General Osteopathic Council

GOsC Response to the NHS 10 year plan call for evidence

Section 1: the 3 shifts

The NHS must change. Our 10 Year Health Plan makes clear our ambition to move from a centralised system to one where patients have greater control over their care and frontline staff are empowered to shape and improve services. We know that those working closest to patients understand best how local services can be delivered.

We want to hear from organisations, clinicians, staff groups and partners who are already driving change at a local level.

We are seeking evidence on how the 3 shifts are being implemented locally, and the impact on your workforce. Where possible, please support your submission with data and measurable outcomes, so we can learn from what is working well and apply those lessons across the NHS.

In this section, please submit evidence of:

- *where you have delivered or observed new digital initiatives that improved patient care*
- *where you have already seen or begun to deliver a shift from hospital-based care to community care*
- *where you have already seen or begun to deliver preventative care services*
- *which professions, roles and skills were critical to successful implementation for each example*
- *any barriers to ensuring the right professions, roles and skills were involved, and how you overcame these barriers*

Digital initiatives:

- Artificial intelligence (AI) is a major digital initiative which is enabling osteopaths to spend more time with patients. As the statutory regulator for osteopathy, with strategic aims of innovation, inclusivity and trust, we have provided guidance to help them to use AI in a competent and ethical way. Our Interim guidance on the use of AI in osteopathic practice (2025) outlines principles and guidance in relation to accountability; AI literacy, transparency and consent and patient safety and confidentiality to support osteopaths to support evolving practice.
- Examples of use that osteopaths have told us about include using AI for case notes which enable the clinician to see more patients, whilst also ensuring that all relevant patient information is captured and reviewed by a human before being finalised ensuring that their values and preferences are captured properly for the purposes of shared decision making.

- The General Osteopathic Council is leading work with the other health professional regulators including the Health and Care Professions Council on a draft cross-regulatory statement on Using AI in health and care professional education. A draft Using AI in health and care professional education of this can be found in our Policy and Education Committee papers at pp50 to 52 and final publication is due on the new year. This includes principles and guidance related to accountability, academic integrity, development of AI literacy for staff and learners and preparation for practice. The draft guidance is being shared in the sector and influencing the review of the design and delivery of osteopathic education which we assure as part of our statutory quality assurance process to ensure that osteopathic students are equipped with the skills including critical appraisal and reflection and the importance of human oversight and professional judgment needed to deliver healthcare in future contexts. The statement has also influenced the development of the Osteopathic Apprenticeship Standard which is currently awaiting ministerial approval.
- During COVID, in April 2020 the General Osteopathic Council issued a statement about remote consultations. Subsequently, UK osteopathic educational institutions introduced remote consultation and tele-health training to sustain supervised musculoskeletal (MSK) education and enabling graduates to graduate as planned during the lockdowns. This increased the workforce available to support patients during this critical time.
- Interestingly, also during this time, there were legislative barriers to osteopaths (allied health professionals) taking a full role, for example, in administering covid vaccines under a patient group direction. We note that although osteopaths are listed in the relevant medicines legislation, they are not listed in the part that enables administration of medicines under a patient group direction. Further information about osteopathic standards and regulation can be found in our briefing.

Community care:

- Osteopaths are required to see 50 new patients and undertake 1000 hours of clinical care as part of their undergraduate or pre-registration degree prior to graduation and qualification as an osteopath. (See our Graduate Outcomes and Standards for Education and Training (2022)). This is primarily (but not exclusively) delivered in osteopathic community clinics attached to the educational institution which are quality assured by the General Osteopathic Council as part of our statutory role.
- Data provided by the Council of Osteopathic Educational Institutions (COEI) states that ‘Osteopathy has always been delivered within community settings, and OEI teaching clinics exemplify this approach. They provide accessible, supervised MSK care to local residents at low cost. When benchmarked against the average £169 NHS MSK appointment, this represents significant public value. For the academic year 2024–25, the [osteopathic hiher education providers] OEIs supplied data on the community-based health and care provided in their teaching clinics, including:

    - Number of patients treated: 25,432
    - Communities served: general local populations, from children to the elderly with some specialist clinics for children, maternity, headache, sports injuries
    - Average cost of treatment: First appointments £33; follow up appointments £24
    - Percentage of patients receiving discounted or free care: average 45%
- COEI also state

  'Further evidence of the profession's contribution to community and primary care is provided by the Introducing Osteopaths to Primary Care: The Role of the First Contact Practitioner (Allardyce, Coffey & Woodward, 2020). This pilot evaluation demonstrated that osteopaths working as First Contact Practitioners (FCPs) in NHS primary-care settings:

    - Managed 97% of patients independently without GP input;
    - Referred only 1% to secondary care; and
    - Achieved high levels of patient satisfaction and positive return on investment.

