Annex A to 12

General Osteopathic Council

Consultation analysis – Guidance on Osteopathic Pre-registration Education and Standards for Education and Training

Introduction

This report provides an overview of feedback received in relation to the consultation on updated Guidance on Osteopathic Pre-registration Education (GOPRE), and the introduction of new Standards for Education and Training (SET). Part A looks at the GOPRE feedback, gained through a range of focus groups and written responses. Themes arising are:

- General comments
- Osteopathic identity
- Techniques and approaches
- Evidence based/informed practice
- Research outcomes
- Leadership and management outcomes
- Education outcomes
- Clinic hours and experience
- Applicability to all work contexts
- Equality, diversity and inclusion

Activities undertaken

The consultation took place between 15 June and 22 September 2021 in accordance with a published consultation strategy[1]. Although the consultation period ended officially on 22 September, we continued to receive some responses in the weeks after this, and have included these within this report.

We also conducted a pilot process in relation to the annual reports required to be submitted by Osteopathic Educational Institutions (OEIs) in December 2021. In this, OEIs agreed to report against the draft SET, providing a narrative and evidence as to how they consider that they currently meet the draft standards. Feedback was sought in relation to this process which contributed to the final consultation process.

We held focus groups or attended meetings with a range of stakeholders and groups. These were:

- The Council of Osteopathic Educational Institutions (COEI)

[1] https://www.osteopathy.org.uk/news-and-resources/document-library/about-the-gosc/council-may-20201-public-item-12b-annex-b-consultation-strategy/

- The Osteopathic Alliance
- Patients
- Students
- Registration Assessors
- Educators
- Regional group leads
- Osteopaths who work in the NHS
- Health Education England

Five written responses were received in relation to the GOPRE consultation document (or aspects of this), plus feedback letters from two further Osteopathic Educational Institutions and from COEI.

Part A: GOPRE

We have evaluated the feedback received both in response to the specific consultation questions, and discussions from the various focus groups, and this is summarised in this section with examples of the notes made of meetings, or of written responses provided. Table A further summarises specific written responses received in relation to the questions in the published consultation document. Table A also includes comments in the right column by way of analysis and response to the issues raised where appropriate.

General feedback

The general feedback in relation to the draft GOPRE was positive – for example:

Draft documents broadly met their expectations, and it was felt that aims and objectives were clear and comprehensive. (Registration Assessor focus group)

Nice balance to allow for the flexibility which each institution will have in their processes (Educators focus group)

In the educator focus group, it was mentioned that '*the document is very positive for moving osteopaths into AHPs, really contemporary document and reflects the changes that institutions have made to align with this. Like how it acknowledges the use of social media in modern practice.'*

In the consultation document, we ask at the end whether there are any further comments generally regarding the draft. One said:

'*Yes - There has clearly been a lot of work put into the update. Congruency with the OPS is most welcome',* but added *'Generally the level of detail feels like it is becoming too specific, detracting from the general requirements. The density of detail will be a challenge for any inspection team to assess fully. Lastly, specifics may change, meaning the document has a more limited shelf life than would be hoped for.'*

A number of general comments about the document were discussed. One participant said that despite being 23 pages long they felt it was user friendly and welcomed the inclusion of URLs for further reading and reference documents. Another felt that there was nothing irrelevant in there, and that 'it covers all ends of the spectrum'.

Another participant said that the document represented a '*good job at compiling education and standards that includes all. It's hard to define an education that struggles with identity*.'

Another indicated that it '*is very positive for moving osteopaths into AHPs, really contemporary document and reflects the changes that institutions have made to align with this.'*

Also that there is a *'nice balance to allow for the flexibility which each institution will have in their processes'*

Another group indicated that the draft documents broadly met their expectations, and it was felt that aims and objectives were clear and comprehensive.

GOsC Comments:
It is reassuring that most felt that the draft GOPRE was a positive move forwards, bringing this up to date, and allowed for an appropriate balance between consistency and flexibility as seen within the different 'flavours' of education providers. Similarly, mention was made of this being a contemporary document that reflected the role of osteopaths as Allied Health Professionals. It was welcome, also, to hear that it seemed user-friendly.

The points about being over specific in some areas was noted, and arises further in relation to some of the themes below, and in response to the consultation questions (see Table A). This has been addressed in the updated draft in conjunction with the Stakeholder Reference Group, and agreed by the Policy and Education Committee (PEC).

There were a number of important cross cutting themes which arose through the consultation process which have been outlined at the outset of this analysis to provide context for the specific points outlined in the consultation.

Osteopathic Identity

Issue: What is osteopathy and is its nature and essence sufficiently incorporated into the document?

Differing views were expressed about whether there was too little or too much osteopathy in the document.

For example, one organisation raised particular concerns regarding the perceived reduction in the osteopathic nature of the outcomes, and the risk that the updated GOPRE outcomes represent a more generic document that dilutes the distinctiveness of osteopathic practice. One concern was that a new education provider, for example, might veer away from some of the key osteopathic concepts and yet still meet this set of more generic outcomes, undermining the distinctiveness of osteopathic philosophy and concepts.

Another point raised was that the GOPRE outcomes need to demonstrate clearly what it is to be an osteopath to guard against any potential changes to the regulation of the profession as a result of regulatory reform. This represented the view that GOsC should ensure GOPRE represents effective teaching of osteopathy, and should therefore not be too light on osteopathic content:

'We cannot emphasise the philosophy and principles underpinning osteopathic thinking clearly enough. If it is too wide and allowing, this document can be misinterpreted and applicable for other professions'

One felt that a lot of space had been devoted to leadership and research within the outcomes, to the detriment of osteopathic content.

The NHS osteopaths we spoke to had a slightly different view:

'I think it's great, focus on patient partnership which links with OPS and EDI, looks at graduating as an 'AHP' rather than just osteopath. It is a challenge to make it specific and at the same time appropriately ambiguous, this does it. Nothing that stops us doing the things that are wider than the document so that's appropriate.'

Patients had another perspective on this:

'……. what patients really want to know is how can an osteopath help them, they are not as concerned about the philosophy of osteopathy.'

Another response (regarding paragraphs 19-25) included: *'A comment about ensuring knowledge is contemporary would be helpful to avoid an over-reliance on AT Still and osteopathic texts dating back to the 1930s.'*

GOsC Comments:

The role for the regulator is to set the standards in accordance with which osteopaths must practice for patients. We have not defined osteopathic principles or philosophy in the document, and neither do we do this in the OPS.

It is for the profession itself to define itself and its identity for the benefit of itself. The regulator is not the judge of this discourse or a tool to promote one view over an alternative view: in other words, it is not for the regulator to reduce osteopathy to a particular perspective and to exclude other perspectives. It is open for the profession itself to define its identity, or identities through its various specialist organisations, professional organisations, colleges or others. This is particularly so because we know from debates within the profession, that there is no unified understanding of osteopathic principles, philosophy or their application in practice. From our updating of the OPS, we learned that many see traditional osteopathic principles as being central to their practice, whereas many others see them as being of historic interest at best, and of little relevance to their contemporary work as osteopaths. A recent article in the International Journal of Osteopathic Medicine[2], for example, provided an ableist critique of osteopathic principles and theory, contending that as a guide to practice, such theories are 'exclusionary, out-dated and harmful', and that 'without reconceptualization of these tenets and a deliberate change to the language used, osteopaths exclude and disadvantage disabled people, as seen by the underrepresentation of disabled people in UK osteopathy'.

Osteopathic concepts are referenced within the GOPRE outcomes, however, in relation to the Knowledge, Skills and Performance section, mirroring the updated (2019) OPS – for example:

[2] MacMillan, Andrew – *Osteopathic ableism: A critical disability view of traditional osteopathic theory in modern practice*, International Journal of Osteopathic Medicine 42 (2021) 56-60

19. The graduate will be able to do the following:
    a. Know and understand the key concepts and bodies of knowledge in order to be able to practise osteopathy, underpinned by osteopathic principles and appropriate guidelines. These key concepts include:
        i. osteopathic concepts of health, illness, disease and behaviours, and related psychological and sociological perspectives
        ii. normal and disordered human structure and function, anatomy, physiology, pathophysiology and pain mechanisms
        iii. relevant knowledge from clinical, biomedical and behavioural sciences to inform patient management
        iv. principles of a healthy lifestyle, and the effects of patients' life choices and lifestyles on their health and well-being
        v. an understanding of common medications and their clinical impacts and implications for osteopathic care
        vi. the context of osteopathy within the wider healthcare environment
        vii. the importance of diversity and individual values and an understanding of equality and anti-discrimination legislation within osteopathic care and how to apply this to practice
        viii. the impact of discrimination and health inequalities and how to explore context to provide better care for patients
        ix. the different settings and contexts within which osteopathic healthcare is provided including the knowledge and skills required to undertake remote and face to face consultations.
20. Understand osteopathic philosophy, principles and concepts of health, illness and disease and be able to apply these, critically, in the care of patients.

The Subject Benchmark Statement for Osteopathy developed by the Quality Assurance Agency (with stakeholder input), and which is currently under review, sets out in more detail a description of what are seen as osteopathic principles, and to contextualise an 'osteopathic' approach. The Benchmark Statement is not a regulatory one, however.

It is acknowledged therefore that underlying concepts and principles are important to many osteopaths, and inform their professional identity and long and successful careers. But it must also be acknowledged that these are open to interpretation, and that many equally successful careers are built on an approach that is less reverential to these underlying concepts.

As stated above, from a regulatory perspective, we are not looking to define osteopathic philosophy, principles, concepts or beliefs for the reasons outlined. We want to ensure that osteopaths meet the Osteopathic Practice Standards, and that graduates of recognised qualifications (RQs) are capable of doing this, and thus fit to join the register. This is why they are referenced in a way that reflects the requirements of the Osteopathic Practice Standards.

Conclusion/recommendation: We have not further strengthened or increased the reference to osteopathic principles and philosophy in the GOPRE outcomes. This is an important area of consideration, however, and we will seek to work with stakeholders to facilitate discussion in relation to professional identity. This was discussed with and

accepted by the Stakeholder Reference Group, and approved by the Policy and Committee.

Techniques and approaches

The key issue here is whether there should be a general list of techniques and approaches or should there be a more general approach articulated as suggested in the draft?

Some of the responses around the inclusion of reference to specific osteopathic approaches and techniques echo some of the issue in relation to osteopathic identity. In the current GOPRE, there is a list of 'osteopathic' approaches and techniques as set out in the WHO benchmark statement for osteopathy. These are included as examples of what *might* be included within an osteopathic education programme, rather than a requirement that they would be. The current list is:

> "a. diagnostic palpation (a clinical examination)
>
> b. direct techniques such as thrust, articulatory, muscle energy and general osteopathic techniques
>
> c. indirect techniques, including functional techniques and counterstrain
>
> d. balancing techniques, such as balanced ligamentous tension and ligamentous articulatory strain
>
> e. combined techniques, including myofascial/fascial release, Still technique, osteopathy in the cranial field, involuntary mechanism and visceral techniques
>
> f. reflex-based techniques, such as Chapman's reflexes, trigger points and neuromuscular techniques g. fluid-based techniques, such as lymphatic pump techniques."

We have suggested adapting this section, and having a more general description of what osteopathic intervention might comprise which would be more accessible to a range of stakeholders (prospective students, patients for example), but would not preclude providers from maintaining a broad approach to education incorporating a wide range of approaches as they do now. The amendment in the consultation draft was as follows:

> "Osteopathic approaches to treatment and patient management should include:
>
> a. working in partnership with the patient including listening to and understanding what matters to the patient

b. a range of manual techniques aimed at improving mobility and physiological function in tissues to enhance health and well-being and reduce pain

c. rehabilitation advice and guidance to facilitate self-management and enhance recovery d. provision of health information, guidance and signposting to resources to support patients' choices and decisions regarding their health and well-being."

