Council (Public)

Tue 15 July 2025, 12:45 - 16:00

Osteopathy House, 176 Tower Bridge Road, SE1 3LU

Please kindly confirm any declarations of interest against agenda items.

Agenda

12:45 - 12:45
0 min

1. Welcome and apologies

Information *Joanna Clift*

For information

Public Agenda - July 2025 - FINAL.pdf (2 pages)

12:45 - 12:45
0 min

2. Questions from observers

Information *Joanna Clift*

12:45 - 12:45
0 min

3. Minutes of the 127th public meeting of Council

Decision *Joanna Clift*

For approval

Public Item 3 - Unconfirmed public minutes of Council May 2025 - FINAL.pdf (16 pages)

12:45 - 12:50
5 min

4. Matters arising

Information *Matthew Redford*

For noting

Public Item 4 - Matters arising - FINAL.pdf (2 pages)

12:50 - 13:30
40 min

5. Section 10 : Fraudulent registration entry

Decision *Sheleen McCormack*

For decision

Public Item 5 - Fraud or Error in relation to registration - FINAL.pdf (6 pages)
Public Item 5 - Annex A - Section 10 Osteopaths Act - FINAL.pdf (2 pages)
Public Item 5 - Annex B - The General Osteopathic Council (Fraud or Error and Appeals) Rules Order of Council 1999 - FINAL.pdf (8 pages)

13:30 - 13:40
10 min

6. Chair's Report

Information *Joanna Clift*

For noting

Public Item 6 - Chairs Report - FINAL.pdf (1 pages)

13:40 - 13:50
10 min

7. Chief Executive and Registrar Report

Decision *Matthew Redford*

For decision

Public Item 7 - Chief Executive and Registrar Report - FINAL.pdf (12 pages)

13:50 - 14:00
10 min

8. Assurance reporting

Information *Matthew Redford*

For noting

Public Item 8 - Assurance reporting - FINAL.pdf (1 pages)

8.1. Business Plan monitoring report to 30 June 2025

Information *Matthew Redford*

For noting

Public Item 8 - Annex A - Business Plan Monitoring to 30 June 2025 - FINAL.pdf (24 pages)

8.2. Financial report to 31 May 2025

Information *Darren Pullinger*

For noting

Public Item 8 - Annex B - Finance Report, May 2025 - FINAL.pdf (11 pages)

14:00 - 14:15
15 min

Break

14:15 - 14:30
15 min

9. Fitness to Practise report and dataset

Information *Sheleen McCormack*

For noting

Public Item 9 - FtP Quarterly Report Q1, 2025-26 - FINAL.pdf (6 pages)
Public Item 9 - Annex A - FTP dataset Q1, 2025-26 - FINAL.pdf (10 pages)
Public Item 9 - Annex B - FTP Council stats dashboard Q1, 2025-26 - FINAL.pdf (5 pages)

14:30 - 14:45
15 min

10. Patient Partner Programme Evaluation Plan

Discussion *Fiona Browne*

For discussion

Public Item 10 - Patient Partners Programme Evaluation Plan - FINAL.pdf (7 pages)
Public Item 10 - Annex A - Draft Patient Partners Programme Evaluation Plan - FINAL.pdf (15 pages)
Public Item 10 - Annex B - Patient Partner Induction plan - FINAL.pdf (3 pages)
Public Item 10 - Annex C - EIA Template - FINAL.pdf (8 pages)

14:45 - 15:00
15 min

11. Annual Report and Accounts 2024-25

Decision *Darren Pullinger*

For approval

Public Item 11 - Annual Report and Accounts - FINAL.pdf (5 pages)

11.1. Draft Annual Report

Decision *Darren Pullinger*

For approval

Public Item 11 - Annex A - GOsC draft Annual Report 31.03.2025 - FINAL.pdf (56 pages)

11.2. Audit Findings Report (Private Council Members only)

Decision *Darren Pullinger*

For approval - refer to separate confidential paper

11.3. Letter of representation

Decision *Darren Pullinger*

For approval

Public Item 11 - Annex C - Letter of Representation - FINAL.pdf (3 pages)

15:00 - 15:15
15 min

12. EDIB Annual Report 2024-25

Decision *Matthew Redford*

For approval

Public Item 12 - EDIB Annual Report 2024-25 - FINAL.pdf (15 pages)

15:15 - 15:25
10 min

13. Annual report to the Welsh Language Commissioner

Decision *Liz Niman*

For approval

Public item 13 - Welsh Language Annual Report 2024-25 - FINAL.pdf (10 pages)

15:25 - 15:35
10 min

14. Marjon Recognised Qualification

Decision *Steven Bettles*

For approval

Public Item 14 - Marjon - Recognised Qualification - FINAL.pdf (10 pages)
Public item 14 - Annex B - Plymouth Marjon RQ Final Report - FINAL.pdf (68 pages)

15:35 - 15:45
10 min

15. BCNO Recognised Qualification

Decision *Steven Bettles*

For approval

Public Item 15 - BCNO Group Recognised Qualification - FINAL.pdf (15 pages)
Public item 15 - Annex B - BCNO Group RQ Report Final - FINAL.pdf (64 pages)

15:45 - 15:55
10 min

16. Committee Annual Reports

Information *Matthew Redford*

For noting

Public Item 16 - Committee Annual Reports - FINAL.pdf (25 pages)

15:55 - 16:00
5 min

17. Policy and Education Committee minutes June 2025

Information *Patricia McClure*

For noting

Public Item 17 - Unconfirmed public minutes of PEC - June 2025 - FINAL.pdf (18 pages)

16:00 - 16:00
0 min

18. Any other business

Discussion *Joanna Clift*

16:00 - 16:00
0 min

19. Questions from observers

Discussion *Joanna Clift*

16:00 - 16:00
0 min

20. Date of next meeting 19 November 2025

Information *Joanna Clift*

General Osteopathic Council

The 128th meeting of the General Osteopathic Council to be held in public on Tuesday 15 July 2025 commencing at 12:45 and concluding at 16:00 before a closed session for Council.

	Item description	Purpose	Executive lead	Timing
	Declaration of conflict of interest: Members are reminded to make a declaration of a conflict of interest that they may have in relation to items on the agenda.			
1.	Welcome and apologies		-	12:45 - 12:50
2.	Questions from observers		-	
3.	Minutes of the 127th public meeting of Council	For approval	-	
4.	Matters arising	For noting	Chief Executive and Registrar	
5.	Section 10: Fraudulent registration entry	For decision	Director of Fitness to Practise and General Counsel	12:50 – 13:30
6.	Chair's Report	For noting	Chair of Council	13:30 - 13:40
7.	Chief Executive and Registrar Report	For decision	Chief Executive and Registrar	13:40 - 13:50
8.	Assurance reporting: A. Business Plan monitoring report to 30 June 2025 B. Financial report to 31 May 2025	For noting	Chief Executive and Registrar, Head of Resources and Assurance	13:50 - 14:00
Comfort break				**15 mins**

	Item description	Purpose	Executive lead	Timing
9.	Fitness to Practise report and dataset Annex A: FtP Dataset	For noting	Director of Fitness to Practise	14:15 - 14:30
10.	Patient Partner Programme Evaluation Plan	For discussion	Senior Policy Officer	14:30 – 14:45
11.	Annual Report and Accounts 2024-25 A. Draft Annual Report B. Audit Findings Report (*Private - Council members only*) C. Letter of representation	For approval	Head of Resources and Assurance	14:45 - 15:00
12.	EDIB Annual Report 2024-25	For decision	Chief Executive and Registrar	15:00 - 15:15
13.	Annual Report to the Welsh Language Commissioner A. GOsC Annual Report to Welsh Language Commissioner 2024-25	For decision	Senior Communications Officer	15:15 - 15:25
14.	Marjon Recognised Qualification	For decision	Head of Policy	15:25 - 15:35
15.	BCNO Recognised Qualification	For decision	Head of Policy	15:35 - 15:45
16.	Committee Annual Reports	For noting	-	15:45 - 15:55
17.	Policy and Education Committee minutes, June 2025	For noting	-	15:55 - 16:00
18.	Any other business			-
19.	Questions from observers			
Date of next meeting: **19 November 2025**				
Council reflection time: closed session			**Meeting ends latest 16:30**	

Meeting of Council

Minutes of the 127th Meeting of Council held in public on Thursday 15 May 2025 at Osteopathy House 176 Tower Bridge Road, London SE1 3LU and via Go-to-Meeting video conference.

Unconfirmed

Chair:	Jo Clift
Present:	Dr Daniel Bailey Harry Barton (Chair, Audit Committee) Professor Debra Towse (Chair, People Committee) Sandie Ennis Professor Patricia McClure (Chair, Policy and Education Committee) Gabrielle Anderson (Council Associate) Caroline Guy Gill Edelman (online) Arwel Roberts (Council Associate)
In attendance:	Fiona Browne, Director of Education, Standards and Development Steven Bettles, Head of Policy and Education David Bryan, Head of Fitness to Practise (Item 8) Lorna Coe, Governance Manager Sheleen McCormack, Director of Fitness to Practise Liz Niman, Head of Communication, Engagement and Insight Darren Pullinger, Head of Resources and Assurance Matthew Redford, Chief Executive and Registrar Ben Chambers, Head of Registration (Item 11) Nerissa Allen, Executive Assistant (Online)
Observer/s	Maurice Cheng, Chief Executive, Institute of Osteopathy Lynne Chambers, Praesta (Board Effectiveness Review) Pete Freeman, Praesta (Board Effectiveness Review) Colette Byrne, Scrutiny Office, Professional Standards Authority (online) Abdul Rahman Lawal, Performance Review Team, Professional Standards Authority. (online) David Propert, Osteopath (online) Ben Katz, Osteopath (online) Arthur Kyeyune, Osteopath

Item 1: Welcome and apologies

1. The Chair welcomed everyone to the meeting. Special welcomes were extended to:

    a. Professor Debra Towse who joined Council on 1 April 2025 as the new Lay Council member from Wales who will be the Chair of People Committee.

    b. Arwel Roberts the new Council Associate.

    c. Lynne Chambers and Pete Freeman from Praesta who are undertaking the Board Effectiveness Review.

    d. Online and external observers.

    e. The Chair explained about the two registrant vacancies that Council was carrying, with interviews taking place the following week. The Chair assured Council that quoracy was still met to allow meeting to take place.

2. Stakeholder observers:

    a. Maurice Cheng, Chief Executive, Institute of Osteopathy (iO).

    b. Colette Byrne, Scrutiny Office, Professional Standards Authority (online)

    c. Abdul Rahman Lawal, Performance Review Team, Professional Standards Authority (online).

3. Apologies were received from:

    a. Dr Jerry Draper-Rodi, Director, NCOR

Item 2: Questions from Observers

4. There were no questions from online observers.

Item 3: Minutes

5. The minutes of the 126th public meeting, 6 February 2025, were agreed as an accurate record of the meeting.

Agreed: Council agreed the minutes of the 126th public meeting 6 February 2025.

Item 4: Matters arising

6. The Chief Executive introduced the report which asked that Council note the workstreams completed and underway.

a. The Chief Executive provided an update on the amendment to s32 of Osteopaths Act noting there would be two online meetings next week to undertake pre-consultation activity with stakeholders and a consultation document would be issued in June.

b. The Chief Executive confirmed that the NCOR concerns and complaints report was now published on the website.

7. In discussion the following points were made and responded to:

a. It was noted that, in the Fitness to Practise report, the Director of Fitness of Practise had commented on the rise of sexual misconduct cases and had advised that training for the relevant groups in terms of handling these would be undertaken. Council asked if there had been specific training on sexual misconduct.

The Director of Fitness to Practise advised she would review the minutes and revert to Council around training and sexual boundaries.

b. Council noted that reference had been made to the work on the 'Theory of Change' but there was a lack of clarity around the timing of when that work would be reported to Council.

The Chief Executive advised that there would be another internal workshop (two had already been held) therefore it was most likely to be reported at November Council.

Noted: Council noted the matters arising from the meeting of 126th public meeting 6 February 2025.

Item 5: Chair's Report

8. The Chair introduced the report and added some verbal updates.

9. The key points were:

a. Recruitment was underway for two new registrant members of Council and there was a strong field of applicants for the re-run of the previously unsuccessful recruitment in 2024.

b. Candidates had been shortlisted for the Patient Partner role and interviews will be in June.

c. The Chief Executive and Chair held a bilateral with the outgoing iO CEO (Maurice Cheng) and the new President (Dan Collis). There will be a new CEO announced shortly.

d. The Chief Executive and Chair would meet with the CEO and Chair of the General Chiropractic Council in May.

e. The Chair and the Chief Executive attended the Institute of Regulation annual conference in March.

f. The Board Effectiveness Review was underway and the report will be presented at July Council.

g. The Chair and committee chairs meet three times a year.

h. The September Council Day would cover:

I. Team building to welcome new members.

II. A workshop held by Praesta to help us plan following the Board Effectiveness Review.

10. The following points were added by the Chair at the meeting:

a. The Professional Standards Authority Chair round table had taken place the day before and the main focus was the GMC Chair giving feedback on its experience around bringing anaesthetist associates and physician associates into regulation.

b. The iO CEO Maurice Cheng was retiring and the new CEO had been appointed.

Maurice Cheng advised the iO had appointed Dr Alison Robinson Canham as new CEO who fitted well with their strategy of investing heavily in education and policy development, as she had significant experience in that area as an academic.

The Chair noted a firm thanks for all the significant contribution which Maurice Cheng had to the profession.

Noted: **Council noted the Chair's report.**

Item 6: Chief Executive and Registrars Report

11. The Chief Executive introduced the item which presented a review of recent activities and performance not reported elsewhere on the agenda.

12. The following points were highlighted and expanded upon by the Chief Executive:

a. The Chief Executive attended and chaired a session at the Professional Standards Authority (PSA) and Patient and Client Council event in Northern Ireland on 'Improving workplace culture in health and social care by listening and involving all healthcare professionals, staff the public'.

b. The Chief Executive attended the Spring Conference of Osteopathy Europe and participated in a panel discussion around challenges for regulated and unregulated countries and presented on the statutory process for handling complaints made against osteopaths.

c. GOsC had responded to a PSA consultation on revisions to the 'Standards of Good Regulation', a call for evidence from the PSA on reviewing Right-touch regulation and had also provided evidence to the PSA for a good practice report on Standard 3 of the Standards of Good Regulation, Equality and Diversity.

d. Non-executive recruitment campaigns continued to run, specifically for two osteopathic Council members.

e. The following decisions were made outside electronically, outside of Council and reported for minutes in Chief Executive's report appointing the following members to the Investigating Committee:

Mickael Iqbal	Lay	1 April 2025	31 March 2029
Sandra Smith	Lay	1 April 2025	31 March 2029
Jennifer Fletcher	Osteopath	1 April 2025	31 March 2029
Chantal Prince	Osteopath	1 April 2025	31 March 2029

f. Annexed to the paper was a document regarding points of reflection relating to the Nolan principles of standards in public life.

Noted: Council noted the content of the report.

Noted: Council noted the decisions taken electronically by Council, outside of the normal meeting cycle, in relation to fitness to practise appointments to the Investigating Committee.

Item 7: Assurance Report

13. The Chief Executive (Annex A) and the Head of Resources and Assurance (Annex B) introduced the item which provided a set of assurance reports to Council on the performance of the organisation. A separate item on the agenda considered a revised approach to performance reporting, using a dashboard, which could replace reports presented to Council during the business year.

14. In discussion the following points were made and responded to in relation to the Business Plan and Monitoring April 2024- March 2025 (Annex A):

a. Council asked if it was possible for the report to have additional horizontal lines to make reading easier.

b. The Chair asked about the revised timing for the financial and asset management strategy.

   The Chief Executive advised that it would be likely the November Council meeting and would include the proposed revised business plan reporting to Council.

a. The Chair of Audit asked for the environmental elements to be considered within the forward plan.

15. **Financial Report to 31 March 2025 (Annex B)**

16. The Head of Resources and Assurance introduced the report noting the figures were year-end but draft whilst the audit was ongoing. The key messages from the report were:

    a. Total income was around £3.03m and £160k over budget for the year.

    b. Expenditure was around £3.07m and £206k over budget for the year. As previously mentioned to Council, the budget for 2024-25 approved in May 2024 had been under-estimated, and members were assured that the budget for 2025-26 was more reflective of the actual spend in each area.

    c. The Balance Sheet remained strong, and GOsC could face future challenges from a position of financial health.

    d. Cash at bank was around £449k lower than at year end; this reflected the increase in costs for our expenditure. A higher proportion of income was received earlier in the financial year and there was a gradual decrease towards the end of the year.

17. In discussion the following points were made and responded to:

    a. Council queried the areas of overspend (education, professional standards and governance) and asked why more had been spent for that year and why the executive was confident next year it would come into line.

       The Chief Executive advised the current Head of Resources and Assurance had inherited a budget that had some issues and that he was confident that moving forward the budget process was much more robust and accurate.

    b. Council asked what the financial forecasting was over the next few years as Council needed to see a longer-term projection.

The Chief Executive advised that budgets set had resulted in small surpluses being achieved in previous financial years. Because of this past experience, the Chief Executive was confident that would continue to be the case going forward.

c. There will be a three-year forecast for November Council.

d. Council asked for the QA overspend to be explained and whether it related to additional activity that was unforeseen.

   The Director of Education, Standards and Development advised that there had been additional visits because institutions had introduced new qualifications and our regulations require that GOsC visit new qualifications under a separate process. Another visit needed to be split in two and the planning was another increased cost. These factors accounted for the majority of the overspend and GOsC did not have the ability, under the regulations, to charge for QA.

e. Council suggested that in future, using some sensitivity analysis (the potential for something you have budgeted for to go higher or lower and consider impact of that on the budget) would help to set a risk tolerance.

f. Council asked if it was expected that external auditors would pick up on the quality of budget forecasting.

   The Chief Executive advised the auditors may do however he did not expect it to be sufficient for any qualification of the accounts.

g. It was clarified that this was a one-off budgeting anomaly for one year based on a budget the current Head of Resources and Assurance had inherited.

Noted: Council note the assurance reports as set out in Annex A and Annex B.

Item 8: Fitness to Practise Report and Dataset:

18. The Director of Fitness to Practice introduced the report and added some opening points:

    a. There were a significant number of cases where Fitness to Practise could not progress (e.g. third-party cases) but they were being actively monitored. The report showed that there were a large number of cases 'screened in' but they remained at the Investigating Committee stage for a period of time. Fitness to Practise had considered a large number of these cases at Investigating Committee and some had been closed and some were progressing.

b. An external audit of threshold cases closed by Investigating Committee were reported to Audit Committee in March. It was emphasised that the headline was that of all cases closed, none of them disclosed public protection concerns. There were some learning points and things that could improve decision making but it was reassuring that none presented public safety issues.

19. The key messages from the report were:

a. In the reporting period, there was a marked increase in the number of concerns received (23) in comparison to the last quarter (13).

b. As of 31 December 2024, 5 of the 30 cases referred by the Investigating Committee (IC) to the Professional Conduct Committee (PCC), were listed for hearings. A breakdown of the cases awaiting hearing was in the quarterly dataset at Annex A (page 6).

c. During the reporting period three cases were considered by the PCC including one review hearing, one rule 8 consideration and the conclusion of a part heard PCC substantive hearing.

d. An audit of all concerns and cases closed by Screeners and the Investigating Committee involving the threshold criteria over the period 1 April 2023 – 30 August 2024 took place in February 2025. No public protection concerns were identified from the cases reviewed by the auditor. The other key findings from the report were summarised within this paper.

e. The Regulation team hosted three training events during the reporting period including the annual training days for the IC and the PCC together with an induction day for new PCC members.

f. A section 32 (protection of title prosecution proceedings) had commenced against one individual, Gareth Milner. The trial had been set for May 2025.

20. The Head of Fitness to Practice made the following points in relation to the Fitness to Practice report and datasets:

a. A high number of concerns had been received and the team had been really busy liaising with complainants. There was a healthy number of screener decisions and the KPI at screener stage had been met.

b. The IC KPI was missed which was due to the large number of cases referred. Half of those considered by IC were third party. If the third-party cases were extracted, the time taken was reduced to 32 weeks. Within those cases there were still very complex and difficult cases involving engaging with complainants who were vulnerable.

c. Regarding cases at IC stage –the number had reduced significantly in the previous quarter from 34 to 24 cases (p1 table dataset). The Head of Fitness to Practise wanted to commend the team for the work that was involved in holding five IC meetings with so much preparation required for these. It was pleasing to report the team had managed this so well and it was highlighted that this was the highest number of cases which GOsC had considered during a quarter.

d. The number of PCC cases had increased from 18 to 30 and the Head of Fitness to Practise advised this was being monitored as it was a significant increase. The FTP team were aware of the need to progress to hearings as quickly as possible.

e. When reporting on quarterly stats on 1 April, five cases were scheduled but since then that had increased to nine being scheduled so PCC would be busy in the summer and beyond.

f. The End-to-End KPI , which is set at 52 weeks, was missed due to one PCC substantive hearing that was third party and involved the police which caused a delay.

21. In discussion the following points were made and responded to:

a. Council commented on the section 32 case where the registrant voluntarily left the register but had continued to represent himself as an osteopath, and asked if GOsC had done all it could to stop this.

   The Director of Fitness to Practise advised that GOsC could not do any more than what was in the provision of section 32. Some registrants had a flagrant disregard for section 32 despite a financial penalty and a criminal record. GOsC had done all it could and continued to send out cease and desist letters.

b. Council commented on the complex case mix with sexual misconduct, boundaries etc. often being more challenging in osteopathy due to single practices, lack of chaperones etc. It was noted that it was hard for those witnesses who had been the target of sexual misconduct to go through a criminal court process and then have to go through a process with the regulator too. Council asked what GOsC did to support these witnesses to avoid those cases being dropped by witnesses.

   The Head of Fitness to Practise advised that there was an independent support service for witnesses and registrants and that this was highlighted by the team as much as possible.

   The regulation team had discussed how they could progress complex cases with vulnerable complainants, the challenge being that each case was very

different. The 'tone of voice' training had proved helpful in relation to this area, but it was an ongoing challenge for the team.

c. The Head of Fitness to Practise did meet regularly with counterparts in other regulators to share experiences.

d. The Director of Fitness to Practise advised that because GOsC had a small case load, the team needed to be cautious in identifying potential trends. People reported to GOsC and then fell away because they felt the osteopath would take action against them or they felt vulnerable in the community. The team do go back to vulnerable witnesses however, if new witnesses raised similar concerns, to see if they would act in the public interest and re-engage with the complaint. The witnesses are always offered support to come forward and take action.

e. Council asked if there was any more colour coding could be used in the Fitness to Practise data that showed when a figure was good or bad without translating it.

It was confirmed that dashboard reporting would be covered in the next item.

Noted: Council noted the report and dataset.

Item 9: New Dashboard Reporting

22. The item was introduced by the Chief Executive who explained that the executive was looking at ways to streamline information presented to Council through the introduction of new dashboard reporting.

23. Key messages from the paper:

a. In order to ensure Council was understanding progress against the strategic objectives and the business plan, the executive was seeking to streamline the information presented through the introduction of new dashboard reporting.

b. The introduction of dashboard reporting would be in two areas:

I. Assurance reporting [covering data on matters related to business plan activities, financial, registration, HR]. Some would be additional data reported to Council that is not already.

II. Fitness to Practise.

c. The introduction of the dashboard reporting would significantly reduce the volume of papers presented to Council, although the detail would be available for scrutiny if required.

d. The draft dashboards were presented to Audit Committee in March 2025 for comment. The attachments to the paper reflected the feedback received.

e. The Chief Executive advised he would like to use it from July onwards and asked Council for views, gaps and discussion.

24. In discussion the following points were made and responded to:

a. Some members of Council welcomed the fact that the dashboard provided additional data e.g. HR, it was more accessible and the visuals were easier to understand.

b. Council asked what the Employee Assistance Programme was.

The Chief Executive advised it was a support service for staff if needed help with financial matters, outside work issues, counselling support etc. It was a small cost to provide a positive benefit for staff.

c. Some feedback was provided on specific points:

i. P5 adding the values on each of the bars would be helpful.

ii. P6 employment costs were the bulk of spend so more granularity around that would be useful e.g. salary or anything else.

iii. Narrative underneath –a sense of e.g. a rag rating on some statements regarding how concerned the executive was about potential variations against the plan, or a swing too far in one direction.

iv. Split operating expenditure and capital expenditure to indicate e.g. spend on website or ad hoc advertising costs.

v. P7 bottom graph those due to renew –helpful to try to show the estimated versus actuals. Consider whether looking at it annually might allow comparisons to see if anything bucking the normal trend.

vi. P8 third bullet – understand role in registration was that statement good or bad or indifferent.

d. Some members of Council felt that whilst the high-level dashboard was welcome, as it included some gaps that were not being monitored through the business plan, there needed to be sufficient granularity for Council to scrutinise things in more detail where necessary and were therefore concerned about losing the granular data.

e. It was suggested that the absence of SMART strategic objectives and milestones of what needed to achieve by when it was hard to know if GOsC was being effective in what it was doing.

f. Council suggested caution was needed when making significant changes before the outcome of the Board Effectiveness Review.

g. The Chair commented that the graphs and pie charts helped to create a sense of what was going on but asked how Council would see the link between strategic objectives and whether they were being successfully delivered.

   The Business Plan dashboard looked quite thin so more granularity around business plan reporting would be helpful, otherwise it was very high level and would not necessarily show areas which needed to be addressed.

h. The discussion led to Council considering that it would need both the dashboard and the detail.

i. The Director of Fitness to Practise advised that a deep dive report on Fitness to Practise data went to each November Council and asked Council to consider if that was sufficient in terms of reporting detail or if it needed more detail on a regular basis than the dashboard would provide.

j. The Chief Executive responded that the detailed points from the Chair of Audit Committee (24c) were helpful and would address those.

k. The Chief Executive asked Council to consider what information was needed to be confident that the day-to-day operation was working effectively and what information it needed to ensure that the executive was delivering against the strategy. The theory of change work played into the latter point and the dashboard was intended to be the assurance on the first point.

l. The business plan report would continue as a working document for SMT. None of the information Council received at present would stop it would be available if Council needed to see it for scrutiny reasons.

m. The Chief Executive advised it had been heard from previous and current iterations of Council that shorter and fewer papers would be welcomed. This had been discussed at Audit Committee in response to comments that the papers were overwhelming.

n. It was suggested that looking at the reporting from the view point of how Council gets the assurance e.g. that the executive was focusing on the right things. This would read across to risk and the delivery of the statutory responsibilities A timeline for activities rather than a list would also be helpful.

o. The Chair summarised that there was value to the short version but not to the expense of the detail. It was suggested that Council look at the outcome of the Board Effectiveness Review and the Scheme of Delegation and make some more concrete decisions in the Autumn but in the meantime keep both.

p. The Chief Executive advised that the executive would continue with the previous form of reporting rather than duplicate work so would pause this for July meeting and then discuss after the Board Effectiveness Review report how Council wishes to take this forward.

q. Council noted that the Chief Executive needed a clear steer from Council of what it was looking for collectively and perhaps there needed to be a clear way of articulating the plan for the delivery of the strategic objectives.

Agreed: Council agreed it would consider how it sought assurance after the Board Effectiveness Review report had been received and digested and the Chief Executive advised that in the meantime the previous form of report would be used to avoid duplication.

Comfort break 1415-1430

Item 10: Health and Disability Guidance

25. The Head of Policy and Education introduced the item which was updated guidance for Osteopathic Education Providers, applicants and students on Students studying osteopathy with a disability or heath condition.

26. The key messages and following points were highlighted:

a. The paper reported on the results of the consultation on the updated guidance which was reported to the Policy and Education Committee at its March 2025 meeting (Annex A):

I. Studying osteopathy with a disability or health conditions: guidance for applicants and students

II. Students with a disability or health condition: Guidance for Osteopathic Educational Providers

III. Easy Read versions of each.

b. Post consultation changes were shown in red in the annexes B and C.

c. Agreement was sought from Council for publication of the guidance documents.

d. Updated versions of the Easy Read versions were being developed as a result of feedback from the Policy and Education Committee.

27. In discussion the following points were made and responded to:

a. Policy and Education Committee were positive around the guidance and had provided some feedback on the easy read versions which maybe oversimplified things and the pictures were not accurate.

   The Head of Policy and Education advised these versions were being edited.

b. Council asked if the easy read approach was something that would be used in the future and if there were the resources to do that.

   The Head of Policy and Education advised it was being trialled on this because workshops with neurodiverse students had highlighted they had known that the guidance was there but it was hard to engage with. They needed something that summed it up in one easy read.

c. The Chair of Policy and Education Committee commended the work that had been done on the guidance for education providers and hoped they would engage with it and use it.

Noted: Council noted the outcome of the consultation on updated guidance:

- **Studying osteopathy with a disability or health conditions: guidance for applicants and students**
- **Students with a disability or health condition: Guidance for Osteopathic Educational Providers**

Noted: Council noted the publication and implementation plans and the updated Equality Impact Assessment.

Agreed: Council agreed to publish the guidance documents.

Item 11: Registration Report

28. The Head of Registration introduced the report which provided an update on registration activity covering the six-month period from 1 October 2024 to 31 March 2025.

29. The key messages and following points were highlighted:

a. At the end of March 2025 there were 5,596 osteopaths on the Register, representing a slight growth this year.

b. The number of non-practising registrants stood at 187 at the end of March 2025.

c. Ten return to practise assessments were completed in the reporting period. Four registration assessments, connected to internationally qualified applicants, were completed.

d. Paragraph 6 provided a comparison of age categories. There was an increased number of registered osteopaths in the 51-60 bracket.

30. In discussion the following points were made and responded to:

a. Council asked whether sensitivity analysis was included when the Chief Executive presented the forward projection of fee income noting how difficult it was to predict what might happen due to external factors e.g. economic environment, the challenges that institutions face etc.

   The Chief Executive responded that forecasts and projections were informed by all key data sources including external factors.

b. Council asked if the Head of Registration had any thoughts about new registrants and patterns.

   Head of Registration advised the team had noticed they were receiving more requests from graduates who had chosen not to register, asking GOsC to write letters to overseas regulators to support their career in osteopathy in other countries.

   The Head of Policy and Education advised that the data on osteopathic student numbers and graduates was available if Council wanted to see it.

c. Council suggested that the dashboard discipline would be helpful i.e. to agree a specific timeframe i.e. a multi-year view or an in-year comparison.

d. NCOR had several projects in the pipeline regarding the register, one looking at whether students were intending to remain in the UK or move overseas and another that would look at predicted changes overall in the profession.

Noted: Council noted the content of the report.

Item 12 Unconfirmed Policy and Education Committee minutes, March 2025:

31. The Chair of Policy and Education Committee introduced the minutes and gave a brief summary of the key discussions.

a. It was noted that Debra Towse needed to be added to attendance list.

Noted: Council noted the Unconfirmed Policy and Education Committee minutes, March 2025

Item 13: Any other business

32. There was no other business.

Item 14: Questions from observers

33. There were no questions from observers.

Date of the next meeting: Tuesday 15 July 2025

Meeting closed at 1441 followed by 15 minutes Council reflection time.

General Osteopathic Council

4

Council
15 July 2025
Matters arising

Classification	Public
Purpose	For noting
Issue	This paper addresses any actions arising from the public minutes of Council of May 2025.
Recommendation(s)	To note the content of the report.
Financial and resourcing implications	None.
Equality and diversity implications	None.
Communications implications	None.
Annex(es)	None.
Author	Matthew Redford, Lorna Coe

Background

1. This paper addresses any matters arising from the 127th public minutes of Council not covered elsewhere on the agenda. The matters arising are set out below:

Minutes of the 127th public meeting of Council:

Item	Minute	Action	Outcome
Item 4: Matters Arising	Para 7a refers	Council asked if there had been specific training on sexual misconduct. The Director of Fitness to Practise advised she would review the minutes and revert to Council around training and sexual boundaries.	At the annual training day on 1 December 2022, the professional conduct committee received interactive training on: Questioning witnesses, focussing on witnesses in sexual boundaries cases. This training was delivered by Sarah Ellson, partner with Field Fisher solicitors. The 2025 training day for members is in development and this matter will be revisited.
Item 9: Dashboard reporting	Paras 22 - 24 refer	Council agreed it would consider how it sought assurance after the Board Effectiveness Review report had been received and digested	**Ongoing:** this is likely to form part of the discussion at the September 2025 Strategy day.
Item 10: Health and Disability Guidance	Paras 25 - 27 refer	Council agreed to publish the guidance documents.	**Ongoing:** The guidance and documents have been translated into Welsh and are going through the design and typesetting process. These will be published during the summer ahead of students and educators returning next term.

Recommendation: To note the content of the report.

General Osteopathic Council

5

Council
15 July 2025
Fraud or error in relation to registration – Report on Registrar's investigation

Classification	Public
Issue	The attached paper sets out a report by the Registrar following an investigation conducted under Section 10(1) of the Osteopaths Act 1993. The investigation related to an entry in the Register which is alleged to have 'been fraudulently procured or incorrectly made' (section 10(1)).
Recommendation	Council is asked to consider the Registrar's report and make a decision in the case as provided in Section 10.
Financial and resourcing implications	None identified
Equality and diversity implications	None identified
Communications implications	The registrant must be notified of Council's decision and a copy of the decision published on the GOsC website
Annexes	A. Section 10 of Osteopaths Act 1993 and the GOsC B. (Fraud or Error and Appeals) Rules 1999 (the 1999 Rules) C. Bundle of supporting documents (Private – Council only) D. Service Bundle (Private – Council only)
Author	Sheleen McCormack

REGISTRAR'S REPORT

Introduction

1. Section 10(1) of the Act provides as follows:

   'The Registrar shall investigate any allegation that an entry in the register has been fraudulently procured or incorrectly made and report on the result of his investigation to the General Council'.