  These findings confirm that osteopaths deliver safe, effective, community-based MSK care that reduces GP workload and secondary-care demand.
- Additionally, a national study of patient reported outcomes in 1721 patients receiving osteopathic care (Fawkes & Carnes, 2021) further evidences osteopathy's community impact:
    - 39.8% of patients had symptoms lasting more than 13 weeks;
    - 55% presented with low-back pain;
    - 89% reported improvement after one week;
    - 92.8% reported improvement after six weeks;
    - Mean Bournemouth Questionnaire score improvement of 56.8%, a statistically significant and clinically meaningful change.'
- The osteopathic educational institutions say that 'Together, these data illustrate that osteopathic community care delivers measurable health gains, high patient satisfaction, and substantial system-level savings.'

Preventative care:

- As a statutory regulator, we set the standards that all osteopaths practice to. These are outlined in the Osteopathic Practice Standards (2019). So, all osteopaths must '*be aware of their wider role as a healthcare professional to contribute to enhancing the health and wellbeing of their patients.*' This includes: being aware of *'public health issues and concerns, and be able to discuss these in a balanced way with patients, or guide them to resources or to other healthcare professionals to support their decision-making regarding these*.'
- Osteopaths are autonomous at the point of registration. GOsC Graduate Outcomes and Standards for Education and Training (2022) map to those expected of other allied health professions, for example, the Health and Care

Professions Council (HCPC) Standards of Proficiency for physiotherapists. Like other regulated health professionals, osteopaths work within an ethical framework including working within the limits of their competence, confidentiality, ethics, professionalism and a competence framework, including keeping knowledge and skills up to date. Osteopaths are trained to take a history, perform an examination, make a working diagnosis, discuss treatment options and prognosis, and formulate a treatment or management plan in partnership with the patient including treatment or referral as necessary and appropriate.

- Our Graduate Outcomes state that every graduate must:
    - '*Promote the importance of physical activity for health, and work in partnership with patients to enable them to incorporate this within their daily lives'*
    - *'Support patients in caring for themselves to improve and maintain their own health and wellbeing'*
    - *'Develop and be able to apply an appropriate plan of care in partnership with the patient … include patient education, mobilisation, manipulation and exercise prescription or other initiatives to promote and facilitate patient self-management, … to provide safe and effective care.'*
    - Our Standards for Education and Training require provides to ensure and demonstrate that '*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*.'
- As outlined by the Council for Osteopathic Educational Institutions: 'Preventive competencies are further reinforced by the QAA Subject Benchmark Statement for Osteopathy (2024), which highlights the requirement for graduates to provide advice and support to the patient for the promotion of wellbeing, preventing illness, and self-care. Together, the Graduate Outcomes, QAA Benchmark, and the evidence from the OsteoMAP study demonstrate that osteopathic education incorporates the prevention and health-promotion priorities central to the 10 Year Workforce Plan.'
- Barriers to osteopaths being involved in community care within the NHS: Osteopaths tell us that barriers to being involved in the NHS include lack of awareness that osteopaths can undertake musculoskeletal roles within the NHS, systems which do not recognise GOsC as the statutory health regulator of the 14th allied health profession, IT systems which do not recognise 'osteopath' as a title'.

  Osteopaths also tell us that not being able to prescribe is also a barrier. Whilst it is recognised that government will have its own decision making processes for deciding which allied health professions should be funded for prescribing and this is not a matter for us as a statutory regulator, we note that osteopaths although are defined as health professionals in medicines legislation, they are not listed in the professions able to administer medicines under patient group directions. This means that osteopaths are legally prevented from administering medicines unless a patient specific direction is issued impacting, for example, on vaccination programmes.

