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This is 'hard'! Case studies are good - however, I think it would be good to do some analysis eg - the following guidance is in the adjuvant therapy, however it is not in the Osteopathic Guidance - so one must be clear how they are following different guidance - hope it makes sense?	I think this has possibly misunderstood the relationship between this particular guidance and the OPS. This shouldn't be setting guidance that conflicts with the OPS – the idea is to illustrate how the OPS apply across a range of scenarios.	N/A
Clear, simple and written in plain English.		
There may need to be another section regarding osteopaths who work in other capacities in the NHS and those with additional qualifications in the health and fitness industry	The case that we've used is one where the osteopath is also a nurse, and continues to work as such. We say that the standards of professionalism will apply across her roles, but that standards requiring her, for example to conduct an osteopathic evaluation would not apply to her nursing role. So there is a contextual element to this. Would it add value and/or clarity to give another example of an osteopath employed in the NHS as, for example, a First Contact Practitioner? They may have qualified for the role because of their osteopathic AHP status, but the role may be different to typical osteopathic practice – comprising	We have retained the current nurse scenario, and not added a further NHS example where someone is employed because of their AHP osteopathic role, to avoid overcomplicating the guidance.

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	triage and evaluation/referral rather than osteopathic manual therapy. This would be similar to the nurse role in that professionalism requirements would apply, but the full context would need to be taken into account should a complaint or concern be raised. The distinction here is that the FCP role is possible *because* they're an osteopath, so the expectations of being a registered healthcare professional would apply alongside the requirements and scope of the role itself.	
Yes - I think the document is quite wordy and one has to read some paragraphs twice to understand them clearly, especially in Case study 3.	This is the one about Lucy, the massage therapist who wants to continue working in this capacity as well as developing her osteopathic practice.	Retained original wording – most feedback was positive on the scenario wording.
Accessible to me, unfortunately doesn't mean accessible to all. I can help out on completing an easy read version for disabled individuals.	We can explore the development of an easy read version.	No changes to draft as a result of this but we will develop easy read version – see EIA.
Easy ready version and translation in other languages is needed. Adding some graphs is also my suggestion	See above. I'm not quite sure how a graph could be factored in to this document, but we can work on the design to make it more visually engaging.	

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The language was clear, but for the public a list of some of what are called "adjunct therapies" might be helpful.	This is a very good point.	We have suggested an update to explain what is meant by this phrase and to give some examples. We have also added a concluding paragraph and a summary of key messages at the end.
There are a number of grammatical typos easily picked out in Word so I am sure you are aware of them.	Will get a full proofread.	Draft reviewed and will undergo further review before final design/publication.
Example 2 is really good - because you are comparing like with like; however the last example is really different and so the Osteopath should put it in writing what is Osteopathic treatment and what the other therapies are and must give advantages and disadvantages	A reasonable point, but we don't necessarily require that osteopaths put such information in writing. Rather that they communicate effectively with patients, explain material benefits/risks and seek informed consent. If there's a mix of approaches with some non-typically osteopathic treatment involved, then this should be made clear, but it doesn't have to be in writing.	No changes made.
Case study 4. The paragraph regarding Aaron's conduct could be written more clearly as it implies that the GOsC would address concerns about a civil matter not involving the care of the	That's right – if it went to an osteopath's honesty, then it could impact on his registration. We picked this example as	No changes made.

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patient. I understand that if Aaron's conduct was found to be dishonest it would have a damaging effect on the reputation of the profession but think a different example, might be more helpful. It also implies a different requirement once Aaron has qualified as an osteopath whereas I believe the same standard of upholding the reputation of the profession would apply when he was a student. It is right for Aaron to believe his building work is separate from his work as an osteopath, it is the issue of honesty that is the concern.	because it relates to non-therapeutic activity. We don't register students, so there is a different requirement, but before they graduate there are student FtoP policies that might be brought into this if a complaint was made to an OEI about a student, for example. And yes – the quality of building work would not impact on FtoP necessarily, but issues such as honesty and integrity could.	
Case study 5, I am not sure novel forms of care or treatment accurately reflects the type of interventions described. final paragraph, "treatment or care offered ……..to a vulnerable patient. I do not consider it necessary to make reference to a vulnerable patient, it could be any patient.	This is the case regarding the 'shamanic healer'. We developed this scenario to reflect something on the more extreme and atypical end of the spectrum of approaches. The reference to vulnerable patients is in this para:Osteopaths should be aware that the consent of a patient does not, on its own, justify a treatment option. In a very small	No change made.