The allegation

2. The allegation to be considered by Council is that Mr Siqueira Silva:

   a) In his application form for Restoration to the Osteopaths Register (the form) dated 27 August 2024, in response to Question 5(d) and 5(e) and 5(g) on the form, namely whether he ever had any disciplinary findings and/or investigations and/ or police investigations made against him in the UK or any other country, he wrote "N" in the box for each question.

   b) He signed the form as accurate and true when he knew (or ought to have known) there were investigations being conducted and/or findings had been made against him:

      (i) by the Deputy Health and Disability Commissioner of New Zealand and/or
      (ii) by the Osteopathic Council of New Zealand and/or
      (iii) by the police in New Zealand.

      In light of paragraphs a) and b) above, the Registrar would not have been satisfied that Mr Siqueira Silva was of good character and permitted him entry onto the Osteopaths Register.

Background

3. In order to register with the GOsC, Mr Siqueira Silva submitted an application for restoration (the form) to GOsC dated 27 August 2024. Question 5(d) on the form asks the following question: 'Have you ever had any disciplinary findings made against you in the UK or another country'. The two options to complete this box are either 'Y' for Yes or 'N' for No. Mr Siqueira inserted 'N' in answer to this question.

4. Question 5(e) of the form asks the following question: 'Are you (i) currently subject to any disciplinary investigations in the UK or any other country, and/or (ii) aware of any impending or future disciplinary investigations in the UK or any other country?' The two options to complete this box are either 'Y' for Yes or 'N' for No. Mr Siqueria Silva inserted 'N' in answer to this question.

5. Question 5(g) on the form asks the following question: 'Are you currently the subject of any police investigation or criminal proceedings in the UK or any other country?'. The two options to complete this box are either 'Y' for Yes or 'N' for No. Mr Siqueria Silva inserted 'N' in answer to this question.

6. As part of the GOsC registration process, Mr Siqueria Silva submitted a Brazilian police check (dated 13 August 2024) and a New Zealand police check (dated 15 May 2024) as part of his application. Both showed that Mr Siqueria Silva did not have a criminal record as at the date issued.

7. GOsC did not receive a Letter of Good Standing from the Osteopathic Council of New Zealand (OCNZ) which is a document that would normally be received for this type of restoration application made by Mr Siqueria Silva. This was an oversight on our part. Mr Siqueria Silva submitted a copy of an OCNZ annual practising certificate to GOsC instead.

8. On 17 March 2025, GOsC received a report from The Health and Disability Commissioner (HDC), based in New Zealand. The report outlined the opinion of the HDC Commissioner having considered concerns raised against Mr Marcelo Siqueria Silva by a patient (Patient A).

9. A summary of the concerns raised within the HDC report is detailed below:

10. Patient A went to see Mr Siqueria Silva while he was working as an osteopath in new Zealand. Her treatment with him commenced in Sept 2021. It is alleged that Mr Siqueria Silva was over friendly with Patient A, and a friendship between them ensued. His text messages to Patient A became flirtatious and then became sexual. Both Mr Siqueria Silva and Patient A would hug at the start of treatment, for example, and that 'the hugs began to feel romantic, and from time to time [Mr Siqueria Silva] would rest his hand on her.' It is further alleged that Mr Siqueria Silva informed Patient A that he needed to touch her vagina as part of a pelvic floor treatment. In June 2022, Mr Siqueria Silva tried to kiss Patient A. In March 2023, he treated Patient A at her home. Patient A told the police in New Zealand that it was during this treatment that Mr Siqueria Silva indecently assaulted her by touching her inappropriately. At a final appointment at the clinic, Patient A claimed that Mr Siqueria Silva again indecently assaulted her. In October 2023 Patient A made a complaint to police in New Zealand against Mr Siqueria Silva setting out the allegations of indecent assault.

Investigation

11. On 02 April 2025, the GOsC sent a notice of suspension to Mr Siqueria Silva to confirm that that we were investigating an allegation that his registration had been fraudulently procured or incorrectly made in accordance with section 10(1) of the Osteopaths Act 1993 and that the GOsC Registrar proposed to suspend his registration pursuant to the above allegation set out at paragraph 2.

12. GOsC wrote to the OCNZ on 8 April 2025, to make inquiries regarding any information they could share in relation to Mr Siqueria Silva and his practice. The OCNZ replied on 9 April 2025, confirming that as a result of the notification from the HDC and with the understanding that Mr Silva had left New Zealand, that interim conditions on Mr Sequeria Silva's scope of practice. Mr Sequeria Silva was provided an opportunity to make submissions on the proposed conditions. OCNZ confirmed that he acknowledged acceptance of the proposed conditions via email.

13. OCNZ also confirmed that they subsequently determined to impose conditions on Mr Sequeria Silva which included informing them if he intended to return to New Zealand and, if he did, that he must seek Council approval for any practice location where he intends to practice. He would also be required to practice at a location where at least one other health practitioner was practising and all patients must be accompanied by a chaperone.

14. On 14 April 2025, Mr Siqueria Silva responded to GOsC's notice of suspension letter by email. Within this email he stated, 'I am writing to formally confirm my acceptance of the registration suspension. I will cease practicing as an Osteopath effective from 17 April 2025, with my last day at the clinic being 16 April 2025'. Mr Siqueria Silva attached a number of documents including a reference from a practice where he worked in Auckland; two patient references; a letter of apology to Patient A; a detailed response to the HDC and a letter from his counsel, Belinda Jones, dated 3 December 2024, addressed to the Director of Proceedings at the HDC where she acknowledged on Mr Siqueria Silva's behalf 'his inappropriate and unprofessional behaviour' towards Patient A. It is also of note that reference was made by Mr Siqueria's Silva's counsel to the HDC's allegations of indecent assault being investigated by the New Zealand Police.

15. GOsC made repeated requests to the New Zealand police in order to obtain further information regarding its investigation into the allegations against Mr Siqueria Silva. In an email dated 4 June 2025, the New Zealand police stated that, while there were able to release information to the OCNZ under the Health Practitioners Competence Assurance Act, that legislation did not apply to requests from outside of New Zealand.

Information from the osteopath concerned

16. The GOsC wrote to Mr Siqueria Silva on 30 May 2025, informing him that Council will consider the matter at its meeting on 15 July 2025 and that he has the right to attend the public parts of the meeting and submit further information for the Council to consider. Mr Siqueria Silva was asked to provide further information by 4 July 2025.

17. On 4 June 2025, the GOsC received an email from Mr Siqueria Silva. Within this email he stated 'I would like to formally inform you that I kindly refuse my right to attend the upcoming public meeting. Thank you for your understanding.'

Issues

18. Section 10 (5) of the Act provides that if, having considered the Registrar's report, the Council is satisfied that the entry in question is fraudulent, it may order the Registrar to remove the entry. There are therefore two matters for the Council to consider in relation to Mr Siqueria Silva's entry on the Register:

    a. Was the entry in question fraudulently procured or incorrectly made?

    b. If the Council is satisfied that it was, on either of those bases, does it wish to order the Registrar to remove the entry?

19. The first question is one of fact. In coming to its decision on fact, the Council may wish to consider the information provided by Mr Siqueria Silva on both his GOsC Application for Restoration form and in light of the subsequent information provided by the HDC and OCNZ. The Council should also take into account the documentation supplied by Mr Siqueria Silva.

20. Once the Council has made its finding on fact, it must then consider whether to order the Registrar to remove Mr Siqueria Silva's entry from the register. In doing so Council members should have in mind the purpose of Section 10 which is to ensure that only those who should be admitted to the register have an entry on it.

The Council's discretionary powers under Section 10

21. In exercising a discretion the Council must demonstrate that it has considered whether the wider public interest will be served by Mr Siqueria Silva's continued registration, in terms of upholding the reputation of the profession and maintaining public confidence in it, but its main focus will be whether, by allowing Mr Siqueria Silva to remain on the Register, the public is protected and patient safety is ensured. In reaching a decision, the Council must take all relevant factors into account, disregard irrelevant ones, and come to a decision to which a reasonable decision maker would come.

22. In coming to its decision, the Council should have regard to:

    a. The GOsC's overarching, statutory objective to protect the public and act in the wider public interest;

    b. The need to maintain the integrity of the GOsC register and uphold the reputation of the profession;

23. The Council should note that, whatever its decision, it does not have to be one to which every decision maker would come, given the same facts, it must simply be one which a reasonable decision maker would make.

Sanction

24. Section 10 provides only that the Council 'may order the Registrar to remove the entry'. As such, the only options available are either to remove the Mr Siqueria Silva's name from the register, or to take no action.

25. The Council would have to consider what mitigating and aggravating features of this case there might be and decide how the public interest is best served: by removing Mr Siqueria Silva from the Register, or by taking no action. If the Council decides to take no action, it would be open to it to mark its disapproval (if indeed it does disapprove) of Mr Siqueria Silva's conduct, in a judgement or statement about the case.

26. The Council should provide reasons for its decision.

Appeal

27. The Council should note that if it decides to order Mr Siqueria Silva's entry to be removed from the register, the Registrar is required to notify Mr Siqueria Silva of that, and that he has a right of appeal to the County Court.

For decision:

28. The Council is asked to:

    a. Consider the Registrar's report, and

    b. Make a decision in the case as provided in Section 10.

Recommendation: Council is asked to consider the Registrar's report and make a decision in the case as provided in Section 10.

Osteopaths Act 1993

10 Fraud or error in relation to registration.

(1)The Registrar shall investigate any allegation that an entry in the register has been fraudulently procured or incorrectly made and report on the result of his investigation to the General Council.

(2)An entry which has been restored to the register under section 6(5) or section 8, or under rules made by virtue of section 8(8), may be treated for the purposes of this section as having been fraudulently procured or incorrectly made if any previous entry from which the restored entry is derived was fraudulently procured or incorrectly made.

(3)The Registrar may, at any time during his investigation, suspend the registration in question if he is satisfied that it is necessary to do so in order to protect members of the public.

(4)The General Council shall by rules make provision, in relation to any case where the Registrar proposes to suspend an osteopath's registration under subsection (3)—

(a)giving the osteopath concerned an opportunity to appear before the Investigating Committee and argue his case against suspension;

(b)allowing him to be legally represented; and

(c)for the Registrar to be made a party to the proceedings.

(5)If, having considered any report of the Registrar, the General Council is satisfied that the entry in question has been fraudulently procured or incorrectly made it may order the Registrar to remove the entry.

(6)Where such an order is made, the Registrar shall without delay notify the person whose entry is to be removed—

(a)of the order; and

(b)of the right of appeal given by subsection (7).

(7)Where such an order is made, the person whose entry is to be removed may appeal **[**F1in England and Wales to the county court or in Northern Ireland**]** to **[**F2a county court or, in the case of a person whose address in the register is in Scotland, **[**F3to**]** the sheriff in whose sheriffdom the address is situated**]** .

[F4(8)Any such appeal must be brought before the end of the period of 28 days beginning with the date on which notification of the order was served under subsection (6).**]**

(9)On an appeal under this section, the General Council shall be the respondent.

F5(10). . . . . .

[F6(11)On an appeal under this section, the court (or the sheriff) may—

(a)dismiss the appeal,

(b)allow the appeal and quash the order appealed against, or

(c)remit the case to the General Council to dispose of the case in accordance with the directions of the court (or the sheriff),

and may make such order as to costs (or, in Scotland, expenses) as it (or he) thinks fit.**]**

(12)The General Council may by rules make such further provision as it considers appropriate with respect to suspensions under subsection (3), including in particular provision as to their duration.

STATUTORY INSTRUMENTS

1999 No. 1846

OSTEOPATHS

The General Osteopathic Council (Fraud or Error and Appeals) Rules Order of Council 1999

Made - - - -	*30th June 1999*
Coming into force - -	*5th July 1999*

At the Council Chamber, Whitehall, the 30th day of June 1999

By the Lords of Her Majesty's Most Honourable Privy Council

Whereas in pursuance of sections 10(4) and (12), 27(3), 28(3) and 29(2) of, and paragraph 21 of the Schedule to, the Osteopaths Act 1993(**1**) the General Osteopathic Council have made the General Osteopathic Council (Fraud or Error and Appeals) Rules 1999 as set out in the Schedule to this Order:

And whereas by sections 35(1) and 36 of that Act such rules shall not come into force until approved by order of the Privy Council:

Now, therefore, Their Lordships, having taken the said Rules into consideration, are pleased to, and do hereby, approve the same.

This Order may be cited as the General Osteopathic Council (Fraud or Error and Appeals) Rules Order of Council 1999 and shall come into force on 5th July 1999.

A. K. Galloway
Clerk of the Privy Council

(**1**) 1993 c. 21.

THE GENERAL OSTEOPATHIC COUNCIL (FRAUD OR ERROR AND APPEALS) RULES 1999

The General Osteopathic Council, in exercise of its powers under sections 10(4) and (12), 27(3), 28(3) and 29(2) of, and paragraph 21 of the Schedule to the Osteopaths Act 1993(**2**), and of all other powers enabling it in that behalf, hereby makes the following Rules:

PART 1

INTRODUCTION

Citation and Commencement

1. These Rules may be cited as the General Osteopathic Council (Fraud or Error and Appeals) Rules 1999 and shall come into force on 5th July 1999.

Interpretation

2.—(1) In these Rules, unless context otherwise requires—

"the Act" means the Osteopaths Act 1993;

"an appeal" means an appeal against a relevant decision;

"legal assessor" means a person appointed under section 27 of the Act;

"medical assessor" means a person appointed under section 28 of the Act;

"a relevant decision" means a decision referred to in section 29(1) of the Act.

(2) Unless the context otherwise requires, any reference—

(a) in these Rules to a numbered rule is a reference to the rule bearing that number in these Rules;

(b) in a rule in, or in the Schedule to, these Rules to a numbered paragraph is a reference to the paragraph bearing that number in that rule or in the Schedule;

(c) in a paragraph in the Schedule to these Rules to a numbered subparagraph is a reference to the subparagraph bearing that number in that paragraph.

Service of documents

3.—(1) Subject to paragraph (4), in these Rules a reference to the sending of a notice or other document to any person (other than a document referred to in paragraph 8(2) of the Schedule which may be sent by post) is a reference to delivering it to him personally or sending it to him by registered post or by the recorded delivery service—

(a) where the person is the Registrar, to the address of any office of the General Council;

(b) where the person is a registered osteopath—

(i) to his address in the register or, if his last-known address differs from the address in the register, his last-known address, or

(ii) if he is represented by a solicitor, to the solicitor's professional address;

(c) where the person is not a registered osteopath or the Registrar—

(**2**) 1993 c. 21.

(i) to his last-known address, or

(ii) if he is represented by a solicitor, to the solicitor's professional address.

(2) Where a notice or other document is—

(a) sent by registered post or by the recorded delivery service it shall be treated as having been sent on the day that it was posted;

(b) delivered personally, if—

(i) it is delivered by the Registrar, it shall be treated as having been delivered when it is handed to the osteopath concerned or the person aggrieved as the case may be;

(ii) it is delivered by the osteopath concerned or the person aggrieved, it shall be treated as having been delivered when it is handed to the Registrar or to his representative or left at any office of the General Council.

(3) Where the Registrar is required to send a notice under rule 4(1) or 5(a), he shall in that notice inform the person to whom it is sent that a notice under rule 4(3) or a notice of appeal under rule 6 as the case may be must either—

(a) be delivered personally; or

(b) be sent by registered post or bythe recorded delivery service.

(4) Notwithstanding the preceding provisions of this rule, a notice sent by post under rule 4(3) or a notice of appeal sent by post under rule 6 other than by registered post or by the recorded delivery service shall be treated as complying with the requirements of paragraph (1) if it is received at any office of the General Council within the time limits specified for sending that notice or notice of appeal as the case may be.

PART II

FRAUD OR ERROR

Fraud or error in relation to registration

4.—(1) Where the Registrar proposes to suspend an osteopath's registration pursuant to an allegation that such registration has been fraudulently procured or incorrectly made, he shall send the osteopath concerned a notice stating that—

(a) he may appear before the Committee and argue his case against suspension if he notifies the Registrar in writing of his intention to do so within the period of fourteen days beginning with the date of the sending of the notice; and

(b) he may be legally represented.

(2) The Registrar may extend the period referred to in paragraph (1)(a) if he is satisfied that in all the circumstances it is reasonable to do so.

(3) Where the osteopath concerned has, within the period referred to in paragraph (1)(a) (or within any extension of that period allowed by the Registrar under paragraph (2)), sent the Registrar a notice stating that he wishes to appear before the Committee, the Registrar shall fix a day on which the Committee is to hear the osteopath or his representative and notify the osteopath of the day on which the time and place at which the hearing is to be held.

(4) The Registrar shall not fix a day for the hearing on any day earlier than the end of the period of twenty eight days beginning with the day on which the osteopath concerned delivered or sent the notice referred to in paragraph (3) to the Registrar.

(5) The Registrar shall be a party to the proceedings under this rule and may appear before the Committee at the hearing and be legally represented.

(6) Both the osteopath concerned and the Registrar may produce documentary evidence to the Committee and may call witnesses and put questions to any person called as a witness before the Committee.

(7) Where the proceedings before the Committee concern an allegation that entry to the register has been fraudently procured, it shall not hear any evidence which would not be admissible if the proceedings were criminal proceedings in any court in that part of the United Kingdom in which the hearing takes place unless, after consultation with the legal assessor, it is satisfied that its admission is necessary in order to protect members of the public.

(8) At the hearing before the Committee the Registrar shall first present the case for suspending the registration of the osteopath concerned and the osteopath shall be given the opportunity to speak last but, subject to these requirements, the procedure at the hearing shall be such as the Committee may determine.

(9) The Committee may adjourn the proceedings from time to time as it thinks fit.

(10) The Committee shall decide whether or not there is reasonable cause for the Registrar to suspend the registration of the osteopath concerned and, if there is reasonable cause, the duration of the suspension.

(11) The duration of the suspension of registration under section 10(3) of the Act shall be for a period of not longer than six months but if, having considered any report of the Registrar, the General Council is satisfied that the entry in question has not been fraudulently procured or incorrectly made, it shall order the Registrar to lift the suspension immediately.

(12) The Chairman of the Committeee shall give the decision of the Committee orally at the end of the hearing and the Registrar shall—

(a) record the decision in writing;

(b) as soon as is practicable after the hearing, send a copy of the decision and the reasons for the decision to the osteopath concerned; and

(c) where the Committee upholds the Registrar's proposal to suspend the registration of the osteopath concerned, send to the osteopath a notice of suspension which includes the duration of the suspension.

(13) In this rule, "the Committee" means the Investigating Committee.

PART III

APPEALS UNDER SECTION 29 OF THE ACT

Notice of Relevant Decision

5. Where the Registrar has made a relevant decision he shall, before the end of the period of seven days beginning with the date on which the decision was made—

(a) send to the person in respect of whom the decision was made notice in writing of the decision; and

(b) inform him that he may—

(i) within the period of twenty eight days beginning with the date on which notice of the relevant decision is sent to him, appeal to the General Council in accordance with these Rules; and

(ii) be legally represented.

Notice of Appeal

6. A notice of appeal shall—

(a) be in writing;

(b) be delivered or sent to the Registrar; and

(c) contain a concise statement of the grounds of appeal on which the person aggrieved intends to rely.

Procedure for determining appeals

7.—(1) The Schedule to these Rules shall have effect with respect to the procedure for determining an appeal.

(2) Subject to the provisions of that Schedule, the procedure for determining an appeal shall be such as the General Council may decide.

SCHEDULE

PROCEDURE FOR DETERMINING AN APPEAL

Hearing of the appeal

1.—(1) As soon as practicable after the person aggrieved has appealed against a relevant decision the Registrar shall—

(a) fix a day on which the General Council is to hold a hearing of the case;

and

(b) notify the person aggrieved of the day on which and the time and place at which the hearing is to be held.

(2) The Registrar shall not fix a day for the hearing on any day earlier than the end of the period of twenty eight days beginning with the day on which the notice under subparagraph (1) has been sent.

(3) The Registrar and the person aggrieved may appear before the Council and be legally represented.

(4) The person aggrieved and the Registrar may produce documentary evidence to the General Council, may (subject to subparagraph (5)) call witnesses and may put questions to any person called as a witness.

(5) The person aggrieved and the Registrar shall each, before the beginning of the period of seven days ending with the date fixed for the hearing, produce to the other a list of witnesses to be called at the hearing failing which a witness may not be called except with the consent of the General Council.

Private Hearings

2. The oral hearing shall be in private unless the person aggrieved requests a public hearing.

Postponement of adjournment of Hearing

3.—(1) The General Council, either of their own motion or at the request in writing of the person aggrieved, may postpone a hearing at any time before the beginning of the hearing and may adjourn the proceedings from time to time as they think fit.

(2) Where a hearing has been postponed or proceedings have been adjourned for more than twenty eight days the Registrar shall send the person aggrieved notice of the date on which the General Council is to hold the postponed hearing or resume the hearing that has been adjourned and the Registrar shall not fix a day for the postponed hearing and the Council shall not resume the hearing on any day earlier than the end of the period of twenty eight days beginning with the date on which the notice has been sent.

Absence of the person aggrieved

4. Where the person aggrieved is neither present nor represented at the hearing, the General Council may nevertheless proceed with the hearing if it is satisfied that all reasonable steps have been taken in accordance with rule 3(1) to serve the notice of the hearing on the person aggrieved.

Procedure at the hearing

5.—(1) The procedure of the General Council at the hearing shall be as follows—

(a) the Registrar shall present the case in support of the relevant decision and may call and question witnesses and may give evidence on his own behalf;

(b) The Registrar and any person called on his behalf may be cross-examined by the person aggrieved and, in the case of persons called on his behalf, may be re-examined by the Registrar and the Registrar may give evidence a second time;

(c) the person aggrieved may present the case against the relevant decision and may call and question witnesses and may give evidence on his own behalf;

(d) the person aggrieved and any person called on his behalf may be cross-examined by the Registrar and, in the case of persons called on his behalf, may be re-examined by the person aggrieved and the person aggrieved may give evidence a second time;

(e) the Registrar may address the General Council concerning the relevant decision;

(f) the person aggrieved may address the General Council concerning the relevant decision.

(2) Where the Registrar or the person aggrieved are legally represented, references in subparagraph (1) to the Registrar or the person aggrieved—

(a) presenting the case;

(b) calling or questioning witnesses; or

(c) addressing the General Council

shall be read as references to the representative of the Registrar or the person aggrieved as the case may be.

(3) Members of the General Council present at the hearing, the legal assessor and the medical assessor may, with the consent of the Chairman of the General Council or, where the Chairman of the General Council is not present at the hearing, the consent of the person who is chairing the hearing, question any person giving evidence at the hearing.

(4) Where it appears to the General Council necessary or expedient either—

(a) for the proper or expeditious running of the hearing; or

(b) for the convenience of a witness at the hearing

that the procedure set out in subparagraph (1) should be changed, the Council may, after consulting the legal assessor and giving the Registrar and the person aggrieved or their representatives the opportunity to be heard on the matter, decide to change the procedure and in particular the Council may decide that the order of the calling of the witnesses be different from that set out in subparagraph (1) and that a witness may be recalled to give further evidence.

Decision of the General Council

6.—(1) The General Council shall in private decide whether to dismiss or allow the appeal.

(2) The General Council shall have power to confirm, overturn in whole or in part, or vary the order of the Registrar as it thinks fit.

(3) The decision of the majority of the members of the General Council who are present at the hearing shall be the decision of the Council, but if the vores are equal, the appeal shall be decided in favour of the person aggrieved.

(4) The decision of the General Council shall be given in writing and the Registrar shall—

(a) as soon as practicable after the hearing, send a copy fo the decision and the reasons for the decision to the person aggrieved; and

(b) inform the person aggrieved of his right to appeal, on a point of law, against the decision of the Council in accordance with section 29(4) of the Act.

Recording of proceedings

7.—(1) The Registrar shall arrange for the proceedings of the General Council at an oral hearing of an appeal to be recorded.

(2) The person aggrieved shall, on application to the Registrar and on payment of a reasonable charge, be sent a transcript of the proceedings.

Given under the official seal of the General Osteopathic Council this day of nineteen hundred and ninety nine.

L.S.

Simon Fielding
Chairman

EXPLANATORY NOTE

(This note is not part of the Order)

This Order, made under the Osteopaths Act 1993 ("the Act"), approves rules made by the General Osteopathic Council ("GOsC")—

enabling an osteopath, where the Registrar of the GOsC during his investigation of whether the osteopath's registration has been fraudulently procured or incorrectly made, proposes to suspend his registration upon being satisfied that it is necessary to do so in order to protect members of the public, to appear before the Investigating Committee of the GOsC to argue against the proposed suspension; and

enabling applicants for registration and those already registered to appeal against adverse decision of the Registrar of the GOsC, the procedure for determining such appeals being set out in the Schedule to the rules.

General Osteopathic Council

6

Chair's report to Council: July 2025 - for noting

Recruitment

- We are recommending appointment of a new registrant Council member (subject to PSA/Privy Council approval). This follows the unsuccessful registrant recruitment last Autumn.

- Unfortunately, we did not appoint a Scottish registrant member, and this recruitment will need to be run for a third time.

- We will be appointing two 'Patient Partner' members for our pilot scheme.

Stakeholders

Institute of Osteopathy

- I have held an initial meeting with the new CEO, Alison Robinson Canham. We discussed collaborative working and creating clear messaging for stakeholders about the respective roles of our organisations

- The iO Conference will be in November in central London (Council have been invited). iO are working with stakeholders on their agenda and we will keep you updated.

Governance

- Council appraisals were completed last week, including the CEO appraisal and my own appraisal.

- I met with the Committee Chairs in late June, and will be meeting three times a year (February, June and September).

September Council day

- We are still finalising the details of the September day, but it will definitely include a workshop held by Praesta to help us plan following the Board Effectiveness Review.

General Osteopathic Council

Council
15 July 2025
Chief Executive and Registrar's Report

Classification	Public
Purpose	For decision.
Issue	A review of activities and performance since the last Council meeting not reported elsewhere on the agenda.
Recommendations	1. To note the content of the report. 2. To agree the appointment of Reena Ainscough as a Patient Partner, from 1 September 2025 for one year. 3. To note that a second Patient Partner will be recommended to Council electronically once we have satisfactorily completed our reference and due diligence checks.
Financial and resourcing implications	None arising from this paper.
Equality and diversity implications	The paper sets out what we have done since the previous Council meeting on matters related to equity, diversity, inclusion and belonging.
Communications implications	None.
Annexes	None.
Author	Matthew Redford

Key messages from this paper:

- The report sets out the activities undertaken by the team since the previous Council meeting not reported elsewhere on the agenda. Headlines include:
    - Our successful performance review report was published for 2024-25. We have again met all 18 Standards of Good Regulation.
    - A consultation on protection of title has been launched and concludes in October 2025.
    - We will be engaging with international colleagues in Germany, Canada and New Zealand over the coming months and we hosted representatives from an osteopathic school in India in June.
    - Interviews for our first Patient Partners identified two candidates. We are recommending one for appointment at this meeting and are completing reference and due diligence checks on the other candidate.
    - We have identified one osteopathic Council member candidate but we will need to readvertise in Scotland as an appointment was not made for a Scottish representative.
    - We are making progress towards the redevelopment of the new website and the implementation of the CRM system.

Introduction

1. This report gives an account of activities of note that have been undertaken by the Chief Executive and Registrar and colleagues since the previous Council meeting, which are not reported elsewhere on the agenda.

Professional Standards Authority for Health and Social Care (PSA)

Standards of Good Regulation

2. Our performance review assessment for 2024-25, which highlighted for 15 years in a row we had met all 18 Standards of Good Regulation, was published by the PSA on 16 June 2025 and can be accessed here: Performance Review Report.

Institute of Osteopathy (iO)

3. The new Chief Executive of the Institute of Osteopathy, Dr Alison Robinson Canham, started in June 2025. Ahead of Alison officially taking up her new role, I had the pleasure of meeting with her and, since appointment, Alison has met with Fiona Browne, Director of Education, Standards and Development and with Jo Clift, Chair of Council. We look forward to continuing to work with Alison over the months ahead.

4. We have been engaging the iO as they prepare for their two-day convention which will be held in November 2025. We look forward to presenting at convention and to having representation and engagement with the profession during the event.

Protection of title

5. We have launched a consultation on protection of title which was informed by two pre-consultation online workshops that had representation from across the osteopathic sector including patients. I would like to thank all stakeholders for their engagement.

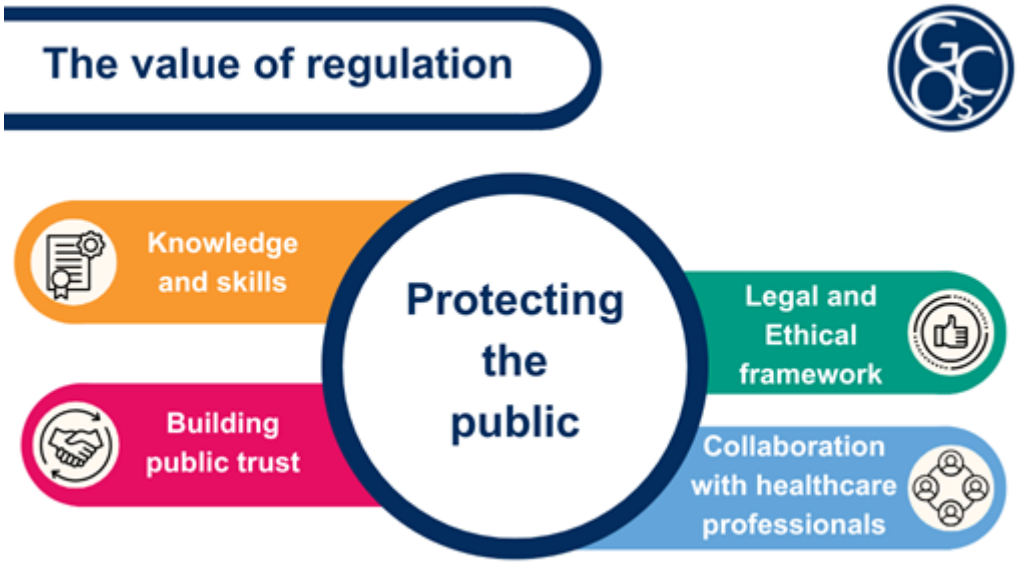
6. The consultation runs until October 2025 with the results due to be presented to the November Council meeting. There will be two online consultation Q&As held in August and September respectively and we are keen to engage with osteopaths and interested parties throughout the consultation period.

7. The consultation has been shared with osteopaths, patients, osteopathic organisations and wider stakeholders including other health regulatory bodies and interested regulatory partners including the Royal College of Veterinary Surgeons. I am also pleased to report that there has been engagement with our international partners and the consultation has been shared through the Osteopathy Europe network and with counterparts in Australia and New Zealand.

8. On the back of the consultation, I have been asked to present on this work at the Osteopathy Europe Autumn Conference in Germany.

Value of Regulation

9. We are taking proactive steps to highlight to osteopaths, patients and stakeholders where the activities we fund and/or undertake demonstrate the value of regulation. This language will feature more in our communications, e.g. I have used this in a recent blog alongside a new graphic (see below), which also features in our Annual Report and Accounts. I would encourage members of Council to support our drive to raise awareness around the value of regulation.



10. Following the blog, I was contacted by Professor Sidney Rubenstein, Endowed professor 'Optimizing Management of Musculoskeletal Health', Vrije Universiteit, Amsterdam; Faculty of Health & Life Sciences, Department of Health Sciences.

11. Professor Rubenstein is a chiropractor, researcher and vice-chair of a Patient Safety Initiative at the World Federation of Chiropractic, who wants to understand what GOsC does around patient safety. A meeting is being arranged for Professor Rubenstein and the Senior Management Team for later in July.

International matters

France, recognition of qualifications

12. We have previously reported to Council that we have been liaising with Phillipe Sterlingot, new President of the Osteopathic International Alliance, to try to better understand the process of UK graduates registering to practise in France, post Brexit, and with the UK having third country qualification status.

13. We have received the English translation of the French requirements, and have mapped these to our own graduate outcomes to identify alignment and any gaps. We have written to Phillipe with the outcome of our review, offering ways of making progress. We will follow-up with Phillipe shortly.

Osteopathy Europe (OE)

14. We will be attending the Osteopathy Europe Autumn Conference in Germany in mid-October 2025. The agenda for this meeting has yet to be determined; however, we are aware of interest from our European colleagues around our work in the area of AI, and as referenced earlier, I have been asked to speak about our protection of title consultation. The conference will also have a focus on the development of the CEN Standard.

15. A fuller report on this meeting will be made in my Chief Executive Report to the November 2025 Council meeting.

Osteopathic International Alliance (OIA)

16. We will be attending the Osteopathic International Alliance (OIA) Annual Conference to be held this year in Toronto in early November. I have been selected as a speaker for the conference and will be presenting on the topic of: *Listening, Learning, Leading: GOsC's Patient Engagement Journey.*

17. A verbal report will be made to the November 2025 Council meeting.

New Zealand

18. The Policy and Education Committee (PEC) considered a paper at its June 2025 meeting which explored the concept of a mutual recognition of registration system with New Zealand. The concept was well received and I am currently planning to bring a paper to the November Council meeting seeking a decision on this matter.

19. I will be taking annual leave in New Zealand in August/September, and while visiting Auckland, I have decided to attend the Osteopathy Conference held by Osteopaths New Zealand and Osteopathy Australia.[1] In attending the Conference I will participate in a panel discussion around international registration; I will hold a tri-lateral meeting with colleagues from Australian Health Practitioner Regulation Agency (AHPRA) and the Osteopathic Council of New Zealand, and I shall also present on our patient engagement activity across the weekend event.