Section 2: modelling assumptions

The workforce we build today will determine whether we can deliver the ambitions of the 10 Year Health Plan. That means challenging old assumptions, testing new ideas and being honest about what the future demands.

Big changes are coming. Artificial intelligence, breakthroughs in genomics and an ageing population will transform the way care is delivered. We need to capitalise on these shifts now or the NHS risks being left behind.

We need the insight of those who see, every day, what really works for staff and citizens - be that in the NHS, in other sectors or in other healthcare systems around the world. Your evidence will help us build a workforce that is ready, resilient and capable of delivering world-class care.

In this section, please submit evidence of:

- *specific assumptions you use in workforce modelling - for example, how service redesign such as new community services or digital models of care might affect the numbers, deployment and/or skill mix of staff*
- *how that impacts on workforce supply and demand, including career and training pathways*

As the healthcare regulator for osteopaths, we publish workforce data to support workforce modelling. As outlined in earlier questions, we have provided a sense of the community impact of osteopathic training as provided by our Council for Osteopathic Educational Institutions.

Like many health professions, osteopathy numbers are falling at the moment. I have provided below some data to illustrate this.

Our six monthly registration report to Council dated March 2025 showed that at the end of March 2025 there were 5,596 osteopaths on the Register. Whilst this represents the highest number of osteopaths registered in recent times, we also know that number of entrants to the osteopathic profession is falling and that student numbers are falling too.

In 2023, we commissioned Middlesex University to look at GOsC's registration data

and explore through predictive modelling what the osteopathic profession might look like in 3-5 years' time. The findings of the Middlesex Report (2023) included modelling which predicts that by 2027/28 there will be:

- A decreasing number of students enrolled on an osteopathic course across all year groups (856).
- A high variation in the number of osteopaths joining the register, but with a negative trend (110).

It is not for the regulator to lobby for the osteopathic profession. Our role is about protecting the public and regulating and developing the osteopathic profession.

However, decreasing numbers will over time have the potential to impact on safety and quality if not addressed. Whilst the actual numbers are higher than predicted to

date, organisations in our sector and research shows that there are structural barriers for entering the osteopathic profession which is impacting on future workforce. Further information from other organisations in the osteopathic sector is outlined below:

As outlined by the Council for Osteopathic Educational Institutions

‘Although osteopaths demonstrate the full range of knowledge and competencies expected of Allied Health Professionals, several systemic factors continue to limit their full participation in NHS workforce planning and service delivery. These include **inconsistent recognition of osteopaths as regulated AHPs**, **incomplete integration within NHS IT** and occupational-coding systems, and **restricted access to student funding**. The **absence of prescribing rights** also constrains osteopaths’ ability to provide seamless care within multidisciplinary teams.

Unlike most other AHPs, **osteopathy currently falls outside key funding mechanisms**: **OEIs do not receive the Practice Education Tariff support**, students are **ineligible for the NHS Learning Support Fund**, and **second-degree applicants have limited access to student loans**. These inequities place a disproportionate financial burden on learners and threaten the sustainability of the education pipeline.

At the same time, **NHS provider departments face persistent workforce shortages**, yet **awareness of osteopaths as a potential solution remains limited**—despite clear evidence of their effectiveness in community and primary-care settings *(Quick Guide to Osteopathy as a Workforce Supply Solution*, iO, 2022). Osteopaths have successfully supported workforce capacity at **Bands 5–9** in several NHS locations. Expanding **pre-registration NHS placement opportunities** would help to embed this contribution more systematically but requires equitable access to placement-tariff funding.

A further barrier lies in the **NHS Electronic Staff Record (ESR)**, which does not consistently apply correct occupational codes for osteopaths; additionally, many independent providers delivering NHS services do not use ESR at all. This undermines workforce data accuracy, distorting vacancy and supply modelling and impeding effective planning. Ensuring osteopaths are accurately coded and recognised as regulated AHPs within ESR is therefore an urgent priority.