This takes into account, also, some feedback from education providers in the development phase of the updated GOPRE, that some of the approaches listed in the current GOPRE were poorly evidenced and not typically included in undergraduate programmes.

In the consultation document, we asked whether this more general description of approaches to osteopathic treatment and patient management is appropriate and sufficient. Three of these five responses said 'yes'. One omitted this question, and one said 'no'.

We asked, also, whether the specific list of approaches as referenced in the current GOPRE should continue to be referenced. The responses were inconclusive, with one omitting this question, one undecided, one saying 'yes' but pointing out the list was not exhaustive, and one saying 'no'.

On respondent, however, suggested the following:

'It would be useful to specify a range of approaches without naming them. The proposed statement: A range of manual techniques aimed at improving mobility and physiological function in tissues to enhance health and well-being and reduce pain could be modified to: A range of direct and indirect manual techniques aimed at improving mobility and physiological function in tissues to enhance health and well-being and reduce pain'

This written response was echoed in a group discussion, where participants supported including greater reference to what osteopaths do, at least mentioning direct/indirect techniques. There was also a call for more reference to palpation, and that this should be taught '*scientifically and artistically*'.

We discussed the outcomes with a representative of Health Education England, specifically in relation to the challenges of demonstrating osteopaths' abilities to meet the requirements of NHS roles, should they want to. Challenges discussed include the parity between osteopaths and physiotherapists, and how this is demonstrated. Also, the scope of osteopathic practice and how this is perceived by potential employers. The reference to osteopathic ethos/philosophy can be off-putting for some employers who see this as claiming to treat conditions which they wouldn't do in the NHS.

Another group participant felt that it is hard to get the balance right taking into account individual beliefs, and though it can be a challenge to please all, the document has good representation across the board. Another queried how do you adapt GOPRE with so many modalities, and felt that osteopaths are not defined by the techniques they use – *'it is more about our adaptation and medical knowledge.*

So, in summary:

Arguments for techniques being specified: although there is no official definition of an 'osteopathic technique', there are some approaches and techniques that might typically be used by osteopaths. Some liked the list of possible techniques and approaches listed in the current GOPRE, as set out above, and these are consistent with the WHO Benchmark Statement for Osteopathy, even if they may not be included in curricula.

Arguments against techniques being specified: As mentioned above, there is no defined or unique 'osteopathic technique' – manual techniques/interventions are not owned by any profession, and might be employed by others working in a similar way. So, listing potential techniques as in the current GOPRE may not be particularly helpful – many within the profession may be unclear about the examples, and they may be confusing for those outside the profession, such as patients, other health care professionals or employers. It is proposed that the updated wording in the draft is clearer to stakeholders about what osteopaths actually do,

The suggestion of adding the term 'direct and indirect' techniques was made by more than one source. The benefit of referencing these may provide reassurance to those who wish to see this general description of types of osteopathic techniques reflected in the document without being overly specific as to what falls within these descriptions. The risk is that 'direct and indirect' may still not be particularly helpful or clear to those outside the profession.

GOsC comment

The options, then were to:

i. Reinstate the list of potential taught techniques as set out in the current GOPRE and mentioned above.
ii. Accept the proposed wording in the consultation draft.
iii. Revise the wording of the updated draft to reflect direct/indirect approaches:

"Osteopathic approaches to treatment and patient management should include:

a. working in partnership with the patient including listening to and understanding what matters to the patient

b. A range of direct and indirect manual techniques aimed at improving mobility and physiological function in tissues to enhance health and well-being and reduce pain'
c. rehabilitation advice and guidance to facilitate self-management and enhance recovery d. provision of health information, guidance and signposting to resources to support patients' choices and decisions regarding their health and well-being."

Recommendation: accept option (iii) as an appropriate compromise in balancing tensions between the potential audiences of the guidance. This was discussed with and accepted by the Stakeholder Reference Group, and agreed by the Policy and Education Committee.

Evidence based/informed practice

Issue: Should evidence based/informed practice be more specifically referenced and required or not? Or does such an approach exclude the effectiveness of techniques which may be effective for particular patients but may have a less strong evidence base?

Discussions in one focus group referenced evidence-based approaches to practice as being too reductive in relation to osteopathic work, though this was not widely reflected in responses to the consultation and other discussions. For example:

'there seems to be much too much reliance on existing evidence in OEI's, so effective treatment approaches are being ignored.'

'EBM (evidence based medicine) is notoriously reductive; the absence of evidence is not the same as the absence of effectiveness. One should aspire to find the evidence, and act on negative evidence, but there is a vast grey area of practice where evidence is not yet forthcoming, or is very difficult to measure…'

Concerns about evidence informed approaches were not raised by undergraduate educators, students or patients or in the written responses.

GOsC Comments

We have referenced this as a theme as it was raised by members of one of the groups, but in the broader sense, it was not a consistent issue of itself. We've mentioned the comment above regarding educational institutions 'relying too much on existing evidence', but this was not something mentioned as an issue by educators, students, patients or any of the other groups or respondents.

The outcomes expressed in GOPRE reflect the requirements of the OPS – in Safety and quality in practice, for example:

> 34. Develop and be able to apply an appropriate plan of care which will take into account their particular needs, for example, cultural or religious, in partnership with the patient, based on the working diagnosis, the best available evidence and their skills, experience and competence, which may include patient education, mobilisation, manipulation and exercise prescription, applying all practical skills with precision, adapting them when required to provide safe and effective care.

This equates with the definition of an evidence informed approach, references 'best available evidence', but also the patient's particular needs, partnership with the patient, and the skills, experience and competence of the osteopath. It is considered that this is an appropriate outcome which will ensure that graduates are able to meet the OPS in using a range of evidence to guide decision making in partnership with patients. The approach is consistent with NICE guidance[3] on shared decision making.

The specific research outcomes in the updated GOPRE also include:

> 28. Demonstrate an appropriate level of research understanding and delivery, which will include being able to:
>
> a. Use critically appraised evidence informed approaches and a range of sources of evidence to inform and address issues arising in practice.

Conclusion/Recommendation: We suggested no change in relation to this issue. The definition is sufficiently broad and in accordance with NICE guidance to avoid the concerns about reductionist approach as expressed under this theme. This was discussed with and accepted by the Stakeholder Reference Group, and agreed by the Policy and Education Committee.

Research

Issue: the expression and appropriate definition of research competences for osteopathic graduates.

The draft document now includes a set of outcomes related to research competences. Focus group discussions were generally supportive of these.

[3] Shared decision making | NICE guidelines | NICE guidance | Our programmes | What we do | About | NICE

One participant liked the integration of research and how to apply this into practice.

One participant queried the broad nature of the outcomes expected, and wondered whether these were more level 7 than level 6[4]. Another participant felt comfortable with this section and said it didn't raise any alarm bells.

The question of academic level in relation to research outcomes would be a significant one if it meant that students not studying at level 7 were disadvantaged. In discussions with Educational Institutions, the question of academic level of the research outcomes was raised, but not referenced further as a concern in specific responses from OEIs or from COEI. One OEI further responded:

[They] report overall agreement that the GOPRE outcomes can relate to both level 6 and level 7 outcomes.

We asked in the consultation document whether the research outcomes were felt to be clear and appropriate. Those who answered this question agreed they were clear, with just one wondering if they were completely appropriate (see Table A). One said:

Yes - It seems a good outcome for realising the tension between undergraduate needs and the needs of the profession in terms of research output. Students should absolutely not be expected to fulfil the profession's need for research output. Many have opted to study to be therapists and we should be mindful of that.

One OEI raised a point about whether the research outcomes as drafted would mean them having to reintroduce action research into the curriculum:

The Course Team took particular interest in Section 28, looking at the Research requirements for undergraduate students. With dual aims of improving student education and creating time to conduct research, the XXX revised our Research units to involve emphasis on critical appraisal of issues relevant to osteopathic practice and a reduction in primary data collection projects. These changes are similar to the AECC UC, Victoria University and Brighton University physiotherapy courses. Final year students conduct either a systematic Literature Review on a chosen topic or a Study Protocol for a primary data collection project presented in a format suitable for publication and aligned with GOsC CPD guidelines. We are considering whether the new GOPRE guidance allows for this or whether it will be necessary to reintroduce action research into the curriculum.

In order to further consider this point, we contacted the Chair of the Council for Allied Health Professions Research (CAHPR), who, in her former role as Director of the National Council for Osteopathic Research, had been instrumental in helping to shape

[4] There is no requirement for a Recognised Qualification to be Level 7, so outcomes should be applicable to level 6 as well. A comparison of the various academic levels is available here: https://www.gov.uk/what-different-qualification-levels-mean/list-of-qualification-levels

the draft research outcomes in GOPRE. It was not the intention of the research outcomes to force students to undertake primary research, necessarily, but to understand the processes that would be involved in this, and this seems consistent with the approach described by this education provider with less focus on primary data collection but an emphasis on critical appraisal of issues relevant to osteopathic practice.

We were interested in the CAHPR Chair perspective, however, in case there was ambiguity in the wording. Her thinking was that that the draft outcomes aligned with the curriculum change outlined by the education provider:

'I would say that Section 28 Explicitly states 'Demonstrate an appropriate level of research understanding and delivery.....In terms of delivery this also means to demonstrate an understanding of the delivery of research especially with patients. I would say it is not necessary deliver research with patients to understand the ethics and good clinical practice in doing so.'

GOsC comment

Most respondents were supportive of the inclusion of research outcomes which is consistent with those in other professions. Although there was some initial concern by educational institutions that the outcomes were all level 7, as mentioned, this was not pursued, and indeed, one of the institutions affected by the issue has on reflection confirmed that the outcomes can be appropriate for both level 6 and 7 students and so any potential disadvantage is not substantiated.

Conclusion:

The concept of research outcomes seems appropriate for the reasons outlined. It is considered that the minor amendments made to the draft are sufficient to clarify the aim of the outcomes (See also issues and minor edits suggested as set out in Table A, and in the updated draft GOPRE), and that it would not be necessary for OEIs to require 'action research'[5] to meet the outcomes. This was discussed with and agreed by the Stakeholder Reference Group, and agreed by the Policy and Education Committee.

[5] 'Action research' is term used to describe a specific type of research where you introduce a change into a setting/environment and then evaluate its impact on that environment and the people involved.

Leadership and Management outcomes

We included two options in relation to leadership and management outcomes, as explained within the consultation document. Option 1 reflected advanced practice frameworks in broader healthcare (developed by HEE), whereas Option 2 adapted these in a more osteopathic educational context.

We asked within the consultation document whether respondents felt such outcomes were appropriate, and which they preferred, and explored this with some of the groups too.

In the groups, responses indicated mixed views as to the preferred options for leadership and management outcomes. Educators tended to prefer Option 2 as being more representative of what a graduate should be able to do, whereas Option 1 seemed more postgraduate in nature, though one participant liked aspects of both. This preference for Option 2 was echoed in the student focus group. One regional osteopathic lead said that when hiring associates, they would be much more interested in recent graduates who could demonstrate the outcomes highlighted in Option 2.

In the written responses, all agreed that having leadership and management options was appropriate. Three out of five preferred option 2, with one (The Institute of Osteopathy) favouring option 1: as reflecting '*a wider context of practice which will be more relevant in the future healthcare model'*.

In a written response from an OEI, Option 2 was preferred:

The second consideration was the Leadership and Management section (27). The team preferred option 2 which seemed to focus more on the current needs and requirements of contemporary osteopathic practice. Option 1 although aspirational seemed to be more relevant to osteopaths working in large organizations which tends to form smaller proportion of osteopaths in practice. The course team also preferred option 2 in the education section (26). There was an acknowledgement of the benefit of both options, however it was felt that option 2 better reflected and prepared students for contemporary practice and the requirements of the new CPD scheme.