India

20. In June, we hosted representatives from the Sri Sri School of Osteopathy, which is hosted at the Sri Sri University, India, who wanted to gain insights into regulatory best practices, explore potential areas of cooperation and discuss pathways for aligning osteopathic education in India with standards in the United Kingdom. The discussion was wide-ranging and informative and we have shared a number of documents with Sri Sri representatives including the Graduate Outcomes and Standards for Education and Training and guidance documentation for international applicants. We anticipate future conversations with Sri Sri School of Osteopathy.

[1] Osteopaths New Zealand and Osteopathy Australia are the professional associations for those two jurisdictions, equivalent to the UK's Institute of Osteopathy

Recognition of Professional Qualifications (RPQ) within the Industrial Strategy and the Trade Strategy

Industrial Strategy:

21. The UK Government has published its Industrial Strategy and alongside it the Professional and Business Services Sector Plan (PBS), although the focus will be, for example, on legal services, architects and engineers. With a greater focus on government on RPQ and offers of support, we may be able to leverage this expertise should we choose to enter into RPQ negotiations with countries with similar regulatory requirements to ourselves.

22. The PBS Sector plan outlines the Government's commitment to enabling growth in regulated sectors through RPQ. It highlights:

    - The economic significance of RPQ, with 204 professions regulated by 80 bodies, covering 20% of the UK workforce and contributing to 36% of UK services exports.

    - In response to the strong industry interest, a renewed focus on negotiating RPQ agreements to support UK professionals entering new markets and growing exports in key overseas markets - particularly in the professional and business services (PBS) sector.

    - As such, the Department of Business and Trade (DBT) will be developing a new package of hands-on support to identify recognition opportunities and negotiate and implement further RPQ arrangements with overseas counterparts. DBT are keen to develop this in collaboration with regulators, and will provide further information on this in due course.

Trade Strategy:

23. The UK Government published The UK's Trade Strategy which sets out the approach and commitment to free, open and fair international trade. The Trade Strategy will work alongside the Industrial Strategy to stimulate economic growth through targeted support for UK industries in a changing global landscape.

24. RPQ is a key lever in both strategies. The Trade Strategy recognises that regulators have an important role to play in unlocking RPQ barriers in high value markets and sectors – '*Through close work with regulators in high value PBS sectors including engineering, architecture, accountancy and legal services (growth-driving sectors which exported £29.7bn of services globally in 2024), and regulated sectors including veterinary medicine and healthcare, we will seek to identify and secure RPQ agreements with key partners in Europe, the US, Canada, Australia, New Zealand, India and the Middle East.'*

25. To deliver on this commitment, the Regulated Professions Policy Team (within the Department of Business and Trade) will be developing a programme of measures to facilitate RPQ Mutual Recognition Agreements. This programme unit will offer hands-on support for regulators to identify recognition opportunities with priority overseas partners (including in the EU) and implement further recognition arrangements.

Osteopathic Education

26. Recognised Qualification reviews have been carried out in relation to the existing programmes delivered at the following providers:

    London School of Osteopathy (LSO) in relation to:
    - Master of Osteopathy (MOst)
    - Bachelor of Osteopathy (Hons)

    Swansea University in relation to:
    - Master of Osteopathy

27. The Visitors' reports were reported to PEC (in March 2025 for LSO and June 2025 for Swansea). The Committee agreed to publish the Visitor reports which provide evidence to continue the recognition of the above programmes with no conditions and no expiry dates.

28. As the programmes are already recognised with no expiry dates, no further decision by Council or Privy Council is required.

29. In June, I attended the London School of Osteopathy Trustee Board meeting, where the Board were undertaking a review of their strategy. I presented on three areas at their request being: (1) insights into developing a strategy (2) future profession risks, opportunities, barriers and (3) regulatory reform. I valued the opportunity to engage with the Trustee Board and have made an open offer to return if they would find it of benefit.

Patient activity

30. We received 12 applications for our inaugural Patient Partner Programme, with five individuals shortlisted for interview in June 2025. Following interview, two candidates were identified for appointment from 1 September 2025 for one year.

31. We are able to appoint one candidate at the July Council meeting (Reena Ainscough), with the second candidate undergoing reference and due diligence checks at the time of writing the report. The details of that candidate will follow to Council when those checks have been completed satisfactorily.

- **Reena Ainscough**
  Reena is a passionate and seasoned commercial procurement leader with over 15 years' experience in leading procurement functions and

transformation across the public and private sectors.

Reena has led numerous change programmes that include centralising services, creating new business models/greenfield functions, system implementation and supplier management, enabling organisations to leverage spend and increase efficiency and innovation.

Reena is currently a Director of Strategic Procurement responsible for developing and delivering procurement activities at A2Dominion. Prior to joining A2Dominion, Reena held senior commercial and procurement roles at the BBC, FCA and Metropolitan Police leading on procurement transformation, strategic outsourcing, insourcing, supplier management and development.

She is a member of the Chartered Institute of Procurement and Supply Chain and is in the process of becoming a Fellow.

Artificial intelligence (AI)

32. In May we published interim guidance on the use of AI in osteopathic practice. The guidance was issued on an interim basis. This has allowed us to issue the guidance quickly, given the speed in which the technology is developing and the need to support osteopaths in this area. Issuing interim guidance also allows us to make updates as needed based on feedback from the sector, developments in government policy and technological developments.

33. Feedback received so far has indicated that the guidance has been well received and osteopaths. We have also invited feedback from osteopaths and will incorporate this when considering updates to the guidance.

34. We are also continuing to work with our education providers and at an inter-regulatory level to consider how we best approach the use of AI in healthcare professional education. We are also developing our approach to AI use within the GOsC and are aiming to run a pilot to explore how best we can use this technology in the next couple of months.

Pride 2025

35. For the third year in a row the osteopathic community will walk in the London Pride Parade under the GOsC banner. At the time of writing the paper we have c.40 people scheduled to participate.

Website redevelopment project

36. We have completed stage 1 of the website redevelopment project which saw 20 companies submit initial tender bids against three essential criteria and one desirable criteria. These were assessed by the panel independently and scored with a moderation meeting held to identify four companies who have progressed

to the second stage of the tender, which will see a full submission including costings, a presentation and interview with the tender panel.

37. The timetable for this work is as follows:

Procurement:

Activity	**Timeline**	**Duration**
Deadline for Stage 2 responses	July 2025	3 weeks
Supplier clarification meetings (presentations)	July 2025	1 week
Evaluate proposals and select	August 2025	2 weeks
Standstill – 10 days	August 2025	2 weeks
Contract award	September 2025	2 weeks
Project initiation	September 2025	2-6 weeks
Stage 2 procurement total duration	**July - Sept 2025**	

Implementation (indicative timetable):

Activity	**Timeline**	**Duration**
Inception and Technical Investigation	September 2025	2 weeks
Development	October - Dec 2025	3 months
Ozone Build & Integration	January 2026	1 month
Content Migration	January - March 2026	3 months
Pre-Launch Testing & Launch	April 2026	2 weeks
Implementation total duration	**September 2025 - April 2026**	**8 months**

CRM implementation

38. The CRM implementation is progressing although we have encountered challenges with the third-party website company making the resources available to help progress the project.

39. We are 100% complete in terms of Salesforce configuration. **o** zone to Salesforce integration has a target completion date of mid-July 2025.

40. Further activity is required of the current website provider to include a new Welsh language renewal form, an optional equality monitoring data collection form attached to the renewal of registration process and new and improved login for the **o** zone. This work is scheduled for August with a potential go-live date of September.

41. On completion of the integration, we will then choose the best date to launch the new CRM system as this will require us to pause access to registration services on the **o** zone. We need to align this approach with our registration renewal/student application cycles so we minimise disruption to the profession. We also need to ensure we allow time for communication with the profession around any changes they may see, for example, around the login to the **o** zone.

42. While there is a delay with the registration CRM, we have taken the opportunity to bring forward activity around using Salesforce to support fitness to practise processes. These currently sit outside of the legacy CRM system.

43. The new CRM will be implemented by the end of 2025.

Charity Governance Code changes

44. Following a previous consultation, the Charity Governance Code is undergoing a review with changes expected to be published later this year, most likely around September. It is anticipated that changes will place emphasis on digital governance, environmental responsibility, and enhanced stakeholder engagement.

45. When published we will review and bring this to Council's attention.

Internal Audit

46. I reported in May 2025 that we appointed TIAA as our new Internal Audit firm. TIAA have developed an internal audit three-year plan which is under consideration by the Audit Committee; however, it was agreed that the first audit would assess Registration processes and this internal audit has been scoped and is soon to be underway.

Appointment and reappointment activity

Council members, 2 osteopath positions

47. We have re-run the recruitment campaign for two osteopaths to join Council. While one recommendation has been made and is going through PSA/Privy Council approval, we were again unsuccessful in our efforts to appoint from Scotland. We will need to re-run the campaign again and would ask Council members, particularly osteopaths, to help promote this via social media and/or other networks. We will advise Council members when the campaign is re-launched.

Investigating Committee, 2 osteopath vacancies

48. Later in the year, we will be running a campaign to appoint two osteopaths to the Investigating Committee and we would encourage Council colleagues to also promote this opportunity.

External meetings – bringing insight into our business

49. Since the previous meeting we have participated in several external events with stakeholders and partner organisations which ensure that we are able to bring insight to our work. These meetings, which have not been referenced elsewhere in the report, include:

- London School of Osteopathy, Trustee Board, Strategy day
- Chief Executives of the Regulatory Bodies forum
- Osteopathic Development Group (including ODG sub group on data insights)
- Inter-regulatory forums including education, communications and engagement, research, EDI, governance and performance, Alliance UK Regulation in Europe and artificial intelligence and meetings with regulators on a variety of topics
- Regulator and Educator Liaison Meetings with members of the Council of Osteopathic Education Institutions
- Meetings with individual existing osteopathic educational providers
- Meetings with prospective osteopathic educational providers
- Meetings of the Trailblazer Group, chaired by osteopaths, Daniel McCarthy and James Gill and including representatives of osteopathic educational providers and the Institute for Apprenticeships and Technical Education (IFATE) developing the Osteopathic Apprenticeship Standard
- Workshop on boundaries and equality, diversity, inclusion and belonging with Waltham Forest Osteopathy Group
- Royal College of Veterinary Surgeons
- Jane Easty and Neil Hayden, Sutherland Cranial College
- Molinari Institute
- Osteopathic Alliance
- Regular supervision meetings with Professor Louise Wallace and Professor Gemma Blackwell-Ryan for our PhD student Kathryn Parkin
- National Council for Osteopathic Research Trustee Board
- Institute of Osteopathy (iO) meetings
- Michael Evans, IT Consultant and BPI On Demand (Salesforce)
- Martin Chaney, IT Consultant (website development)
- Nick Jones, Chief Executive and Registrar, General Chiropractic Council
- Gillian Robinson, Pharmaceutical Society of Northern Ireland
- Ongoing engagement with osteopaths including contributions to consultations and focus groups
- Ongoing engagement with patients including contributions to consultations and focus groups and a Patient Involvement Forum Development Day
- Praesta
- All staff meetings and workshops

Recommendations:

1. To note the content of the report.

2. To agree the appointment of Reena Ainscough as a Patient Partner, from 1 September 2025 for one year.

3. To note that a second Patient Partner will be recommended to Council electronically once we have satisfactorily completed our reference and due diligence checks.

General Osteopathic Council

Council
15 May 2025
Assurance reporting

Classification	Public
Purpose	For noting.
Issue	A set of assurance reports are provided to Council on the performance of the organisation.
Recommendations	To note the assurance reports set out at Annex A and B.
Financial and resourcing implications	The Business Plan monitoring report is attached at Annex A. The financial report is attached at Annex B.
Equality and diversity implications	These are dealt with within the Annexes.
Communications implications	None.
Annexes	A. Business Plan Monitoring Report to 30 June 2025 B. Financial report to 31 May 2025
Author	Matthew Redford, Darren Pullinger

GENERAL OSTEOPATHIC COUNCIL

Business Plan

April 2025 - March 2026

Monitoring Report as at 30 June 2025 – TO BE UPDATED

GOsC BUSINESS PLAN 2025-26

Our vision is to be an inclusive, innovative regulator trusted by all. And we recognise that to achieve our vision we need to make progress each year against the three strategic priorities agreed by Council which are:

- Strengthening trust
- Championing inclusivity
- Embracing innovation

This document, the Business Plan Monitoring Report 2025-26, sets out the detailed activities in support of each of the goals and our progress against each.

Legend

Status
 On track
 Delayed
 Cancelled/postponed

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
Seek changes to enhance public protection under Section 32 of the Osteopaths Act - Protection of Title.	Undertake consultation and analyse responses.	March - June 2025	Chief Executive, Fitness to Practise, Professional Standards, Communications		Consultation launched on 17 June with wide ranging communication activity to encourage awareness and participation	
	Agree Council position.	July 2025			Later start to consultation has pushed this work back.	November 2025
	Seek amendment to Section 32 with Department of Health and Social Care.	From July 2025			Later start to consultation has pushed this work back.	From November 2025
Implementation of Strategic Patient Partnership Programme at Council level.	Patient partner recruited and induction and ongoing support in place.	September 2025	Professional Standards			

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Ongoing development of the Patient Involvement Forum to enhance quality of patient input to our policy development.	July 2025			We are the early stages of developing a recruitment campaign to expand membership.	
	Ongoing evaluation.	Post October 2025				
Develop and publish guidance and other online resources specifically for participants in GOsC remote hearings Zoe.Lorna 03/07/2025 14:21:39	Undertake a comprehensive review of remote guidance for witnesses and registrants for preparing for, and appearing in, GOsC remote hearings inviting contributions from stakeholders including Victim	From June 2025	Regulation, Communications		Communications and Regulation team are meeting in July to discuss. As part of the wider FtP work, remote guidance has been highlighted as a priority.	

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Support and the Witness to Harm project at Open University.					
	Undertake consultation on guidance.	August - October 2025				
	Publish guidance.	November 2025				
Take long-term financial and asset decisions which support delivery of statutory responsibilities and GOsC strategic aims. Coe Lorna 03/07/2025 14:21:39	Consideration of future registration fee modelling undertaken with any relevant consultations launched, responses analysed and results published.	From July 2025	Chief Executive, Resources, Communications			

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
To support students and osteopaths to practise to high standards in accordance with the Osteopathic Practice Standards.	Publish NCOR Concerns Report collaborating with NCOR, iO and insurers.	February 2026	Professional Standards, Communications			
	Development of joint statement with insurers around professional responsibilities.	July 2025			Further consideration of feedback from stakeholders required to find ground on which there can be collective agreement.	November 2025
	Ongoing development of resources and engagement to support implementation of standards.	All year				

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Ongoing quality assurance activity as quality assurance of osteopathic education brought in-house.	All year to March 2025				
	Begin review of the Osteopathic Practice Standards by launching call for feedback.	From June 2025			PEC have agreed for us to launch a call for feedback on the existing standards by the Autumn. We are developing our delivery plans to meet this timeframe.	
	Provide ongoing analysis of standards and ethical queries and responses to inform OPS call for feedback.	October 2025			An analysis was provided to PEC in June 2025. We are continuing to record all queries we receive from stakeholders.	
	Complete report on Osteopathic Practice Standards call for feedback and	March 2026				

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	launch Review of the OPS.					
Implementation of actions arising from independently facilitated review of GOsC Tone of Voice.	Independent review completed with action plan.	April 2025	Communications, Registration, Fitness to Practise		Ongoing sharing of resources to maintain momentum.	
	Implementation of agreed actions.	From May 2025				
Raise awareness of our role and increase engagement with stakeholders and implement DJS actions.	Implement student engagement plan.	From April 2025	Communications, Professional Standards		Promotion of first meeting of student forum has begun, with 6 students having shown interest so far. Posters promoting the forum have been sent to providers with most sharing with their students. One provider will begin promoting from September when the students return. Student visit programme for 2025/26 year being agreed before being shared with educators. Promotion of student ebulletin has begun on social media, and via student ebulletin and posters to education providers. No signs up yet but aware this is exam period.	

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
					Launched section 32 consultation which focuses on our role as the regulator Discussions are underway with Gilly Woodhouse of OsteopathyWorks about GOsC guesting on one of her podcasts. Additionally provided her with myths and Independent Support Service details to share in her Facebook group. Conversations underway with Independent Support Service about a new poster for promotion of the service.	
	Explore appetite for holding an educator conference.	October 2025	Professional Standards			
	Undertake ongoing face to face regional engagement with osteopaths.	All year	All staff		We met with the Waltham Forest Osteopathy Group in June 2025 to discuss boundaries and equality, diversity, inclusion and belonging.	

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Update fitness to practise sections of the website to include digital assets to explain the process clearly and accessibly.	July 2025	Communications, Regulation		Fitness to practise and 'Raise a concern' sections on the website have been updated to include visuals on the concerns process/timelines, myth busters, and hearing set ups. The content has been reviewed following the publications of the FtP annual report and updated to reflect the report. A podcast episode on FtP was published in April and audiograms highlighting the FtP process and the Independent Support Service were shared on social media. Work is ongoing to enhance the FtP content, including a jargon buster, remote hearing visuals and further promotion of Independent Support Service.	
	Update social media strategy and monitor use and impact of new communication channels and approaches including updated social	March 2026	Communications		The monthly digital report has been established, evaluating social media (and other digital channels). The report highlights social media audiences and key learnings. The comms team will reflect on the evaluation every 12 weeks and use it to enhance social media content. A short paper looking at discontinuing use of X (formerly Twitter) is being drafted for SMT. The social media strategy will be drafted following	

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	media, WhatsApp and Drop in Sessions and evaluate.				this. WhatsApp launched in late January 2025 and has seen consistent engagement with approximate 50-60 messages each month. Response times are consistently improving with most enquiries receiving a response within 5-30 minutes. Promotion of WhatsApp will begin on social media.	

Championing inclusivity: **It is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so**						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
Collect, analyse, publish equality, diversity and inclusion data changes made, or mitigations put in place, where we have identified there is an undue impact on those with protected characteristics.	Publish information, throughout the year, including but not limited to: - Registration renewal - Governance and appointments - Fitness to practise - registrants and complainants - Policy development and consultations.	From April 2025	Chief Executive supported by Professional Standards, Regulation, Communications, Registration, Resources and Human Resources			

Championing inclusivity: It is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Equality Impact assessments for all policies and processes which allow GOsC to demonstrate changes made or mitigations put in place.	From April 2025			Our approach to Equality Impact Assessments is considered by the Senior Management Team and their monthly team meetings. We are also considering whether an Internal Audit of how we conduct Equality Impact Assessments, to ensure consistency across the GOsC, should be a feature of our new Internal Auditors plan for 2024-25.	
Promote our Equality Duty responsibilities and the actions we intend to take to further our commitment to Championing Inclusivity. Coe Lorna 03/07/2025 14:21:39	Demonstrate progress against the new Equity, Diversity, Inclusion and Belonging Framework to include: • Updated social media, and image strategy • EDIB progress updated on website • Key messaging for the CRM roll out to encourage	All year with a specific Council annual report, July 2025	Chief Executive, Communications		Promotion of the student ebulletin and forum created and shared in Welsh too. Student ebulletin sent out in Welsh in May to students living and/or studying in Wales. Consultation on Section 32 published in June including an assessment of the impact on opportunities to speak Welsh. New images showing a wider diversity of people have been sourced and are being used across the ebulletin and social media.	

Championing inclusivity: It is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	completion of EDI data • Compliance with the Welsh Language Standards • Ongoing monitoring and reporting of equality impact assessments including for policy development and consultations • Ongoing support and resources for implementation of EDIB CPD subject to consultation.					
Implementation of recommendations arising from	Independent review completed.	From May 2025	Human Resources, Chief Executive		Independent report completed and considered by People Committee. Agreed that the development of an action plan will be	

Championing inclusivity: It is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
independent review into non-executive recruitment activity.					presented to the October 2025 People Committee for sign-off.	
	Action plan arising from independent review developed.	June 2025				October 2025
	Implementation of agreed actions.	From July 2025				From October 2025
Support workforce recruitment and retention to maintain and increase a sustainable, diverse profession and to support osteopaths to practice in accordance with high standards.	Publication of NCOR Research projects on recruitment and retention.	July 2025	Professional Standards, Communications			
	Implementation of NCOR research recommendations.	September 2025 onwards				
	Transition into practice: Hold workshop with Osteo pathic Development Group	June 2025			Slight delay in arranging the workshop which will be independently facilitated.	September/October 2025

Championing inclusivity: It is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	organisations to explore and inform sector wide actions including development of GOsC guidance.					
	Consideration of workshop findings and agreement to next steps.	October 2025				
	Ongoing discussions with European Regulators to clarify requirements for the recognition of professional qualifications and agree next steps.	All year			We have written to our contact in France outlining the similarities with regards to UK and French training and are awaiting a response. We also attended meetings with Osteopathy Europe, which has enabled us to raise our profile with European colleagues and forge relationships to aid work on qualification recognition.	
Implement and evaluate health and disability guidance.	Publish health and disability guidance for students.	July 2025	Professional Standards, Communications		Work is underway and the student version is almost complete, the educator version is being designed and both versions have been translated into Welsh ready for design. A comms plan is to follow which will include a	August 2025

Championing inclusivity: It is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
					look at how and if this project can be integrated into any other projects.	
	Take steps to integrate health and disability guidance into engagement plans.	August 2025				
	Collect data on awareness and use of guidance.	Ongoing to March 2026				
	Publish evaluation report in implementation.	March 2026				
Strengthen Equity, diversity, inclusion and belonging with the GOsC CPD scheme. Coe Lorna 03/07/2025 14:21:39	Complete consultation and analysis of results on updated CPD scheme strengthening communication and consent requirements through a focus on mandatory EDI	June 2025	Professional Standards		We consulted on adding a mandatory requirement to incorporate CPD in boundaries and EDIB to the current mandatory communication and consent element of the scheme. The consultation outcomes were reported to our Policy and Education Committee in June 2025. Further resources in each will be developed and osteopaths encouraged to undertake CPD in these areas, with a further decision on making this mandatory to be revisited by PEC.	

Championing inclusivity: It is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	and boundaries activities.					
	Agree and implement new CPD scheme.	August 2025				

Embracing innovation: We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
Through tendering, identify a supplier and develop a new public website which provides scope for more modern, innovative and engaging channels and content.	Invitation to Tender process concludes with identification of supplier.	June - July 2025	Communications, Chief Executive		We received 20 submissions in response to our ITT. We have shortlisted 4 suppliers and presentations are due to take place in July.	
	Development of new public website.	From July 2025				Contract awarded and project initiated with supplier: September 2025
	Implementation of new public website.	March 2026			Implementation timeline will be agreed with chosen supplier	
Review the impact of changes in the delivery of healthcare including artificial intelligence on osteopathic education and osteopathic care and the use of artificial intelligence in	Analysis of feedback on use of AI and agreement to statement about expectations and use of AI in education and practice (if possible in collaboration with health professional regulators).	June 2025	Professional Standards, Chief Executive, IT, Human Resources		We launched our interim guidance on the use of AI in osteopathic practice in the middle of May. We will provide further supporting materials later in the summer/early Autumn to aid promotion of the guidance. We have held one further meeting at an inter-regulatory level on exploring a joint position with regards to AI and education and presented some draft text for comment. We are continuing to work with osteopathic educators to develop a shared position with regards to AI use and osteopathic education.	

Embracing innovation: **We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation**						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
health care for patients and to consider impact on osteopathic standards and regulation.	Commission research to support ongoing understanding about use of artificial intelligence ongoing in osteopathic practice.	July 2025			We are still considering our approach to this and aim to make further progress by Autumn 2025.	October 2025
	Agreement to process of updating and next steps.	July 2025				

Embracing innovation: We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Procure appropriate models of AI for GOsC and ensure updates and training for all staff to ensure a skilled workforce fit for the future.	June 2025			A project plan and timeline is being developed. We aim to pilot an AI tool internally in the Autumn in order to develop proof of concept that could inform further phases.	October 2025
Seek continuous improvement arising from independent reviews of board effectiveness and internal audit activities.	Results of board effectiveness review presented to Council.	July 2025	Chief Executive, Governance, Resources		Paper to be presented to Council 15 July with the headline themes set out by Praesta (reviewers).	
	Implementation of actions identified through board effectiveness review.	From August 2025			Action plan arising from BER report will be developed in a facilitated session at Council Strategy Day in September.	September 2025
	Internal Audit plan agreed by Audit Committee.	June 2025			Three-year plan for 2025-2028 developed with TIAA and presented to Audit Committee in June. First audit (Registration) underway. Audit Committee will review scopes of further audits in October 2025.	

Embracing innovation: **We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation**						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Internal Audits programme commences.	From July 2025			The Registration process is the first audit to be carried out, and will be underway in July following a planning meeting in mid-June.	
Refine and implement Theory of Change to measure progress and implementation of the Strategy.	Hold theory of change workshops with staff.	June 2025	Professional Standards			
	First draft of Theory of Change to Council for consideration.	July / September 2025			On Council private agenda, July 2025	
	Ongoing development and agreement to final evaluation strategy and refine data collection.	October 2025				

Embracing innovation: **We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation**						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
Implement more streamlined approach to data mapping, collection, insight and analysis and actions.	Collate comprehensive data map across organisation and update privacy policy and collection notices.	From May 2025	Professional Standards and Research, Data and Insight			
	Align data sets and develop systematic analysis and reporting.	November 2025				

Annex A to 8

GOsC metrics to help ensure we are delivering efficient and effective regulation.

In 2025-26 we expect to:

Metric	Status	Narrative, if relevant
Process c5,500 registration forms (UK and International applicants and annual renewal of registration forms) and c5,000 reminder notices.		2,770 renewal of registration forms processed to end June 2025. 2,354 fee reminders (28-day). 123 (14-day fee and renewal form).
Support c220 first-time applicants to join the UK Register (including applications from internationally qualified applicants and from UK qualified graduates).		25 new applications fully processed at end June 2025. 0 international applications fully processed at end June 2025.
Receive c200 queries from patients, members of the public, registrants and other healthcare professionals, leading to c75 fitness to practise cases being opened, of which c30 will be referred for investigation leading to c12 being referred for a final determination hearing.		As of 30/06/2025: 34 queries/concerns received 19 opened as an FTP case, of which 3 currently referred for Investigation Four substantive hearings heard and zero cases disposed of by Rule 8 process (consensual disposal)
Undertake quality assurance processes with 7 osteopathic educational providers including analysis of 7 annual reports and undertaking visits to four osteopathic educational providers.		Ongoing.
Holding 3 good practice events and continue to engage on a 1:1 basis with all osteopathic educational providers during the year.		We have continued to meet with COEI as a group and with education providers on a 1:1 basis. We continue to offer engagement with all new students (in person or online) to introduce them to regulation and professionalism, and to any other student year group as requested by the provider/s.
Respond to c2,000 enquiries into our osteopathic information support service for osteopaths, patients and the public; c60 policy and ethical queries related to our standards; c4,600 registration queries and c650 student queries.		431 queries received at 27 June 2025. 26 policy and ethical queries related to the application of the OPS at end June 2025. 256 registration queries received at end June 2025. 54 student queries received at end June 2025.
Send out 12 monthly ebulletins to registrants achieving an open rate of c60%.		April - 58% May - 59%

Metric	Status	Narrative, if relevant
Send out 4 quarterly English language student ebulletins to 450 students (penultimate and final year) achieving an open rate of c40%.		February: 64% May: 55%
Send out 4 quarterly Welsh student ebulletins to 70 students living in Wales (penultimate and final year) achieving an open rate of c30%.		February: 55% May: 53%
Receive and fulfil 150 requests for personalised Registration Marks		27 requests received at end June 2025
Attend and participate in upwards of 25 osteopathic sector meetings, webinars and regional events engaging with osteopaths, students, patients and osteopathic organisations and other stakeholders reaching approximately 250 students and 500 osteopaths.		15 events attended by June, with c125 osteopaths, students and other stakeholders attending.
Ensure the patient voice informs the work of the GOsC through at least 100 interactions (formal and informal) with members of the patient involvement forum.		1 patient engagement event held as at end June 2025. 11 individual touch-points with patients including where patients provide follow-up ideas to our work to end June 2025
Host 2 recruitment webinars attracting c200 attendees including c80 osteopaths and engage with c150 interested applicants for our independent fitness to practise panel positions.		Likely to happen later in the business year
Continue to regularly receive feedback after our webinars and events that attendees have shifted their perceptions in a positive way e.g. are less fearful and have a deeper understanding about the topic		As above
Ensure Council and Committee scrutiny and oversight of our work through servicing 15 meetings.		Council and Committee meetings have been held throughout the business year.
Provide training, development and strategy opportunities for c.50 members of the GOsC governance (decision making) structure, as well as those who advise on our statutory decision making including 12 education visitors and 8 registration assessors.		Council and Committees happened in May, June and July. Induction meetings for new members happened from April.
Provide training and development opportunities for our staff team.		Ongoing throughout the year.

Annex B to 8

Financial Report 2025-26 (two months to May 2025)

Key messages from the report:

- Total income is around £541k and is £8k under budget for the first two months of the year.
- Operational expenditure is around £497k and is £57k under budget for the two month period. Spending from designated reserves was £44k in the first two months of the year.
- The Balance Sheet remains in a strong position, and we can face future challenges from a position of financial health and confidence.
- Cash at bank is currently around £24k lower than at year end; however, we are expecting the cash position to improve due to a larger portion of registration renewals occurring between May and September.

Background information

1. Our current financial year commenced on 1 April 2025 and will conclude on 31 March 2026. In this report it will be referred to as FY2025-26.

2. The budget for FY2025-26 was approved by Council in February 2025.

3. Council receives a financial report at each meeting which presents the cumulative financial results for a given period. Where possible, the reports try to cover quarterly periods within the financial year.

4. In circumstances where the Council papers are being dispatched close to the end of a quarter, it may not always be possible for the financial report to cover the full period. To give Council more robust financial information, we may from time to time shorten the reporting period and issue reports outside of the Council meeting cycle.

5. The financial quarters are as follows:

	Start	**End**
Quarter 1	1 April	30 June
Quarter 2	1 July	30 September
Quarter 3	1 October	31 December
Quarter 4	1 January	31 March

6. This financial report covers the period ending 31 May 2025, which is two months through the financial year.

7. Forecast figures will be provided from the second quarter onwards once we have progressed more into the year, and can reanalyse the figures based on actual income and expenses.

8. The structure of this report is:

    - Summary of financial position - income/expenditure narrative
    - Income and Expenditure Account (top-level department summary)
    - Balance Sheet, including explanatory notes
    - Cash flow: overview and projection
    - Annex A: Expenditure Account (detailed departmental summaries)

Summary of financial position

9. At the end of the two month period to 31 May 2025, the income and expenditure account shows a surplus position (before designated spending from reserves) of £44k. Spending from reserves budgets in the two month period was £44k.

10. We have budgeted a surplus position of around £6k, before designated spending, by year end.

Income

11. The primary source of income is from registration fees paid by osteopaths. The GOsC does not have a single registration date meaning that in every month there is a proportion of osteopaths due to renew their registration. In accordance with accounting rules, we need to ensure that we account for, and report, only the proportion of the fee relevant to the financial period.

12. At 31 May 2025, total income totalled around £541k, which is approximately £8k under budget for the same period. Registration fees accounted for 94% of the total income received. Investment gains, registration assessments, bank interest, and other income accounted for around 6% of income in the same period.

Expenditure

13. After the first two months of the year, we have recorded actual expenditure of around £497k. This is approximately £57k under budget for the same period, but we are expecting this variance to level off as the year progresses.

Income and Expenditure Account (top-level summary)

14. The Income and Expenditure Account is set out below:

	Year to Date 1 April 2025 – 31 May 2025				
	Actual	**Budget**	**Variance**		**FY Budget**
			£	**%**	
Income					
Registration fees	508,966	518,871	(9,905)	(2)	3,113,225
Registration assessments	690	3,333	(2,643)	(79)	20,000
Other income	31,311	10,842	20,469	189	65,050
Total	**540,967**	**533,046**	**7,921**	**1**	**3,198,275**
Expenditure					
Employment costs	300,962	324,338	23,376	7	1,933,025
Education and professional standards	38,093	39,148	1,055	3	119,539
Communications, research and development	15,775	15,198	(577)	(4)	91,186
Registration administration	-	3,333	3,333	100	20,000
IT and infrastructure	19,245	20,852	1,607	8	125,110
Fitness to practise, including legal	62,132	66,666	4,534	7	400,000
Governance	27,462	43,408	15,946	37	260,450
Central resources and financing	33,213	41,203	7,990	19	243,217
Total	**496,882**	**554,146**	**57,264**	**10**	**3,192,527**
Surplus before designated spending	**44,085**	**(21,100)**	**65,185**		**5,748**
Designated spending	43,540	41,083	(2,457)		246,500
Surplus after designated spending	**545**	**(62,183)**	**62,728**		**(240,752)**

NB: a positive variance indicates better than budgeted performance, and vice versa. This applies to all tables which show a variance in this paper.

15. The detailed departmental expenditure accounts can be found further down the document.

Balance Sheet

16. The Balance Sheet for the period ended 31 May 2025 shows total reserves of £2.60m (including designated funds). Cash held in hand and at bank totals £254k with a further £1.34m in the managed investment portfolio. The balance sheet below reflects the December 2024 valuation of the investment portfolio.

