ensure an appropriate overview of both service and training, it is appropriate to consider the totality of care and service required and therefore the education required to support this. Embracement of small professions is only likely to be successful and beneficial to patients at a local level if there is a strong national representation on HEE.

Osteopathy undergraduate clinical placements are funded either privately, or through HEFCE funding, and do not rely on any NHS funding.

Question 29: What should be the scope for central investment through the Multi-Professional Education and Training budget?
No comment. Osteopathy does not benefit from central MPET funding.

Question 30: How can we ensure funding streams do not act as a disincentive to innovation and are able to support changes in skill mix?
No comment.

Question 31: How can we manage the transition to tariffs for clinical education and training in a way that provides stability, is fair and minimises the risks to providers?
We note the proposal in paragraph 8.13 that '...tariffs would enable a national approach to funding of all undergraduate clinical placements (both medical and non-medical)...' At present, osteopathic training does not attract NHS funding at either undergraduate or postgraduate level. If such a transition is to occur then the local nature of osteopathic provision needs careful consideration.

Question 32: If tariffs are introduced, should the determination of the costs and tariffs for education and training be part of the same framework as service tariffs?
No comment.

Question 33: Are there alternative ways to determine the education and training tariffs other than based on the average national cost?
No comment.

Question 34: Are there alternative ways to determine these costs other than by a detailed bottom-up costing exercise?
No comment.

Question 35: What is the appropriate pace to progress a levy?
No comment

Question 36: Which organisations should be covered by the levy? Should it include healthcare providers that do not provide services to the NHS but deliver their services using staff trained by the public purse?
Osteopathy does not benefit from central MPET funding.

The definition of healthcare service providers needs to be carefully worded. Most osteopaths (around 85%) work outside an NHS setting and are not involved in the training of pre-registration osteopaths. Pre-registration osteopathic students are usually trained in dedicated osteopathic clinics or outreach community clinics which are attached to the OEIs. If funding was to be provided to these clinics through the HEE model, it may be appropriate for 'healthcare service providers' to include OEI clinics provided this would not mean an overall reduction in funding available for osteopathic education. However, it may not be appropriate for the definition of 'healthcare service providers' to include all practising osteopaths, the majority of whom will not be involved in training osteopaths.

As well as not conforming to the definition of healthcare service providers, many osteopaths will not have received any public funding for their education and training or for the establishment of their practices and will not be involved in the training or employment of healthcare professionals. Therefore any requirement for individuals to pay a levy would be wholly unfair and unjustifiable. Levies would appear to be appropriate only for NHS or NHS contractors.

Question 37: How should a levy be structured so that it gives the right incentives for investment in education and training in the public interest?
No further comment.

Question 38: How can we introduce greater transparency in the short to medium term?
No further comment.

Question 39: How can transaction costs of the new system be minimised?
No further comment.

Question 40: What are the key quality metrics for education and training?
Our recently revised GOsC / QAA Handbook is currently out for consultation and available at http://www.qaa.ac.uk/health/GOsC/consultation/CPhandbook.pdf. Our challenge is balancing academic and professional aspects of the courses. A greater challenge in considering multi-professional quality metrics will be the development of effective metrics which align service and education in a multi-professional way. As osteopathy is currently not funded in the way set out in this consultation paper, we have not undertaken work so far on these wider aspects of quality.

Nevertheless, we would be very open to working with HEE on such quality metrics and to considering the implications for osteopathic education and training.

Question 41: What are the challenges of transition?
One of the additional challenges of transition will be the management and integration of arrangements for health professions which are not currently involved in the current funding structure to ensure effective alignment across the public and private sector, recognising the numbers of treatments of patients paying privately who are not therefore seeking NHS treatment. This is not alluded to in the paper, but will be needed to ultimately, develop the most effective and efficient care pathways for patients.

Question 42: What impact will the proposals have on staff who work in the current system?
The majority of staff associated with provision of osteopathic healthcare do not work within the current NHS environment.

Question 43: What support systems might they need?
No comment.

Question 44: What support should the Centre for Workforce Intelligence provide to enable a smooth transition?
In order to ensure a smooth transition, it would be appropriate for those healthcare professions currently trained outside the NHS to share information with the Centre for Workforce Intelligence to ensure that steps could be taken to develop efficient and effective care pathways with subsequent impacts on education and training.

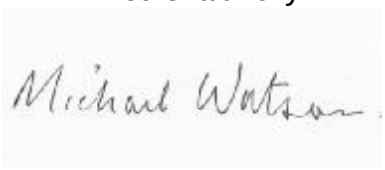
Question 45: Will these proposals meet these aims and enable the development of a more diverse workforce?
As indicated earlier, a situation which meant that all healthcare professions were considered in the same way in terms of access and funding would be taking steps towards a more diverse and effective workforce.

Question 46: Do you think any groups or individuals (including those of different age, ethnic groups, sexual orientation, gender, gender identity (including transgender people), religions or belief; pregnant women, people who are married or in a civil partnership, or disabled people) will be advantaged or disadvantaged by these proposals or have greater difficulties than others in taking part in them? If so, what should be done to address these difficulties to remove the disadvantage?
See above.