GOsC Comment

The Option 2 outcomes were most popular amongst participants and respondents. Only the Institute of Osteopathy preferred Option 1 in its entirety.

Conclusion

Recommendation to accept Option 2 Leadership and management outcomes as being more relevant to the undergraduate osteopathic context. This was discussed with and

accepted by the Stakeholder Reference Group, and is reflected in the updated draft and agreed by the Policy and Education Committee.

Education outcomes

The document contained similar options 1 and 2 in relation to the education outcomes, with Option 1 being based more on Advanced Practice frameworks, and Option 2 adapted more for the osteopathic context. When discussed in focus groups, the clear preference of participants expressed was for option 2, as being more suited to undergraduate outcomes for osteopathic students – the general feeling expressed was that option 1 outcomes related much more to advanced postgraduate practice

From the written responses, all agreed that having outcomes related to skills as educators was appropriate, with one commenting:

'Absolutely imperative that we foster team work which inherently needs practitioners to have educator skills even if it doesn't form the major party of their work. It's also a core skill to help patients self-manage problems ie we need to be able to educate our patients.'

The majority favoured Option 2 again as being clearer, more accessible and appropriate for undergraduate programmes:

'Option 2 - The language in option 2 is more accessible than option 1 and it allows a little more space for interpretation which I feel is necessary because rules that are too tight may have unintended consequence of preventing the development of programmes by erecting too many hurdles.'

'Option 2 - Option 1 is advanced – not expected to be advanced educators on graduation.'

The Institute of Osteopathy was the only respondent to favour Option 1, potentially because this reflects a wider context of practice which will be more relevant in the future healthcare.

GOsC Comments

As with the leadership and management options, Option 2 seems to be regarded as more relevant and accessible to an undergraduate osteopathic context.

Conclusion:

Recommendation to accept Option 2 education outcomes as being more relevant to the undergraduate osteopathic context. This was discussed with and accepted by the Stakeholder Reference Group and is reflected in the updated draft as agreed by the Policy and Education Committee.

Clinic hours and experience

It is a challenge to express a clinical requirement in a way that both provides assurance that graduates are sufficiently experienced, yet does not provide an unreasonable and onerous burden on education providers and students. We were keen to explore views on the outcomes in relation to clinic experience, especially the expectation of 1000 hours clinical experience, and the more flexible approach as to how clinical experience might be gained, as set out within the consultation document.

There is an argument about adhering to an outcomes-based approach rather than setting out an exact requirement as to clinical hours, and largely this is what we have aimed to do within GOPRE, but defining what this looks like in terms of clinical hours and numbers of patients seen can be helpful in putting undergraduate education in context (for example, in comparison to other AHP roles).

The key issues are whether there is a 'minimum' expectation to be required in order to demonstrate the breadth and depth of the outcomes or whether it is appropriate to have some flexibility to enable a focus on the quality or nature of the experience in order to demonstrate the outcomes?

Discussions in some focus groups explored the concept of quality as opposed to quantity in relation to clinical experience, with the point being that having a defined requirement of 1000 hours did not necessarily ensure that such hours were useful, and that it was more about the meeting of clinical outcomes, rather than meeting hours for their own sake.

One participant favoured an outcome-based approach rather than a set and rigid hour requirement, which was consistent with what other professional bodies say, and suggested it would be better to say that meeting the outcomes would probably equate to around a certain number of hours.

Some participants were confused by the reference to clinical experience equating to around 25% of the programme. Some interpreted this as meaning that only 25% of clinical hours should be dedicated to direct patient contact, rather than 25% of the whole programme, and questioned the usefulness of this statement. The 25% suggestion was originally proposed as an alternative to the specific 1,000 hours expectation, to allow a degree of flexibility within programmes which, perhaps, were

not typical in their delivery. This is picked up further with a suggestion to address the issue below.

One group discussed the value of placements in external/non-osteopathic clinics and that those hours should be counted towards the 1,000 hours requirement – though this would depend on the quality and management of such placements.

In the educators group, one participant acknowledged the challenges of balancing quality and quantity, and the usefulness of having a defined expectation of clinical experience:

'I can see why hours are used, it's easy and measurable all of the other areas we use to measure isn't as easy. My concern is that we have had to graduate students with less hours due to COVID and they are doing ok, what about the people who challenge that? You are holding me back but passed people last year with less? My concern is about the 1000 hours are just a guideline and what happens when we are challenged. I see the challenge of also removing a figure too.'

One questioned the way this is described:

'Shift in language maybe? Clinical exposure/clinical activity as a term perhaps instead? Isn't always direct contact with patients, it is a difficult one and more guidance is needed on it- what clinical exposure might look like would be welcomed. Things like peer discussions that would happen in clinic other than one on one patient treatment could help shape flexibility, ie how we can make up those 1000 work.'

Another indicated:

'We agree that there needs to be a means of quantifying clinical training to ensure public confidence in osteopathic training, but there should be a caveat in there that allows educators to use their professional judgement to make competence-based decisions for individual students if required.'

In the written responses, only one felt that the 1,000 hour expectation should not be maintained:

'No - This has been discussed at great length. Hours as a proxy for learning is just that – a proxy. Equally we have been told that when the original numbers were stated, they were simply 'made up'. To continue with this charade seems odd. Why 50 NPs? Why not 55, or 45?'

In discussions with the Council of Osteopathic Educational Institutions, some concern was raised regarding the 1,000 hour expectation and the potential this had to impact on the flexibility of osteopathic education delivery. The response received from COEI however, related more to the suggested reference to clinical hours as a percentatge of the programme:

'The only area of concern was around the wording of section 63 which could put the OEIs under pressure to deliver. Although there is an implication that it doesn't have to be direct contact, the wording perhaps is open to interpretation and so legal challenge by students about delivery. This in particular relates to the 25% direct clinical contact between the student and patient which could be seen as an individual requirement and is contrary to the style suggested of multiple clinical opportunities. An option might be to remove that line…'

This view was reflected in other written responses:

'I am entirely unsure if this is useful without looking at the hours spent learning across all the current UK courses. Is it on average 25%? Is this too onerous?'

'No - 1000 and 50 patients enough. Percentage is irrelevant as does this mean if modules increase then patient contact must increase too in order to stay at 25%?'

'No - I'm not really sure what this means. Direct patient contact to me would be students interfacing with a patient – so taking a case history or examining a patient or treating a patient. An undergrad MOst is usually 480 credits, so 4800hrs student effort. 25% is 1200hrs. I don't believe that any of our courses have students interacting – personally – with patients for this amount of time.'

An education provider responded:

'Our course team did identify some areas for further consideration. The first being section (63) concerning 1,000 hours of clinical practice. We see the need for a measureable figure to be attached to this but it was felt that clinical capability is better met through achieving specific outcomes and competencies, such as those identified in the draft GOPRE document rather, than focusing on a specific number of hours. A student attending 1000 clinic hours still may not meet the requirements to be a safe and competent osteopath whereas a student could meet or evidence meeting the requirements to be a safe and competent osteopath without needing 1000 hours specifically. This has been highlighted by the impact of the 2020 lockdown clinic closures, which resulted in students qualifying with less than the 1000 hours and finding that they were still ready for professional practice. We have spoken to a group of the graduates from last year and they are reporting no deficiencies in their preparedness. We are also aware that all of this being the case, and with evidence to support that the 1000 hours may not be necessary, we may be challenged in holding students back based on completed hours alone.'

We asked in the consultation document whether it would be helpful to have a more precise definition of how clinical experience and 'hours' could or should be met? Whether, for example, an hour in a teaching clinic taking the lead in the management of a patient and providing hands on treatment, may not be viewed as equivalent to an

hour in a simulated clinical setting, or observing on placement with another healthcare provider. Views were mixed, with two saying 'yes', and two saying 'no', but with a suggestion that it's more about defining how clinical experience may be gained. No particular suggestion was made as to what the definition of 'hour' should be, however. One suggested that perhaps stipulating a minimum of hands-on clinical experience within the clinic hours would be helpful, for example, 75%.

The sections within the 'Common presentations all osteopaths should be familiar with at graduation' were seen as positive and provided a good amount of depth: '*If OEIs can demonstrate that students can meet these requirements it would help to overcome the issue with quality versus quantity related to paragraph 63.'*

GOsC comment:

The challenge is to strike the right balance between specificity and flexibility and detail to ensure graduates are individually able to demonstrate the breadth and depth of outcomes but also ensuring consistency, parity and fairness.

We suggested (as suggested by COEI and others) reviewing the draft clause to remove reference to clinical hours as a percentage of the overall programme hours, and clarify expectations of hours and numbers of patients seen, for example, by referring to programmes as 'typically' including 1,000 hours of clinical practice, and 'typically' having seen fifty new patients.

The Policy and Education Committee, whilst approving some of the changes to this section in relation to how clinical experience might be obtained, were less keen on the 'typical' reference, and approved a revised wording, which is now shown in the final version:

62 *Graduates must have the opportunity to consolidate their clinical skills before graduation. In order to support this, pre-registration osteopathic education should include a minimum 1,000 hours of clinical practice, graduates should undertake a minimum of 1,000 hours of clinical practice, though what is important is the meeting of outcomes rather than just accumulating hours. The gaining of sufficient depth and breadth of experience may be achieved in a variety of ways, for example, through simulations involving actors, virtual and remote clinics, through observation and direct clinical interaction, placements with other osteopaths, health professionals or the NHS, as well as the provision of hands-on clinical care in the teaching clinic. Graduates should have seen around 50 new patients in order to include the presentations set out below. Graduates should also ensure that they have seen patients on repeated occasions to enable them to explore these presentations fully.*

In relation to the definition of a clinical hour, no definitive view emerged as to whether this needs to be more precisely expressed. We discussed with the Stakeholder Group whether there should be specific guidance that activities such as clinical placements or observations, for example, should count for fewer 'hours' than hands on patient experience? The consensus was that generally this specificity is not required, given that students are required to see around 50 new patients in any case, and meet the other GOPRE outcomes.

Applicability to all work contexts

In the focus groups, some views emerged about the applicability of updated GOPRE outcomes to support osteopaths to work in a diverse range of work contexts including on their own, with other osteopaths, in a multi-disciplinary context, the NHS and other contexts. This reflected the intent to ensure that the outcomes did not just equip osteopaths intending to work in private practice, but enabled osteopaths to access broader career pathways beginning to emerge within the NHS, for example, should they wish to do so.

A patient made the point that students should have an understanding of how the health system works even if they work in private practice as they will be asked to refer patients onwards – and they can't work in partnership with other health professionals if they don't understand how their local health economy works. For example, there will be a need to talk through treatment options with patients that could require a referral.

In terms of demonstrating osteopaths' readiness to work in broader roles, one participant felt that the profession needed to be more accessible to NHS roles and that there were barriers to this. These included that osteopathy is not massively visible to potential NHS employers. This is coupled also with the fact that there is a 'large supply pipeline' of physiotherapists joining the profession and taking up these roles. Another issue is that osteopaths are not 'socialised' in the language of the NHS and often don't even have the skills to know what it's like to work in an organisation. This means that even if they get interviews, they often aren't successful. In terms of the GOPRE document, it was asked whether this could be made more specific in signalling the NHS as a potential career destination, with two areas as being crucial:

1. Getting students into NHS placements
2. To get osteopath students working with other AHPs

The point was made, also, that although we reference advanced practice, we need to ensure that we make clear this isn't equipping graduates to claim they're advanced

practitioners. This is an issue in other professions too. Although the four pillars of advanced practice should run through the whole of practice life, it will be at a different level for novices to, say, those working at consultant level.

We spoke to two osteopaths working in NHS roles. Both indicated that it was good to see how GOPRE could prepare them for NHS work, and felt that this guidance would prepare someone for what is expected to succeed in the NHS.