17. The Balance Sheet as at 31 May 2025 is set out below:

	31 May 2025			31 March 2025	
	£	£		£	£
Non-current assets					
Assets (fixed/intangible)		1,712,640			1,717,043
Investment (portfolio)		1,348,299			1,317,560
Current assets					
Debtors	176,009			193,311	
Cash in bank and in hand	254,410			277,969	
	430,419			**471,280**	
Liabilities					
Creditors:					
within one year	(889,739)			(904,809)	
	(889,739)			**(904,809)**	
Net current liabilities		**(459,320)**			**(433,529)**
Total assets less total liabilities		**2,601,619**			**2,601,074**
Reserves					
General reserve		2,009,470			2,065,385
Designated funds		592,149			535,689
Total Reserves		**2,601,619**			**2,601,074**

Balance Sheet explanatory notes

Debtors

18. Debtors have decreased to £176k from the year end position of £193k. This is predominately due to movements in the prepayment balance. We would expect to see a fluctuation throughout the year as expenses are processed through the system.

Creditors

19. Creditors have decreased to £890k from the year end position of £905k. The main contributor since year end is in relation to expense accruals and invoices payable; we have a lower creditor balance than we did in March 2025.

Designated reserves update

20. Spending on designated reserves in the year is shown below:

Reserve	Reserve at March 2025	New allocation in year	Spend in year	Reserve at May 2025
IT investment	152,093	-	16,964	135,129
Registrant perceptions	3,772	-	-	3,772
General legal reserve	123,031	-	-	123,031
NCOR infrastructure costs	123,500	-	4,429	119,071
Website development	136,005	-	10,747	125,258
Innovation fund	-	100,000	11,400	88,600
IO Convention 2023	(2,712)	-	-	(2,712)
Total	535,689	100,000	43,540	592,149

NB: We capitalised the spend on the new CRM system in the previous year, and will amortise the cost of this over its useful life once it has been implemented. As the current year progresses we will make an assessment at as to what additional IT investment costs can be capitalised.

Cash flow and investments

21. Council closely monitors its cashflow and reserves. The following section provides an overview of the cash flow position and current cash flow projection.

22. The cash at bank balance has decreased to £254k from the year end position of £278k. as we enter the peak registration renewal season (roughly occurring between May and September) we expect the cash position to pick up.

Investment portfolio

23. At 31 May 2025, the investment portfolio stood at £1.39m, up from £1.32m at the year end. Withdrawals from the portfolio would need approximately 10 day's notice, although our expectation is that we will not need to draw down on the investment this year.

Charity Commission reporting

24. As well as being a statutory regulator, GOsC is also a registered charity, and there are certain circumstances where we must make reports to the Charity Commission, including for example, serious adverse events such as significant reduction in income.

25. We do not foresee any need to make a report to the Charity Commission during financial year 2025-26.

Departmental Expenditure Accounts

26. The individual departmental accounts are listed below with further narrative to support each business area.

Employment costs

	Year to Date 1 April 2025 – 31 May 2025				
	Actual	**Budget**	**Variance**		**FY Budget**
			£	**%**	
Expenditure					
Salaries & Pensions	270,929	307,667	36,738	12	1,846,000
Recruitment	12,785	2,500	(10,285)	(411)	15,000
Staff development & training	9,142	6,404	(2,738)	(43)	38,425
Temporary staff & other employment costs	4,574	3,017	(1,557)	(52)	5,100
Employee benefit insurance premiums	2,772	2,833	61	2	17,000
Other staff costs & benefits	760	1,917	1,157	60	11,500
Total	**300,962**	**324,338**	**23,376**	**7**	**1,933,025**

27. The position after the opening two months of the year shows a total expenditure of £301k, against a year-to-date budget allocation of £324k. The underspend is predominately due to salaries and pension costs, with an offset in recruitment and staff training costs. The majority of the Recruitment spend was for a one-off exercise to review GOsC's recruitment processes.

Education and professional standards

	Year to Date 1 April 2025 – 31 May 2025				
	Actual	**Budget**	**Variance**		**FY Budget**
			£	**%**	
Expenditure					
Quality assurance	36,824	34,076	(2,748)	(8)	89,105
Osteopathic Practice Standards	1,157	368	(789)	(214)	2,209
Research projects	112	4,371	4,259	97	26,225
Publications & subscriptions	-	333	333	100	2,000
Total	**38,093**	**39,148**	**1,055**	**3**	**119,539**

28. The position after the opening two months of the year shows a total expenditure of £38k, against a year-to-date budget allocation of £39k. The underspend is predominately due to Research Projects. We are expecting work on research to pick up as the year progresses, and budget is in place for projects such as OPS reviews and CPD developments.

29. There is an overspend of just under £3k on Quality Assurance (QA) work; with the QA being brought in-house from July we are expecting the costs to gradually slow down in this area.

Communications, research, and development

	Year to Date 1 April 2025 – 31 May 2025				
	Actual	**Budget**	**Variance**		**FY Budget**
			£	**%**	
Expenditure					
Digital	4,536	4,299	(237)	(6)	25,795
Publications	2,604	970	(1,634)	(169)	5,818
Welsh Language Scheme	1,668	1,401	(267)	(19)	8,406
Engagement and events	284	1,861	1,577	85	11,167
Research					
IJOM	6,683	6,667	(16)	0	40,000
Total	**15,775**	**15,198**	**(577)**	**(4)**	**91,186**

30. The position after the opening two months of the year shows a total expenditure of £16k, against a year-to-date budget allocation of £15k. The overspend is predominantly in Publications, with an underspend in Engagement and Events. The overspend in Publications relates to two invoices from Mighty Agency which were sent late by the suppler; the work was in the previous financial year but missed the year end cut off.

Registration administration

	Year to Date 1 April 2025 – 31 May 2025				
	Actual	**Budget**	**Variance**		**FY Budget**
			£	**%**	
Income					
Registration assessment income	690	3,333	(2,643)	(79)	20,000
Total	**690**	**3,333**	**(2,643)**	**(79)**	**20,000**
Expenditure					
Registration assessments	-	3,333	3,333	100	20,000
Total	**-**	**3,333**	**3,333**	**100**	**20,000**
Net expenditure	**690**	**-**	**690**	**(100)**	**-**

31. The position after the opening two months of the year shows a total net expenditure of less than £1k. The cost of registration assessments is largely offset by the fee-paying applicants applying for the assessments, and we expect the income and expenditure to be largely equal and opposite once assessments are completed.

IT infrastructure

	Year to Date 1 April 2025 – 31 May 2025				
	Actual	**Budget**	**Variance**		**FY Budget**
			£	**%**	
Expenditure					
CRM and infrastructure	9,799	12,752	2,953	23	76,510
IT Security	3,728	3,742	14	0	22,450
Software - Licensing	2,306	3,025	719	24	18,150
IT Consultancy cover	1,830	833	(997)	(120)	5,000
Other IT costs	1,582	500	(1,082)	(216)	3,000
Total	**19,245**	**20,852**	**1,607**	**8**	**125,110**

32. The position after the opening two months of the year shows a total expenditure of £19k, against a year-to-date budget allocation of £21k. The underspend is predominately due to spending on CRM & Infrastructure costs, with an offset overspend in Other IT costs which includes small sundry items for staff, including those working remotely.

Fitness to practise, including legal

	Year to Date 1 April 2025 – 31 May 2025				
	Actual	**Budget**	**Variance**		**FY Budget**
			£	**%**	
Expenditure					
Statutory committee costs:					
• - Professional Conduct Committee, incl. Health Committee	16,767	49,850	33,083	66	299,100
• - Investigating Committee	17,259	10,667	(6,592)	(62)	64,000
FtP panel member holiday pay & pension	28,106	3,333	(24,773)	(743)	20,000
Section 32 cases	-	733	733	100	4,400
Other FtP projects	-	2,083	2,083	100	12,500
Total	**62,132**	**66,666**	**4,534**	**7**	**400,000**

33. The position after the opening two months of the year shows a total expenditure of £62k, against a year-to-date budget allocation of £67k. There is an underspend of £26k in costs across the various committees in the year so far.

34. Members should note that panel member holiday pay and pension costs; £27k of the amount paid so far relates to the two years to 31 March 2025. We have £20k budgeted per year for this, and will make a decision as the year progresses whether or not to move the two year backdate period to reserves.

35. There is also additional budget for projects such as an external audit on the function, and for survey actors. No spend has gone through in the year to date for these items.

36. Statutory committee costs (including panel member holiday pay & pension costs) represent 100% of the department expenditure so far this year, and reflect the work of the Investigating, Professional Conduct and Health Committees. Council members are aware that this area of business represents the most significant area of risk to the expenditure forecasts in terms of volatility.

37. As of 27 June 2025, the following hearings and meetings for the next six months are scheduled:

July 2025	**August 2025**
x1 1-day IC ISO hearing x2 1-day IC meetings x1 4-day PCC hearing x1 2-day PCC hearing	x1 3-day PCC hearing x1 1-day IC meeting
September 2025	**October 2025**
x1 1-day IC meeting	x1 4-day PCC hearing x1 3-day PCC hearing x1 1-day IC meeting
November 2025	**December 2025**
None yet scheduled	x2 1-day IC meetings

38. An induction and training day for new IC panellists is due to be held in July 2025.

Governance

	Year to Date 1 April 2025 – 31 May 2025				
	Actual	**Budget**	**Variance**		**FY Budget**
			£	**%**	
Expenditure					
Honorariums & responsibility allowances	16,343	18,332	1,989	11	110,000
Council and committee costs, incl. reappointments	8,058	10,002	1,944	19	60,010
PSA levy	2,611	2,707	96	4	16,240
Equality & Diversity	450	333	(117)	(35)	2,000
Board effectiveness	-	6,000	6,000	100	36,000
Internal Audit	-	2,400	2,400	100	14,400
Skills audit	-	1,967	1,967	100	11,800
Tax liability (expenses)	-	1,667	1,667	100	10,000
Total	**27,462**	**43,408**	**15,946**	**37**	**260,450**

39. The position after the opening two months of the year shows a total expenditure of £27k, against a year-to-date budget allocation of £43k. The majority of the underspends are due to the new projects for Board Effectiveness, Internal Audit, and a skills audit of Governance members. No spend has gone through in the year to date for these items.

40. Honorarium and responsibility allowances of £16k represent 60% of the total expenditure for the two month period.

Central resources and financing

	Year to Date 1 April 2025 – 31 May 2025				
	Actual	**Budget**	**Variance**		**FY Budget**
			£	**%**	
Expenditure					
Premises	13,388	14,037	649	5	80,220
Depreciation	9,679	8,983	(696)	(8)	53,900
Office administration	6,521	6,195	(326)	(5)	37,170
Financing	4,651	5,666	1,015	18	34,000
Publications and subscriptions	1,262	837	(425)	(51)	5,019
International conferences	532	1,117	585	52	6,700
Financial audit fee	(2,820)	4,368	7,188	165	26,208
Total	**33,213**	**41,203**	**7,990**	**19**	**243,217**

41. The position after the opening two months of the year shows a total expenditure of £33k, against a year-to-date budget allocation of £41k. The majority of the underspend relates to Audit fees; this will reduce once the year end accounts are signed off and the final fee is paid to bring the balance back into a debit position.

42. The two principal areas of expenditure within the Central resources department (not including depreciation or financing) are the cost of premises including rates and service contracts (£13k), and office administration including insurance, postage, and photocopying (£7k). These two areas represent 61% of the total expenditure after the two month period.

General Osteopathic Council

Council
15 July 2025
Fitness to Practise report

Classification	Public
Purpose	For noting
Issue	Quarterly update to Council on the work of the Regulation department and the GOsC's Fitness to Practise committees.
Recommendation	To note the report.
Financial and resourcing implications	Financial aspects of Fitness to Practise activity are considered in Annex B of the Chief Executive and Registrar Report.
Equality and diversity implications	Ongoing monitoring of equality and diversity trends will form part of the Regulation department's future quality assurance framework.
Communications implications	None
Annex	A. Fitness to Practise Data Set B. Fitness to Practise Dashboard
Authors	Sheleen McCormack and David Bryan

Key messages from the paper:

- In this reporting period, there was a slight decrease in the number of concerns received (19) in comparison to the last quarter (23).

- As of 30 June 2025, we have listed 6 of the 29 cases referred by the Investigating Committee (IC) to the Professional Conduct Committee (PCC). A breakdown of the cases awaiting hearing can be found in the quarterly dataset at Annex A (page 5-6).

- During the reporting period four substantive cases were considered by the PCC.

- On 22 May 2025 we successfully prosecuted Gareth Milner for unlawfully describing himself as an osteopath contrary to section 32 of the Osteopaths Act 1993.

- An short update is provided in this report regarding the recent 'Tone of Voice' training and its evolving application within the work of the Regulation team.

- The Regulation team welcomed a new starter within the team during this reporting period.

Fitness to practise case trends

1. In this reporting period, the Regulation Department received 19 concerns, with 11 formal complaints being opened. By way of comparison, during the same period last year, the Regulation Department received 23 concerns and four formal complaints were opened.

2. Of the 19 concerns; five related to a transgression of boundaries, one related to poor communication, one related to conduct during treatment, four related to conduct not linked to treatment, six related to inadequate treatment and in two cases a misuse of social media.

3. Of the eleven formal complaints, these related to; breach of boundaries (5), conduct during treatment (1), driving offences (2) and a lack of insurance (3).

4. As previously reported to Council, we continue to encounter delays in the progress of some cases related to third-party investigations. During the reporting period 23% of our total caseload is currently, or has been, with third parties. This is represents a decrease from the previous quarter (29%).

5. We also continue to experience ongoing difficulties in terms of engaging complainants, which has also had an impact on our ability to progress some cases expeditiously. This has been particularly challenging over this reporting period. There have been several serious cases involving vulnerable patients, with regard to their fluctuating / inconsistent engagement with the FtP process. In these cases we have sought to utilize and continue the momentum from our recent 'tone of voice' training to encourage engagement and we have, in some cases,

managed to engage the witness. However this has increased the time taken to progress the case.

6. During the reporting period there was one application to the Investigating Committee (IC) for the imposition of an Interim Suspension Order (ISO). We progressed this matter to an ISO hearing within five weeks of receipt of the concern. The IC decided not to impose an order in this case.

7. During the reporting period four substantive cases were considered by the PCC.

Fitness to practise case load and case progression

8. As at 30 June 2025, the Regulation Departments fitness to practise caseload was 86 cases (62 formal complaints and 24 concerns). In comparison, the Regulation department's fitness to practise caseload as of 30 June 2024, was 72 fitness to practise cases (51 formal complaints and 21 concerns).

9. Performance against the performance targets for this reporting period, is as follows:

Case stage	Key Performance Indicator	Performance Target	Median figures achieved this quarter	Median figures excluding 3rd party cases
Screening	Median time from receipt of concern to the screener's decision	9 weeks	6 weeks	6 weeks
Investigating Committee	Median time from receipt of concern to final IC decision	26 weeks	51 weeks	37 weeks
Professional Conduct Committee	Median time from receipt of concern to final PCC decision	52 weeks	91 weeks	68 weeks
Health Committee	Median time from receipt of concern to final HC decision	52 weeks	N/A	N/A

10. In this reporting period the Screener KPI was exceeded at six weeks.

11. The IC KPI was not met in this quarter. Of the eight cases considered by the IC, three were third party cases and in another three cases we experienced delays due to the disengagement of witnesses.

12. The median output of the PCC cases was 91 weeks. One of the cases was a third party case, with the police investigation taking time to progress the matter(s) to a charging decision and eventual conviction imposed in the criminal court.

13. Six out of the 29 cases at the PCC stage have been listed for a substantive hearing. A detailed breakdown of these cases is set out in the dataset in the Annex to this paper. We are actively scheduling more hearings over the coming weeks.

Third party investigations - data comparison

14. We are unable to progress cases that are being investigated by the police and/or are before the courts and it was considered that it would be beneficial to assess performance and case progression in those cases where there are no third-party investigations. We have provided a table below where 'third party' investigations have been excluded from the median figures provided.

	Median age including 3rd party cases	Median age excluding 3rd party cases	Total number of 3rd party cases at each stage
Pre-screener stage	7 weeks	7 weeks	0 (0%)
IC stage	25 weeks	23 weeks	8 (28%)
PCC stage	92 weeks	89 weeks	12 (41%)
Total	**35 weeks**	**25 weeks**	**20 (23%)**

Section 32 Prosecution

15. Under section 32 of the Osteopaths Act 1993, it is a criminal offence for anyone who is not on the GOsC's register to describe themselves (either expressly or by implication) as an osteopath.

16. On 22 May 2025, we brought a successful prosecution against Gareth Milner for continuing to unlawfully describe himself as an osteopath after leaving the GOsC's Register of osteopaths. Mr Milner appeared at City of London Magistrates' Court and was found guilty of using the osteopathic title while not registered with the GOsC. Mr Milner had resigned from the GOsC's Register in July 2011, and he therefore no longer permitted to use the title of osteopath.

17. The offence related to information that Mr Milner continued to provide on his websites, which implied that he was still an osteopath, despite the fact that he had resigned from the GOsC's Register in 2011. Mr Milner was given warnings by the GOsC that by continuing to use the osteopathic title he was breaching section 32 (1) of the Osteopaths Act, and may be committing a criminal offence. Despite this, he failed to make any changes to his websites.

18. Mr Milner was fined £2,000 and ordered to pay costs of £1,080 to the GOsC. Mr Milner was also ordered to pay a victim surcharge of £800. The court made a Collection Order in relation to the full amount of £3,880.

19. This is the second prosecution that the GOsC has brought against Mr Milner. On 4 March 2021, Mr Milner was convicted for the same offence and on that occasion fined £1,300 and ordered to pay costs of £360 to the GOsC.

Working with others

20. The Director of Fitness to Practise attend the inter-regulatory Directors of Fitness to Practise meeting that took place remotely on 23 May 2025. A central theme under discussion was the support provided to witnesses and registrants in FtP proceedings. Some regulators experience registrants representing themselves during proceedings. Other regulators agreed that they too have observed a greater proportion of witnesses disengaging during proceedings.

Tone of voice workshop

21. As Council will recall from the Chief Executives report at the previous meeting, all staff attended the 'Tone of voice' workshop, facilitated by Nockholds Solicitors on 30 April 2025. The main purpose of this workshop was to identify how communication plays a part in the GOsC being an effective regulator and to enhance the GOsC's approach to how we communicate with external stakeholders.

22. The training assisted members of the Regulation to reflect and continue the momentum and discussion falling out of this simulating, interactive session. Whilst we have actively sought to engage with parties in an investigation, we have sought to mindfully apply the approaches discussed in the workshop in several of our ongoing investigations in our communications, particularly with case parties including registrants and witnesses. For example, as mentioned in paragraph 5 above in this report, we have struggled recently with the fluctuating engagement of complainants who have reported serious concerns to us, most of which relate to transgression of sexual boundaries. We have reflected this in the language and content in our correspondence and communications which we consider has led to us successfully engaging, or re-engaging, with complainants in some of the most difficult and serious of cases. We are actively considering how this can be mapped out more systemically in our concerns procedure encompassing our template correspondence and regulation manual through to hearings.

Dashboard

23. In addition to our normal FTP dataset, we again provide Council with the new FTP dashboard at Annex B for Council consideration. We have tried to incorporate a 'traffic light' system into the dashboard, although this is challenging as it does lend itself easily to all statistics.

24. Where we have used a traffic light system the colour green represents that this statistic is on target, amber represents that the fact we are over KPI but there is both active progression of cases and cogent reason for being over KPI, with red representing that there was no active progression of cases and cogent reasons for being over KPI.

New starter

25. The Regulation team would like to welcome Nyasha Nations, who has joined the team on a 7 month fixed term contract as a Case Manager. This post is to cover another team member currently on maternity leave.

Recommendation: To note the report.

Annex A to 9

Fitness to practise dashboard 01 April 2025 to 30 June 2025 (Q1)

Case progression – at a glance

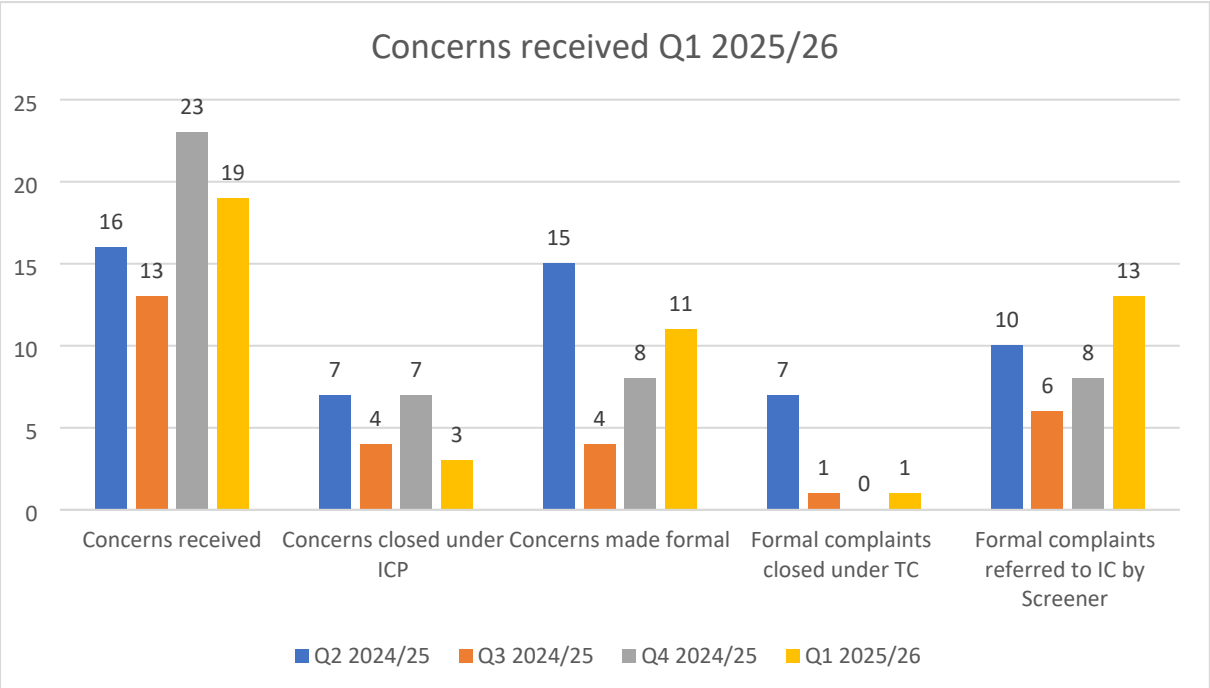
- We have received 19 new concerns during the reporting period, a slight decrease from the previous quarter (23 concerns).
- The Investigating Committee (IC) met remotely on three occasions and considered 8 cases.
- During this reporting period the Professional Conduct Committee (PCC) concluded four cases.

Referrals Received	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Formal complaints referred to IC by Screener	10	6	8	13
Formal complaint referred to IC by Screener but not yet considered (as at end of quarter)	36	34	24	29
Referred to PCC/HC by IC but not yet heard (as at end of quarter)	17	19	32	29
Referred to PCC/HC by IC and listed for hearing (as at end of quarter)	4	3	5	6
PCC/HC Cases part heard (as at end of quarter)	0	2	1	2
Formal complaints open (as at end of quarter)	66	57	56	62
Cases that need review hearings (as at end of quarter)	4	4	3	4

Age of Caseload from Date Received	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
52 weeks – 103 weeks	14	20	19	19
104 weeks – 155 weeks	4	10	10	14
156 weeks and above	1	1	3	6

New Referrals

- We have received 19 new concerns during the reporting period.
- Three cases were closed under the Initial Closure Procedure (ICP).
- One case was closed under the threshold criteria.
- There were 17 cases considered by screeners, 13 of these were referred to the IC.



Referrals Received	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Concerns received	16	13	23	19
Concerns closed under ICP	7	4	7	3
Concerns made formal	15	4	8	11
Formal complaints closed under TC	7	1	0	1
Formal complaints referred to IC by Screener	10	6	8	13

Note – the number of concerns received during the reporting period will not directly correlate to the number of concerns that are made formal, or decisions by the screeners, during the reporting period.

Source of formal complaints	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Self-referral by the registrant	2	0	0	1
Registrar's allegation	1	0	0	1
Non-NHS employer	1	0	0	0
Patient or service user	7	3	6	14
NHS	0	0	0	0
Another registrant	2	0	1	1
Anonymous informant	0	0	0	0
Another regulatory body	0	0	0	0
Any other informant	2	1	1	2
Total	**0**	**0**	**8**	**19**

Allegations in formal complaints	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Conduct	15	4	6	19
Conviction	0	0	1	0
Competency	0	0	0	0
Adjunctive therapies	0	0	0	0
Health	0	0	1	0
Total	**15**	**4**	**8**	**19**

Key Performance Indicators

- The Screener KPI was met, at six weeks.
- The Investigating Committee KPI was not met.
- The Professional Conduct Committee KPI was not met.

Performance at a glance

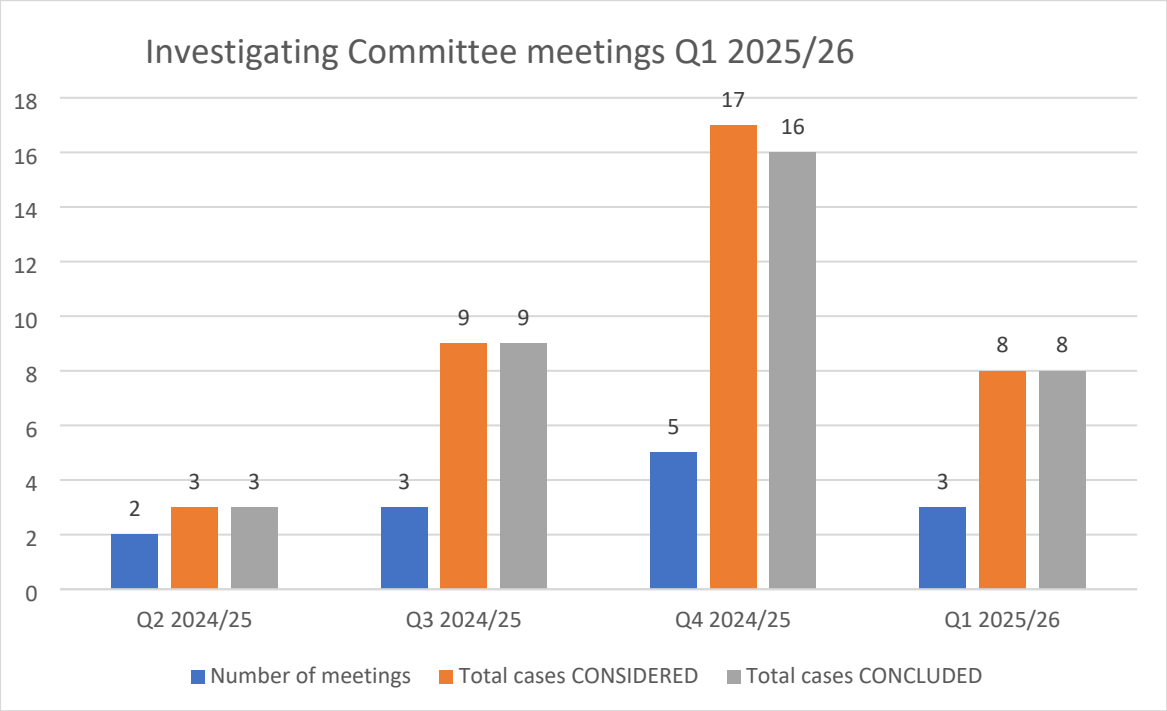
Case stage	Key Performance Indicator	Performance Target	Q2 24/25	Q3 24/25	Q4 24/25	Q4 24/25
Screening	**Median time from receipt of concern to the screener's decision**	**9 weeks**	9 weeks	4 weeks	8 weeks	6 weeks
Investigating Committee	**Median time from receipt of concern to final IC decision**	**26 weeks**	31 weeks	48 weeks	52 weeks	51 weeks
Professional Conduct Committee	**Median time from receipt of concern to final PCC decision**	**52 weeks**	58 weeks	67 weeks	82 weeks	91 weeks

Performance in detail

Time from receipt of complaint to the screener's decision (9 weeks)	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Median	9 weeks	4 weeks	9 weeks	6 weeks
Longest case	68 weeks	27 weeks	24 weeks	22 weeks
Shortest case	1 week	0 weeks	1 week	0 weeks
Time from receipt of complaint to final IC decision (26 weeks)	**Q2 2024/25**	**Q3 2024/25**	**Q4 2024/25**	**Q1 2025/26**
Median	31 weeks	57 weeks	52 weeks	51 weeks
Longest case	40 weeks	217 weeks	123 weeks	84 weeks
Shortest case	28 weeks	13 weeks	6 weeks	29 weeks
Time from final IC decision to final PCC decision or other final disposal of the case (26 weeks)	**Q2 2024/25**	**Q3 2024/25**	**Q4 2024/25**	**Q1 2025/26**
Median	26 weeks	29 weeks	49 weeks	36 weeks
Longest case	76 weeks	32 weeks	49 weeks	80 weeks
Shortest case	13 weeks	16 weeks	49 weeks	18 weeks
Time from receipt of referral to final PCC decision or other final disposal of the case (52 weeks)	**Q2 2024/25**	**Q3 2024/25**	**Q4 2024/25**	**Q1 2025/26**
Median	58 weeks	67 weeks	82 weeks	91 weeks
Longest case	120 weeks	94 weeks	82 weeks	141 weeks
Shortest case	39 weeks	52 weeks	82 weeks	43 weeks
Median time to interim order committee decision:	**Q2 2024/25**	**Q3 2024/25**	**Q4 2024/25**	**Q1 2025/26**
From receipt of referral	NA	NA	3 weeks	5 weeks
From decision that there is information indicating the need for an interim order	NA	NA	2 weeks	3 weeks

Investigating Committee

- The IC met remotely on three occasions during the reporting period and considered eight cases.
- The IC KPI was not met during this quarter. Of the eight cases considered by the IC, three were third party cases and in another three cases we experienced delays due to the disengagement of witnesses.
- The number of cases at the IC stage has increased from 24 to 29 cases. This is due to a higher referral rate from screeners to the IC.
- 8 of the 29 cases (28%) at the IC stage are currently recorded as third party.
- The IC considered one Interim Suspension Order (ISO) application during the reporting period.

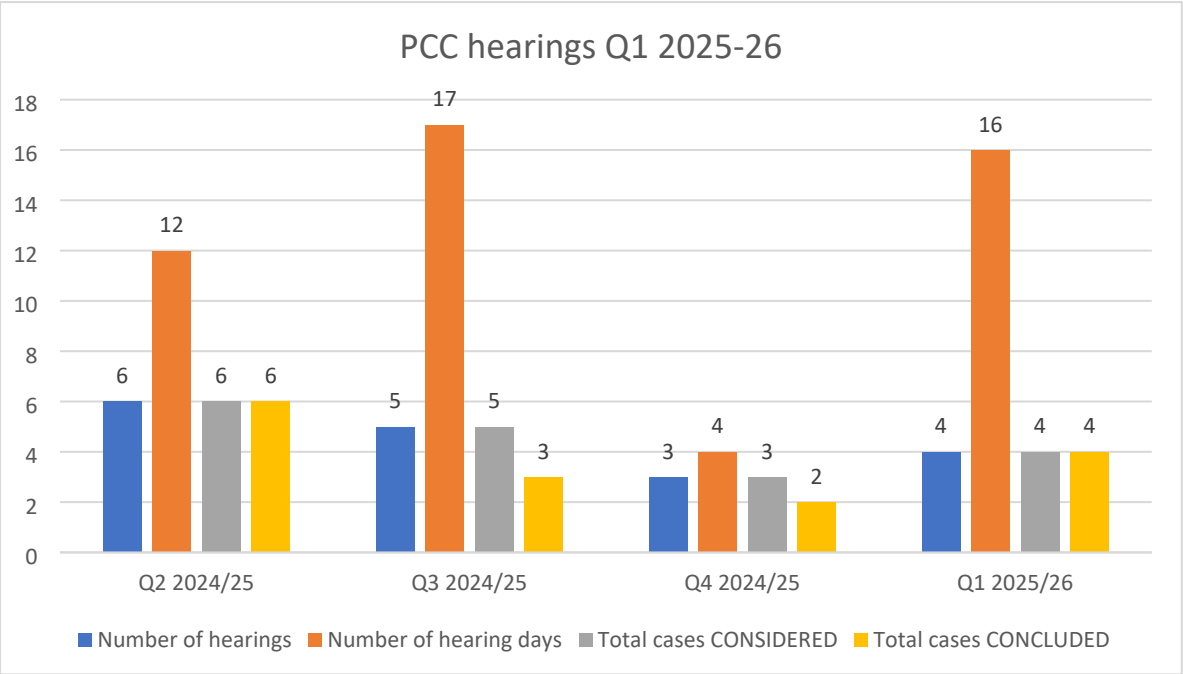


Investigating Committee Decisions	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
No Case to Answer	0	4	1	4
No Case to Answer with advice	0	0	1	1
Referred to PCC	3	5	14	3
Referred to HC	0	0	0	0
Referred to PCC and HC	0	0	0	0
Adjourned	0	0	1	0
Stayed	0	0	0	0
Rule 19 agreed	0	0	0	0

Professional Conduct Committee

- During the reporting period four cases were considered by the PCC, all of which were substantive hearings.
- The number of cases at the PCC stage has decrease slightly from 32 to 29 cases over the quarter.
- 41% of cases at the PCC stage are third party cases which is a slight decrease from 43% at the end of the previous quarter.
- Of the 29 cases at the PCC stage. The breakdown of which are as follows:
    - 11 cases are third party cases
    - Six have been scheduled for a hearing
    - In two cases we are awaiting the completed listings questionnaire from the Registrant before we can schedule a hearing
    - In two cases we are awaiting a potential referral of a second case against the same Registrant from the IC, before we can progress to a hearing
    - In four cases we are preparing service
    - In two cases we are proceeding with a rule 8 application
    - In two cases we are proceeding with a rule 19 application

Professional Conduct Committee Hearings	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Number of hearings	6	5	3	4
Number of hearing days	12	17	4	16
Total cases CONSIDERED	6	5	3	4
Total cases CONCLUDED	6	3	2	4



PCC Decisions	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Allegation not 'well founded'	0	1	0	1
Admonished	2	0	1	1
Conditions of Practice	0	0	0	1
Suspension	1	0	0	0
Removal	0	0	0	0
Rule 19	0	0	0	0
Adjourned	0	2	0	0
Conditions/Suspension to expire at end of order	0	0	1	0
Rule 8 Admonishment	3	2	1	0
Stayed	0	0	0	0
Referred to the HC	0	0	0	0
Referred to PCC hearing (rule 8)	0	0	0	0
Conviction has no material relevance	0	0	0	1

Health Committee

- The Health Committee (HC) considered no hearings during the reporting period.