Yours faithfully

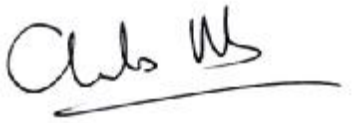
Tim Walker
Chief Executive
and Registrar,
General Osteopathic
Council

Yours faithfully



Michael Watson
Chief Executive,
British Osteopathic
Association

Yours faithfully



Charles Hunt
on behalf of the
Council of
Osteopathic
Educational
Institutions

Further information
Fiona Browne
Head of Professional Standards
General Osteopathic Council
Osteopathy House
176 Tower Bridge Road
London SE1 3LU
Tel: 020 7357 6655 x 239
Email: fbrowne@osteopathy.org.uk

ANNEX

About osteopathy

Osteopaths are primary healthcare practitioners. This means that they are able to undertake an initial consultation with any patient. This includes taking a case history, performing an examination of the patient, formulating a differential diagnosis and undertaking treatment where appropriate. Osteopaths are trained to refer patients to other healthcare professionals when they are not the most appropriate professional to manage an underlying condition (although they may still provide treatment to the individual referred).

Osteopaths are able to treat patients exhibiting a significant number of symptoms with a range of osteopathic approaches.

Most osteopaths work in private practice. However, up to 15% do provide services within an NHS setting.

Background to osteopathic regulation

The General Osteopathic Council (GOsC) is the statutory regulator (by virtue of the Osteopaths Act 1993) tasked with developing and regulating the profession.

By law osteopaths must be registered with the GOsC in order to practise in the UK.

- The GOsC keeps the Register of all those permitted to practise osteopathy in the UK.
- We work with the public and osteopathic profession to promote patient safety and we set, and monitor the maintenance and development of standards of osteopathic training, practice and conduct.
- We also assure the quality of osteopathic education and ensure that osteopaths undertake continuing professional development.
- We help patients with any concerns or complaints about an osteopath and have the power to remove from the Register any osteopaths who are unfit to practise.

The osteopathic educational environment

There are two publicly funded Universities – Oxford Brookes University and Leeds Metropolitan University delivering Bachelors and Masters degrees in osteopathy.

There are also six independent colleges (the British School of Osteopathy, the British College of Osteopathic Medicine, the College of Osteopaths (at Keele and Borehamwood), the European School of Osteopathy, the London School of Osteopathy and the Surrey Institute of Osteopathic Medicine) awarding degrees from validating universities including the University of Greenwich, University of Bedfordshire, Keele University, Middlesex University, University of Surrey and Anglia Ruskin University. Most of these colleges receive public HEFCE funding allocated via their validating university. It is normally awarded at Band B.

There is one other college which awards a postgraduate qualification: Member of London College of Osteopathic Medicine. This postgraduate diploma is only awarded to medical practitioners who already have a primary medical degree allowing registration with the General Medical Council.

All these osteopathic educational institutions are required to deliver education that meets our standards in order to obtain and retain recognition. The standards are available on our website at www.osteopathy.org.uk.

The award of a Recognised Qualification (RQ) means that the holder is capable of practising, without supervision, to the standards expected in the GOsC Code of Practice and the Standard of Proficiency. These standards are available on the GOsC website at: http://www.osteopathy.org.uk/practice/standards-of-practice/

Once a RQ has been awarded, an osteopath is able to be registered on the GOsC's Register, subject to satisfying statutory character and health requirements. There are currently around 4436 osteopaths on the GOsC Register, practising throughout the UK.

Educational Institutions are able to award 'Recognised qualifications' following a decision by the General Osteopathic Council to enable them to do so. The process of recognition is a detailed process overseen on our behalf by the Quality Assurance Agency. Visitors scrutinise documentation and visit educational institutions and prepare a report recommending (or not recommending) the award of RQ status with conditions, if appropriate. The reports are scrutinised by the GOsC's Education Committee prior to the decision to recognise a qualification being made by our Council. This decision is then approved by the Privy Council. Quality assurance is also overseen through an annual monitoring report and action plan along with targeted requests for information and visits if information provided requires this. Further information is available on our website at http://www.osteopathy.org.uk/about/our-work/ and http://www.qaa.ac.uk/health/gosc/consultation/

Alongside this, the General Osteopathic Council with the OEIs also promote good practice through the Annual Reports and through an annual seminar, to facilitate the sharing of good practice between educational institutions.

Once registered, osteopaths are fully responsible for their own training and development (as well as that of their employed staff). All osteopaths are required to undertake regular CPD both by themselves and with others and to submit an annual summary form to the GOsC. Each year a sample of these forms and the folders underpinning them are audited by the GOsC.

Osteopaths also self-fund and self manage their postgraduate osteopathic education. Whilst not statutorily regulated, there are academically accredited postgraduate education courses available for osteopaths to undertake. Many of these are specific to osteopathy and OEIs, and many include multi-professional programmes such as MSc courses in sports medicine. In due course, it is envisaged that postgraduate training programmes may enhance further patient pathways in particular areas. As demand for these patient pathways grows, it will be appropriate for structures such as Colleges or Deaneries to oversee them and to be involved in the structures developed under the proposals in the Liberating the NHS: Developing the workforce consultation paper.