'I think it's great, focus on patient partnership which links with OPS and EDI, looks at graduating as an 'AHP' rather than just osteopath. It is a challenge to make it specific and at the same time appropriately ambiguous, this does it. Nothing that stops us doing the things that are wider than the document so that's appropriate.'

One thing that was featured in their NHS roles, was a strong emphasis on 'personalised care', which isn't expressed in this way in GOPRE, though is not inconsistent with many aspects of osteopathic care.

GOsC comment:

It was helpful to hear from the NHS osteopaths who felt that the document was reflective of most of the skills they needed to work in the NHS.

In relation to the point regarding 'advanced practice', this is referenced in the context of the four pillars of advanced practice within the Option 1 leadership and management and education sections. As Option 2 is recommended in each case, then this issue is resolved as it makes clearer that the osteopathic graduates are not yet at advanced level – but are on that journey and have a foundation in those areas.

There is a potential tension in setting outcomes which reflect what is perceived as the distinctiveness of osteopathic practice, with its broader alignment with other allied health professions and NHS roles. The number of osteopaths working in the NHS is still relatively low (up to around 5%) but numbers and opportunities are growing and we are mindful of the fact that the outcomes should reflect this growing context, and certainly not inhibit such opportunities.

To Consider:

In order to reference the possibility of working in NHS roles and of osteopathy as an allied health profession, we have suggested adding NHS and AHP placements as an example of clinical experience in paragraph 63. The benefit of this is raising awareness of such options without making it an actual requirement. A potential disadvantage is for those who might see this as a dilution of osteopathic identity. That said, the NHS osteopaths that we spoke to still felt that they had an osteopathic professional identity and that this was welcomed and encouraged within their working environment.

We discussed this with the Stakeholder Reference Group, and the suggested reference to NHS and other placements was accepted, with the addition of 'osteopaths' as potential placement providers too, as reflected in the updated draft agreed by the Policy and Education Committee.

Equality diversity and inclusion

The expansion of EDI throughout the GOPRE document is broadly welcomed. A few issues emerged in discussion – one was the citing in the document of specific examples of EDI issues, for example, the reference to British Sign Language (BSL) in paragraph 10 (and elsewhere in the document). These specific aspects were suggested to be included by our equality and diversity consultant because it was suggested that by their very nature, including particular examples raises awareness of mechaisms for communicating that people might otherwise be unaware of rather than relying on an assumption that people are aware of different examples. Some queried whether this meant that students were expected to learn BSL, or wondered whether the inclusion of some examples inevitably excluded others. One pointed out that reference to BSL might exclude those for whom their sign language was not 'British'.

One participant suggested that it's more that graduates understand that patients have different needs, being aware and making reasonable adjustments (by asking the patients what they needed).

An educator said that GOPRE is written with an assumption that the osteopath is the one without any additional needs, and questioned if this needs considering? '*How we as an institution deliver the curriculum to meet the needs of others - need emphasizing? Excellent section on recruitment, do we need ore connection between these 2 areas?'*

We would expect that all osteopaths would demonstrate the same outcomes, but with reasonable adjustments made in terms of how these were met and this would be expected as part of the Standards for Education and Training rather than amendments to the outcomes themselves?

One participant suggested that the term 'protected characteristics' varies in definition throughout the GOPRE Document – it needs more continuity and to specify the Equality Act definitions. However, we recognise that the definitions of protected characteristics and the Equality legislation is the same in England, Wales and Scotland and similar but different in Northern Ireland.

In the consultation document, we asked if respondents think that these aspects of equality, diversity and inclusion are sufficiently represented within the outcomes. All

providing a response agreed that they were. Only one suggested further amendments, echoing some of the points raised in the focus groups:

'Yes - 17ciii includes the unhelpful specific communication styles – direct reference to these should be removed:

29 the reference to 'easy read' as a direct example should be removed.

49e the multitude of examples are not helpful.'

We asked in relation to the clinical outcomes section of GOPRE whether there were any additional points to be made, and one responded that '*there are a couple of sections that may raise student expectations beyond what can logistically and reasonably be accommodated.'*

They stated that *'Whilst we try to have some flexibility: in relation to clinical outcomes, educational providers should ensure that the resources available take account, proactively, of the diverse needs of students. (for example, the provision of plinths that can be operated electronically, the use of electronic notes as standard, rather than paper notes which are more difficult for students with visual impairments, availability of text to speech software, adaptations to clothing and shoe requirements to take account of the needs of students, published opportunities to adapt the timings of clinical sessions to take account of students' needs) seems excessive.*

GOsC comment:

Whilst the inclusion of more specific outcomes for graduates in relation to EDI issues was welcomed, the reference to examples of what this might include was not so broadly supported. These references were included as they were suggested by an EDI consultant, having seen the initial draft GOPRE:

'The draft includes a second 17.c., which concerns obtaining consent. While capacity to consent necessarily contains the concept of a binary construct (ability or lack of ability to consent), it would be helpful to emphasise the concept of reasonable adjustments to / flexibility in obtaining consent, for example through verbal, written and alternative formats, Sign language, Makaton, etc.'

Some found this confusing (several asked do students need to learn British Sign Language, for example) and this seemed to distract from the actual message.

For clarification, the examples cited are:

10. Osteopathic training providers equip osteopathic students for the demands of independent practice. This includes scientific and clinical knowledge, and clinical and

professional skills (including recording and reflection), underpinned by tailored communication (for example, British Sign Language or easy read formats)…..'

17.c..iii: demonstrating clear and effective communication skills including written, verbal and alternative formats (for example communicating via an interpreter, British Sign Language, Makaton, Easy Read and other formats, where helpful) to enhance patient care

Conclusion:

The examples were added at the suggestion of EDI consultants to try and explain what such measures might include. The critique from a number of respondents as to the repeated reference to these examples is noted, however. Our suggestion is to retain the examples, but in a more streamlined form - for example, mentioning some possible examples once, but publishing separate guidance/resources to support the effective implementation of these outcomes. This was discussed with and accepted by the Stakeholder Reference Group and is reflected in the updated draft as agreed by the Policy and Education Committee.

Other comments

Queries about the outcomes or suggestions for further additions included:

- No mention of first aid training in GOPRE. If osteopaths are entering private practice they should have first aid. Again – a general feeling that there should be first aid training for health care professionals.
- A student was confused by the intent of the final sentence which mentions 'putting the patient's interests before their own'. The student interpreted this as osteopaths must treat patients even when there is tension between the views of the practitioner and the patient – for example – a patient wants a particular treatment approach which the osteopath does not feel is appropriate.
- The GOPRE document is written in the third person, but should it be written in second person? This was just one respondent who felt it might be more personalised in the second person.
- Suggested that the term 'raise a complaint' has a very negative connotation/could be intimidating to students but that raising a concern has a less negative connotation. There should be a focus in GOPRE that these situations present an opportunity for learning and a chance to reflect on learning, as the term complaint almost precludes learning
- Paragraph 65.2: Confusion regarding the use of the term 'presenting complaint' as it is used in two ways in the document. One in which a person makes a

complaint about another person, but also a person presents with a complaint meaning a health problem. Suggestion: change to the word to 'condition'.

GOsC Comment:

In relation to First Aid training, this is not a requirement of joining or remaining on the register, but it is hard to argue that first aid knowledge and skills should be optional for health care practitioners. We raised this with the HCPC to see what other AHP programmes say regarding first aid, and this is from their basic proficiency standards for all 15 regulated professions:

be able to use basic life support skills and to deal safely with clinical emergencies

HCPC indicate that this is pitched as an output and at a level suitable to allow for flexibility in how curriculum is put together to deliver this through learning outcomes. Profession specific curriculum guidance produced by professional bodies will usually provide the next level of detail to inform provider approaches.

The General Chiropractic Council publish additional guidance on First Aid for chiropractors, putting this requirement in the context of their Code (the standards relating to chiropractic practice). This states:

It is a requirement of our educational programmes that students are trained to deal with medical emergencies. Thereafter it is important that chiropractors keep their knowledge and skills up to date. Evidence shows how quickly skills erode and how standard first aid training does not necessarily address the needs of a healthcare professional.

See below (and the draft) for a suggestion regarding this.

In relation to the third person style of the document, this continues the current style of the GOPRE document, and acknowledges that not all those reading it will be osteopaths.

In terms of the reference to 'presenting complaint' in the 'common components of consultations' section, this is not unusual language within the profession, but the point is noted - see point for consideration below.

To consider:

We have discussed with the Stakeholder Group adding an outcome regarding first aid/medical emergencies, for example:

Demonstrate an understanding of the principles and application of first-aid and take appropriate action in the event of a medical emergency.'

Although the usefulness of first aid was accepted, there were mixed views as to whether this should be added. COEI followed up with a further response:

"Given that it is not reflective of the OPS, OEIs have very different practices relating to the timing and extent of first-aid training, or if they provide it at all. Therefore, introducing first-aid in the documentation at this stage presents significant implications for OEIs that have not been discussed or evaluated."

It's not entirely correct to say that first aid is not referenced within the Osteopathic Practice Standards. Standard C5 states that *You must ensure your practice is safe, clean and hygienic, and complies with health and safety legislation*. The guidance to C5 includes: *You must ensure that you have appropriate procedures in place in the event of a medical emergency*.

The paragraph suggested above was retained in the draft approved by the Policy and Education Committee, and very much welcomed.

In 'Common components of consultations', we suggested changing reference to presenting complaint to 'presenting 'symptoms' or 'patient's concerns'?

'Complaint' as terminology is firmly embedded in healthcare language, but that does not mean that we cannot review its use, and choose something more appropriate[6]. Referencing a patient's complaint implies they are 'complaining', rather than telling you about something concerning or troubling them. Referencing symptoms seems also less 'ableist' when considered in the context of patients with underlying long-term conditions or disabilities. This was accepted by the Stakeholder Reference Group and reflected in the updated draft as agreed by the Policy and Education Committee.

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4507913/

Part B: Standards for Education and Training

We will report here on key issues discussed or arising in relation to the draft themes of the SET. A further summary of the written responses made in relation to the specific consultation document is included as Table B.

General

General feedback on the draft standards was positive, and the development of specific standards for osteopathic education was welcomed. A few general issues raised in group discussions included:

SET contained all the elements they expected to see.

Students welcomed the development of osteopathic education-specific SET.

A student strongly suggested that there should be a reference to 'high quality education' within the standards.

In response to a question with regard to the stem phrase 'Education providers must', one respondent said:

'No - Whilst there is mention of innovation at one point, by using 'must' there is really no room for development. Should seems a better option.'

Others, however felt 'must' was appropriate:

'Yes - Education providers must demonstrate that their course meets regulator/professional body/students expectations. Quality assurance key.'

GOsC Comment:

The suggestion to there being a reference to 'high quality' education is interesting. In a sense, the standards demonstrate what this should actually be, so it could be argued that there is no need to specify 'high' quality, as this is implied if all (minimum) standards are being met.

In terms of the stem phrase 'Education providers must', there was only one suggesting 'should' would be better. The standards were developed to support consistency and ensure minimum standards required for delivery, and therefore having flexibility as to whether these 'must' or 'should' be met would not, on the face of it, be consistent with this. That said, we would not want to impair reflective reporting from education providers where they, perhaps, consider that there is work to do to better meet a standard.

Recommendation:
To retain the stem phrase 'Education providers must'. This was accepted by the Stakeholder Reference Group and agreed by the Policy and Education Committee.

Programme design, delivery and assessment

There were no specific comments raised about the standards within group discussions.

In written responses, a range of issues were raised. In relation to the reference to EDI issues, one respondent indicated:

'Whilst the intention is laudable, by specifying including all outcomes including effectiveness in teaching students about health inequalities and the non-biased treatment of diverse patients this seems to suggest that this is more important that anything else - so more important for example than safe and effective treatment.'