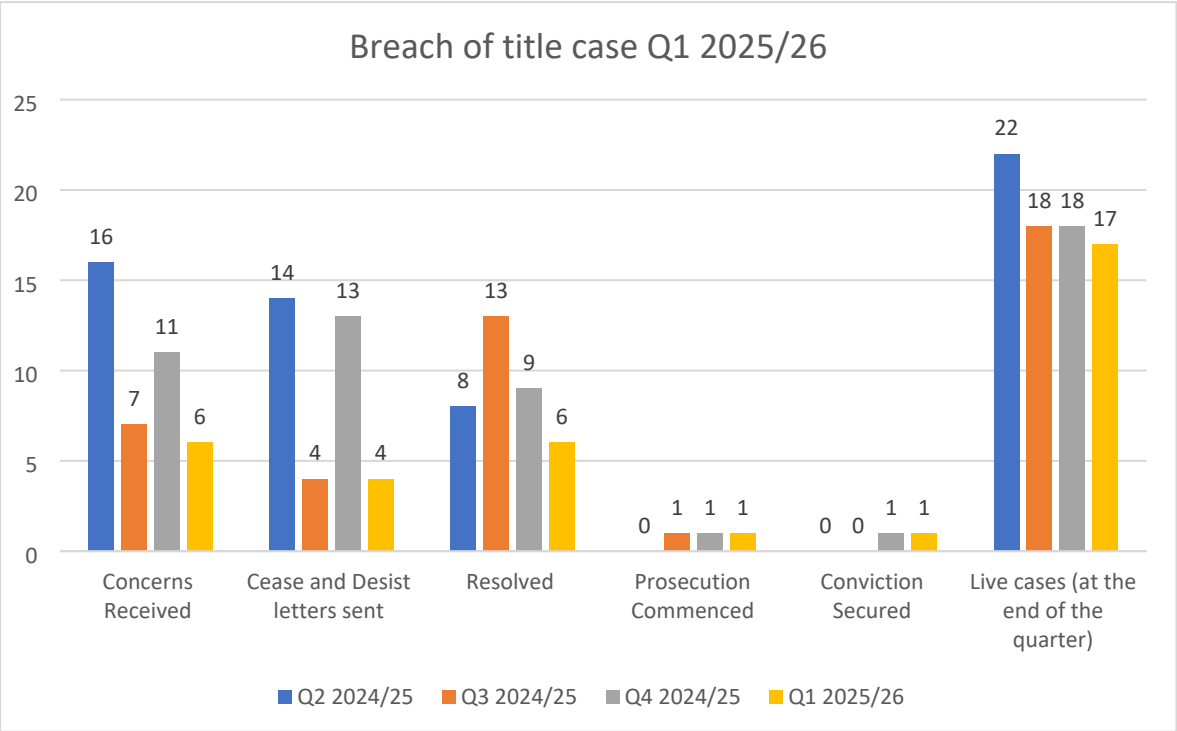
Interim Suspension Orders

IC Interim Suspension Order Decisions	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
Applications made	0	0	1	1
Interim Suspension Order imposed	0	0	1	0
Undertaking	0	0	0	0
Adjourned	0	0	0	0
Median time to IC decision from receipt of referral	N/A	N/A	N/A	5 weeks
Median time to IC decision from decision that there is information indicating the need for interim order	N/A	N/A	N/A	3 weeks

PCC/HC Interim Suspension Order Decisions	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
Applications made	0	0	1	0
Interim Suspension Order imposed	0	0	1	0
Undertaking	0	0	0	0

Protection of Title

- There are currently 17 active Section 32 investigations as at 30 June 2025, an increase from 11 recorded in the previous quarter.



Protection of Title	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Concerns Received	16	7	11	6
Cease and Desist letters sent	14	4	13	4
Resolved	8	13	9	6
Prosecution Commenced	0	1	1	1
Conviction Secured	0	0	1	1
Live cases (at the end of the quarter)	22	18	18	17

Appeals

- No Registration appeals were received, or considered, during the reporting period by the Registration Appeal Committee.

Total number of registrant appeals in the quarter which are:	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Ongoing	0	0	0	0
Opened	0	0	0	0
Concluded	0	0	0	0
Outcomes of registrant appeals against final fitness to practise decisions:	**Q2 2023/24**	**Q3 2023/24**	**Q4 2023/24**	**Q1 2025/26**
Upheld and outcome substituted	0	0	0	0
Upheld and case remitted to regulator for re-hearing	0	0	0	0
Settled by consent	0	0	0	0

Voluntary Removal

- We received one voluntary removal application in the reporting period, which was granted.

Number of voluntary erasure/removal applications: Subsequent to the FTP case being considered by an IC.	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Received	0	1	1	1
Granted	0	1	0	1

Fitness to Practise dashboard - 01 April 2025 – 30 June 2025 (Q1) to 9

Annex B

Statistics at a glance

	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Screener stage				
Formal concerns referred to IC by Screener	10	6	8	13
IC stage				
Concerns referred to the PCC	3	5	14	3
Awaiting IC consideration	36	34	24	29
PCC stage				
Awaiting PCC consideration	17	18	32	29
Awaiting PCC consideration – listed for hearing	4	3	5	6
PCC/HC Cases part heard	0	2	1	2
Cases that need review hearings	4	4	3	4
General statistics				
Formal complaints open	66	56	56	62

	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26
Receipt to screener decisions (9 weeks)	4 weeks	9 weeks	9 weeks	6 weeks
Receipt to IC decision (26 weeks)	57 weeks	52 weeks	52 weeks	51 weeks
Receipt to PCC decision (52 weeks)	67 weeks	82 weeks	82 weeks	91 weeks

Third party statistics

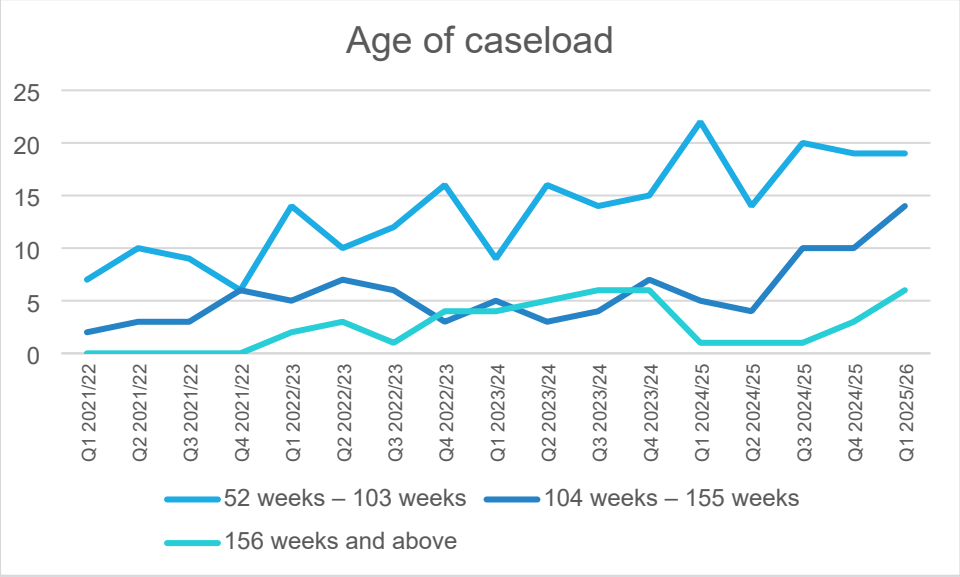
	Median age including 3rd party cases	Median age excluding 3rd party cases	Total number of 3rd party cases at each stage
Pre-screener stage	7 weeks	7 weeks	0 (0%)
IC stage	25 weeks	23 weeks	8 (28%)
PCC stage	92 weeks	89 weeks	12 (41%)
Total	**35 weeks**	**25 weeks**	**20 (23%)**

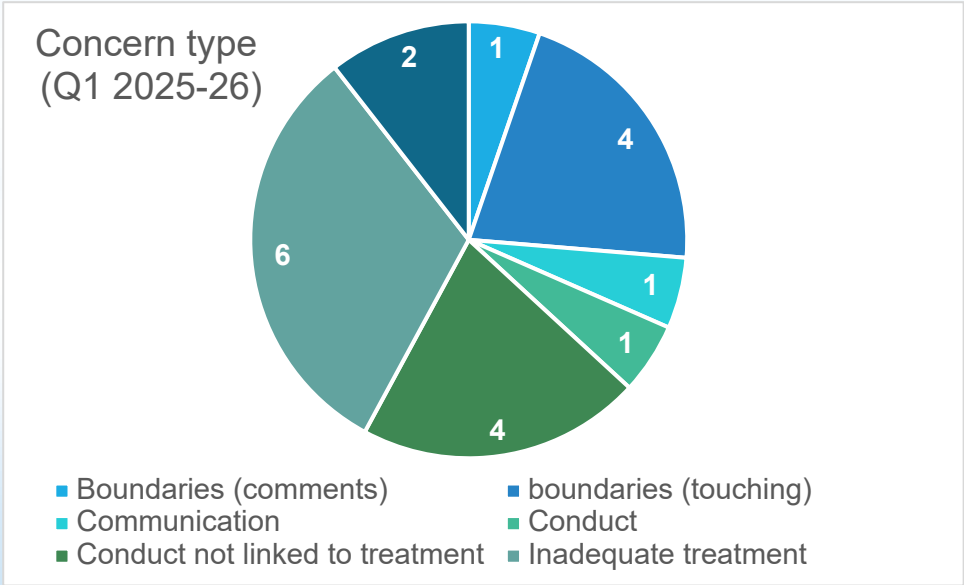
Fitness to Practise dashboard - 01 April 2025 – 30 June 2025 (Q1)

Annex B to 9

Screener decisions made	24	11	16	17

Age of Caseload





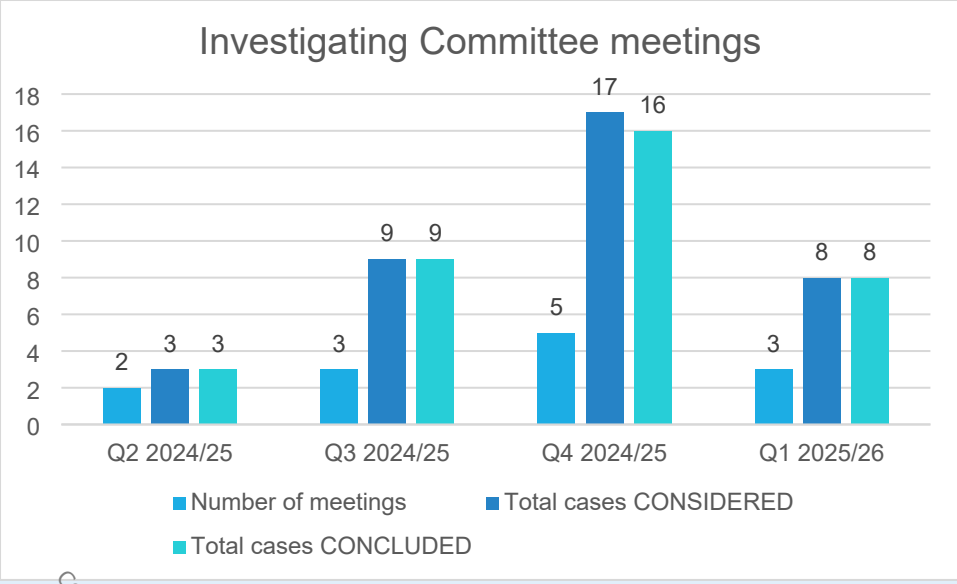
Screener stage

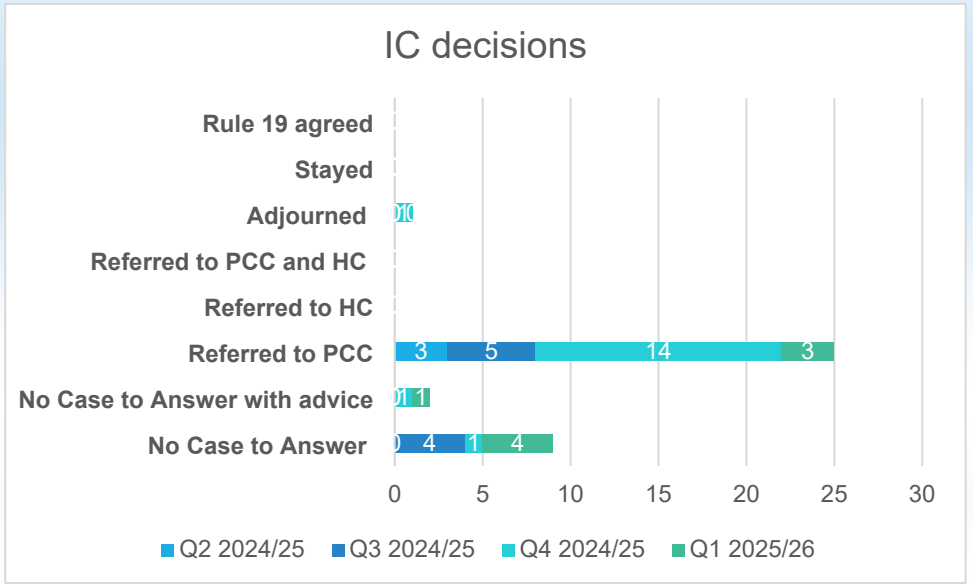
Referrals Received	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Concerns received	16	13	23	19
Concerns made formal	15	4	8	13

Source of formal complaints	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Self-referral by the registrant	2	0	0	1
Registrar's allegation	1	0	0	1
Non-NHS employer	1	0	0	0
Patient or service user	7	3	6	14

NHS	0	0	0	0
Another registrant	2	0	1	1
Anonymous informant	0	0	0	0
Another regulatory body	0	0	0	0
Any other informant	2	1	1	2

Investigating Committee stage



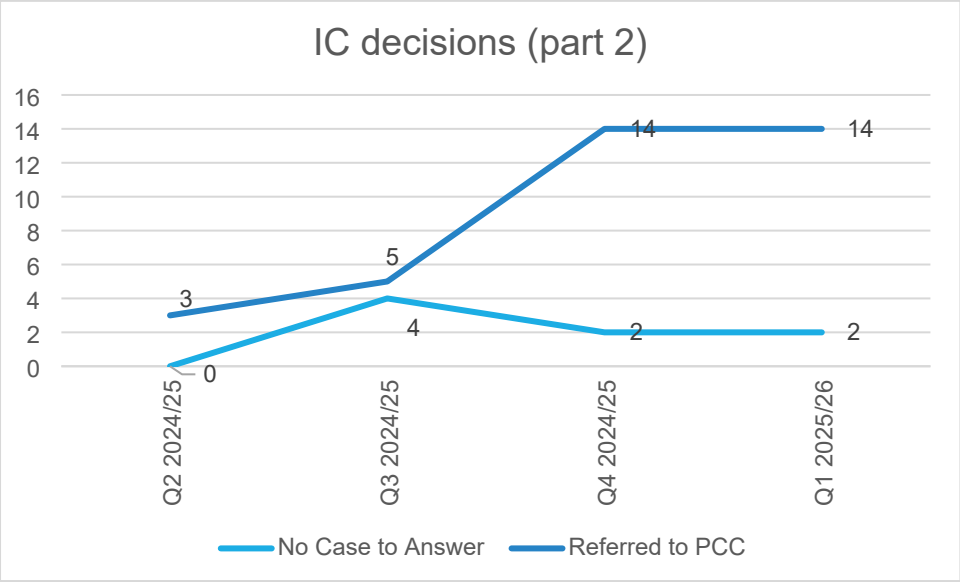


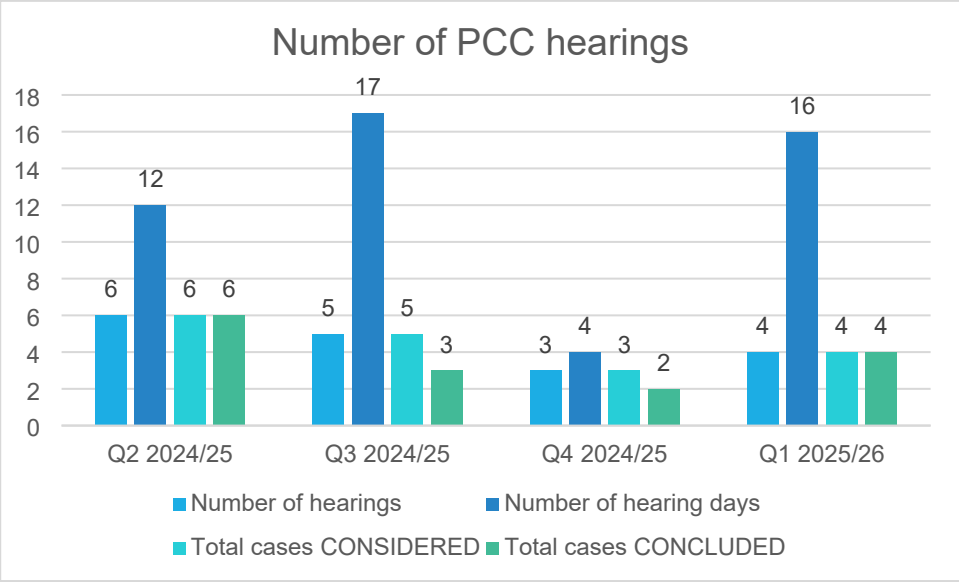
IC stage observations

- There were 13 cases referred to the IC by the screeners. This high referral rate follows a previously high referral rate last quarter.
- Feedback from the IC seems to suggest that cases are taking longer for the IC to consider at meetings. Such causes are the particulars being lengthy and that the remote environment can cause technical delays.

Fitness to Practise dashboard - 01 April 2025 – 30 June 2025 (Q1)

Annex B to 9





Professional Conduct Committee stage

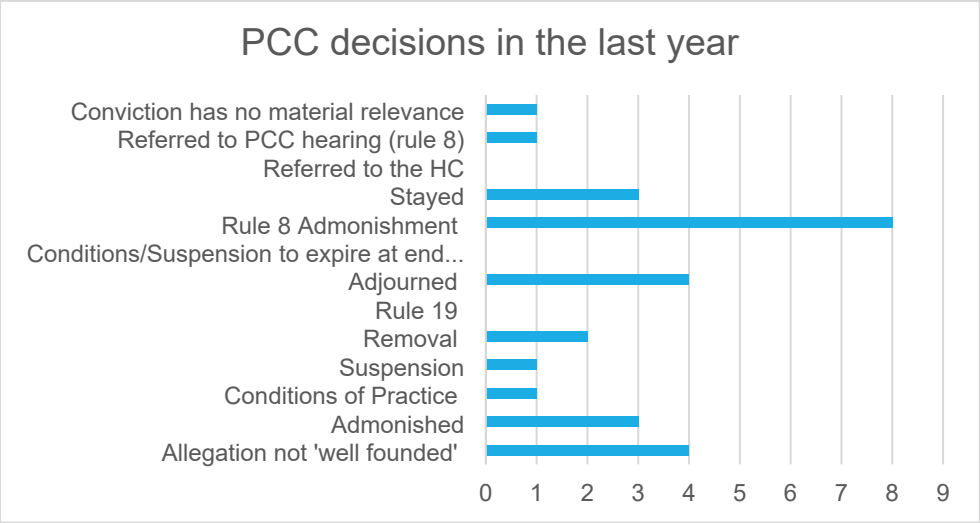
PCC stage observations

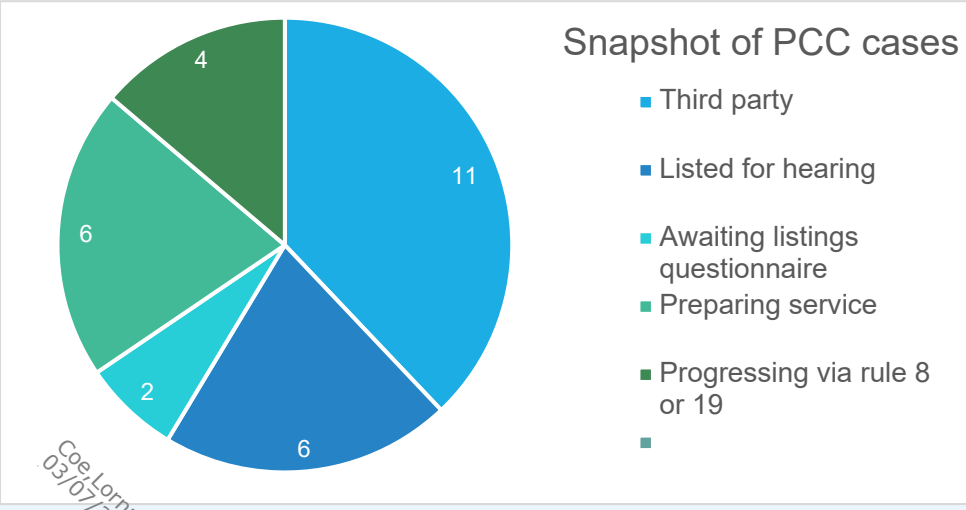
- Four cases were considered by the PCC during the reporting period.
- We are in the middle of attempting to schedule some particularly lengthy and complex hearings.

Fitness to Practise dashboard - 01 April 2025 – 30 June 2025 (Q1)

Annex B

to 9





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General Osteopathic Council

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Council
15 July 2025
Draft Evaluation Plan for the GOsC Patient Partner Pilot Programme

Classification	Public
Purpose	For decision
Issue	Consideration and reflection on the draft evaluation plan for the Patient Partner Pilot Programme
Recommendation	1. To consider the proposed evaluation plan for the Patient Partner pilot. 2. To note the focus on influence, integration, support, psychological safety and organisational learning. 3. To agree the evaluation plan to ensure the Patient Partnership Pilot delivers on its intended goals of influence, learning, support and inclusion.
Financial and resourcing implications	Evaluation activities (surveys, interviews, analysis) are planned to be delivered in-house.
Equality and diversity implications	The evaluation is underpinned by the Equality Impact Assessment we have completed and includes specific criteria to assess whether the governance environment supports inclusive participation. The learning will help GOsC improve its broader diversity and engagement strategies.
Communications implications	The evaluation plan offers an opportunity to showcase GOsC's commitment to transparency, learning, and patient-centred governance, strengthening public trust and stakeholder confidence. A communications plan has been drafted to support promotion and evolution of the programme.
Annex	A. Draft Evaluation Plan includes Draft Reflective Questions for Patient Partners 6-month evaluation and Draft Feedback Survey for Council and Staff B. Patient Partners Induction Plan C. Equality Impact Assessment
Authors	Rachel Heatley and Stacey Clift

Key messages from paper:

- A robust evaluation plan is critical to ensure the pilot is meaningful, transparent, and leads to impact.
- The evaluation aims to:
    - Measure the integration and influence of Patient Partner as well as the support provided to Partners and individual and organisational learning.
    - Identify enablers and barriers to successful strategic-level patient involvement and to continuously improve the integration of Patient Partners into the governance work of the GOsC, ensuring meaningful involvement, shared influence, and sustainable impact.
- The design of the evaluation has been informed by HM Treasury guidance (*The Magenta Book)* and the Four Types of Impact Framework.
- The plan has three phases: 3-month check-in, 6-month co-reflection, and a 12-month review.
- Once the pilot is concluded a final evaluation report will be presented to Council detailing lessons learned and will include recommendations for role continuation or evolution.

Background

1. Council agreed in November 2023 to pilot a programme to include patients in GOsC governance, beginning with the appointment of two Patient Partners who will:
    a. Sit on Council without voting rights (2025-26).
        i. NB: The initial appointment is expected to last one year with a possibility of a further one-year extension.
    b. Inform and shape Council decisions, strategy, and direction.
2. The purpose of the Patient Partner pilot is to:
    a. Test whether this model puts the patient voice at the heart of our decision making.
    b. Test whether the voice at the heart of decision making improves the quality of strategic discussions and decision making (e.g. by bringing different perspectives, insights and challenge)
    c. Gain feedback about opportunities and challenges about bringing the patient voice into decision making

d. Gain feedback about how we can support a patient partner to understand GOsC and contribute to discussions in a Board environment.

3. The pilot recognises the value of co-production, the need for inclusive and psychologically safe board environments, and the complexity of embedding lay voices at strategic level.

4. Phase two of the Patient Partners Programme – subject to a successful evaluation of the 2025-2026 pilot – would involve the recruitment of an osteopathic patient as a full Council Lay member with decision making rights.

Discussion

Overview of the Evaluation Plan

5. The evaluation plan outlines a structured, year-long approach to assess the integration, influence, learning and support of the two Patient Partners appointed to sit on Council. It has been designed to track Patient Partners' experience and contribution through three key review points at 3, 6, and 12 months, using a mix of interviews, self-reflection, surveys, and meeting observations.

6. It has been informed by HM Treasury guidance (*The Magenta Book*), which promotes proportionate, evidence-based evaluation rooted in a clear theory of change. Additionally, it has been informed by the Four Types of Impact Framework, which encourages a holistic view of change across individual experience, relationships, organisational systems, and strategic influence. Drawing on both frameworks ensures that the evaluation is both rigorous and sensitive to the complex, cultural nature of embedding the patient voice in governance.

7. We have identified the following evaluation objectives (indicators of success and methodology are outlined in Annex A: Draft Evaluation Plan)

    a. **Integration:** Assess how effectively Patient Partners have been integrated into Council, by exploring the experience of the Patient Partners, Council members, staff and observers, through self-evaluation, satisfaction surveys, and qualitative feedback.

    b. **Influence:** Evaluate the Patient Partners' effect on Council discussions and Council's quality of decision-making over time, using structured observation tools and evidence of influence in meeting outputs.

    c. **Learning:** Explore learning of Patient Partners, Council and staff throughout the pilot using 360-degree feedback, self-reflection and interviews.

    d. **Support:** Assess the effectiveness of the support provided to Patient Partners, including onboarding, role clarity, and development opportunities,

by gathering feedback on their confidence, preparedness, and ability to contribute.

8. Patient Partners will attend only four Council meetings and a few committee or engagement meetings during the year. This means the evaluation needs to be proportionate, realistic, and focused. The three-phase evaluation provides a structured approach to track early integration, mid-point development, and long-term impact of the Patient Partner role within GOsC's governance.

    a. **3-month check-in**

    Integration: Assess early role clarity and how well Patient Partners are being welcomed and included in Council activity.

    Support: Review effectiveness of onboarding, access to information, and initial guidance or mentoring.

    b. **6-month co-reflection session**

    Focus: Influence, Support and Learning

    Influence: Examine how confident and able Patient Partners feel to contribute to meetings and whether their input is being taken seriously.

    Support: Review development needs, role fit, and any adjustments required to sustain meaningful involvement.

    Learning: Reflect with Council and staff on how the presence of Patient Partners is affecting collaboration and discussions.

    c. **End-of-year review**

    Focus: Influence, Learning, Integration and Support

    Influence: Identify if and how Patient Partners have contributed to GOsC decisions, policies, or cultural change.

    Learning: Evaluate lessons for future models of involvement, including what stakeholders have learned about embedding lay perspectives.

    Integration: Assess whether the role is now fully embedded in governance structures and processes.

    Support: Reflect on whether Patient Partners felt equipped, valued, and included throughout the year.

Strategic Considerations

9. As GOsC continues to embed the patient voice at the heart of its regulatory work, it is essential that the pilot is underpinned by a transparent and well-evidenced evaluation. This will not only support our credibility as a forward-thinking regulator, but also provide critical insights to shape future governance models and ensure that equity, diversity, inclusion and belonging are embedded in how we work and who we involve.

10. Furthermore, the insights generated through this evaluation will be of value not only to GOsC, but also to the wider regulatory community. As other health and professional regulators explore ways to strengthen patient and public involvement and improve strategic decision-making, the Patient Partner model - and its evaluation - can serve as a practical example of inclusive, co-produced governance in action. Sharing our learning will contribute to sector-wide dialogue on embedding lived experience at the heart of regulation, supporting innovation, accountability, and trust across the system.

11. Strategic considerations include:

    - **Reputation and credibility:** A robust evaluation will reinforce GOsC's leadership in co-production and strategic engagement.
    - **Future governance design:** Findings will inform potential changes to Council structure or future lay recruitment.
    - **EDIB priorities:** The plan incorporates a lens on equality, diversity and inclusion (See Annex C: Equality Impact Assessment Template), helping us understand how inclusive our governance environment is.

Risks and Mitigations

12. Recognising the complexity of embedding patient voices at strategic level, the evaluation plan proactively identifies potential risks—such as tokenism or unclear role boundaries—and outlines practical mitigations to support meaningful involvement and sustained engagement.

13. The risks identified below are framed in relation to the four core purposes of the Patient Partner Pilot—**Integration**, **Influence**, **Learning**, and **Support**—which underpin our evaluation approach. These risks represent potential barriers to achieving the pilot's aims and have been paired with mitigation strategies designed to ensure the patient voice is meaningfully embedded in GOsC governance.

Risk (linked to pilot purpose)	Mitigation
Tokenistic involvement *(Influence)*	Regular feedback loops and focus on genuine influence; assign a 'Council buddy' to provide active support and encourage participation.
Role ambiguity *(Integration, Support)*	Clarify expectations through a well-structured induction, clear evaluation questions, and a shared understanding of the purpose among all Council members.
Missed learning opportunities *(Learning)*	Build in co-reflection sessions and collect feedback from across the organisation to ensure insights are gathered and acted upon.
Lack of buy-in from Council or staff *(Integration, Influence)*	Clearly communicate the intended outcomes of the Patient Partner role and show how these are being achieved; engage stakeholders early and align the pilot with GOsC values and strategy.
Limited organisational learning captured *(Learning)*	Establish feedback loops throughout all evaluation stages, including formal reflections from Council and staff participants.
Risk of siloed working or isolation of Patient Partners *(Integration, Support)*	Promote a buddy system, collaborative working opportunities, and informal interactions between Patient Partners, Council members, and staff.
Misalignment between expectations and experience *(Support, Learning)*	Clarify the role scope and support structures during induction and use regular check-ins and reviews to adapt as needed.

Conclusions

14. The evaluation plan is a critical tool to ensure that the Patient Partner pilot delivers genuine influence, supports inclusive governance, and generates learning to inform future Council composition.

Questions for consideration

15. To consider the implications of the robustness of the evaluation plan, in particular:

    a. Do you feel the proposed evaluation approach will give us the insights we need to judge whether the Patient Partner role is effective and sustainable? (Strategic relevance)

b. Are there any additional outcomes or indicators that you believe we should be measuring? (Completeness of the framework)

c. How can we ensure that all Council members contribute to creating an inclusive and psychologically safe space for Patient Partners? (Shared responsibility for cultural impact) where constructive challenge is valued and appreciated by all.

d. What would success look like to you at the end of this pilot—and how should we evidence that? (Shared vision and evaluation alignment)

e. Do you foresee any barriers to embedding learning from this pilot into future governance decisions or structures?

Recommendations:

1. To consider the proposed evaluation plan for the Patient Partner pilot.

2. To note the focus on influence, integration, support, psychological safety and organisational learning.

3. To agree the evaluation plan to ensure the Patient Partnership Pilot delivers on its intended goals of influence, learning, support and inclusion.

Annex A: Draft Patient Partners Programme Evaluation Plan

Contents

Purpose of Evaluation

The purpose of the evaluation is to:

- Measure the integration and influence of Patient Partners, the support provided to Partners as well as individual and organisational learning.
- Identify enablers and barriers to successful strategic-level patient involvement and to continuously improve the integration of Patient Partners into the governance work of the GOsC, ensuring meaningful involvement, shared influence, and sustainable impact.

Objectives

We have identified the following objectives:

1. **Integration:** Assess how effectively Patient Partners have been integrated into Council, by exploring the experience of the Patient Partners, Council members, staff and observers, through self-evaluation, satisfaction surveys, and qualitative feedback.

2. **Influence:** Evaluate the Patient Partners' effect on Council discussions and Council's quality of decision-making over time, using structured observation tools and evidence of influence in meeting outputs.

3. **Learning:** Explore learning of Patient Partners, Council and staff through the introduction of Patient Partners learning, though participation in the pilot using 360-degree feedback, self-reflection and interviews.

4. **Support:** Assess the effectiveness of the support provided to Patient Partners, including onboarding, role clarity, and development opportunities, by gathering feedback on their confidence, preparedness, and ability to contribute.

Phase 1: 3-Month Evaluation (*Integration and Support*)

Purpose:

- **Integration:** Assess early role clarity and how well Patient Partners are being welcomed and included in Council activity.

- **Support:** Review effectiveness of onboarding, access to information, and initial guidance or mentoring.