Finally, limitations in **scope of practice**, specifically the lack of **prescribing rights**, restrict the full integration of osteopaths in First Contact Practitioner and Advanced Practice roles. Addressing this restriction would bring osteopathy in line with comparable AHP professions, support continuity of patient care, and enable more efficient multidisciplinary service delivery.’

We would also repeat the point above that whilst it is recognised that government will have its own decision making processes for deciding which allied health professions should be funded for prescribing and this is not a matter for us as a statutory regulator, we note that osteopaths although defined as health professionals in medicines legislation, are not listed in the professions able to administer medicines under patient group directions. This means that osteopaths are legally prevented

from administering medicines unless a patient specific direction is issued impacting, for example, on vaccination programmes.

There are a range of initiatives underway to support recruitment and retention in the profession across the sector.

The establishment of a new apprenticeship standard for Osteopathy that meets the GOsC's Graduate Outcomes and Standards for Education to improve and widen access to the profession.

The Institute of Osteopathy publishes a range of research and other information relevant to ongoing workforce development following the recognition of osteopaths as the fourteenth allied health profession in England in 2017.

The General Osteopathic Council is currently partnering with the Health and Care Professions Council to support registrants and managers in the NHS to raise awareness of and optimise scope of practice and to support workforce development within the NHS. Further information about the GOsC / HCPC webinars is available here.

Working with prospective providers in relation to education, standards and quality assurance and the potential for osteopathic courses to enable universities to support their local communities.

In relation to staff retention and wellbeing and with the impact of this on patient care and outcomes in mind, we have undertaken research to explore the experience of those new to the register. The challenges that some reported within a context of largely independent practice led us to facilitate a recent multi-party forum to create a joined up approach to supporting new registrants in the early stages of their practice. This involved representation from the professional body, new graduates, educators and employers, and a follow up workshop is being planned. There are parallels here to some of the NHS preceptorship approaches, which would apply to osteopaths working in NHS settings, but less so in other employed or self-employed scenarios. Potential outcomes for this work include charters and more structured support and supervision, mentorship and pilots to support supervised graduate care to the community and this is ongoing.

Section 3: productivity gains from wider 10 Year Health Plan implementation

In his independent investigation of the NHS in England, Lord Darzi said:

Falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds.

To deliver transformational change we must improve productivity. This does not mean asking staff to work harder, it means changing the way we deploy staff in response to other developments, making it easier for them to do their jobs and bringing back their enjoyment of work.

In this section, please provide evidence of:

- *the top digital initiatives you have delivered - in the NHS, other sectors or internationally - that have successfully increased workforce productivity or reduced demand*
- *actions taken to identify and address gaps in training (pre or post-registration) that support delivery of the 3 shifts*
- *policies or initiatives that have enabled the NHS to play a bigger role in local communities (for example, widening access, creating opportunities or supporting underserved groups)*
- *where you have managed changing expectations and increased patient participation in their care through digital tools and, where applicable, you have adjusted workforce planning to reflect this (for example, increased training to deliver new approaches to diabetes management to reflect new digital tools)*

Please provide specific examples, supported by data where available.

GOsC is leading the professional regulators in setting a cross-regulatory statement on AI in education. The draft statement can be found in our October 2025 Policy and Education Committee papers (see pp 50 to 52)

We also repeat the points made in Section 1 which are repeated here for the purposes of the submission.

Section 4: culture and values

The 10 Year Health Plan made it clear that great culture and great leadership go hand in hand with better quality care. When staff feel valued and supported, patients see the benefits.

We are committed to empowering leaders and managers at every level of the NHS to do better - to focus relentlessly on access, experience and outcomes for patients and communities. We know the best ideas often come from those already driving change on the ground.

We want your evidence and experiences on what works in building a positive culture where leadership is strong, the quality of care is high and staff are supported to thrive - and what must change to make that the norm everywhere.

In this section, please provide evidence of:

- *policy interventions that have directly improved workforce outcomes and patient outcomes (for example, retention, staff wellbeing, reducing sickness absence, as well as better quality care)*
- *approaches that have successfully embedded strong core values into everyday leadership, decision making and service delivery*
- *systems or practices that ensure leaders at all levels actively listen to staff feedback - particularly from underrepresented groups - and act on it*

Please provide specific examples, supported by data where available.