One also pointed out: *'No, assurance that the institution itself advertises/ensures EDI with its own staff/practices'.*

Full details of written responses are set out in Table B

GOsC comment

This is the paragraph referred to above regarding health inequalities:

'the programme designed and delivered reflects the skills, knowledge base, attitudes and values, set out in the Guidance for Pre-registration Osteopathic Education (including all outcomes including effectiveness in teaching students about health inequalities and the non-biased treatment of diverse patients)'

It is not considered that this prioritises a knowledge of health inequalities over the delivery of safe and effective care, as the full range of outcomes in GOPRE are clearly mentioned first. The wording in brackets clarifies that this should include a knowledge of health inequalities and diversity issues, however, which permeates the approach to clinical care.

1.ix refers to educators teaching osteopathic content or supervising clinical experience should be GOsC registered. This is also repeated in relation to Staff support and development and in that context about this being limiting in the context of providing multi-disciplinary learning opportunities or placements. We have suggested a revision of the wording as follows:

subject areas are delivered by educators with relevant and appropriate knowledge and expertise. Those teaching osteopathic content or supervising in teaching clinics, remote clinics or other clinical interactions must be registered with the GOsC or with another UK statutory health care regulator if appropriate to the provision of diverse education

The intention here is not to dilute the osteopathic content of programmes or educators, but to facilitate an element of multi-disciplinary learning and the possibility, for example, of placements with other AHPs or specialist clinic.

Recommendation

Our recommendation was to retain the wording as drafted above regarding health inequalities and non-biased treatment of diverse patients, and to consider the wording of 1.iX in relation to the requirement to be GOsC registered as suggested above. These were discussed with and accepted by the Stakeholder Reference Group and agreed by the Policy and Education Committee.

Programme governance, leadership and management

No particular issues were raised in relation to this section, which seemed to be accepted as drafted.

Learning culture

Again, there was a general acceptance of the standards in this section, with respondents and participants happy with the content.

Quality evaluation, review and assurance

Comments in relation to this section included:

'Should there be a stated time for a review period – it is stated 'reviewed regularly to ensure they are kept up to date'.'

GOsC Comment:

In relation to the reference above to specifying a review period, this is what is said in the draft SET:

4.iii there is an effective management structure, and that relevant and appropriate policies and procedures are in place and kept up to date.

It is not considered that specifying a time period would necessarily add value to this, as this would be implied within the existing wording. 'Keeping up to date' would suggest a regular review cycle within the provider's QA mechanisms.

Recommendation

To retain the wording of 4iii as drafted – accepted by the Stakeholder Reference Group, and agreed by the Policy and Education Committee.

Resources

One respondent commented on 5iv:

'5iv: is it necessary for a non-campus OEI provider to be required to provide places for students to meet privately? How private do they need to be?'

In relation to the reference to 'diverse' in this theme, the following comment was raised:

'Regarding 'diverse' should it be more specific around cultural aspect?'

GOsC comment:

'Diverse' is referenced in 5iii and 5iv:

5iii: in relation to clinical outcomes, educational providers should ensure that the resources available take account, proactively, of the diverse needs of students. (examples are then given)

5iv: there is sufficient provision in the educational provider to account for the diverse needs of students, for example, there should be arrangements for mothers to express and store breastmilk and space to pray in private areas and places for students to meet privately

In relation to the provision of private spaces, the intent here was not to place an onerous requirement on providers, nor to ignore the fact that the context of osteopathic education is varied across the sector. It's more about ensuring a space suitable for the particular need, within the constraints of the particular provider. In that sense, we would suggest it's not necessary to define the degree of privacy.

As to the cultural aspects of diversity, the references are to the diverse needs of students, which would cover any needs arising through particular characteristics. We can consider the range of examples given as to whether these are representative enough.

Recommendation:

To retain the reference to 'diverse needs of students' as drafted, but to consider whether the examples given are sufficiently broad to reference cultural needs. This was discussed with the Stakeholder Reference Group and the wording as drafted accepted, and agreed by the Policy and Education Committee.

Students

No particular issues were raised in relation to the standards within the 'Students' theme.

Clinical experience

In this section, one group participant raised the following in relation to 7.i: that the way this is written currently may lead students to expect to be offered to attend clinics virtually rather than face-to-face.

In written responses, one respondent thought this was fine, but suggested perhaps stipulate a minimum face to face contact – maybe 75% of clinic time?

One, however queried the need to mention other forms of clinical experience: *'Why is there a requirement to provide simulation, virtual & remote clinics?'*

GOsC comment:

There are just two standards in this theme:

i. *clinical experience is provided through a variety of mechanisms including face to face, through simulation (for example using actors), through virtual and remote clinics and ensuring different patient groups (a range of settings should also be offered, if available)*
ii. *there are effective means of ensuring that students gain sufficient access to the clinical experience required to develop and integrate their knowledge and skills, and meet the programme outcomes, in order to sufficiently be able to deliver the Osteopathic Practice Standards.*

Conclusion:

In relation to 7.i there was a suggestion to refer to a minimum amount of face-to-face clinical contact. This was also referenced in relation to the GOPRE clinical hour outcomes. It may be sufficient to stipulate the outcome requirements in GOPRE, and to refer to that here in standards. For example:

clinical experience is provided through a variety of mechanisms to ensure that students are able to meet the clinical outcomes set out in the Guidance on Pre-registration Osteopathic Education. ~~including face to face, through simulation (for example using actors), through virtual and remote clinics, and placements, and ensuring different patient groups (a range of settings should also be offered, if available)~~

Given the discussions in relation to the GOPRE clinical outcomes, the Stakeholder Group accepted the suggested redraft above, and this is reflected in the updated draft as agreed by the Policy and Education Committee.

Staff support and development

This section drew some comment in group discussion and in written responses. This was largely favourable:

'Importance of staff development, really a key/important area - acquiring teaching knowledge, this could do with being more detailed. Overall really impressed.'

'Staff dev and training: regarding safeguarding of teaching team, some specific guidance on how they can be upskilled and supported as they are essential, for clinic tutors on zero hours.'

One thought that the requirement to have a teaching qualification might limit the use of guest lecturers:

'This will exclude guest speakers and limits possible interprofessional input. For example the consultant rheumatologist who delivers a differential diagnosis session does not meet the above, but offers an invaluable insight into this specialism. She has worked in research and clinical practice, but does not have an educational qualification - nor would we expect her to be working towards one.'

One said: it would seem appropriate to state what recent means i.e. give a time period.

Another highlighted a potential limitation in requiring all clinical tutors to be GOsC registered (as opposed to being registered with another healthcare regulator):

'Part ix requires those supervising "other clinical interactions" to be on the GOsC register. It was felt this could discourage future interprofessional student placements such as those within non-osteopathic settings (GP practices, NHS etc.); as the supervising clinician may be from another health profession and thus not registered with GOsC.'

This was also reflected in some of the group discussions:

'key things, we need to encourage that mutual respect between other health professionals, we can't say that no one other than an osteopath can teach. It would be a really good thing to have other AHPs contributing to the clinical side of things in there. It should be about, can they show they have the skills? That's how we would like to be seen with other AHPs'

'The more professionals that we can Involve in the training of osteopaths, that only stands to improve the standards of our profession.'

'The general consensus was that restricting educators to only those on the GOsC Register was not a positive move. Registration Assessors felt that it would be beneficial for students to have exposure to other medical disciplines in order to appreciate what

they can offer patients. The text they suggested instead was 'must be on the GOsC Register/or a registered health professional.'

Students were concerned at the requirement that educators teaching osteopathic content must be on the GOsC Register. They suggested that this meant retired osteopaths with lots of experience would be unable to teach and that knowledge would not be able to be shared with students. In that context we discussed, also, the possibility of clinical supervision from registered healthcare practitioners who might not be osteopaths – a physiotherapist, for example, and the group saw the advantage in aspects of multidisciplinary approaches – for example, a specialist post-surgery rehab clinic, provided the osteopathy wasn't lost.

GOsC comment:

In relation to being on the GOsC register, this is what the consultation draft stated:

there are sufficient numbers of experienced educators with the capacity to teach, assess and support the delivery of the recognised qualification (those teaching practical osteopathic skills and theory, or acting as clinical or practice educators, must be registered with the General Osteopathic Council)

The consensus amongst respondents and group participants was that this should be expanded to:

there are sufficient numbers of experienced educators with the capacity to teach, assess and support the delivery of the recognised qualification (those teaching practical osteopathic skills and theory, or acting as clinical or practice educators, must be registered with the General Osteopathic Council or with another UK statutory health care regulator if appropriate to the provision of diverse education opportunities)

As mentioned in relation to Programme delivery above, this would not be intended as a means of replacing osteopathic educators with other professions, but to acknowledge that there may be some circumstances when the expertise of another registered health care professional might provide helpful learning – for example, a clinic focused on post-surgical rehab. It would also allow for the supervision of osteopathic students by other professionals on placements, should they occur. The supervisor in practical classes or clinical sessions will have clinical responsibility, and therefore needs to be registered.

In relation to educators being qualified – 'educators either have a teaching qualification, or are working towards this, or have relevant and recent teaching experience.', then this does not preclude guest lecturers with particular skills being engaged. Nor does it, in fact insist that all have a teaching qualification or be working

towards this if they have relevant and recent teaching experience, so it is considered that the provides sufficient flexibility for providers.

As to defining what 'recent' meant in this context, we would not seek to be overly prescriptive and would suggest leaving this to the discretion of the education provider.

Conclusion:

We discussed the additional wording as outlined above with the Stakeholder Reference Group, and this was accepted, and is reflected within the updated draft.

In relation to educators having or working towards an education qualification or having relevant and recent experience, the Stakeholder Group agreed to retain the wording as drafted.

This was agreed by the Policy and Education Committee.

Patients

In relation to the 'patients' theme, one respondent questioned the reference to the availability of 'psychological support':

'Whilst the bio-psychosocial model infers an awareness and inclusion of the psychological domain in diagnosis, it seems a stretch to suggest that student osteopaths are qualified to provide psychological support. I wonder if the BPS or BACP have an opinion on this?'

Another respondent queried whether there should be reference made to safeguarding in this section.

GOsC comment:

The psychological support reference is in this paragraph:

patients are able to access and discuss advice, guidance, psychological support, self-management, exercise, rehabilitation and lifestyle guidance in osteopathic care which takes into account their particular needs and preferences.

Conclusion:

This was not drafted with the intention of specifying a particular psychological intervention or expanding into psychological therapies, but more to cover strategies

and approaches other than manual intervention which might help patients to cope with their symptoms and conditions. This could include things like mindfulness and acceptance in the case of chronic pain patients, for example. Would it be better to delete the word 'psychological'? we considered this with the Stakeholder Group, and the feeling was that reference to 'phycological' in this context did add some value.

In relation to safeguarding, we discussed adding a further standard:

Effective safeguarding policies are developed and implemented to ensure that action is taken when necessary to keep patients from harm, and that staff and students are aware of these and supported in taking action when necessary.

The consensus was that this would be a helpful addition to the Patients theme, and it is included in the updated draft, as agreed by the Policy and Education Committee.