3-Month Evaluation Criteria:

Integration

- Patient Partners report clarity about their role, responsibilities, and expectations.
- Patient Partners feel welcomed and included by Council members and staff.
- Patient Partners have established working relationships with at least one Council member and a staff liaison.
- Council and staff demonstrate efforts to include Patient Partners in relevant discussions or activities.
- Meeting environments support participation (e.g. invitations to speak, inclusive facilitation).
- Observation shows Patient Partners engaging in Council discussions or informal interactions.

Support

- Patient Partners report that their induction helped them understand GOsC structures, culture, and meeting processes.
- Access to key information (e.g. meeting papers, briefing materials, contacts) is timely, appropriate, and accessible.
- A buddying relationship has been initiated and is perceived as helpful.
- Any initial support or access needs raised have been acknowledged and addressed.

Methods:

- **Structured Check-In Interview** with each Patient Partner
- **Feedback Survey** to key staff and Council members on Patient Partner engagement and contributions.
- **Self-Reflection Form** completed by Patient Partners:
    - What has gone well?
    - What has been unclear or challenging?
    - Suggestions for better support.

Outputs:

- Short internal report (2–3 pages) summarizing findings.
- Immediate adjustments to support, communications, or expectations if required.

Phase 2: 6-Month Evaluation (Influence, Support and Learning)

Purpose:

- **Influence**: Examine how confident and able Patient Partners feel to contribute to meetings and whether their input is being taken seriously.
- **Support**: Review development needs, role fit, and any adjustments required to sustain meaningful involvement.
- **Learning**: Reflect with Council and staff on how the presence of Patient Partners is affecting collaboration and discussions.

6-Month Evaluation Criteria:

Influence

- Patient Partners report feeling confident to contribute during meetings.
- Patient Partners perceive their input is welcomed, acknowledged, and taken seriously.
- Evidence of Patient Partner contributions being referenced in discussions or minutes.
- Council members and staff perceive that Patient Partner insights are influencing discussions or perspectives.
- Patient Partners are actively invited to contribute by Chairs or other members.

Support

- Patient Partners have clarity on their role and responsibilities at this stage.
- Patient Partners report that the support provided (e.g. buddying, induction, staff liaison) has been sufficient and effective.
- Development needs are identified and have appropriate follow-up actions (e.g. training, resources etc).
- Any adjustments to role expectations, meeting processes, or logistics are surfaced and acted upon.

- Staff and Council report improved confidence in supporting inclusive participation.

Learning

- Council members can identify specific ways the presence of Patient Partners has affected how they think, communicate, or frame decisions.
- Staff and Council describe increased openness to diverse perspectives and enhanced collaborative behaviours.
- Patient Partners reflect on personal learning (e.g. understanding governance, influence tactics, sector knowledge).
- Shared learning is being captured and used to inform wider governance development (e.g. onboarding materials, chairing practice).
- There is growing mutual trust and understanding among Patient Partners, Council members, and staff.

Methods:

- **Midpoint Progress Report** completed by each Patient Partner (see page 13):
    - Highlights of their contribution.
    - Reflections on inclusion and influence.
    - Any development needs.
- **Feedback Interviews** with:
    - Assigned staff liaison
    - 2–3 Council members
- **Notes** from the minutes of Council meetings

Outputs:

- Mid-year evaluation summary (including strengths, development areas, and any role adjustments).
- Co-reflection session between Patient Partners and Chair.
- Adjustment plan if required (e.g., development, mentoring, role expectations).

Phase 3: 12-Month Evaluation (Influence, Learning, Integration and Support)

Purpose:

- **Influence**: Identify if and how Patient Partners have contributed to GOsC decisions, policies, or cultural change.
- **Learning**: Evaluate lessons for future models of involvement, including what stakeholders have learned about embedding lay perspectives.
- **Integration**: Assess whether the role is now fully embedded in governance structures and processes.
- **Support**: Reflect on whether Patient Partners felt equipped, valued, and included throughout the year.

12-Month Evaluation Criteria:

Influence

- Documented examples where Patient Partner input influenced Council decisions, policy development, or strategic priorities.
- Stakeholders (Council/staff) confirm that Patient Partners' contributions had meaningful impact.
- Minutes, reports, or outputs show evidence of patient perspectives being explicitly referenced or shaping recommendations.
- Chairs and executive staff acknowledge changes in tone, framing, or decision-making linked to Patient Partner input.
- Patient Partners perceive that their insights have been seriously considered and, where appropriate, acted on.

Learning

- Council and staff articulate specific learning gained from working with Patient Partners (e.g. about co-production, inclusivity, or governance design).
- Patient Partners reflect on what they've learned about regulation, governance, and influence.

- Evaluation identifies key enablers and barriers for embedding lay perspectives in governance structures.
- Insights have been captured and shared to inform potential adaptations to future involvement models (e.g. induction, expectations, meeting design).

Integration

- Patient Partners are regularly and confidently participating in Council activities.
- Stakeholders view the role as a natural and valued part of Council and committee work.
- Patient Partners are included in key preparatory activities (e.g. pre-meeting briefings, policy discussions).
- Council processes (e.g. meeting planning, documentation) have adapted to ensure inclusive participation.
- The role is recognised in internal systems (e.g. terms of reference, governance handbooks, evaluation cycles).

Support

- Patient Partners report that they felt equipped and supported to contribute meaningfully throughout the year.
- Feedback from Partners highlights psychological safety, respect, and responsiveness from the organisation.
- Training, mentoring, and support were timely and adapted to evolving needs.
- Patient Partners felt their contributions were valued, not tokenistic.
- Any challenges encountered were acknowledged and acted upon.

Methods:

- **End-of-Year Review Report** by each Patient Partner (prompted reflections on their journey, influence, challenges, and impact).
    - Self-assessment of their contribution
    - Satisfaction survey
    - Their assessment of their skill development
    - Observational tools
    - 360 assessment regards relationship building with others
- **Case Examples** of contributions made by Patient Partners (e.g., meeting minutes, recommendations).
- **Final Feedback Survey** Council and Staff reflections on the Patient Partner Pilot Programme across the organisation (see page 14).

Outputs:

- **Final Evaluation Report** (for Governance and Council):
    - Summary of evaluation findings.
    - Case studies of impact.
    - Lessons learned and suggestions for improvement. Recommendation: continue, adjust, or scale the role.
- **Forward Plan:**
    - Options for recruitment, continuity, and institutional learning.
    - Recommendations for training and inclusion.
    - Future evaluation cycle suggestions.

Indicators of success

1. **Evaluate the integration, influence and impact of Patient Partners in GOsC governance structures.**

   Quantitative Indicators:

   - % attendance at Council (and any other committee) meetings by Patient Partners.
   - Number of agenda items or papers on which Patient Partners commented.

   Qualitative Indicators:

   - Evidence from minutes or stakeholder interviews of Patient Partner contributions being acknowledged or acted on.
   - Perceived value of their input by Council members and staff (survey or interview).

2. **Measure how well the role supports patient involvement in strategic decision-making.**

   Quantitative Indicators:

   - Number of decisions or policy areas where Patient Partner feedback was incorporated.
   - Number of examples illustrating Partner influence on policy or regulation.

Qualitative Indicators:

- Testimony from stakeholders about the depth and timing of Partner involvement (e.g., were they involved early enough to influence?).
- Changes in the tone, language, or priorities of decisions based on patient input.
- Partner reflections on their confidence and agency in decision-making spaces.

3. **Identify the influence of Patient Partners on GOsC strategy, decision-making, and culture.**

   Quantitative Indicators:

   - Number of strategic documents or outputs influenced by Patient Partners.

- % of Council/staff agreeing that the programme has influenced organisational thinking or values.

Qualitative Indicators:

- Cultural change narratives from staff or Council members (e.g. “we think differently now…”).
- Examples of patient-centred language or framing emerging in strategy documents post-involvement.
- Influence mapped through sociograms.

4. **Understand and improve the experience and support of the Patient Partners.**

Quantitative Indicators:

- Patient Partners rating of onboarding/support
- Number of development sessions or support check-ins delivered.

Qualitative Indicators:

- Partner reflections on inclusion, psychological safety, and empowerment.
- Feedback on barriers experienced (e.g. language, hierarchy, process clarity).
- Suggestions for improvement directly from Patient Partners.

5. **Support inclusive and effective participation through timely feedback and development.**

Quantitative Indicators:

- % of meetings where Patient Partners receive pre-meeting and post-meeting debriefs.
- Number of feedback cycles completed (e.g. bi-monthly reflections or mentor catch-ups).
- Completion rate of structured development plans.

Qualitative Indicators:

- Perceptions from Patient Partners about whether feedback is timely, actionable, and respectful.
- Staff feedback on how support has improved Partner engagement.
- Examples of changed behaviour, confidence or capability resulting from feedback or development.

6. **Assess sustainability and future options for the Patient Partner role.**

   Quantitative Indicators:

   - Cost per year of the programme (vs. perceived value by stakeholders).
   - Number of stakeholders recommending continuation or expansion of the model.
   - Number of expressions of interest in future Patient Partner roles.

   Qualitative Indicators:

   - Options appraisal feedback (e.g. integration into Council, flexible term limits, hybrid models).
   - Reflections from Partners and staff on long-term viability and fit with GOsC strategic goals.
   - Benchmarking against similar roles in other regulators or organisations.

7. **Explore learning of Patient Partners, Council and staff**

   Quantitative Indicators:

   - Number of 360-degree feedback responses completed across Patient Partners, Council, and staff.
   - Number of individuals participating in interviews or reflective sessions.
   - Completion rate of reflective logs or guided self-assessments by Patient Partners.

   Qualitative Indicators:

   - Evidence of individual or collective learning from reflective interviews (e.g. “I now see the value of...”, “I've learned to...”).
   - Partner reflections on what they’ve learned about governance and their role.
   - Council/staff reflections on how the pilot has changed their perceptions or understanding of patient involvement.

6-Month Evaluation: DRAFT Reflective Questions for Partners

Aspect of programme	Questions
Role Understanding and Contribution	• How well do you understand your role as a Patient Partner? • Are there specific areas of your role that need further clarification or support?
Participation and Engagement	• Have you felt able to contribute to discussions during meetings? • Do you feel confident sharing your perspectives and ideas?
Integration and Collaboration	• How well have you integrated with other council members and staff? • Are you able to work effectively with the team to achieve shared goals? • What could GOsC do to make the governance environment more inclusive and supportive?
Knowledge and Skills	• Have you gained an understanding of GOsC's regulatory role and strategic priorities? • Are there any gaps in your knowledge that could benefit from further training?
Skills and Development	• Are there particular skills or strengths you've brought to the council? • Are there areas where you'd like additional training or resources?
Areas for Improvement and Support Needed	• Have you faced any challenges in adapting to your role as a Patient Partner? • Are there specific resources or support that could help you overcome these challenges?
Future Goals	• What goals would you like to focus on in the next 6 months? • How can we support your growth and contribution?
Overall Assessment	• Strengths and Achievements • Opportunities for Growth

12-Month Evaluation: DRAFT Council and Staff Feedback Survey — Reflections on the Patient Partner Pilot Programme

Purpose:
To gather insights from Council members and staff on the integration, participation, and impact of the Patient Partners within GOsC's governance structures. Your feedback will inform the future development of the role.

Section 1: Role Clarity and Understanding

1. I did **not** fully understand the purpose and responsibilities of the Patient Partner role.
   Strongly disagree / Disagree / Neutral / Agree / Strongly agree
2. The Patient Partners' role in strategic decision-making was clearly communicated.
   Strongly disagree / Disagree / Neutral / Agree / Strongly agree
3. It was sometimes unclear how Patient Partners were expected to contribute to discussions.
   Strongly disagree / Disagree / Neutral / Agree / Strongly agree
4. **Any additional comments on role clarity and understanding (Optional)**

Section 2: Participation and Collaboration

4. The Patient Partners **did not** regularly contribute in a meaningful way to Council meetings or related activities.
   Strongly disagree / Disagree / Neutral / Agree / Strongly agree
5. There was mutual respect and positive collaboration between Patient Partners and other Council members/staff.
   Strongly disagree / Disagree / Neutral / Agree / Strongly agree
6. Patient Partner contributions significantly enhanced the diversity of perspectives in discussions.
   Strongly disagree / Disagree / Neutral / Agree / Strongly agree
7. The Council/organisation did **not** provided an environment that felt psychologically safe and inclusive for Patient Partners.
   Strongly disagree / Disagree / Neutral / Agree / Strongly agree
8. Any additional comments on participation and collaboration (Optional)

Section 3: Impact and Influence

8. I saw little evidence that Patient Partner insights had an impact on Council discussions or decisions.
   Strongly disagree / Disagree / Neutral / Agree / Strongly agree
9. The presence of Patient Partners strengthened the quality of GOsC's strategic work.
   Strongly disagree / Disagree / Neutral / Agree / Strongly agree
10. My thinking about patient involvement in governance has **not** changed as a result of this pilot.
    Strongly disagree / Disagree / Neutral / Agree / Strongly agree
11. Any additional comments on impact and influence (Optional)

Section 4: Support and Development

12. The support and induction provided to Patient Partners was appropriate and sufficient.
    Strongly disagree / Disagree / Neutral / Agree / Strongly agree / Don't know
13. I am **not** aware of how Patient Partners were supported to build confidence in their role.
    Yes / No / Not sure
14. Any additional comments on support and development (Optional)

Section 5: Final Reflections (Compulsory)

15. What has worked well in the Patient Partner pilot? (Free text)
16. What, if anything, could have been improved to support the Patient Partners or strengthen their impact? (Free text)
17. Any other final comments or suggestions? *(Free text)*

Annex B to 10

Patient Partner Induction Plan

1. Pre-Induction Preparations

Welcome Pack

- A letter of welcome from the Chair or CE&R
- The GOsC governance handbook
- An overview of Patient Partner responsibilities
- Key policies
    - Code of Conduct,
    - Conflict of Interest
    - Remuneration Policy
    - Travel/Accommodation booking

Technical Setup

- Provide access to GOsC specific platforms e.g., email, virtual meeting platforms.
- Set up on Admincontrol for access to meeting books/previous documents.

Introductory Meetings

- One-on-one introductions with the CE&R, Buddy etc.
- Suggestion: One-on-one introduction with Chair.
- Observation opportunities for council/committee meetings.
    - Can be arranged through Governance Manager. E.g. July Council meeting.

2. In-person Orientation

Welcome meeting:

- Introduction by the CE&R and Governance Manager.
    - Overview of GOsC's vision, mission, and strategic objectives.
    - Regulatory Role: Overview of GOsC's role in protecting the public, regulating osteopathy, and promoting patient safety.

  - Explanation of the role and responsibilities of council members, committees, and executive team.
  - Explanation of the evaluation plan
- In-Person tour of the office
- Meet key staff from governance, communications, and policy.
- Attend Council strategic development day

3. Training Modules

- Equity, Diversity, Inclusion and Belonging (EDIB) training
- GDPR training
- Mental health training
- Cyber Security training

4. Ongoing induction: Active Participation and Learning

Council/ Committee Meetings

- First meeting: Patient Partner has introduced themselves, observed group dynamics and governance processes, and made at least one contribution or inquiry that brings a patient or public interest perspective into the conversation.
- Second meeting: the Patient Partner is actively contributing to discussions, beginning to frame their input in relation to GOsC's regulatory role, and reflecting on their development and support needs.
- Provide an opportunity to ask questions and debrief after the meeting with a buddy or Chair.
- Patient Partners to attend relevant committees based on their expertise and interests.

Communications

- 1 Sept: Launch announcement
- W/C 1 Sept: Social media posts
- Sept GOsC Newsletter

- Mid-Sept: Stakeholder briefing email
- December: Follow-up story on progress of Patient Partners

Stakeholder Engagement

- Introduction to key stakeholders, including:
  - Institute of Osteopathy/NCOR etc.
  - Patient Involvement Forum
  - OEIs/COEI meeting

Ongoing Support and Development

- Buddy Program: Council member to guide them through the length of their appointment.
- Staff support: Governance Manager assigned as a liaison for Patient Partners.

Continuous Learning

- Access to webinars, regulatory updates, and sector-specific news.

Performance Feedback

- 3-month evaluation: A check-in after the first three months to gain a holistic assessment of performance.
- 6-Month Evaluation: Evaluate the ongoing participation, perceived value, and integration of Patient Partners in Council business.
- 12-Month Evaluation: Assess overall impact, outcomes, lessons learned, and potential for continuing or expanding the role.

Equality Impact Assessment Template

Step 1 – Scoping the EIA

Prompts: In completing this section think about the policy or activity that is being introduced and what its impact would be if implemented immediately.

Think about the purpose of the policy or activity – how would you briefly describe it to someone outside of the GOsC who did not understand healthcare regulation? Who would be affected by the policy or activity if implemented immediately?

Think about the data that you might need in order to take the policy or activity forward to implementation. Do you know what data you need and where you might find the data? Do you know if there is data which relates to each protected characteristic? If there are gaps in the data, how might this be addressed through consultation?

Title of policy or activity
Patient Partners Programme
Is a new or existing policy/activity?
New (Pilot initiative)
What is the main purpose and what are the intended outcomes of the policy/activity?
To embed the patient voice at the strategic level of the General Osteopathic Council's (GOsC) governance structure by recruiting Patient Partners who will act as independent critical friends to Council. The programme aims to enhance patient-centred regulation, support public protection, and promote co-production between patients and osteopaths in decision-making processes Intended outcomes: • To bring patient perspectives into the Council's strategic decisions. • To build trust, transparency, and inclusivity in osteopathic regulation. • To develop a culture where patient partnership is normalised at governance level. • To contribute to public protection through a more diverse and representative governance framework
Who is most likely to benefit or be affected by the policy/activity
Directly: Patients recruited as Partners, Council members, GOsC staff, Patient Involvement Forum members. **Indirectly:** The wider osteopathic profession, other health regulators, and the patients/public receiving osteopathic care.

Does this policy or activity impact on the Welsh Language?	
No direct impact identified. Accessibility of all resources in appropriate formats will be considered.	
Dates of the EQIA	
• When did it start?	Recruitment commenced in March 2025
• When was it completed	June 2025
• Scheduled review	August 2026 (post-pilot evaluation)

Useful information

What information would be useful to assess the impact of the policy/activity on equality?
• Equality monitoring forms from applicants • Evaluation report of the pilot programme • Ongoing Staff and Patient Involvement Forum feedback • Learning from PEC/Council discussions
Is there data relating to people with any/each of the protected characteristics and, if relevant, on the Welsh Language?[1]
• Equality monitoring forms from applicants
Where can we get this information and who can help?
HR team

Step 2 – Involvement and consultation

Prompts: Thinking about your policy or activity, have you been liaising with any individuals and/or groups to inform the development of the policy or activity? Has there been pre-consultation events which have provided insight into your policy or activity development?

[1] The nine protected characteristics in the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Think about your answer in Step 1 around data. If there were gaps in the data that you needed to inform your policy or activity development, how are you planning to address them through the involvement and consultation phase?

If you have involved stakeholders, briefly describe what was done, with whom, when and where. Please provide a brief summary of the response gained and links to relevant documents, as well as any actions.
Stakeholders consulted include: • Members of the Patient Involvement Forum. • Members of PEC and Council. • Sector colleagues from other regulators. • Patient organisations and charities. **Nature of involvement:** • Stakeholder feedback on role design and purpose • Review of public engagement best practice • Council workshop discussions and papers (2021–2024) **Key insights from stakeholders:** • Strong support for embedding patient voice in strategic governance. • Importance of recruiting diverse participants with lived experience. • Need to offer training, support, and fair remuneration. • Agreement that governance-level participation offers meaningful influence.

Step 3 – Data collection and evidence

Prompts: In completing this section think about the data and evidence that you have already collected and, when completing the EIA at an early stage of the development of the policy or activity, the data that will be collected through consultation. Where possible, try and show this separately and update your EIA as the policy or activity progresses.

Do you need to undertake further research or data collection? But remember, you will never have a perfect set of data in which to make a decision.

What evidence or information do you already have about how this policy might affect equality for people with protected characteristics under the Equality Act 2010 and on the Welsh Language Scheme? Please cite any quantitative (such as statistical data) and qualitative (such as survey data, complaints, focus groups, meeting notes or interviews) relating to these groups. Describe briefly what evidence you have used.
• **Disability:** Accessibility is core to programme design; applicants can request adjustments.

- **Gender reassignment:** EDI principles embedded; anonymised shortlisting to reduce bias
- **Marriage/Civil Partnership:** Not specifically addressed; no barriers identified, but asked at application stage, so is monitored along with other 8 protected characteristics
- **Pregnancy/Maternity:** Flexibility and carer costs included; support for inclusive scheduling;
- **Race:** Targeted outreach to ethnic minorities; underrepresentation in governance acknowledged
- **Religion/Belief:** Respect for faith needs; inclusive environment promoted
- **Sexual orientation:** Inclusive language and engagement encouraged; no issues identified
- **Sex (Gender):** Open to all; efforts made to achieve gender balance in representation.
- **Age:** No upper age cap; digital exclusion mitigated by offering paper and verbal access
- **Welsh Language:** Materials can be translated; verbal and written support can be arranged if needed.
- **Working Pattern:** collected at application stage as we anticipate that protected characteristics such as disability, pregnancy and maternity or age may have an impact on working pattern decisions.

What additional research or data is required to fill any gaps in your understanding of the potential or known effects of the policy? Have you considered commissioning new data or research?

- Continued monitoring of uptake and representation across protected groups alongside other GOsC governance structure positions. Patient Partner EDIB data will be added to EDIB recruitment data for governance structure posts, for comparability
- Evaluation of the experience of Patient Partners post-appointment.

Step 4 – assessing impact and strengthening the policy

Prompts: Think about each of the nine protected characteristics and consider the potential positive and negative impacts on each group. If you have identified a negative impact on a particular group, what are the actions that you plan to take to address the negative impact, if at all? Think about what else you might be able to do in order to strengthen equality further in relation to your policy or activity.

What does the data reviewed tell us about the people the policy/activity affects, including the impact or potential impact on people with each/any of the protected characteristics and on the Welsh Language?

Positive impacts identified:

- Greater visibility and influence of patients in health regulation.

- More inclusive and responsive decision-making.
- Strengthened public trust and confidence in the GOsC.

Potential negative impacts or barriers:

- Accessibility challenges for digitally excluded or
- Accessibility challenges for disabled individuals.
- Perception of limited influence due to absence of voting rights.
- Underrepresentation of certain demographic groups in applications.

Are there any implications in relation to each/any of the different forms of discrimination defined by the Equality Act and on the Welsh Language?

- **Disability?**
- **Gender reassignment?**
- **Marriage or civil partnership?**
- **Pregnancy or maternity?**
- **Race?**
- **Religion or belief?**
- **Sexual orientation?**
- **Sex (gender)?**
- **Age?**

- **If relevant, on the Welsh Language?**

No, not identified at present

What practical changes will help to reduce any adverse impact on particular groups?

- **Disability?**
- **Gender reassignment?**
- **Marriage or civil partnership?**
- **Pregnancy or maternity?**
- **Race?**
- **Religion or belief?**
- **Sexual orientation?**
- **Sex (gender)?**
- **Age?**

- **If relevant, on the Welsh Language?**

Actions to mitigate negative impact:

- Clear role profile and support provided from application through induction.
- Payment of honoraria and reasonable expenses (e.g. travel, carers).
- Inclusive meeting practices (hybrid attendance, accessible documents).
- Anonymous application shortlisting to reduce bias.

What could be done to improve the promotion of equality within the policy?

- Proactive communications plan to reach a wider, more diverse audience.
- Support for candidates with no prior governance experience.
- Use of EDI principles throughout design, implementation, and evaluation.

Step 5 – making a decision

Prompts: In completing this section, consider all of the data you have collected, the potential impact (positive and negative) on all of the protected characteristics. Where do you see your policy or activity now? You have four options:

a. No barriers or impact were identified, therefore activity will proceed.

b. You have decided to stop the policy or practice because the evidence shows bias towards one or more groups.

c. You have adapted or changed the policy in a way which you think will eliminate the bias.

d. Barriers and impact identified, however having considered all available options carefully, there appear to be no other proportionate ways to achieve the aim of the policy or practice (e.g. in extreme cases or where positive action is taken). Therefore you are going to proceed with caution with this policy or practice knowing that it may favour some people less than others, providing justification for this decision.

Now summarise your decision and think about how you might explain this to someone outside of the GOsC who has little to no understanding of healthcare regulation.

Summarise your findings and give an overview of whether the policy will meet the GOsC's objectives in relation to equality.
The Patient Partners Programme offers a proportionate, inclusive, and evidence-informed approach to embedding the patient voice in governance. While the pilot structure does not include voting rights, Partners will have influence, visibility, and developmental support. The design reflects best practice from other sectors and addresses equality gaps in a strategic, scalable way.
What practical actions do you recommend to reduce, justify or remove any adverse/negative impact?
• Provide support package and tailored onboarding for Partners • Ongoing support from staff and dedicated Council "Buddy"
What practical actions do you recommend to include or increase potential positive impact?
• Deliver inclusive training and buddying system • Publish anonymised EDI data post-recruitment • Establish accessible feedback channels for Patient Partners • Conduct midpoint and final evaluation of EDI impact

Step 6 – monitoring, evaluation and review

Prompts: If the policy or activity is to be introduced, in this section think about how you plan to measure the impact and effectiveness once it has been introduced. How will you do this? How frequently will you monitor the policy or activity? Which individuals or groups will you be asking/collecting data from to inform the monitoring, evaluation and review.

How will you monitor the impact/effectiveness of the policy/activity?
• EDI monitoring of applicants and appointees • Evaluation of feedback from Partners, Council, and staff • Appraisal of Partner impact and experiences • Regular PEC/Council oversight
What is the impact of the policy/activity over time?
Indicators of success: • Diverse applicant pool and appointments • Partners report feeling valued and heard - impact in terms of deep, clear, wide and high • Evidence of influence in Council decisions • Sector interest or replication of the model

Where/how will this EIA be published and updated?

Step 7 – Action planning

Prompts: The final section of the EIA is to detail the actions which have arisen as a result of completing the EIA and who is the person responsible for those actions and the date by which they will be completed.

Please detail any actions that need to be taken as a result of this EIA		
Action	**Owner**	**Date**
Launch inclusive recruitment with anonymised shortlisting	HR	March 2025
Provide support package and tailored onboarding for Partners	Governance Team	July 2025
Conduct 3-Month check-in with Patient Partners		
Conduct midpoint reflection with Patient Partners		
Deliver full evaluation and updated EIA		

Produced by	Reviewed by	Date of review
Senior Research and Policy Officer	Director of Education, Standards and Development and Head of Research, Data and Insight	June 2025
TBC	Director of Education, Standards and Development and Head of Research, Data and Insight	May 2026

General Osteopathic Council

11

Council
15 July 2025
Annual Report and Accounts

Classification	Public
Purpose	For decision
Issue	Approve the publication of the Annual Report and Accounts for the financial year 2024-25.
Recommendations	1. To note the Audit Findings Report. 2. To note the Letter of Representation to be e-signed by the Chair of Council. 3. To approve the Annual Report and Accounts for e-signing by the Chair of Council. 4. To note the annual reporting requirements associated with the Charity Commission.
Financial and resourcing implications	The Annual Report and Accounts have been typeset for publication on the website, but not produced as a printed document.
Equality and diversity implications	The Annual Report and Accounts sets out work we have undertaken on equality, diversity and inclusion.
Communications implications	The Annual Report and Accounts are a public document and will be published on the GOsC website.
Annexes	A. Annual Report and Accounts 2024-25 B. Audit Findings Report C. Letter of Representation
Author	Darren Pullinger

Key messages from the paper:

- The annual financial audit was undertaken by HaysMac (formerly Haysmacintyre) in May and June 2025.

- The Executive have developed the Annual Report (Annex A) which details the activity we have undertaken in the year across our three strategic goals, our narrative around our areas of risk and our financial report, which again includes the Value Proposition, our articulation of where our regulatory approach adds value.

- The audit ran smoothly for the most part, except for a change which was brought to our attention by the auditors quite late in the process. Further information is in the paper.

- No new control points were identified for the second year in succession.

- The Audit Committee recommend the Annual Report and Accounts to Council subject to Council agreeing the adjustment to debtors and deferred income.

- Audit Committee considered information provided by the Executive on whether the GOsC was a going-concern. The Executive and Audit Committee concluded that the GOsC remained a going-concern.

- Council will be asked to approve the Letter of Representation (Annex C) which will be signed by the Chair alongside the Annual Report and Accounts.

- The Annual Report and Accounts need to be laid before both Houses of Parliament by 30 September 2025 and we also need to submit the accounts to the Charity Commission within nine months of our year end.

Background

1. The General Osteopathic Council (GOsC) publishes its accounts as soon as reasonably practicable after they have been audited and provides copies to the Privy Council to be laid before Parliament.

2. The 2024-25 accounts are the eighth set of accounts produced since the GOsC became a registered charity. The accounts will also be submitted to the Charity Commission alongside a charity Annual Return.

3. The financial audit was conducted by HaysMac in May and June 2025.

4. The audit was carried out remotely, in line with the hybrid working model adopted by the GOsC. Following the conclusion of the audit, Haysmacintyre produced an Audit Findings Report (AFR) which highlighted the key issues affecting the results of the GOsC and the preparation of the financial statements.

5. The AFR was presented to the Audit Committee by Adam Halsey; Partner, Head of Charities; on 19 June 2025 and is attached at Annex B for Council members only. At the request of HaysMac, the AFR will not be made publicly available online, and this is in line with normal auditing practice.

6. The audited accounts are accompanied by an Annual Report setting out the activities of the GOsC over the previous twelve months.

7. If a member of Council identifies a significant problem with the Annual Report and Accounts, this should be brought to the attention of the Chief Executive and Registrar and Head of Resources and Assurance in advance of the meeting. This will ensure that the Annual Report and Accounts can be signed electronically by the Chair of Council post the July Council meeting.

Discussion

Audit Findings Report

8. A summary of the issues outlined in the AFR, and considered by the Audit Committee, are set out below:

Potential for significant risk	**Conclusion**
Presumed risk in revenue recognition	No significant issues were identified.
Presumed risk of management override	No significant issues were identified.
Legal cases & corresponding provisions: NMC Vs Somerville impact	No significant issues were identified. A contingent liability should be recognised in the accounts.
Deferred income	It is considered that GOsC use an unconventional way of calculating deferred income. Refer to paragraphs 11-17 below.

9. Overall, the AFR provided assurance to the Audit Committee that the internal financial controls and operational processes continue to be robust.

10. In relation to the third item, a note has been added to the Annual Report to outline the contingent liability (see note 15 on page 55).

Proposed change to the Annual Report and Accounts requested by HaysMac – debtor and deferred income adjustment

11. Towards the end of the audit, as the June 2025 Audit Committee papers were being finalised, the auditors proposed a change to the debtors and deferred income balances. This is due to a change in methodology proposed by the auditors when accounting for registrants who pay by direct debit. Currently,

those registrants paying by direct debit are issued their fee at their point of renewal, and their instalments reduce their 'debt' to GOsC month by month. This is why we have historically included them in the debtor listing for any amounts still unpaid at the year end point.

12. HaysMac argue that those registrants who pay by direct debit are at no stage a debtor as their fees accrue monthly and are then paid off straight away, as opposed to a registrant who pays in one lump sum each year.

13. The premise also applies to the deferred income calculation, in which we allocate each registrant's income equally throughout the year, regardless of when they actually pay.

14. A summary of the adjustment required to adjust the debtor and deferred income positions is shown below:

    Reduce debtors by £273,485
    Reduce creditors (deferred income) by £273,485
    No change to income or expenditure

15. The prior year comparative has been restated with a corresponding adjustment, for £278,229. The entry has been adjusted in the same way as above.

16. At the Audit Committee meeting, the members agreed that the adjustment should be processed, and the draft accounts presented in Annex A include this adjustment.

17. Members may note similarities to the situation last year when late adjustments to the accounts were required as a result of how the Somerville provision should be accounted.

Signing the accounts

18. Audit Committee are content to recommend to Council that the Annual Report and Accounts be signed electronically by the Chair of Council.

Letter of representation

19. The letter of representation from Council to HaysMac is attached at Annex C. The letter sets out responsibilities and representations made by Council to the auditors to confirm that certain matters have been undertaken, and to confirm the responsibilities of Council to ensure there is no misunderstanding between the two parties.

Annual Reporting requirements

20. Once the Chair of Council has signed the Annual Report and Accounts electronically, the steps below will be followed:

    a. The Annual Report and Accounts emailed to HaysMac for e-signing by the Audit Partner during the afternoon of 15 July 2025.

    b. Once signed by both parties, the Annual Report and Accounts are presented to Privy Council for pre-laying approval.

    c. Privy Council agree the Annual Report and Accounts and confirm the number of copies required for laying in front of both Houses of Parliament; the number of copies required for the Welsh Assembly and the number of copies required for the Votes Office of the House of Lords.

    d. The Annual Report and Accounts are laid before both Houses of Parliament by 30 September 2025.

    e. The GOsC publish the Annual Report and Accounts on our website after the document is laid before both Houses of Parliament.

    f. The Annual Report and Accounts are filed with the Charity Commission along with an Annual Return that covers such things as:

        i. Income (including from overseas sources)

        ii. Senior salaries

        iii. Payments to trustees

        iv. Risk management

        v. Safeguarding

        vi. Serious incidents.

Recommendations:

1. To note the Audit Findings Report

2. To note the Letter of Representation to be e-signed by the Chair of Council.

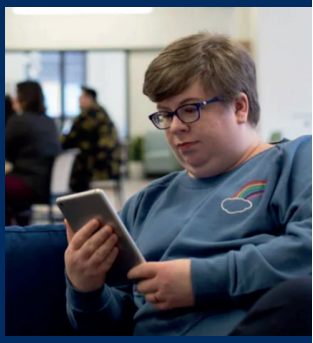
3. To approve the Annual Report and Accounts for e-signing by the Chair of Council.