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	number of circumstances, treatment or care offered by an osteopath may be considered by the osteopathic profession not to have any possible benefit to a vulnerable patient. Osteopaths should always be able to provide a narrative to explain the benefits of the treatment offered to the patient. Such a narrative may, for example, take into account academic research or discussion with peers and will take into account a detailed account of the discussion It is correct to say that this could relate to any patient rather than a vulnerable one, specifically. This developed with a vulnerable one in mind to illustrate that someone may consent to things for various reasons, however, and that consent of itself does not mean that the osteopath might undertake an approach which would be regarded by peers or experts in that approach as being of no possible benefit in such circumstances.	

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These are very helpful and well described. They can give an overall idea of how to diversify different roles of a single clinician.		
These are helpful, but very descriptive	In making the scenarios quite descriptive, we were just trying to make them more engaging and illustrative. They could potentially be shortened, but might then lose their impact.	
Yes - The scenarios do not address scenarios in the NHS whereby the osteopath is providing a specific therapy at the direction of another clinician (usually the consultant), eg acupuncture or shockwave. This can lead to a conflict especially when the care pathway specifies that the patient cannot undergo treatment X until they have completed a course of treatment Y and either the patient or the osteopath does not want to continue the treatment (for clinical or non-clinical) reasons but feels they have to in order for the patient to gain access to the next step in the pathway. The osteopath is therefore in breach of OPS as regards partnering the patient, shared decision making, consent etc..	This is an extension of the issue raised above regarding NHS roles. In this case, the point is that there may be a clash between the expectations of the OPS and a particular NHS role. Again, the context would apply here, and the constraints of particular NHS pathways or roles can still coexist with shared decision making and patient partnership. The practitioner can still discuss care options, benefits and risks and what the patient can reasonably expect from them in that context and make a decision as to how to proceed. These may be different to the options available in independent practice, but that is beyond the osteopath's control in those circumstances. Presumably similar tensions	

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	arise in other NHS roles where there is a choice between NHS/Private care.	
osteopath is also a health and fitness professional (separately insured) such as a coach and is using their knowledge about the patient gained in the osteopathy setting to inform specific exercise programs, but the patient goal (eg complete a triathalon despite an Achille's tendinopathy) is not congruent with the osteopathic treatment program. The osteopath would have to discharge the client from both their osteopathy care AND their coaching care in order to satisfy the OPS as the osteopath cannot unlearn or unadvise the osteopathically informed management plan as well as continue to keep the coaching going, although in doing so they are facilitating the patient's coaching goals. (The fitness side is insured separately).	In whatever context, it would be about understanding what was important to the patient, explaining benefits and risks and reaching a shared decision as to how to proceed. The osteopath may give advice, but it would be for the patient to act on this or not, and their decision may be to ignore the advice. That does not, of itself mean that the osteopath must withdraw from treatment, and in the circumstances outlined here, there doesn't have to be a tension between the goals of osteopathy/coaching. Some patients will be able to or be prepared to rest from sports/occupations etc, and some may not. Osteopathic care is unlikely to be seen as conditional on a particular approach being undertaken as this scenario implies.	No change made.
If the Osteopaths have difficulty in deciding what might be more beneficial for the patient - is there anyone or any organisation that can help them unpick what might be 'very good' or may cause harm to the patient? Are there any	These are good points, but stray beyond the scope of the guidance – it's not about providing clinical advice or comparative evidence for different approaches, but about explaining the default position that	No change made.

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comparable guidance from different schools of alternative/complimentary therapies? Are all students taught about the issues that may arise from different types of work a professional therapist may undertake and the consequences of these types of work?	the OPS are applicable to the work of osteopaths, whatever form that takes.	
Yes - Guidance for treating animals as the OPS do not cover this and it is a practice used by many osteopaths	We take the point and recognise this is a relatively common aspect of osteopathic care, but have deliberately left it out as we do not regulate animal osteopathy. This is a legislation issue.	No change made.
The guidance steers a narrow course between useful guidance and standing the bl--ding obvious - which it is often necessary to do these days!		
When I qualified over 30 years ago it was commonplace to be studying with individuals who were already qualified in some aspect of health care but had decided to move towards a more 'holistic' approach. I myself came from a pharmacy background and I studied alongside nurses, doctors and massage therapists. There were few younger individuals straight from school. I'm sure the demographic has changed	We are not trying to apply restrictions on different therapy approaches, but rather to clarify how the OPS might apply to an osteopath in a variety of scenarios. We know many osteopaths undertake therapies that go beyond typical osteopathic practice, or are dual registered, and would not wish to adversely impact this. What we are saying	No change made.