Annex A to 12

Table A – summary of written responses to GOPRE consultation with commentary

Question	Summary of responses	Comment
1. Does the Introduction section, with the changes summarised above, set the context of the guidance and of osteopathic practice sufficiently?	Considered it useful to add reference to 'clinical assessment' here and suggested that 'osteopathic evaluation/assessment' could be added. It would be useful also to add about formulating and delivering a treatment plan (this would be consistent with later mention of a treatment plan in point 32). The importance of treatment plans has been highlighted in the past by insurers to avoid excessive treatment without appropriate onward referral in the event of lack of positive outcomes/treatment progress. No - Para 8 would benefit from some reference to osteopathy. For example the sentence could read:This includes being able to take and record a patient's case history and to undertake an appropriate clinical osteopathic assessment… 9. Would it be useful to introduce the concept of goal setting by patients as an example. Patients and clinicians could then discuss what are realistic and unrealistic goals which could, in turn, help to manage patients' expectations. 10. Independent practice is mentioned. Although this may include the largest proportion of osteopaths do, we need to consider also osteopaths who work in the NHS, occupational health or some other format for care delivery.	Paragraph 8 in the consultation draft was: *Osteopaths must be capable of taking full clinical responsibility for, and working in partnership with their patients. This includes being able to take and record a patient's case history and to undertake an appropriate clinical assessment, formulate an appropriate working diagnosis or rationale for care in the context of potential prognosis, and explain this clearly to the patient to support discussion of treatment options. It also includes recognising and working within the limits of their own training and competence as a practitioner and providing appropriate treatment and care, referring to another healthcare professional when required and crucially, putting the patient's interests before their own.* The reference to 'clinical assessment' mirrors that of Standard C1.1.2 guidance of the OPS. Standard C1 itself refers to the conduct of 'an osteopathic patient evaluation'. The risk is that by adding references to 'osteopathic assessment', the breadth of the outcome is obscured

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	Para10 is not improved by the inclusions of specific examples. This may actually raise false expectations in readers. 11. I would add geographical constraints to this list also. It would be useful to add a sentence about the importance of belonging to or creating their own community of practice. This could be face-to-face but could easily be via electronic media (Zoom/Skype/Teams) or a hybrid of the two. Para 11: again, whilst setting out examples might seem helpful, they quickly date – whereas more generic statements are more likely to accommodate future developments. Yes - Further on from the work with HEE and with the iO project evolving careers there may be a proposal for an addition of a higher level of education in leadership to match the level that osteopaths qualify at, with NHS opportunities for entry above level 6 (as osteopaths do a Masters level qualification).	to those outside the profession who do not know what this is. References to geographical constraints and communities of practice in is reflected in the updated draft.
2. Do you think that the outcomes in this theme sufficiently reflect the communication skills required to facilitate effective patient partnerships, that take patients' preferences and values into account?	17. Could you add a link about protected characteristics to be clear about all of the items this includes e.g. https://www.equalityhumanrights.com/en/equality-act/protected-characteristics. Yes - Although it is useful to have the skills for remote consultations embedded in the programme	These points were considered by the Stakeholder Reference Group.

Question	Summary of responses	Comment
	delivery ensuring graduates have accessed these skills at that point, it may not be possible for all osteopaths in private practice, once graduated, to provide that service. During this current situation (COVID 19 2020-2021) it also evident that many patients are accessing osteopaths because they do not want remote consultations! Yes - 17ciii repeats the unhelpful specific communication styles. Two other respondents answered 'yes'.	
3. Do you think there is anything missing from the proposed outcomes in relation to Theme A of the Osteopathic Practice Standards 'Communication and patient partnership'?	A suggested addition to this section would be about communication about patients electronically, and what information is and is not appropriate to include in an email. A reminder about not forwarding patients' emails without permission would be useful also. Yes - Unsure if there should be some reference to listening in the section, although this is acknowledged later in Q32? Three other respondents answered 'no'.	The point regarding emails is noted but these outcomes reference the OPS standards and guidance, and we have tried to keep them aligned.
4. Do you have any other comments in relation to this Communication and patient partnership section?	18. Add "and patients" after "their practice". Yes - c iii. I like the wording "in a way they can understand" used in OPS - A couple of other points that may be included:Not allowing your own beliefs and values to override patients (touched on in paragraph 36 – Safety and Quality of Practice) and Respect modesty Three others stated 'no'.	Considered by the Stakeholder Reference Group and reflected in the updated draft to ensure alignment with OPS.

Question	Summary of responses	Comment
5. Do the outcomes in paragraphs 19-25 of the guidance sufficiently set out the knowledge and skills required by graduates to support their work as osteopaths?	A comment about ensuring knowledge is contemporary would be helpful to avoid an over-reliance on AT Still and osteopathic texts dating back to the 1930s. Four other respondents answered 'yes'.	There was also some repetition in this section which has been addressed in the updated draft.
6. In paragraphs 19(i) and 20, we have retained reference to 'osteopathic' concepts of health, illness, disease and behaviours...'. Some initial feedback in developing the draft suggested that the word 'osteopathic' was not needed here. Others felt it important to emphasise a distinct 'osteopathic' flavour to these outcomes. Do you think that the reference to 'osteopathic' concepts in this context should be retained?	9. iv. Perhaps lifestyle for health and wellbeing is more suitable than just "healthy lifestyle". Raising awareness about public health interventions might also be useful here as well as appearing later in the text. A reference to Making Every Contact Counts might be useful (https://www.makingeverycontactcount.co.uk/). Yes - It is important to osteopaths to have this specified as a comment that is oft made is that if osteopaths are taken into an MDT, for example, they do not wish to lose their 'identity'. Yes - At this point in time, I do think it needs inclusion. If we believe osteopathy holds some specific therapeutic characteristic distinct from other disciplines then it should be kept. It may be that this changes over time and hence the need for these updates/reviews. Yes - 19 a i. osteopath not required as already stated in introductory paragraph. 23. suggest add … "reflect upon" and enhance their practice….	The osteopathic references tread a balance between ensuring the key elements of osteopathic identity are maintained, but not holding back osteopaths from broader healthcare roles. Reference to 'philosophy and principles' are maintained in the outcomes, but are not understood outside of the profession. In relation to public health interventions and advice, this is covered later under Safety and Quality, as it aligns to OPS C6.

Question	Summary of responses	Comment
	Yes - If the word 'osteopathic' is not included, there is nothing to differentiate these standards from any other manual therapy.	
7. Do you agree with the inclusion of outcomes relating to skills as educators within the GOPRE outcomes?	Yes - Absolutely imperative that we foster team work which inherently needs practitioners to have educator skills even if it doesn't form the major party of their work. It's also a core skill to help patients self-manage problems ie we need to be able to educate our patients. Three others agreed 'yes'.	
8. Which option do you prefer?	Option 1 Option 2 - The language in option 2 is more accessible than option 1 and it allows a little more space for interpretation which I feel is necessary because rules that are too tight may have unintended consequence of preventing the development of programmes by erecting too many hurdles. Option 2 - Option 1 is advanced – not expected to be advanced educators on graduation. 11 in introduction states time of transition and intensive learning. Option 2 - There are some inconsistencies with the grammar, remediation of which would be helpful to improve clarity.	The majority of respondents favoured Option 2, and this is reflected in the updated draft.
9. Would you suggest any changes to your preferred option?	Yes - It could be further streamlined. There is also a missed opportunity to include the concept of mentorship, and suggest that students are able to	Mentorship has been referenced within the updated draft.

Question	Summary of responses	Comment
	consider the value of and engage in mentorship, initially as a mentee, but with scope for becoming a mentor. Two others answered 'no'.	
10. Do you agree with the inclusion of outcomes relating to leadership and management within the GOPRE?	27. Leadership and management. Options 1 and 2, suggested amendments: Evaluate and undertake clinical audit Plus four just answered 'yes'.	Again, Option 2 leadership and management outcomes were more favourably received, and this is reflected in the updated draft.
11. Which option do you prefer?	Option 1 - Option reflects a wider context of practice which will be more relevant in the future healthcare model Option 2 - : It reflects my option 2 preference for educator skills above. The language is a little more accessible and allows interpretation. We must be careful not to shift the focus of programmes too far from the patient care core work. These skills can be developed further at post-grad level. Programmes are already very full curricula; let's not fill it even more! Option 2 - Option 1 is advanced – not expected to be leaders on graduation. 11 in introduction states time of transition and intensive learning Option 2	
12. Would you suggest any changes to your preferred option?	Yes - Must reference a sole practitioner more explicitly No	The references to what comprises leadership are noted, but the draft outcomes were developed from outcomes specifically related to leadership activity.

Question	Summary of responses	Comment
	Yes - Again this could be further streamlined. Many of the points seem to relate to self-evaluation, reflection & feedback which is not really leadership – these sit better with education.The actual outcomes required are probably more along the lines of: students should be able to:Understand the concepts of leadership and followership, and be able to use this knowledge to enhance team work, including conflict resolution. AND Step into a leadership role in patient care when situationally relevant.	
13. Do you consider the research outcomes to be clear and appropriate for undergraduate osteopathic education?	Yes - It seems a good outcome for realising the tension between undergraduate needs and the needs of the profession in terms of research output. Students should absolutely not be expected to fulfil the profession's need for research output. Many have opted to study to be therapists and we should be mindful of that. Yes - These could be streamlined. Again it is the outcome that is important – are students sufficiently prepared to be able to read, understand and critique research (whether qualitative or quantitative), and do they understand the processes & procedures including ethical and consent issues. Two more 'yes' The XXX Course Team took particular interest in Section 28, looking at the Research requirements for undergraduate students. With dual aims of improving student education and creating time to conduct research, the XXX revised our Research units to involve emphasis on critical appraisal of	General support for these outcomes subject to the comments in the next questions. The issue in relation to having to re-introduce action research into the curriculum was not the specific intention of the outcomes as drafted. We have sought clarification from the former NCOR chair on this issue (the proposer of the outcomes) and who considers that the approach described by this OEI is consistent with the outcomes as drafted.

Question	Summary of responses	Comment
	issues relevant to osteopathic practice and a reduction in primary data collection projects. These changes are similar to the AECC UC, Victoria University and Brighton University physiotherapy courses. Final year XXX students conduct either a systematic Literature Review on a chosen topic or a Study Protocol for a primary data collection project presented in a format suitable for publication and aligned with GOsC CPD guidelines. We are considering whether the new GOPRE guidance allows for this or whether it will be necessary to reintroduce action research into the curriculum. Section 28d. requires students to be able to understand and use technical research language which allows a very wide interpretation and 28j. refers to an understanding of ethics and governance aprocal procedures in relation to staring and delivering research. These elements remain a part of the XXX M.Ost but the extent to which these are taught is tailored to the work the students do.	
14. Do you think there is anything missing from the proposed research outcomes?	Yes - In l it mentions clinical practice. In section j it is mentioned about ethics in research. Should ethics be added in relation to good clinical practice in relation to direct patient/participant care? Three said 'no'.	Considered by Stakeholder Group, but original wording retained.
15. Do you think any of the proposed research outcomes are inappropriate or require amendment?	Add as (a) "be able to critically appraise evidence and evaluate its quality and appropriateness to apply to clinical practise. c) Research evaluation should be service evaluation.	These suggestions are reflected in the updated draft.

Question	Summary of responses	Comment
	f). Suggest "understand outcome measurement in the context of clinical practice and research projects" Yes - These could be streamlined. Again it is the outcome that is important – are students sufficiently prepared to be able to read, understand and critique research (whether qualitative or quantitative), and do they understand the processes & procedures including ethical and consent issues. Three others said 'no'.	
16. Do you think that a more specific outcome in relation to business skills and knowledge should be included within GOPRE?	No - It is acknowledged that graduates may lack information around business skills, and the iO with GOsC is looking into this so this may have to be altered in the future. Yes - I think this is a very tricky area and agree with the comments in the summary box above but this area is one where undergraduate student feedback is generally that they feel let down buy the programmes offerings with regard to business skills. This might also go for retirement planning, sickness insurance etc etc. Where we have a profession which is currently mostly self-employed perhaps there should be something specified by GOPRE? Students pay a lot of money to train and it could be argued that poor business skills may impact on patient care. I would recommend reflecting on this. Yes - Yes – Paragraph 13 in Introduction – "Failure to [develop strategies in establishing, marketing, managing, maintaining a practice] could distract from patient care during first years of practice"	Opinion is mixed on this, and as one pointed out, para 50 already contains outcomes that relate to the running of a business, including marketing legally and ethically. The Stakeholder Group felt that the existing wording was sufficient.