4. To note the annual reporting requirements associated with the Charity Commission.

General Osteopathic Council

Annual Report and Accounts 2024-25



General Osteopathic Council

Annual Report and Accounts 2024-2025

Presented to Parliament pursuant to section 40(5) of the Osteopaths Act 1993

Any enquiries about this publication should be sent to the General Osteopathic Council, please email **info@osteopathy.org.uk** or call **020 7357 6655**.

This publication is available from our website: **osteopathy.org.uk/annualreport**

Contents

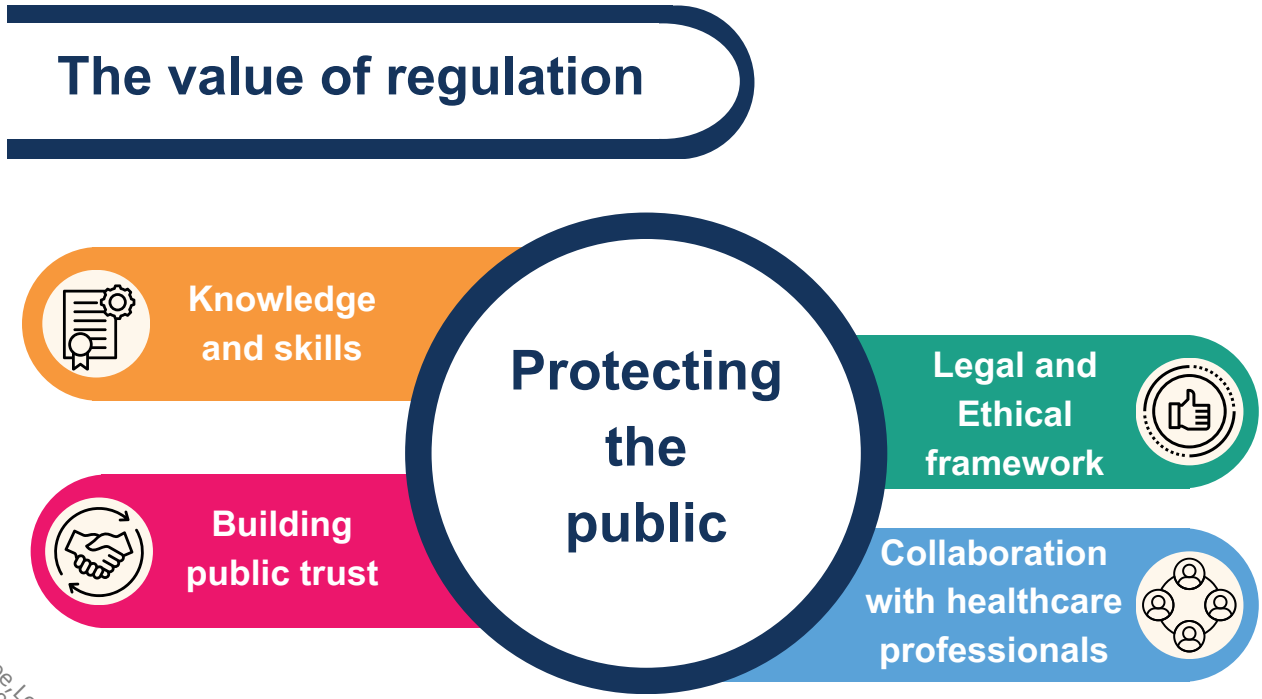
1 About the General Osteopathic Council

The General Osteopathic Council (GOsC) was established under the Osteopaths Act 1993 and has a statutory duty to regulate and develop the osteopathy profession in the UK to ensure public protection.

We work with osteopaths, patients, and partner organisations to support safe, high quality patient care. We also work to maintain public confidence in osteopathy by protecting the reputation of the osteopathic profession.

We do this by keeping our public Register of osteopaths up to date, and by promoting high standards of practice and conduct, setting standards for osteopathic education and training, investigating concerns about osteopaths, and protecting the osteopathic title from misuse.

This is the value of regulation (see graphic below): to protect the public through ensuring that osteopaths maintain their knowledge and skills; work within a legal and ethical framework; collaborate with other osteopaths and other healthcare professionals; and help build and maintain public trust.



Our role

The General Osteopathic Council (GOsC) is the regulator for osteopaths in the United Kingdom. By law, osteopaths must be registered with the GOsC to practise in the UK.

It is our role to protect the health, safety and wellbeing of the public, and to protect the reputation of the osteopathic profession. We are responsible for making sure the public continues to have confidence in the profession of osteopathy, and we are responsible for the professional standards that osteopaths and osteopathic students must follow in order to practise safely.

What we do:

- Keep a Register of all those allowed to practise osteopathy in the UK.
- Work with the public, patients and osteopathic profession to decide on, maintain and develop high quality standards of osteopathic practice and conduct.
- Help patients with any concerns they raise about an osteopath and have the power to remove from the Register any osteopaths who do not meet the professional standards and who are unfit to practise.
- Check the quality of osteopathic education and decide on the standards of practice that osteopathic students must demonstrate before they graduate.
- Protect the osteopathic title from misuse by making sure that only those with the correct qualifications are able to call themselves an osteopath.
- Make sure that osteopaths carry out activities to support their continuing professional development (CPD).

The statutory objectives of the GOsC are also its charitable objectives. By meeting our statutory objectives as outlined through the activities in this report, the Trustees (who are also members of Council) are able to confirm they have had due regard to the Charity Commission's guidance on public benefit. The GOsC is a charity registered with the Charity Commission for England and Wales and has been since April 2017 (registration number 1172749).

This Annual Report and Accounts has been laid before both Houses of Parliament and submitted to the Charity Commission.

2 Introduction from Chair of Council

I have found my first year as Chair of the GOsC Council to be very interesting and have been pleased to meet and work with many of our external stakeholders.

One of my main areas of focus over the past year has been recruitment of new Council members, as several of our members have recently come to the end of their terms. It has been good to onboard both new lay and registrant members (and a new Associate member), and to build the Council team.

I am pleased that – once again – the executive team has reached all the Professional Standards Authority's 'Standards of Good Regulation'.

I know that there is always more work to be done. Council received the results of the first GOsC registrant survey this summer. This has given us a breadth and depth of information about what our stakeholders want and need from us, and some clear areas that we can focus on to improve our communications and engagement. I am also aware that the higher education sector faces significant challenges at the moment, and osteopathy is not an exception to this.

I am planning for us, as a Council, to engage more with the profession over the next months and years. I was pleased to attend the Institute of Osteopathy conference in London in November, and to represent the UK at the Osteopathy Europe conference in Luxembourg in the autumn. I have started to visit the osteopathic educational providers and will continue this in the coming year.

Finally, a reminder that anyone with an interest is very welcome to attend our Council meetings in person or online, you just need to register in advance so please email **council@osteopathy.org.uk**. We would be pleased to see you.

Jo Clift
Chair of Council
15 July 2025

3 Introduction from Chief Executive and Registrar

The business year of 2024-25 represents the first year of the new GOsC Strategy.

A significant milestone this year was the publication of the results arising from the independent registrant and stakeholder perceptions survey of the GOsC. The results of the research provide fresh impetus and energy to the GOsC team to change and enhance how we work.

We know there are misconceptions around our work that we need to correct; we know trust in us as a regulator is not as high as we would like; and we know there can be fear associated with our work such as around fitness to practise.

We heard the results and we are taking action.

Since the survey we have introduced new communication channels to enable osteopaths to contact the GOsC staff team. We are holding weekly drop-in sessions where osteopaths can log into a Zoom link and ask any questions directly to GOsC staff, and we have introduced a new WhatsApp channel which is proving popular with osteopaths who have used this.

We are also continuing to promote the free and confidential Independent Support Service, which is available to all parties, including osteopaths, who find themselves involved in the fitness to practise process.

And I am delighted that Council has agreed to set aside resources to upgrade the GOsC website which we all acknowledge is outdated and does not allow us to communicate and engage with the profession as easily as we would like. This is an exciting project, and we look forward to sharing more news on this development in the coming year.

Finally, I would like to offer my thanks to all those who have contributed to our work this year, particularly my staff team, whose efforts are reflected in the successful year we report on in this Annual Report and Accounts.

Matthew Redford
Chief Executive and Registrar
15 July 2025

4 Our strategic aims

This Annual Report reflects the work of the General Osteopathic Council (GOsC) in the year to 31 March 2025.

Our **Strategy, taking us from 2024 through to 2030**, sets out our commitment to continuing to perform as a highly effective healthcare regulator, increasing our understanding of how our actions might impact upon or improve trust between the GOsC – as the regulator for osteopathy – and the profession and patients.

The purpose of our Strategy is to:

- describe what the GOsC's Council wishes the organisation to achieve
- set the direction of the GOsC's work, led by the Chief Executive and Registrar
- provide a framework for the monitoring of the GOsC's performance by Council

Our Strategy sets out our three strategic aims:

Strengthening trust:

We will work to enhance and improve our relationships with those we work with so together we can help protect patients and the public.

Championing inclusivity:

It is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so.

Embracing innovation:

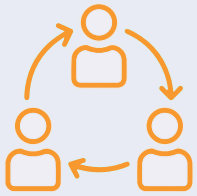
We will continually seek out and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation.

Our vision and values

Our strategic aims are built from our vision and values.

Our vision is to be an inclusive, innovative regulator trusted by all.

Our values underpin the way we work now and in the future. This includes how we work with patients, the public, osteopaths and stakeholders, and how we work within our organisation. We work collaboratively to be an influential and respectful regulator with an evidence-informed approach.



Collaborative

We work with our stakeholders to ensure patients and osteopaths are at the centre of our approach to regulation.

Influential

We seek to support and develop those we work with to enhance public protection.

Respectful

We seek to hear, understand and consider the views of the people with whom we engage.

Evidence-informed

We use a range of evidence to guide our work to ensure the best outcomes for patients and the public.

5 Our governance, management and risks

The General Osteopathic Council (GOsC) consists of a Council, committees, and a small executive team. The GOsC identified principal risks in a number of areas in 2024-25 along with key mitigating actions.

Council

The GOsC Council consists of 10 members – five lay and five registrants. Council is supported in its governance work by nearly 40 lay and registrant members of our statutory and non-statutory committees, as well as registration assessors, legal assessors, medical advisers and others. Council members are also charity trustees, responsible for ensuring that the GOsC is meeting its statutory duties under the Osteopaths Act 1993 and other legislation.

Brief biographies of current Council members are available on the GOsC website at: **osteopathy.org.uk/council**

Committees of Council

Council is supported in the delivery of its objectives by a number of statutory and non-statutory committees. There are three committees of Council: the Policy and Education Committee (PEC); the Audit Committee; and the People Committee.

Each committee includes members of Council and appointed external members. External members are appointed by Council under the guidance of the People Committee.

Information about our committees, including the membership of each, is available on our website: **osteopathy.org.uk/committees**

Council members' attendance at Council and committee meetings

Individual members also attend working groups, training and development days, ad hoc meetings and appraisals throughout the year.

Name	Council	PEC	Audit	People
Jo Clift	5/5			
Daniel Bailey	5/5	4/4		
Harry Barton	5/5		4/4	3/3
Gill Edelman	4/5	3/4		
Elizabeth Elander	4/5			3/3
Sandie Ennis	5/5		3/4	3/3
Caroline Guy*	4/5	1/1*	4/4	
Simeon London	5/5	4/4		
Patricia McClure	5/5	4/4		
Chris Stockport**	3/3	1/2		0/1

* Caroline Guy was co-opted to PEC on 6 June 2024 to ensure the minimum number of members were in attendance due to conflicts of interest of other Committee members

** Chris Stockport was a member from September 2024 to February 2025

Independent fitness to practise committees

There are three committees that support the GOsC's fitness to practise functions:

- the Investigating Committee
- the Health Committee
- the Professional Conduct Committee

The GOsC is responsible and accountable for the operation of these committees, but their decision-making is independent of the GOsC Council.

The committees operate as panels, which typically have three or five members to consider concerns and referred cases.

The committee members are appointed by Council following a public recruitment process and under the guidance of the People Committee.

Information about the independent Fitness to Practise Committees, including the membership of each, is available on our website. See information about all of the GOsC's committees:
osteopathy.org.uk/committees

The GOsC Executive Team

GOsC operations are managed day-to-day by the Chief Executive and Registrar, Senior Management Team and other staff.

The GOsC Senior Management Team comprises:

- Matthew Redford, Chief Executive and Registrar
- Fiona Browne, Director of Education, Standards and Development
- Sheleen McCormack, Director of Fitness to Practise and General Counsel

GOsC advisers

Auditors
HaysMac LLP
10 Queen Street Place
London EC4R 1AG

Bankers
Royal Bank of Scotland
62-63 Threadneedle Street
London EC2R 8LA

Our risks

The principal risks identified in 2024-2025 by the GOsC continue to be as described last year, however, we have strengthened our mitigating actions including commissioning an audit of initial stage Fitness to Practise decisions, which demonstrated no areas of concern but provided some useful guidance.

Risk area	Mitigating actions
Strategic ambitions undermined by pressures on sustainability	Close monitoring of income and expenditure allowing Council to consider strategic priorities and make longer term plans around the deployment of resources.
IT infrastructure not able to support GOsC activity and/or future transformation programme	Independent IT audits to assess approach to IT security. Upgrade of GOsC registrant database and planned development of new GOsC website.
Volume and complexity of fitness to practise cases	Comprehensive and consistent quality assurance review mechanisms alongside continuous programme of training for panel members.

Strategic ambitions undermined by pressures on sustainability:

As an organisation with a single main source of income, we recognise our strategic ambitions as a regulator would be undermined if our resources were insufficient. We keep abreast of the composition of the Register to ensure we are aware if there is any significant change taking place and what this may mean for our future plans. We ensure we have a structured and risk-focused approach to managing our reserves and our investment portfolio.

We mitigate this risk by undertaking longer-term financial planning so that we can make decisions around how we best use our assets, and this includes physical, people and financial assets.

IT infrastructure not able to support GOsC activity and/or future transformation programme:

There is a risk in relation to our IT infrastructure if it does not provide us with the security we require, or legacy systems prevent us from undertaking our work efficiently and effectively. To mitigate these risks, we are implementing a new registration database which will enhance our efficiency and operation, with the project supported by an expert IT consultant. We have also committed to redeveloping our website platforms, so these are reflective of our modern and inclusive approach to regulation.

Volume and complexity of fitness to practise cases:

Every healthcare regulator has risks associated with the volume and complexity of fitness to practise cases and the potential for appeals against decisions reached. There are risks associated with the efficiency and timeliness of the cases being completed, which is connected to one of our key targets monitored by the Professional Standards Authority for Health and Social Care. And currently our caseload is impacted by delays in third-party reports, such as those from the police or hospitals.

While we are pleased that our fitness to practise activities are managed in a cost effective, timely and proportionate manner, our outdated legislation continues to require us to think laterally and be innovative in fitness to practise reforms which can be implemented without recourse to legislative changes.

6 How we performed against our strategic aims in 2024-25

Strategic aim one: Strengthening trust

We commissioned an independent research company, DJS Research, to explore how osteopaths, students, educators and partner organisations perceive GOsC, including how we perform our role as regulator.

We wanted to know the extent to which the profession understands our role, and how they think we are performing as the regulator, to identify where we need to focus our resources, and where we need to make changes. We put strengthening trust at the heart of our Strategy for 2024 to 2030. We wanted to be able to measure how much the profession trusts us now and their views of us, to help us improve and measure the impact of our ongoing work.

The research, carried out between January and June 2024, involved a survey of osteopaths and students, in-depth interviews with osteopaths, students and educators, and focus groups with partner organisations. The survey received 629 responses in total (from osteopaths and 11 responses from students), and 24 people took part in the interviews.

Findings of independent research

Findings showed that many respondents hold negative perceptions of GOsC, based largely on the experiences of other osteopaths and some common misunderstandings of our role. Those with positive views of GOsC were found to be more likely to have had direct experiences with us and to have a better understanding of our role. 'Fear' and 'necessary' were the two most common words associated with GOsC. Conversations highlighted some of the key sources of fear, including the process of investigating concerns raised against osteopaths, and the tone of some of GOsC's communications with the profession.

We published an analysis of the findings and are implementing an action plan to take the next steps towards strengthening trust with osteopaths and the profession.

Steps taken to increase trust

To help increase understanding of our role, we have made updates to our website and social media channels. We have produced and are promoting a mythbuster to help address the common misunderstandings about GOsC and help increase clarity about our role among the profession.

To help make us more approachable, we have improved our contact information and how our phone system is set up. We have started publishing more staff profiles to demonstrate that as an organisation we are proud to be comprised of our staff. We continue to consistently encourage osteopaths, educators and students to attend our Council meetings which are held in public.

To help increase trust we have ensured that we demonstrate that we are more available for osteopaths who wish to speak to us. We have increased and diversified the ways that osteopaths can contact us, for example:

- In January, we launched our new WhatsApp channel. We are receiving a growing number of messages each month, and we are responding swiftly to queries. Feedback so far has been very positive.
- We are offering regular weekly online drop-in sessions, so osteopaths can meet staff across the organisation and ask questions, suggest an idea or discuss an issue with no set agenda. To make it easy for osteopaths, staff are available at the same time each week and no booking is required. We've had interesting discussions so far ranging from the use of AI, transition from education to practice and how to fill out a Peer Discussion Review planning section for an osteopath's next continuing professional development (CPD) cycle.
- Opportunities have been introduced for video calls for those osteopaths and students who prefer to see who they are speaking to.
- We have committed to redeveloping the GOsC's websites.

We have updated our suite of registration renewal correspondence taking into account the impact these have on many osteopaths with a view to improving the tone and making the content more helpful.

We have also produced a timeline visual of the fitness to practise process as an example of the work we are doing to be open and transparent and try to help reduce fear and increase understanding about this process. This was first published in the most recent Fitness to Practise Annual Report which explains how we handle the fitness to practise concerns we receive and the timescales for managing those concerns. This year's report was presented differently with more concise explanations as to how we manage fitness to practise concerns.

Reaching out

In January, we met online with the National Engagement Advisor at the Australian Health Practitioner Regulation Agency (AHPRA) in Australia to share insights and learning. The AHPRA has done a great deal of work on kindness within regulation, and we are keen to learn from this. In turn we were able to share our insights including the fact that we provide an independent support service which is free and confidential for anyone involved in our fitness to practise process.

We have engaged extensively with osteopaths through attending regional group meetings, giving presentations on topics such as professionalism and boundaries. We have also given presentations to students on topics such as regulation, as well as offering ongoing support in relation to ethical queries. We continue to meet with and expand our network of partner organisation relationships to help inform our action plan in response to these findings.

We are also expanding our engagement with the postgraduate educators to increase clarity and transparency about our role and our purpose and to help gain a deeper understanding of their needs and concerns.

This year we held a development day for our Policy and Education Committee. For the first time, this involved inviting stakeholders to spend time with the committee and for the committee to listen to their views on current

opportunities, challenges and priorities for the future in osteopathic education. Through holding this event, GOsC facilitated dialogue and greater understanding between stakeholders and the Committee about roles and context, which supports our aims to improve trust across the profession.

Following consideration of the CPD evaluation survey findings, we consulted on establishing and maintaining professional boundaries and Equality, Diversity, inclusion and Belonging (EDIB) as mandatory components of CPD. A decision will bemade later this year

We have appointed a PhD student, who is jointly supervised by GOsC and the Open University to support our work on boundaries.

Quality assurance of osteopathic education

We have piloted a values, culture and behaviour document for educational providers, and for our quality assurance education provider visitors (visitors are osteopaths who assess education providers' training programmes to ensure they meet our standards). This document was developed in collaboration with visitors and educational providers to ensure the tone of the visit is explicit and clear, to aid communication.

We have worked collaboratively with the education providers to respond to their feedback. We have held regular meetings with education providers as a group, but also individually to provide earlier feedback on committee decision making and outcomes. We have worked hard to reflect on the tone of communications to education providers, and to build on the relational aspect of quality assurance.

Strategic aim two: Championing inclusivity

We have embarked on a range of projects and initiatives to champion inclusivity from involving patients to establishing a new EDIB framework.

Draft guidance for students with disabilities

We published separate draft guidance for students and for educational providers about studying osteopathy when you have a disability or health condition. For the first time this included an easy read version following feedback in the pre-consultation phase from students with disabilities.

Involving patients

We held our first patient information forum development day which brought our patients together. We used this to appreciate their contributions, as well as building their knowledge and understanding of regulation and skills. This helped them to contribute effectively and was also an opportunity for them to give feedback on our website development.

We published an evaluation of the contribution to our work of the patient voice and developed actions to enhance the contribution it makes.

There is ongoing collaboration with patients to gain feedback on various consultations, including the Professional Behaviours and Student Fitness to Practise consultation, our draft health and disability guidance and the planned update to our continuing professional development (CPD) guidance.

To ensure patients' voices are heard, we continue to promote resources which support patients to make explicit what is important to them when they are seeing an osteopath.

We provide guidance and resources around Equality, Diversity, Inclusion and Belonging (EDIB) for osteopaths to support inclusive practice with patients and we have promoted these during the year.

Patient partners

We have begun recruitment of two patient partners who will join Council as part of a pilot programme. The aim is to include the patient perspective and for the patient partners to act as 'critical friends' to Council to enhance our decision-making process. This will ensure their voices are heard in strategic decision-making.

Non-executive recruitment

During this year we handled 404 applications, which is the most applications we have ever received from Professional Conduct Committee/Investigating Committee recruitment campaigns. Across all our completed applications we have seen higher numbers of applicants who are:

- female (241 or 59%)
- older ie in the 55-59 or 60-64 age group (78 and 61 or 19% and 15%)
- White or White British (306 or 76%)
- of Christian faith (172 or 42.5%) or no religion or belief (59 or 15%)
- heterosexual (323 or 80%)
- married/in a civil partnership (252 or 62%)
- part-time workers (206 or 51%)

We have a greater proportion of completed applications demonstrating minority protected characteristics:

- disability (49 or 12%)
- Asian and British Asian (47 or 12%)
- Black or Black British (21 or 5%)
- gay/lesbian (25 or 6%)
- cohabiting (35 or 9%)
- pregnancy or maternity (7 or 2%)

Review of guidance

We conducted a comprehensive review of all fitness to practise guidance both at the initial stages and at the hearings stage of the fitness to practise process to ensure the guidance adequately addressed allegations that involve racist and discriminatory behaviours.

New framework

Our new EDIB Framework 2024-30 was published in July 2024. The Framework was expanded to include 'Belonging', which entails creating a psychologically safe organisation where our people (staff and non-executives) feel confident to be themselves, without risk of embarrassment or rejection, to help us to be the best regulator we can. We will ensure our people feel they can be creative and innovative and can constructively challenge existing practices for the benefit of patients, osteopaths and stakeholders.

The new EDIB Framework established our current benchmark and set out a series of actions to be taken over the next 18 months.

Strategic aim three: Embracing innovation

The GOsC has numerous innovative projects underway, for example relating to the regulatory response to the sustainability of the profession.

National Council for Osteopathic Research projects

We have commissioned new research to support recruitment and retention issues.

The projects consist of:

- Enablers and barriers for students studying/completing an osteopathic course
- Qualitative explorations of reasons for leaving the GOsC Register
- Evaluation of GOsC Register resignations (quantitative survey)

International recognition of qualifications

We are working collaboratively with others to achieve recognition of professional qualifications internationally to ensure UK standards are maintained and EU/UK relations are developed.

Mutual collaboration on transition into practice

We are undertaking work around stakeholder relations and transition into practice. We are exploring how we as the regulator can bring the sector together to enhance the transition to practice process for osteopaths. Our plan is to organise a collaborative workshop with representatives across the sector to identify what opportunities exist for mutual collaboration. The focus will be on sharing existing models of best practice in the sector and developing collective actionable solutions to better support new graduates.

Quality assurance of education

We announced our decision to take quality assurance of education in house from July 2025 for all UK training courses for students of osteopathy. Assuring the quality of education helps us make sure our standards for osteopathic education are being met, and that 'Recognised Qualifications' are only awarded to graduates who meet the Osteopathic Practice Standards (OPS). This ensures patient safety and public protection are at the heart of all education activities.

Data sharing

Each osteopathic education provider provides us with annual data on enrolment, progression, EDI and faculty, for example, teaching staff profile, student-tutor ratios. We share this data with key stakeholders such as the Institute of Osteopathy and the providers themselves so that collaboratively we can explore issues on recruitment and retention of osteopaths and potential solutions can be identified to remedy any challenges.

New website

Council agreed to set aside resources to upgrade the GOsC website. This will allow us to bring our multiple sites together into a more modern and cohesive single website that will help us to communicate clearly with the profession. Planning is underway and the tender process will begin shortly.

Guidance on AI

We have been developing our first piece of guidance on the use of AI (artificial intelligence) in osteopathy. This will explore current and future use of AI in osteopathic practice to inform our approach to ensuring patient safety and public confidence. This includes how the OPS supports osteopaths to use AI appropriately. We have been developing plans to consult on this guidance. We plan to continue working with educators and other stakeholders to further explore a statement on AI in osteopathic education. We will continue to engage with other regulators and the Professional Standards Authority to ensure an aligned approach on AI in health professional regulation.

IT infrastructure

We continued working on the implementation of the new CRM system (registrant database system), investing in future-proofing our internal systems to make it easier and more efficient for osteopaths to update their details. The new CRM will be able to integrate with modern tools that will allow the GOsC to better communicate with osteopaths and enable better and faster processes internally.

7 Operational efficiency, effectiveness and performance

We were pleased that the Professional Standards Authority for Health and Social Care (PSA), which reviews the work of all the healthcare professional regulators annually, reported that GOsC met all its standards of good regulation, for the fourteenth year running. We are the only healthcare professional regulator with such a record.

During 2024-25 we continued to deliver our core functions consistently, including management of our fitness to practise caseload and maintenance of our Register.

Fitness to Practise performance

In 2024-25, we received 75 concerns. Of these, 31 were made formal. During the year, GOsC's Investigating Committee reached a final decision in 39 cases. Of these, 27 were referred to a full hearing of the Professional Conduct Committee (PCC); in one case the registrant was issued with advice by the Investigating Committee and in the remaining 11 cases, it was determined that there was no case to answer and no further action was taken.

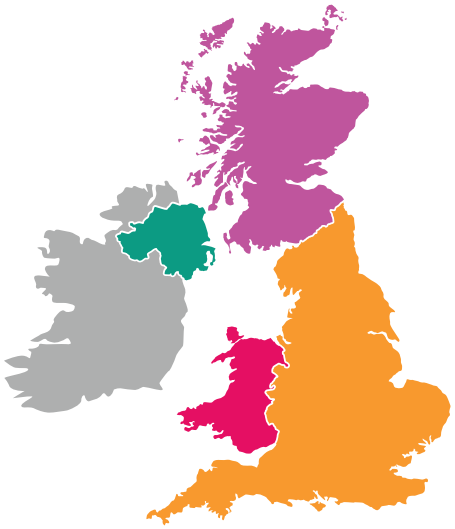
Over the year, the PCC concluded 14 cases; in 12 of those cases, a sanction was imposed against the osteopath (see table).

Sanctions imposed in cases considered by the Professional Conduct Committee 2024-25	Number of cases
Admonished	9
Suspended	1
Removed	2
Total	**12**

We commissioned an external audit of all cases and concerns closed by screeners (a screener is an osteopath member of the Investigating Committee who reviews concerns to determine whether the evidence amounts to an allegation) and the Investigating Committee involving the threshold criteria over the period 1 April 2023 to 30 August 2024. This took place in early 2025. No patient protection concerns were identified but there was some useful learning for the organisation.

About the Register

As at 31 March 2025, there were 5,596 osteopaths registered with the GOsC.



4,832 osteopaths in England

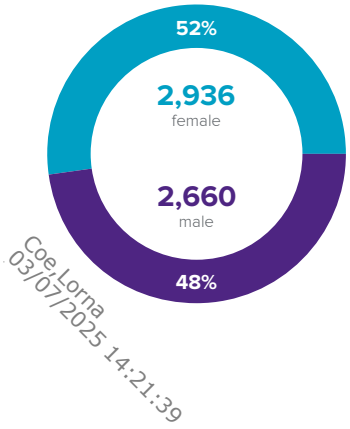
150 osteopaths in Scotland

164 osteopaths in Wales

30 osteopaths in NI

420 osteopaths in rest of world

Gender	Number
Male	2,660 (48%)
Female	2,936 (52%)
Total	**5,596 (100%)**



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The 302 new or returning osteopaths to the Register were trained at the following education providers:

Place of training	Number joining the Register
British College of Osteopathic Medicine	29
College of Osteopaths	28
European School of Osteopathy	48
Health Sciences University (formerly UCO)	94
London School of Osteopathy	28
Oxford Brookes University	1
North East Surrey College of Technology	12
Swansea University	40
The University of St Marks and St John (Marjon)	15
Overseas	7
Total	**302**

Our team of Registration Assessors, all of whom are qualified osteopaths, undertook a total of 34 registration assessments in 2024-25, this compares to 46 registration assessments undertaken in the previous year.

Type of assessment	Number
Non-UK qualification assessment	4
Further evidence of practice assessment	4
Assessment of clinical performance	6
Return to practice interview	20
Total	**34**

8 Looking ahead to the next year

This year was the first year of our new Strategy, through to 2030. The Strategy sets out our future vision, strategic priorities and our key actions, all of which are underpinned by our new organisational values.

Looking ahead, in 2025-26, we will be delivering against our Strategy through the following activities:

Strengthening trust: We will work to enhance and improve our relationships with those we work with so together we can help protect patients and the public.

What do we intend to do?

- Starting work to strengthen the protection of the title 'osteopath' through a consultation to gather views.
- Raise awareness of our role and the value of regulation.
- Increase engagement with partner organisations and other stakeholders and also raise awareness of this engagement.
- Take long-term financial and asset decisions which support delivery of our statutory responsibilities and GOsC strategic aims.
- We will continue to implement activities to increase trust and reduce fear in line with the findings of the independent perceptions research published in October 2024.

Championing inclusivity: It is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so.

What do we intend to do?

- Implement a Strategic Patient Partnership Programme at Council level with the appointment of two patient partners who will join Council as part of a pilot. The aim is to include an explicit patient perspective and for the patient partners to act as 'critical friends' to Council to enhance our decision-making process.
- Collect, analyse, and publish, anonymous equality, diversity and inclusion data and any changes we make, or mitigations we put in place, where we have identified there is an undue impact on those with protected characteristics.
- Implement any recommendations arising from the independent review we have commissioned into our non-executive recruitment activity.
- Support student recruitment and retention to maintain and increase a sustainable, diverse profession.
- Implement and evaluate the health and disability guidance we published for students and education providers to support students studying osteopathy with a disability or health condition.

Embracing innovation: We will continually seek out and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation.

What do we intend to do?

- Through a tender process, we will identify a supplier and develop a new public website which provides scope for more modern, innovative and engaging content.
- Review the impact of changes in the delivery of healthcare including AI (artificial intelligence) on osteopathic education and osteopathic care and the use of AI in health care for patients. We will also consider the impact of AI on osteopathic standards and regulation.
- Seek continuous improvement arising from independent reviews of board effectiveness and internal audit activities.
- Refine and implement our Theory of Change model to measure progress and implementation of the GOsC Strategy.

9 Financial report and accounts for 2024-25

Introduction

The 2024-25 financial year saw inflation levels fall further from their post-pandemic highs; however they are still slightly above the Bank of England's 2% target. The cost-of-living crisis continues as energy costs and food prices reflect world events. The UK is under new leadership since the previous annual report, with the Labour party being elected in July 2024, following a landslide victory in the General Election.

The financial result for the year was a deficit of £281,000, which was worse than budget by around £285,000. We spent around £161,000 from designated funds. Registration fees were over budget by around £160,000, and were supported by an investment gain of around £37,000, along with an underspend of around £5,000 on Communications, research, and development. However, this was offset by some overspends in Education and Professional standards of around £86,000, Governance (£73,000), Fitness to Practise (£66,000), IT and infrastructure (£46,000), and Central resources and Financing (£18,000).

At the General Osteopathic Council, we regularly look at our approach to regulation to ensure we continue to add value. Questions we ask include:

- How can we make our work more streamlined and cost-effective?
- How can we ensure we are listening, engaging, and communicating effectively in a time where face-to-face interactions have diminished?
- How are we ensuring we continue to deliver on our core statutory responsibilities in a measured and appropriate manner?

Four years ago, we introduced our Value Proposition, through which we describe how our work adds value. We have set out in this report where our work in 2024-25 is aligned with this approach.

The Value Proposition

Our approach to regulation is articulated through **Our Strategy: taking us from 2024 through to 2030** and our underpinning business plans which we develop each year.

The activities set out in the annual business plans are designed specifically for:

- **Strengthening trust** – we will work to enhance and improve our relationships with those we work with so together we can help protect patients and the public.
- **Championing inclusivity** – it is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so.
- **Embracing innovation** – we will continually seek out and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation.

The principles which underpin the Value Proposition

The Value Proposition is underpinned by a set of core values which support how we work and inform the development of our business plans and budgets.

These principles are:

- **Delivery of our core statutory functions:** we will ensure appropriate levels of funding are available so that our core statutory functions can be delivered.

- **Hearing the patient voice:** we will allocate resources so that the patient voice informs our current and future work.
- **Look upstream:** we will ensure we identify and fund activities which support upstream regulation, and which are relevant and appropriate for our context.
- **Continuous improvement:** we will use our resources to drive continuous improvement so that we can be a better organisation tomorrow, than we are today.
- **Digital first:** our focus will be on developing a digital first approach to our operation to streamline activities we undertake.
- **Cost efficiency and cost effectiveness:** we ensure we are careful where our resources are deployed to be cost efficient and cost effective.