Points to make in response:

The General Osteopathic Council is committed to a diverse and inclusive profession. To this end, it has developed Graduate Outcomes and Standards for Education and Training (2022) which thread through and measure specific standards in relation to inclusivity and speaking up. Demographic data is demonstrating increasing diversity in students and the profession as a whole. We jointly commissioned Overcoming barriers to equality, diversity, inclusivity, and sense of belonging in healthcare education: the Underrepresented Groups' Experiences in Osteopathic Training (UrGEnT) mixed methods study (2024) (Draper-Rodi et al) research to explore how to make environments more inclusive and there is a programme of work across the sector to put the recommendations into place.

The General Osteopathic Council introduced a peer based CPD scheme in 2018 with objectives of engagement, support and community to support high quality osteopathic care meeting standards. It was based on relational principles, and supported by ground breaking research Exploring and explaining the dynamics of osteopathic regulation professionalism and compliance with standards in practice by Professor Gerry McGivern in 2015 and an update report in 2020 demonstrating how relational regulation is more effective in assuring compliance with standards..

Our CPD evaluation June 2024 showed that:

- We have achieved 'consistent progress against our strategic aims of engagement support and community. With consistent proportions of respondents (more than a third up to over half) perceiving positive steps in terms of gaining benefits and support for themselves, their patients and their practice. The strategic aim of community shows around a quarter of respondents increasing their networks and more than half not increasing their networks.'
- NCOR complaints and concerns (2024) – showing that concerns and complaints have been statistically significantly reduced since the introduction with the scheme and that a focus on CPD in communication and consent has driven down concerns in that area and also concerns as a whole since the scheme was introduced in 2018.
- Additionally, a national study of patient reported outcomes in 1721 patients receiving osteopathic care (Fawkes & Carnes, 2021) further evidences osteopathy's community impact:
- 39.8% of patients had symptoms lasting more than 13 weeks;
- 55% presented with low-back pain;
- 89% reported improvement after one week;
- 92.8% reported improvement after six weeks;
- Mean Bournemouth Questionnaire score improvement of 56.8%, a statistically significant and clinically meaningful change.'

We have also introduced a more relational and collaborative approach to our Quality Assurance process to support a more dynamic, responsive and supportive yet robust quality assurance scheme to assure standards of regulation in an environment of

resource challenges. Feedback from interested parties to date has been very positive and we will be publishing a formal evaluation of our approach in the future.

In relation to staff retention and wellbeing and with the impact of this on patient care and outcomes in mind, we have undertaken research to explore the experience of those new to the register. The challenges that some reported within a context of largely independent practice led us to facilitate a recent multi-party forum to create a joined up approach to supporting new registrants in the early stages of their practice. This involved representation from the professional body, new graduates, educators and employers, and a follow up workshop is being planned. There are parallels here to some of the NHS preceptorship approaches, which would apply to osteopaths working in NHS settings, but less so in other employed or self-employed scenarios. Potential outcomes for this work include charters and more structured support and supervision, mentorship and pilots to support supervised graduate care to the community.

Section 5: any additional comments

Please include any other comments, information or evidence you would like to share as part of this call for evidence that you think would help deliver the ambitions of the 10 Year Health Plan. (Optional, maximum 250 words.)

About the General Osteopathic Council:

Osteopathy is a statutorily regulated health profession in the four UK countries (like physiotherapists at the HCPC and doctors at the GMC). The key objective of all statutory regulators is protection of the public. Osteopathy is an allied health profession in England.

The General Osteopathic Council has statutory functions to set standards of education and training, set standards of competence and conduct, hold the Register and ensure that osteopaths on the Register meet our standards and fitness to practise powers to remove or restrict practice where necessary.

It is illegal to practise as an osteopath in the four UK countries unless on the GOsC Register.

The General Osteopathic Council is a high performing regulator and leading thinker in regulation as evidenced by the Professional Standards Authority published annual reviews and external publications in the wider health field around relational regulation, shared decision making and values-based practice.

We are committed to supporting high quality osteopathic practice, public protection and patient safety and working with the Department of Health and Social Care and other regulators and the osteopathic sector to help ensure that osteopaths can play their part in providing high quality care for patients and the public.