Question	Summary of responses	Comment
	No - Section 50 a, b & d encompass much of the business requirements. 50c needs rewording (to only apply to those who choose to use SM). Section 13 sets out: Osteopaths must be conversant with the demands and challenges faced by practitioners (including the challenges of establishing, marketing, managing and maintaining a new business) and develop strategies for managing these before graduation. This pretty much covers it.	
17. In relation to paragraph 34, initial feedback questioned why the focus was just on the biopsychosocial model of healthcare. We have expanded this paragraph to refer to a range of healthcare models, and to be able to apply these in different situations with different patients based on their preferences and beliefs, but also to be able to use the biopsychosocial model to inform assessment and patient management. Do you agree with this approach?	34. Suggest adding "other initiatives to promote and facilitate patient self-management". Yes -The biopsychosocial model states that the workings of the body, mind, and environment all affect each other. Should environment be specifically stated? 38. Perhaps add social prescribing as an example. 40. Add "treatment" before "plan". Three others said 'yes'.	These points were considered by the Stakeholder Group.
18. In relation to the use of social media in this section (paragraph 49c), we have amended this to clarify that graduates should have the ability to use social media 'legally, safely and ethically' in relation to professional practice. This does not mean	50c). Current suggestion is that "graduates should have the ability to use social media 'legally, safely and ethically'". Some students may have particular ethical concerns about social media generally so I don't think this should be a requirement: it would perhaps be better as a suggested option for communication. A surprising omission from this is the requirement that any form of social media/electronic communication should be	Having a knowledge of the professional use of social media within legal and ethical parameters seems appropriate even if some do not intend using this. These issues were considered by the Stakeholder Group- see updated draft.

Question	Summary of responses	Comment
that graduates must use social media in relation to their practice, but should have the skills to do so 'legally, safely and ethically' if they choose to use it. Do you agree with this approach?	professional at all time whether that relates to business or personal activity. This is emphasised in other professions and it is surprising this doesn't feature here. Irresponsible behaviour on social media can potentially have considerable repercussions for an individual osteopath and the wider profession. Yes - Osteopaths must use social media even in a social capacity in an ethical way so as not to influence the reputation of their, or their colleagues practice. No - 50c reads that they must have the ability to use social media. We do not agree that this is an essential skill. Perhaps because we have more mature students, this is not part of their communication strategy. If the intention is to stipulate that those who use SM must do so appropriately, legally etc then this section needs re-wording. Two others said 'yes'.	
19. Do you think there is anything missing from the proposed outcomes in relation to Theme C of the OPS 'Safety and quality in practice'?	56. Shouldn't there be something about identifying/clarifying patients' expectations at the outset? It would be better to add this first rather than just trying to work out how to mitigate not meeting their expectations. Four others said 'no'.	The expectations issue is covered in the Communication and patient partnership outcomes.
20. Do you have any other comments in relation to this section?	61. Can we add a link to the hubs page here please? https://www.ncor.org.uk/category/hubs/	The comment regarding 'diagnostic overshadowing' is noted, though this arose from an EDI perspective, and the known tendency for those with disabilities

Question	Summary of responses	Comment
	Yes - Para 34 'diagnostic overshadowing'. This reads as if one of the contributors has a particular interest or focus on this. I think the quote could be removed it's very understandable without it. It's really useful for reviewing assessment outcomes! Yes - Paragraph 30 – "and be able to produce on request" Yes - 50 e – the detailed examples are unhelpful. One other said 'no'.	of medical conditions to have every symptom attributed to this. The use of the quote is out of kilter with the rest of the document and will be reviewed. See updated draft.
21. Do you think that the outcomes in this section in relation to professionalism are sufficient and appropriate on entry to the profession?	Yes - Duty of candour an important factor in this section recognising issues with colleagues' behaviour without fear of reprisal from colleague. Three others said 'yes'.	
22. We have added an outcome (paragraph 61) that graduates should understand the need to take steps to integrate themselves into the professional community and to be aware of the support available from a variety of sources. Previously, this was a statement within the current GOPRE, but feedback indicated it would be more useful and appropriate as an assessed outcome. Do you agree with this approach?	Yes - More relevant with the proposals for healthcare as in the White Paper. Yes, but would it be useful to state it in terms of 'support' not 'guidance'. Use of the word support indicates a less judgemental community. Actually the wording in your Ques 22 is more useful than that in the draft GOPRE. Two others said 'yes'.	This now says 'support'.
23. Do you think there is anything missing from the	Four said 'no'.	

Question	Summary of responses	Comment
proposed outcomes in relation to Theme D of the OPS 'Professionalism'?		
24. Do you have any other comments in relation to this section?	65a). Why is sexual orientation given as an example as a case history patient profile question? Personally, I think this is intrusive and I would not ask it without specific clinical reasoning. 67a). Suggest include "goal setting". What about baseline assessments using patient reported outcome measurement? This is a key part of national healthcare practice and is still lacking in undergraduate curricula. No - As with previous sections, the more detail that is added, the more the document is likely to need constantly updating. More general statements would make the document less dense and simpler to follow. Three others said 'no'.	These issues were considered and are reflected in the updated draft.
25. Do you agree that there should be an expectation of 1,000 clinical hours experience during pre-registration training, and a need for the student to take the lead with 50 new patients?	Yes - Generally yes, but I wonder about the post-grad courses where students already have some clinical training in an associated field eg doctors and physios. Might there be some flexibility where they have already demonstrated some aspects of clinical care. Eg communication, note keeping, professional value systems etc etc? Yes - But not an absolute requirement as above – some flexibility required Yes	See discussion outlined earlier on this within the thematic analysis. The reference to a percentage of hours being devoted to clinical experience was not popular, and several pointed out the balance between quantity and quality with outcomes being favoured over hours pe se. But these are not mutually exclusive – it's possible to have defined outcomes (as we have here), and to state that meeting these would typically involve undertaking a certain amount of clinical

Question	Summary of responses	Comment
	No - This has been discussed at great length. Hours as a proxy for learning is just that – a proxy. Equally we have been told that when the original numbers were stated, they were simply 'made up'. To continue with this charade seems odd. Why 50 NPs? Why not 55, or 45? Can GOsC provide the evidence for the validity of these figures please?	hours without making this an absolute requirement that removes any flexibility on this. We reviewed the point regarding 25% of programme hours with the OEI lead who originally suggested it to reflect the circumstances of their own institution, and the revised wording as suggested in the draft was accepted. These issues were again discussed with the Stakeholder group, and the outcome reflected in the updated draft.
26. Do you find it helpful to include the reference to 25% of the course being dedicated to direct patient contact between student and patient?	Yes I am entirely unsure if this is useful with out looking at the hours spent learning across all the current UK courses. Is it on average 25%? Is this too onerous? Can you be very much more explicit about this. Is it 25% of the whole programme or just the clinical module? No - 1000 and 50 patients enough. Percentage is irrelevant as does this mean if modules increase then patient contact must increase too in order to stay at 25%? No - I'm not really sure what this means. Direct patient contact to me would be students interfacing with a patient – so taking a case history or examining a patient or treating a patient. An undergrad MOst is usually 480 credits, so 4800hrs student effort. 25% is 1200hrs. I don't believe that any of our courses have students interacting – personally – with patients for this amount of time. Can GOsC explain why they feel this is necessary and what the evidence for this is please?	

Question	Summary of responses	Comment
27. Do you agree that the clinical requirement could be met in a variety of ways, as well as through direct clinical interaction (for example remote clinics, simulated clinical experiences, observations/placements with other allied health providers/students)?	Yes - Integration through observation and placements with AHPs as an undergraduate to widen knowledge of osteopathy (to them) and other specialties (for osteopathic students) is more relevant and important now. Simulated clinical experiences have their place, but they are scripted, so direct 'real' patient contact must remain the main focus. Osteopathy is an intervention that requires touch and manipulative practice. Yes, sometimes necessary as tutors may provide a case study of case that does not present to uni clinic but is important and effective learning tool when delivered well. Yes Yes - Clarity from GOsC on this would be welcome.	The guidance states that clinical experience 'may' be achieved in a number of ways, and gives examples without being overly prescriptive. It's not intended that simulated or remote clinics, for example, would form the bulk of clinical experience, and the expectations around patient numbers, and the types of presentations etc, should ensure that direct patient involvement is indicated.
28. There is no precise definition of what comprises a 'clinical hour'. For example, an hour in a teaching clinic taking the lead in the management of a patient and providing hands on treatment, may not be viewed as equivalent to an hour in a simulated clinical setting, or observing on placement with another healthcare provider. Would it be helpful to have a more precise definition of how	Yes Yes - See above comment about 25% No - I believe a clinic setting is enough. Perhaps a minimum of hours must be hands on student to patient – 75%? Not what a clinic hour is, no. How clinic experience may be gained, yes (see above).	

Question	Summary of responses	Comment
clinical experience and 'hours' could or should be met?		
29. Do you have any further comments in regard to this section and the way that clinical hours and experience are set out in the GOPRE?	Our response to this would be that they do need an outcome regarding business skills. Just ensuring osteopaths practice in accordance with GOsC OPS guidelines seems a little weak. There is considerable attrition in the profession within the first 2 years for a variety of reasons and some business training/talks from osteopaths who have successful practices (not just chronic practices) using different models would be helpful. Adding some form of assessment like creation of a business plan, and how they will create and maintain their own networks could be a simple measure. Yes - There are a couple of sections that may raise student expectations beyond what can logistically and reasonably be accommodated. In the NHS, a placement is a placement - normally the shifts are non-negotiable. Whilst we try to have some flexibility, stating: in relation to clinical outcomes, educational providers should ensure that the resources available take account, proactively, of the diverse needs of students. (for example, the provision of plinths that can be operated electronically, the use of electronic notes as standard, rather than paper notes which are more difficult for students with visual impairments, availability of text to speech software, adaptations to clothing and shoe requirements to take account of the needs of students, published opportunities to adapt the timings of clinical sessions to take account of students' needs) seems excessive. Also, why electronic plinths? Is a hydraulic plinth insufficient? A	The issue of business skills was considered by the Stakeholder Group, and the consensus was that the existing draft was sufficient, without further specifying assessed business plans. These elements relate more to the draft standards, so will be considered in that context.

Question	Summary of responses	Comment
	student who cannot use a hydraulic plinth is unlikely to be able to manoeuvre a patient. Is it appropriate to mandate electronic note taking? What happens if a graduate goes to work as an associate, and the clinic does not have the budget to buy the required licence?. As stated previously, the more detail that is added, the more it sets the expectation that if it is not on the list it doesn't count, which is clearly contrary to the intention. Three others said 'no'.	
30. Do you agree that the types of presentation outlined in this section and the common components of an osteopathic intervention are appropriate and sufficient?	74. It's unfortunate that the term "evidence-informed" doesn't feature in this section in relation to patient management. Yes - There is no mental health disorder, or least anxiety/depression. Two others said 'yes'.	The Safety and Quality in practice outcomes reference 'the best available evidence' in relation to the formulation of management plans, so this isn't, in fact, overlooked. In relation to depression/anxiety, the conditions listed in this section relate to those typically treated by osteopaths, or issues they're likely to encounter which impact on their management. Only one has suggested mental health issues should be added here – largely these were seen as sufficient as drafted. That said, mental health issues are something that osteopaths are likely to encounter regularly, and may well impact on a patient's presentation or perception of their symptoms and outcomes. The issues were considered by the Stakeholder Group.