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as a result of the increased profile of the profession generally. I found having professional diversity within the college setting and then in the profession helped to keep my thoughts on applying osteopathic principles open to different ideas and viewpoints. I'd hate to think that applying restrictions on different therapy approaches meant that we become to narrow minded as a profession.	is that osteopaths cannot assume the OPS will not apply should their professionalism be called into question in relation to such activity.	
Yes - It might be useful to provide scenarios of an osteopath who is also an educator, and a scenario of a non-practicing osteopath. Perhaps develop the nurse/osteopath scenario to include a concern in nursing eg incorrect medication administered but on the order of the consultant; a concern raised in her osteopathic practise where botox injections or a steroid injection of some kind is given to an osteopathic patient?	The expansion of the nurse one seems perhaps too detailed to include as suggested, but scope to reflect an educator role. Potential issue with botox issue and the legal constraints on being able to inject medications as a nurse, and this not then applying to her role as an osteopath.	No change made.
Yes - It may be helpful to discuss a scenario where for example the osteopath is a sportsperson, sent off during a match for causing the concussion/injury to another player. Subsequently the injured player raises a concern to the regulator…	This scenario may raise more questions than it answers – it's potentially more niche than the guidance is aimed aiming to be.	No change made.

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Yes - Suggest this needs to be an evolving piece of guidance and perhaps needs to take into account developments in regulation and other legislation eg Wray.	The guidance would be periodically reviewed as with all our guidance.	
Yes - More as a general issue around osteopaths who may be GOsC registrants in other countries where they may be criminalised because of a characteristic protected in the UK. Clarity on how the regulator should respond would be welcome.	Interesting point, but perhaps more detailed and technical than is required for a top level overview of the principles like this?	No change made.
Yes - In spite of the Equality Act 2010, there is still a great deal of ignorance around many of the protected characteristics including sexual orientation and especially the cultures which are part of the LGBTQ+ communities. Professional Standards set by regulators do not evidence that they have been developed looking through the lens of all the protected characteristics. Consequently, it is likely that there will be (unintended?) unfairness due to confirmation bias. In order to mitigate any perceived or actual unfairness, it might be helpful to have a panel	We will get input from EDI consultant/s	

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of volunteers who identify with the protected characteristics to review guidance / st		
age n/a disability need to be addressed gender reassignment need to be addressed marriage and civil partnership n/a pregnancy and maternity perhaps need to be explained what an osteopath can do race n/a religion or belief you can perhaps touch on choosing a clinician of same gender, chaperone, what to expect from an osteopath (body parts that can be exposed) sex n/a sexual orientation n/a	Not quite sure how this applies in this case?	
I think the case studies are really good and cover a whole range of 'other work' - however it would be good to specify what particular issues may need to be looked at in some details (you would only be able to do a few) Do you ask those who are registering as Osteopaths if they are doing or planning to do other types of work and if so can you tell them or alert them that the Osteopathic standards will apply what ever work one does; I am aware that for example nurses although working in hospitals can have their registration questioned if they are involved in car accidents	This is the guidance that we hope will do exactly this – explain that the OPS will apply whatever work one does as an osteopath. We would be reluctant to specify further as the list isn't exhaustive.	

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Creating an animated video. Unfortunately you can have a lot of guides, but how many people are you really reaching with them? Short key messages in a visual format are what people nowadays find more easy to engage with. Long text is not easy to digest for young people, older people, people with disability and learning difficulties.	This is a good point. Once the document is finalised, we can explore ways in which we can enhance its accessibility. We do use videos in explaining policy issues, and this could be considered.	We have not changed the draft in this respect, but will address accessibility as outlined in the EIA.
Yes - Suggest that it might be useful include a statement which unpacks (c) – I would like to see wording which is more collaborative eg "engaging and supporting". It would equally be helpful to have something around values and especially EDI.	Not sure in what context this is suggested	
Disabled people in general have a barrier on accessing this kind of info/guidance	This will apply across all our output and is a broader consideration that just this guidance.	
As discussed at consultation session, osteopaths must ensure that patients are aware of the difference between treating them as an osteopath and other therapies. As in the case of consent, this may be an ongoing conversation with patients so that they are fully aware of the manner in which they are being treated. In the	This touches on guidance within the OPS (A3 and A4) on providing information to patients and seeking informed consent.	We have suggested some additional wording to further address this issue.

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same way, when an osteopath treats another part of the patient's body, for good reason, s/he should make clear to the patient what s/he is doing and why. As ever, clear communication is key to the patient's understanding.		
The iO as the professional body who also provides insurance would want any possible insurance implications made clear.	Yes, but this isn't providing insurance advice – it's about the standards.	
Not sure - I think as long as patients are treated on individual basis and are given full understandable information, then I think this should cover all groups - I think the 'operative' word is 'understandable' information		
The clarity of the document makes things very clear to a public that is unfamiliar with osteopathy/healthcare/medicine		