Question	Summary of responses	Comment
31. Are there any presentations which you would amend or add to this section?	No. Yes. Paragraph 68 b. "material"? Am not sure this is the correct term to use in this context, I could be wrong though. Yes - The scenario: Cases where patients do not respond according to the expected prognosis. It would be helpful to specify that students should be able to cope when a patient does not get better. The above wording has elicited from students patient scenarios where the patient has improved unexpectedly quickly. Clearly this is gratifying, but does not demonstrate student resilience.	'Material' is the correct word in this context, and reflects the OPS and the law as established by the Montgomery judgement. The outcome does specify a case where patients do not respond according to the anticipated prognosis, but it's true that It doesn't set out that they should show the resilience to cope with this.
32. Do you think that the more general list of approaches to osteopathic treatment and patient management in the draft updated GOPRE is appropriate and sufficient?	3 X 'Yes' 1 x 'No'.	
33. Would you prefer to see specific osteopathic approaches referenced, as in the current GOPRE? These include: diagnostic palpation; direct techniques such as thrust, articulatory, muscle energy and general osteopathic techniques; indirect techniques, including functional techniques and	Unable to directly comment as needs individual osteopath approach. Yes but it's useful to say the list is not exhaustive. I'm undecided on this question. No.	See the narrative section in relation to osteopathic techniques.

Question	Summary of responses	Comment
counterstrain; balancing techniques, such as balanced ligamentous tension and ligamentous articulatory strain; combined techniques, including myofascial/fascial release, Still technique, osteopathy in the cranial field, involuntary mechanism and visceral techniques; reflex-based techniques, such as Chapman's reflexes, trigger points and neuromuscular techniques; fluid-based techniques, such as lymphatic pump techniques.		
34. Do you think that anything needs amending or adding to this section?	As above 2 X 'No'. Yes - It would be useful to specify a range of approaches without naming them. The proposed statement: A range of manual techniques aimed at improving mobility and physiological function in tissues to enhance health and well-being and reduce pain could be modified to: A range of direct and indirect manual techniques aimed at improving mobility and physiological function in tissues to enhance health and well-being and reduce pain	The suggestion of referring to direct/indirect techniques is referenced in the narrative discussion, and an amendment considered and accepted by the Stakeholder Group.
35. Do you think that these aspects of equality, diversity and inclusion are sufficiently represented within the outcomes?	Yes - Of course we might not always know what specific cultural needs are present but we need to be open to them. Yes - Those already mentioned in previous points	

Question	Summary of responses	Comment
	Plus 2 X 'Yes'.	
36. Would you suggest any amendments or additions to the draft outcomes in relation to equality, diversity and inclusion?	Yes - 17ciii includes the unhelpful specific communication styles – direct reference to these should be removed. 29 the reference to 'easy read' as a direct example should be removed. 49e the multitude of examples are not helpful. The guidance would be improved as set out below: 49e: Ability to develop appropriate, clear, inclusive and accessible patient information in a variety of formats and approaches to provide patient information that individual patients can understand in advance of an appointment.' Two said 'No'.	This relates to the examples given in various sections of EDI resources such as easy-read formats and, an awareness of BSL, for example. These are discussed within the narrative section above and reflected in the updated draft.
37. Do you have any further comments as to other ways in which the implementation of GOPRE might be effectively supported?	Use the iO for promotion of the new GOPRE! It's a big change having GOPRE strengthened to incorporate some of what was/still is done by QAA etc so communication with the providers is essential but in addition making sure that providers filter this down to include all teaching staff is essential One assumes that the AMR process should reflect the congruency between course provision and GOPRE.	
38. Do you have any further comments regarding the updated Guidance for Pre-registration osteopathic education?	Three said 'No'. Yes - There has clearly been a lot of work put into the update. Congruency with the OPS is most welcome. Generally the level of detail feels like it is becoming too specific, detracting from the general	

Question	Summary of responses	Comment
	requirements. The density of detail will be a challenge for any inspection team to assess fully. Lastly, specifics may change, meaning the document has a more limited shelf life than would be hoped for.	

Annex A to 12

Table B – summary of responses to Standards for Education and Training Consultation with commentary

Question	Summary of responses	Comment
Programme design and delivery and assessment		
1. Do you agree that the stem phrase to each theme; 'Education providers must ensure and be able to demonstrate that', is appropriate?	We have none to offer, the main essence about a safe, nurturing inclusive and fair environment that stimulates curiosity and facilitates student learning to explore that curiosity is captured. We hope it translates into practice. Yes - Education providers must demonstrate that their course meets regulator/professional body/students expectations. Quality assurance key. Yes No - Whilst there is mention of innovation at one point, by using 'must' there is really no room for development. Should seems a better option.	There was one point here about using 'should' rather than 'must', and this is discussed further in the narrative section above. The updated draft retains 'must'. 'Innovation' isn't actually mentioned in this theme, but is in theme 4 (Quality evaluation, review and assurance).
2. We have referenced aspects of equality, diversity and inclusion throughout this theme, for example: 1.ii: there are equality and diversity policies in relation to applicants, and that these are effectively implemented and monitored 1.iv: all staff involved in the design and delivery of programmes are trained in all policies in the education provider	No – assurance that the institution itself advertises/ensures EDI with its own staff/practices Yes Yes - Whilst the intention is laudable, by specifying including all outcomes including effectiveness in teaching students about health inequalities and the	See also the EDI theme within the narrative section of this report.

(including policies to ensure equality, diversity and inclusion), and are supportive, accessible, and able to fulfil their roles effectively 1.vii: the programme designed and delivered reflects the skills, knowledge base, attitudes and values, set out in the Guidance for Pre-registration Osteopathic Education (including all outcomes including effectiveness in teaching students about health inequalities and the non-biased treatment of diverse patients) Do you think this is sufficient?	non-biased treatment of diverse patients this seems to suggest that this is more important that anything else - so more important for example than safe and effective treatment.	
3. In 1.vi, we have referenced the involvement of students, patients, and, where appropriate, the wider public in the design and development of programmes. Do you agree with this requirement?	Yes - 1(vi) states 'where possible' in the draft. Would 'possible and appropriate' be the better phrase to use here? Yes	
4. Do you have any other comments or feedback as to the standards as set out within this theme?	Yes - Previously mentioned re Institution E & D No Yes- Please see comments in the GOPRE feedback.	
5. Are there particular issues relating to admissions, teaching and learning and assessment that you don't feel are currently covered?	Yes - Assurances of funding/Visa for course length, more relevant perhaps to overseas students post Brexit. Yes - First Aid – as discussed on the forum.	We do not think there should be a specific standard on assurance regarding funding here – this might change over time, and the requirements will be set in other forms. First aid is discussed in the narrative section and draft with a suggested outcome for consideration.

Programme governance, leadership and management		
6. Do you think that the requirements of this theme are appropriate and sufficient in setting out how effective governance, leadership and management is demonstrated?	Iv – or a police authority when appropriate or cultural organization Two said 'Yes'.	These points were considered by the Stakeholder Group.
7. We have added reference in this theme to cultural aspects – where it is safe for students, patients and staff to speak up (2.iv), and where those who make mistakes or are unsure what to do, can seek help and support (2.v). Do you agree with these requirements?	As above Yes - Really important for effective learning Yes - The inclusion of specific links is perhaps unhelpful as these may become out of date.	The point regarding links is noted, but these can always be reviewed and updated within a digital document, which is what this will be.
8. Do you have any other comments or feedback on the standards set out within this theme?	Two said 'No'.	
Learning culture		
9. Do you think that the requirements of this theme adequately embody a positive learning culture?	Two said 'Yes'.	
10. Do you have any other comments or feedback as to the standards set out within this theme?	Three said 'No'.	
11. Do you think that the requirements in this theme are appropriate and sufficient in relation to quality evaluation?	No - Should there be a stated time for a review period – it is stated 'reviewed regularly to ensure they are kept up to date' Two others said 'Yes'.	See draft.
12. In relation to resource requirements related to the diverse needs of students,	No - Please see feedback set out in the GOPRE document.	

patients and staff, do you think that these are appropriate and sufficient?	Two others said 'Yes'.	
13. Do you have any other comments or feedback as to the standards set out within this theme?	Yes - Regarding 'diverse' should it be more specific around cultural aspect? No Yes - 5iv: is it necessary for a non-campus OEI provider to be required to provide places for students to meet privately? How private do they need to be?	Some of these aspects are considered in more detail within the narrative section of this report.
Students		
14. Do you think that the requirements of this section are appropriate and sufficient?	Yes - Some aspects are covered in different areas of GOPRE Two others said 'Yes'.	
Clinical experience		
15. Do you agree with the requirement to provide clinical experience in a range of ways, including virtual, simulated and remote methods?	Yes - Yes in general is useful and at times necessary (covid) but perhaps stipulate a minimum face to face contact - 75% ? No - See also GOPRE feedback. Why is there a requirement to provide simulation, virtual & remote clinics? One other said 'Yes'.	The question of virtual/remote clinical opportunities arose from variations in the way clinical care may be delivered as a result of the pandemic, but demonstrate the variety of these. Concerns regarding emphasis may be covered by stipulating a typical percentage of face-to-face contact. Issues were considered by the Stakeholder Group and suggested amendments accepted to this section.
Staff support and development		
16. Do you think that the requirements in this section sufficiently encompass what should be demonstrated in relation to staff recruitment, training and	No - v - it would seem appropriate to state what recent means i.e. give a time period.	See comments in the narrative too – the requirement for staff to have recent experience, a qualification or be working towards this is not intended to preclude a

development, and the delivery of osteopathic education?	Yes. 8v: educators either have a teaching qualification, or are working towards this, or have relevant and recent teaching experience. This will exclude guest speakers and limits possible interprofessional input. For example the consultant rheumatologist who delivers a differential diagnosis session does not meet the above, but offers an invaluable insight into this specialism. She has worked in research and clinical practice, but does not have an educational qualification - nor would we expect her to be working towards one. A final consideration was in *the "Staff support and development"* section part v. The team felt this could be strengthened and simplified from *"educators either have a teaching qualification, or are working towards this, or have relevant and recent teaching experience"* TO "*educators either have a teaching qualification or are actively working towards this".* It was felt that requiring educators to have or actively work towards a teaching qualification would continue to encourage a consistent high standard of education across the OEIs. There were also some minor concerns about the requirements discussed in section (75) standards for education and	specialist guest lecture as outlined in the comment.

	training. Part ix requires those supervising "other clinical interactions" to be on the GOsC register. It was felt this could discourage future interprofessional student placements such as those within non-osteopathic settings (GP practices, NHS etc.); as the supervising clinician may be from another health profession and thus not registered with GOsC. An indirect example would be the recent physiotherapy placements that several of the OEIs took part in, in partnership with the iO, in which physiotherapy students were supervised by osteopaths not physiotherapists. If this placement program were to become reciprocal and osteopathic students were supervised by physiotherapist, it may not count toward the clinical interaction hours under the draft guidance.	
Patients		
17. Do you think that the requirements of this theme sufficiently embody patient safety and put well-being at the centre of osteopathic education?	No - Should a mention of safeguarding be mentioned here? Whilst the bio-psychosocial model infers an awareness and inclusion of the psychological domain in diagnosis, it seems a stretch to suggest that student osteopaths are qualified to provide psychological support. I wonder if the BPS or BACP have an opinion on this?	The mention of safeguarding in this comment is helpful and and additional standard has been included within the updated draft. The comment regarding psychological support is addressed in the narrative to this report.

18. Do you find the draft Standards for Education and Training clear, accessible and easy to understand?	Two said 'Yes'. The GOPRE section seems overly detailed and thus somewhat dense. The SET section is more accessible.	
19. Do you have any further comments or feedback regarding the draft Standards for Education and Training? If so, please add them to the box below	All generally clear and accessible	