We consider our value proposition to have three components:

1. **Ensuring public protection**
2. **Developing the profession**
3. **Delivering robust governance**

Component one: Ensuring public protection

This area focuses on our work to ensure patient and public protection and maintaining public confidence in the profession.

Our activities to ensure public protection include:

- the quality assurance of education and training
- developing, setting, and maintaining Osteopathic Practice Standards
- maintaining the integrity of the statutory Register of osteopaths
- managing concerns through our fitness to practise processes

Public protection is central to the work we undertake, and this is reflected by the activities under this component which cover the full range of our business.

In the financial year 2024-25, we spent £1.68m on our activities to ensure public protection (2024: £1.37m).

This was equal to 51% of our total budget (2024: 45%) and means that for every £570 registration fee we receive, we spend £290 of that on ensuring public protection (2024: £256).

Component two: Developing the profession

This area focuses on our work to ensure we develop the profession and provide appropriate support for it to be able to maintain high quality patient care.

Our activities to develop the profession include:

- supporting the profession to undertake continuing professional development (CPD) activities to maintain and enhance skills and knowledge
- contributing funding to the National Council for Osteopathic Research
- funding a profession-wide subscription for the International Journal of Osteopathic Medicine (IJOM) and other research journals
- a range of communication activities with a new emphasis on listening and engaging

In the financial year 2024-25, we spent £0.80m on our activities to ensure we developed and supported the profession (2024: £0.71m).

This was equal to 24% of our total budget (2024: 24%) and means that for every £570 registration fee we receive we spend £137 of that on developing the profession (2024: £137).

Component three: Delivering robust governance

This area focuses on the importance of delivering robust governance. Good governance should ensure an organisation remains stable, productive and that risks are appropriately managed.

Our activities to deliver robust governance include:

- appointing, training, and maintaining a governance structure that consists of Council, the Policy and Education Committee, the Audit Committee, and the People Committee
- holding Council meetings in public and making the meeting papers available in advance
- investing in our IT infrastructure and new digital ways of working
- subjecting our work to independent audits and review

In the financial year 2024-25, we spent £0.84m on our activities to ensure we delivered robust governance

(2024: £0.93m). This forecasted increase reflects the fact that we have been managing, in-house, a significant volume of non-executive appointments (16 positions) as the periods for Council and committee members came to their natural end.

This was equal to 25% of our total budget (2024: 31%) and means that for every £570 registration fee we receive we spend £143 of that on delivering robust governance (2024: £177).

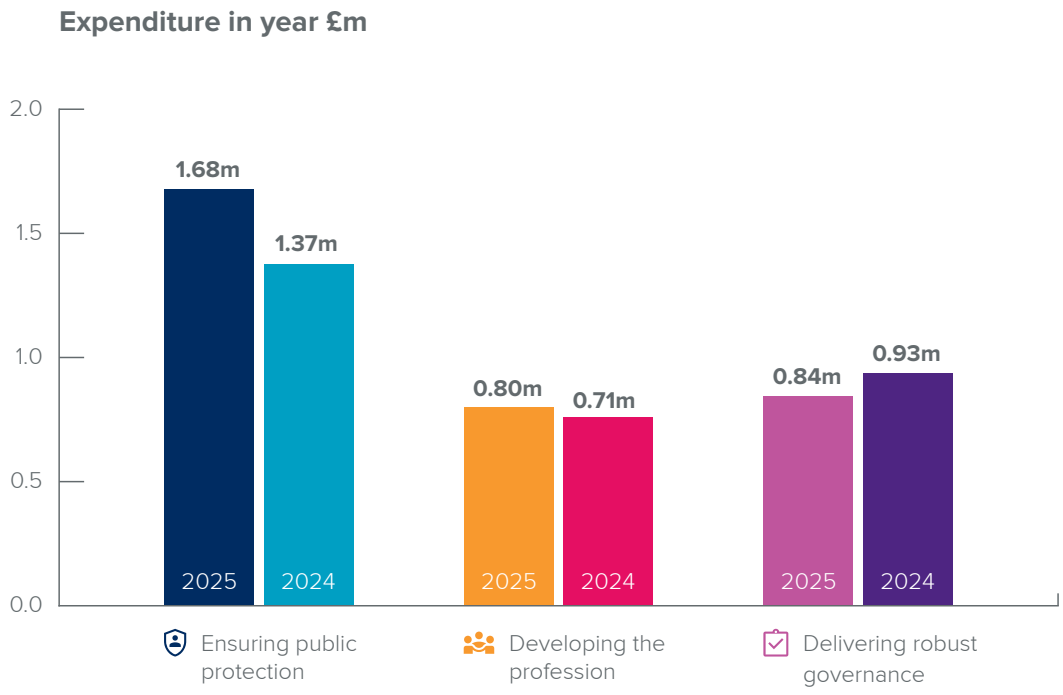
Table showing Value Proposition, expenditure in year, % of total spending and proportion of £570 registration fee

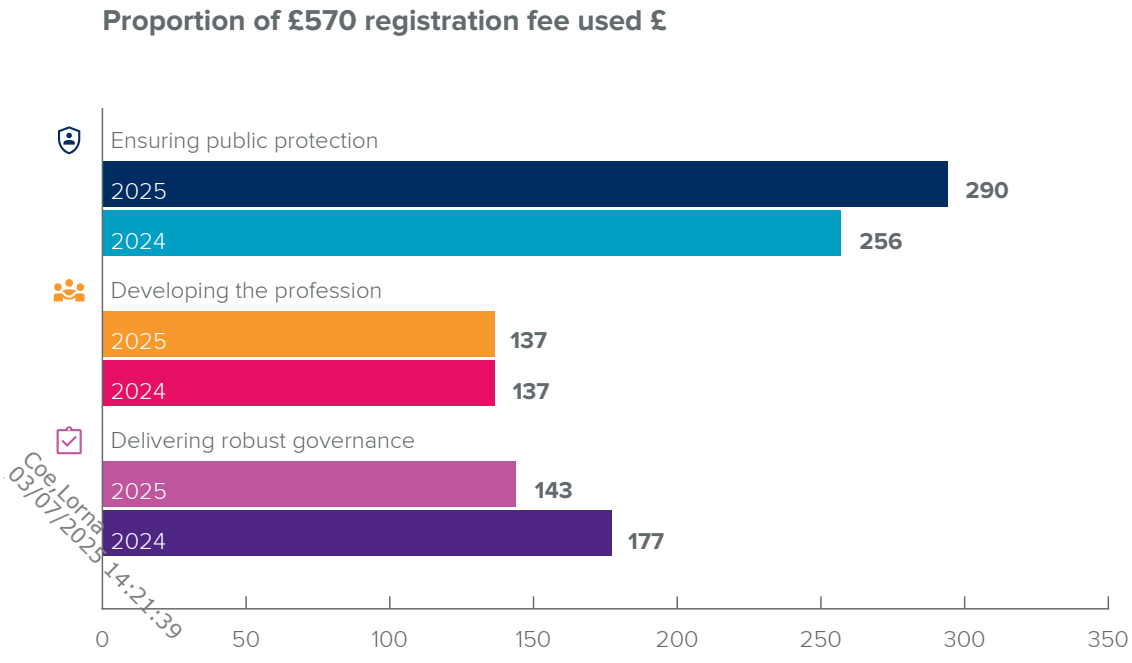
Value Proposition components	Expenditure in year[1] £	Percentage of total spending %	Proportion of £570 registration fee used £
Ensuring public protection	1.68m (2025)	51% (2025)	290 (2025)
	1.37m (2024)	45% (2024)	256 (2024)
Developing the profession	0.80m (2025)	24% (2025)	137 (2025)
	0.71m (2024)	24% (2024)	137 (2024)
Delivering robust governance[2]	0.84m (2025)	25% (2024)	143 (2025)
	0.93m (2024)	31% (2024)	177 (2024)

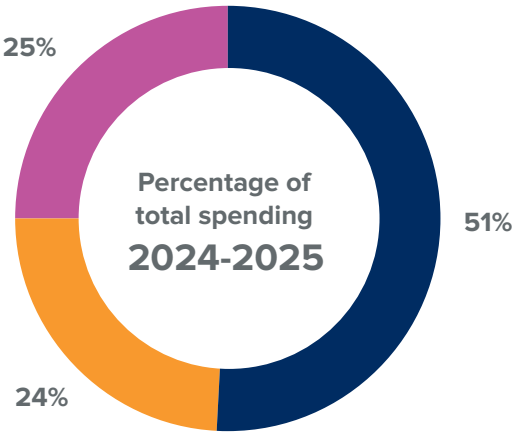
1 Excluding investment losses and/or charges

2 Please note that the figures contained in the value proposition for Governance do not relate to the notes on Governance in the notes to the accounts

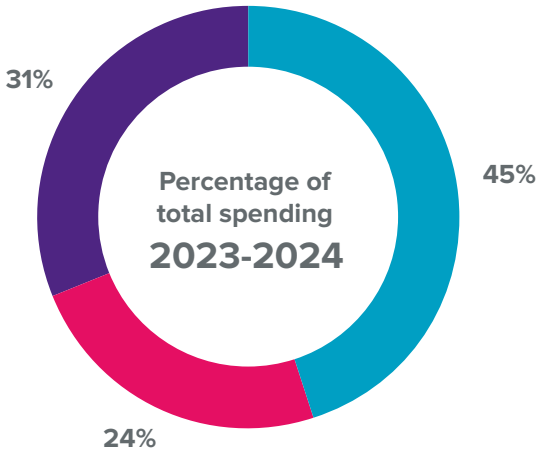
What does the registration fee fund by value proposition?
The headline registration fee of £570 is broken down to show the amount of spend across the GOsC value proposition in 2024-2025.







- Ensuring public protection **51%**
- Developing the profession **24%**
- Delivering robust governance **25%**



- Ensuring public protection **45%**
- Developing the profession **24%**
- Delivering robust governance **31%**

Income and expenditure

The accounts, which are set out in more detail over the following pages, are presented in accordance with the Charity SORP (Financial Reporting Standard 102).

The GOsC ended the financial year with a deficit of £281,356; the deficit was reduced by an investment gain of around £37,000.

At the year-end, total income was £2,993,458. Registration fee income accounted for 98% of total income. Registration fees have once again been maintained at their current level – the eleventh year in a row, which represents a reduction in real terms. The remaining income came from areas such as investment portfolio gains, bank interest, and registration assessments.

The General Osteopathic Council has no fundraising activity requiring disclosure under S162A of the Charities Act 2011.

Expenditure for the year was £3,311,444 after designated spending; the breakdown of this is shown on the next two pages.

Regulation and development costs

The costs of the GOsC's regulatory activities fall into the following four main areas (note that staffing costs are included within each of these):

- **Education and professional standards**

  Quality assuring osteopathic educational providers continues to be a fundamental element of the work undertaken in this area, alongside the development and implementation of the continuing professional development (CPD) scheme.

  In 2024-25, direct costs incurred in this area were £652,447 in the year, compared to £525,382 in the previous year, an increase of 24%. Direct costs in relation to quality assurance were around £232,000, and we spent around £11,000 on research activities.

- **Registration**

  In 2024-25, direct costs incurred in this area were £177,533 in the year, compared to £175,986 in the previous year, an increase of 1%. Total non-staffing costs were around £12,000 and included registration assessment costs and associated expenditure for the training and appraisal of registration assessors.

- **Fitness to practise and legal**

  The cost of conducting investigations and holding hearings remains the single largest non-staffing element of the GOsC's expenditure.

  In 2024-25, direct costs incurred in this area were £859,657 in the year, compared to £618,335 in the previous year, an increase of 39%. This included costs of the Investigating Committee, which were around £173,000 with the Professional Conduct Committee incurring expenditure of around £238,000.

- **Communications, research and development**

  In 2024-25, direct costs incurred in this area were £490,415 in the year, compared to £434,964 in the previous year, an increase of 13%. Costs relating to website development and maintenance, and publications, were around £37,000. In addition, the overall costs of the department include the provision of free access to research journals for osteopaths, and an allocation to infrastructure costs for the National Council for Osteopathic Research which totalled around £65,000.

Administration and overhead costs

Other GOsC cost areas are those relating to operating the infrastructure of the organisation, including building and IT costs, and administering the GOsC Council and committees, which are essential functions for the discharge of our statutory duties.

- **Governance**

  Governance costs relate to Council members' allowances, committee expenses, appraisals, and the recruitment of new members.

  In 2024-25, governance costs were £539,819, compared to £497,715 in the previous year, an increase of 8%. This was predominantly due to increases in the cost of council meetings and council honorariums. Within governance costs was the levy on all healthcare professional regulators for the costs of the Professional Standards Authority for Health and Social Care; the GOsC paid a levy of £14,294.

- **IT infrastructure**

  This year saw a focus on ensuring the GOsC IT infrastructure was secure and fit for purpose, including some spend on cyber security and running penetration tests on the various GOsC websites. Expenditure on IT reflects the cost of the GOsC Register, the customer relationship management (CRM) system and other office services.

  In 2024-25, direct IT costs were £132,879, compared to £216,849 in the previous year, a decrease of 39%. This is predominantly due to a decrease in infrastructure costs.

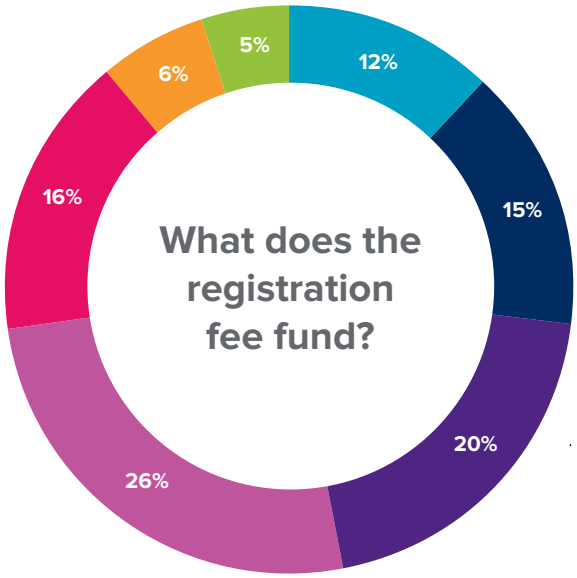
- **Central resources and financing**

  Expenditure in this area reflects the costs of premises, general office administration and travel. It also includes audit fees, bank interest, investment charges, and depreciation.

  In 2024-25, admin costs were £255,340, compared to £245,725 in the previous year, an increase of 4%. This is predominantly due to an increase in audit fees, and some other inflation-linked increases.

What does the registration fee fund?

The headline registration fee of £570 is broken down below to show the amount of spend on each GOsC function in 2024-25:



Central resources and financing (£68.83) 12%

Includes premises, office administration and audit fees.

Communications and research (£84.42) 15%

Includes GOsC communications and free access to research journals for osteopaths via the o zone.

Education and professional standards (£112.31) 20%

Quality assuring osteopathic education providers; CPD scheme, and reviewing and updating the OPS.

Fitness to practise, including legal (£147.97) 26%

Conducting investigations and holding hearings; Committees and legal costs.

Governance (£92.92) 16%

Running of Council and Committees and also includes levy to Professional Standards Authority of £14,118.

IT and infrastructure (£32.99) 6%

Infrastructure for the Register, customer relationship management system, and cyber security

Registration (£30.56) 5%

Maintaining the Register and registration assessment costs.

Reserves and investments

Reserves policy

The GOsC holds reserves as part of good business practice to ensure that it has funds available should unforeseen events materialise, such as an increase in expenditure or a reduction in income. The trustees review the reserves position on an annual basis. The reserves position for 2024-25 is set out as follows.

The Balance Sheet shows total reserves of £2,601,074. All the GOsC reserves are unrestricted.

The trustees have considered the areas in which they feel the GOsC has greatest financial risk, and these are:

- increased volume of concerns
- judicial reviews or legal appeals
- uninsurable losses eg data protection fines
- unforeseen increase in quality assurance activity

Having considered these risks and the possible financial impact should they materialise; the trustees have concluded that it would be prudent to hold reserves within a target range of £350,000-£700,000.

At the end of the financial year 2024-25, the trustees are holding reserves equal to £348,342, which has been calculated as follows:

	£
Reserves held	2,601,074
Restricted reserves	–
Designated reserves	(535,689)
Operational fixed assets	(1,717,043)
Reserves remaining	348,342

Operational fixed assets consist of the total of the tangible and intangible assets of the GOsC.

Reserves are currently just below the target range (less than one percent). The trustees will consider the level of reserves and how these may be used in the 2025-26 financial year. The trustees have concluded that the accounts should be presented on a going concern basis.

Investment strategy

Investments are valued at market value as at the Balance Sheet date. Realised and unrealised gains and losses arising on the revaluation of investments are credited or charged to the Statement of Financial Activities. Investments include cash deposits where monies are not required for short-term working capital.

The GOsC has an investment of £1,317,560 in a medium-risk, diversified portfolio. The fund is managed by Brewin Dolphin and is classified on the Balance Sheet as a non-current asset.

Statement of Council's responsibilities

Council (whose members are also Trustees of the charity) is responsible for preparing the Annual Report and the financial statements in accordance with applicable law and regulations. The Osteopaths Act 1993 requires Council to prepare financial statements for every financial year. Under that law, Council has elected to prepare the financial statements in accordance with UK Generally Accepted Accounting Practice (UK Accounting Standards and applicable laws).

Council will not approve the financial statements unless it is satisfied that these give a true and fair view of the state of affairs and profit or loss of the GOsC for that period. In preparing these financial statements, Council is required to:

- select suitable accounting policies and then apply them consistently.
- observe the methods and principles in the applicable Charities SORP.
- make judgements and accounting estimates that are reasonable and prudent.
- state whether applicable UK Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements.
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the GOsC will continue in business.

Council is responsible for keeping adequate accounting records that are sufficient to show and explain the GOsC's transactions and disclose with reasonable accuracy at any time the financial position of the GOsC. They should also enable Council to ensure that the financial statements comply with the Osteopaths Act 1993 and the Charities Act 2011.

Council is also responsible for safeguarding the assets of the GOsC and takes reasonable steps to assess and manage risk, undertake non-financial audit activities of the GOsC's work, and ensure the prevention and detection of fraud and other irregularities. The Chair of the Audit Committee is a member of Council and is able to report on relevant matters at each Council meeting.

Approved by Council on 15 July 2025 and signed on their behalf by:

Jo Clift
Chair
15 July 2025

Independent auditor's report to the trustees of the General Osteopathic Council

Opinion

We have audited the financial statements of the General Osteopathic Council for the year ended 31st March 2025 which comprise the statement of financial activities, balance sheet and cashflow statement, and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion, the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31st March 2025 and of the charity's net movement in funds for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with the Act and relevant regulations made or having effect thereunder. We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The trustees are responsible for the other information. The other information comprises the information included in the Trustees' Annual Report. and the Introduction from Chair of Council. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require us to report to you if, in our opinion:

- adequate accounting records have not been kept by the charity; or
- sufficient accounting records have not been kept; or
- the charity financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees for the financial statements

As explained more fully in the trustees' responsibilities statement set out on page 35, the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

Based on our understanding of the charity and the environment in which it operates, we identified that the principal risks of noncompliance with laws and regulations related to regulatory requirements of the Osteopaths Act 1993], and we considered the extent to which non-compliance might have a material effect on the financial statements. We also considered those laws and regulations that have a direct impact on the preparation of the financial statements such as General Data Protection Regulation (GDPR), taxation legislation, the charities act 2011 and employment legislation.

We evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting inappropriate journal entries to revenue and management bias in accounting estimates. Audit procedures performed by the engagement team included:

Discussions with management including consideration of known or suspected instances of non-compliance with laws and regulation and fraud;

- Evaluating management's controls designed to prevent and detect irregularities;
- Identifying and testing accounting journal entries, in particular those journal entries which exhibited the characteristics we had identified as possible indicators of irregularities; and
- Challenging assumptions and judgements made by management in their critical accounting estimates.

Because of the inherent limitations of an audit, there is a risk that we will not detect all irregularities, including those leading to a material misstatement in the financial statements or non-compliance with regulation. This risk increases the more that compliance with a law or regulation is removed from the events and transactions reflected in the financial statements, as we will be less likely to become aware of instances of non-compliance. The risk is also greater regarding irregularities occurring due to fraud rather than error, as fraud involves intentional concealment, forgery, collusion, omission or misrepresentation.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: **www.frc.org.uk/auditorsresponsibilities**. This description forms part of our auditor's report.

Use of our report

This report is made solely to the charity's trustees, as a body, in accordance with section 144 of the Charities Act 2011 and regulations made under section 154 of that Act. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an Auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity's trustees as a body for our audit work, for this report, or for the opinions we have formed.

HaysMac LLP
Statutory Auditors
15 July 2025

10 Queen Street Place
London EC4R 1AG

HaysMac LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

Statement of Financial Activities for the year ended 31 March 2025

	Notes	2025 £	2024 £
Income from			
Charitable activities	2	**2,971,497**	2,902,861
Investments	3	**21,961**	20,834
Total		**2,993,458**	2,923,695
Expenditure on			
Charitable activities	4	**3,311,444**	2,994,590
Total expenditure		**3,311,444**	2,994,590
Net expenditure before gains on investments		**(317,986)**	(70,895)
Net gains on investments		**36,630**	94,561
Net (expenditure)/income		**(281,356)**	23,666
Reconciliation of funds			
Total funds brought forward		**2,882,430**	2,858,764
Total funds carried forward	13	**2,601,074**	2,882,430

The (deficit)/surplus for the year arises from the GOsC's continuing operations.

All income and expenditure is unrestricted.

Balance sheet

As at 31 March 2025	Notes	2025 £	Restated 2024 £
Non-current assets			
Intangible assets	8	**213,962**	–
Tangible assets	8	**1,503,081**	1,547,271
Investment (portfolio)	9	**1,317,560**	1,269,682
Total non-current assets		**3,034,603**	2,816,953
Current assets			
Debtors	10	**193,311**	129,381
Cash in bank and at hand		**277,969**	726,897
Total current assets		**471,280**	856,278
Current liabilities			
Creditors: amounts falling due within 1 year	11	**(904,809)**	(790,801)
Total current liabilities		**(904,809)**	(790,801)
Net current (liabilities)/assets		**(433,529)**	65,447
Net assets		**2,601,074**	2,882,430
Represented by:			
Unrestricted reserves			
- Designated reserves		**535,689**	496,213
- General reserves		**2,065,385**	2,386,217
Total reserves		**2,601,074**	2,882,430

The prior period has been restated to reflect a change in methodology for calculating trade debtors and deferred income. This change is reflected on the Balance Sheet and in notes 10-12.

Approved and authorised for issue by the members of Council on 15 July 2025 and signed on their behalf by:

Coe, Anna
03/07/2025 14:21:39

Jo Clift
Chair

Statement of cash flows for the year ended 31 March 2025

	Notes	2025 £	2024 £
Reconciliation of net (expenditure)/income to net cash flow from operating activities:			
Net (expenditure)/income for the reporting period (as per the statement of financial activities)		**(281,356)**	23,666
Depreciation		**56,354**	60,310
Gains on investment		**(47,878)**	(101,690)
Dividends, interest and rents from investments		**10,712**	13,705
Increase in debtors	10	**(59,186)**	(13,663)
Increase/(decrease)in creditors	11	**109,264**	(16,129)
Net cash provided by operating activities		**(212,090)**	(33,801)
Cash flows from investing activities			
Dividends, interest and rents from investments		**(10,712)**	(13,705)
Purchase of intangible fixed assets	8	**(213,962)**	-
Purchase of tangible fixed assets	8	**(12,164)**	(17,001)
Net cash used in investing activities		**(236,838)**	(30,706)
Change in cash and cash equivalents in the reporting period		**(448,928)**	(64,507)
Cash and cash equivalents at the beginning of the reporting period		**726,897**	791,404
Cash and cash equivalents at the end of the reporting period		**277,969**	726,897
Cash at bank and in hand		**277,969**	726,897

Notes to the financial statements – for the year ended 31 March 2025

1. Principal accounting policies

Basis of accounting

The General Osteopathic Council (GOsC) was established under the Osteopaths Act 1993 and is domiciled in the United Kingdom, and the principal office address is Osteopathy House, 176 Tower Bridge Road, London SE1 3LU.

These financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with 'The Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland' Charities SORP (FRS 102) and the Charities Act 2011.

The financial statements have been prepared on an historic cost basis as modified by the revaluation of investments.

The financial statements are presented in sterling (£). The GOsC meets the definition of a 'public benefit entity' under FRS 102.

Critical accounting estimates and judgements

To be able to prepare the financial statements, the GOsC has reviewed its accounting policies, and the amounts recorded in the annual accounts to ensure any estimates and judgements which have the most risk of causing a material adjustment to the accounts are disclosed. In the view of the Council there are no significant estimates or judgements involved in the preparation of the financial statements other than the contingent liability concerning the potential for additional payments to panellists arising from an ongoing employment tribunal case featuring the Nursing and Midwifery Council.

Intangible assets

In accordance with Charities SORP (FRS 102), the cost of cloud-based servers and software (costing more than £750) are treated as intangible assets and will be subject to amortisation. Amortisation is provided on intangible assets, on a straight-line basis, as follows:

Computer software	5 years

Tangible fixed assets

All assets with a useful economic life of more than one year and costing more than £1,000 (or more than £750 for computer equipment), are capitalised. Depreciation is provided on fixed assets, on a straight-line basis, as follows:

Freehold building	50 years
Office furniture	5 years
Office equipment	3 years
Computer hardware	3 years

Land is not depreciated.

Income

Registration and other fee income is recognised over the period that a service is provided and so the GOsC earns entitlement to the income. For registration fee income this is over the period of one year from the date the individual was first entered onto the Register. Investment income including bank interest income is accounted for as earned.

Investments

Investments are valued at market value as at the balance sheet date. Realised and unrealised gains and losses arising on the revaluation of investments are credited or charged to the Statement of Financial Activities. Investments include cash deposits where monies are not required for short-term working capital and the intention is for that cash to be held to generate a return for more than 12 months.

Provision for liabilities

A liability is measured on recognition at its historical cost and then subsequently measured at the best estimate of the amount required to settle the obligationat the reporting date.

Expenditure

All expenditure is accounted for on an accruals basis. A liability is recognised when the GOsC enters into a legal or constructive obligation to make a payment to a third party. Expenditure directly related to a single activity is allocated to that activity in the notes to the financial statements. Costs attributable to more than one category of expenditure are apportioned on the basis of the estimated amount of staff time attributable to that activity in the year.

Pension contributions

The GOsC operates a defined contribution pension scheme for qualifying employees. The employer's contribution for the year is charged to the Statement of Financial Activities in the period it is earned by the employee.

Fund accounting

The General Reserve consists of unrestricted funds that are available for use at the Council members' discretion in furtherance of the objectives of the GOsC. Designated funds are unrestricted funds set aside at the discretion of the Council members for specific purposes.

Short-term deposits

Short-term deposits comprise cash sums held on deposit with recognised banks.

Going concern

Reserves have been accumulated over previous financial periods in order to withstand any unforeseen circumstances, and the members of Council (who are also Trustees) continue to adopt the going concern basis of accounting in preparing the financial statements. One of the measures used to determine going concern is the reserves level. As the reserves are above target range, Council has concluded that the accounts be presented on a going concern basis with no material uncertainties.

Financial instruments

The GOsC has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at amortised cost using the effective interest method. Financial assets held at amortised cost comprise cash and bank and in hand, together with trade and other debtors. Financial liabilities held at amortised cost comprise accruals, trade and other creditors.

2. Income from charitable activities

Registration fees are the primary source of income, with other income received set out in the analysis below:

	2025 £	2024 £
Registration fees	**2,961,625**	**2,877,915**
Other income	**9,872**	**24,946**
Total	**2,971,497**	**2,902,861**

3. Income from investments

	2025 £	2024 £
Interest from investments (incl. bank interest)	**21,961**	**20,834**
Total	**21,961**	**20,834**

4. Charitable activities

Expenditure for each function in the year was as follows:

	Direct £	Support costs £	Total 2025 £	Total 2024 £
Charitable activities				
Education and professional standards	652,447	328,103	**980,550**	822,964
Registration	177,533	214,965	**392,498**	411,571
Fitness to practise	859,657	328,104	**1,187,761**	1,027,509
Communications and research	490,415	260,220	**750,635**	732,546
Total	**2,180,052**	**1,131,392**	**3,311,444**	2,994,590

5. Support costs

	Management £	Governance £	Admin £	IT £	Total 2025 £	Total 2024 £
Support costs						
Education and professional standards	145,412	70,108	74,048	38,535	**328,103**	297,582
Registration	95,270	45,933	48,515	25,247	**214,965**	235,585
Fitness to practise	145,412	70,108	74,049	38,535	**328,104**	409,174
Communications and research	115,327	55,603	58,728	30,562	**260,220**	297,582
Total	**501,421**	**241,752**	**255,340**	**132,879**	**1,131,392**	1,239,923

Support costs (IT, Governance, and Central Resources and Financing) have been recharged across the other areas of business on the basis of staff numbers in those departments.

6. Governance

	2025 £	2024 £
Governance costs		
Council members fees (including National Insurance)	**106,980**	103,992
Council associates fees (including National Insurance)	**4,800**	3,800
Other governance costs	**129,972**	112,662
Total	**241,752**	220,454

Payments to non-executive members

Council members

In the reporting year, the total value of honorariums paid to Council members (10 in total) was £103,700 including responsibility allowances (2024: £101,250). In addition, expenses paid directly to Council members and to suppliers for travel and accommodation totalled £25,327 (2024: £24,684).

Name	Position	Location	Day rate £	National Insurance £
Jo Clift	Chair	London	30,000	2,884
Daniel Bailey	Member	Wolverhampton	7,800	-
Harry Barton[1]	Member	Birmingham	10,050	132
Gill Edelman	Member	Dorking	7,800	-
Elizabeth Elander[2]	Member	Cheshire	10,050	132
Sandie Ennis	Member	London	7,800	-
Caroline Guy	Member	Isle of Wight	7,800	-
Simeon London[3]	Member	Scotland	7,800	-
Patricia McClure[4]	Member	Northern Ireland	10,050	132
Chris Stockport[5]	Member	Wales	4,550	-
Total			**103,700**	**3,280**

Expenses shown in the table above include those paid directly to Council members and those paid to suppliers to cover travel and accommodation costs.

The Osteopaths Act 1993 allows for the remuneration of Council members.

Council associates

The GOsC Council Associates programme allows for two osteopaths to shadow Council and attend and contribute to meetings to develop their governance and leadership skills. Council associates do not have voting rights.

Name	Position	Location	Day rate £	National Insurance £
Gabrielle Anderson	Council Associate	Plymouth	1,400	-
Harriet Lambert[6]	Council Associate	London	200	-
Laura Turner[7]	Council Associate	Exeter	3,200	-
Total			**4,800**	

1 Includes a responsibility allowance of £2,250 paid as Chair of the Audit Committee
2 Includes a responsibility allowance of £2,250 paid as Chair of the People Committee. Term ended March 2025
3 Term ended March 2025
4 Includes a responsibility allowance of £2,250 paid as Chair of the Policy and Education Committee
5 In position from September 2024 to February 2025
6 Term ended March 2024; paid one month in arrears
7 Term ended March 2025

Investigating Committee and Professional Conduct Committee members

In the reporting year, a daily attendance fee of £330 was paid to members of the Investigating Committee and the Professional Conduct Committee when attending GOsC meetings and hearings. Members of the Investigating Committee also receive a reading allowance of £75 per day and a screening fee of £25 per case screened. Members of these committees claimed daily attendance fees which totalled £82,961 with expenses paid directly to the committee members and to suppliers for travel and accommodation totalling £15,890.

External members of other committees

In the reporting year, a daily attendance fee of £330 was paid to external members of the Policy Education Committee, Audit and People Committees when attending GOsC meetings. Co-opted members of these committees claimed daily attendance fees of £6,786 with expenses paid directly to the committee members and to suppliers for travel and accommodation totalling £8,720.

Net expenditure after charging

	2025 £	2024 £
Net expenditure for the year stated after charging		
Fees paid to HaysMac LLP		
- External audit	**24,960**	23,760
Depreciation of assets	**56,355**	60,310

7. Employees and staff costs

Staff costs during the year were as follows:

	2025 £	2024 £
Staff costs		
Salaries	**1,402,573**	1,369,045
Employer's National Insurance	**146,666**	139,592
Pensions	**134,315**	148,273
Total	**1,683,554**	1,656,910

In the financial year 2024-25, redundancy and severance costs of £nil (2024: £22,000) were incurred.

	2025	2024
Average staff numbers		
Chief Executive and Registrar's office	**5**	4
Education and Professional Standards	**6**	5
Registration	**4**	4
Resources	**3**	3
Fitness to Practise	**7**	7
Communications	**5**	5
Total	**30**	28

Key management personnel remuneration

The key management personnel comprise the Chief Executive and Registrar, Director of Education, Standards and Development, and Director of Fitness to Practise.

The total emoluments for the key management personnel were £402,905 (2024: £391,391)

The total number of staff whose taxable emoluments fell into higher salary bands was:

	2025 £	2024 £
£60,000-£70,000	**1**	1
£70,000-£80,000	**0**	0
£80,000-£90,000	**0**	0
£90,000-£100,000	**0**	1
£100,000-£110,000	**2**	1
£110,000-£120,000	**0**	0
£120,000-£130,000	**1**	1

Pension costs

The contributions paid in the year in respect of the Council's pension scheme included contributions payable for the year of £134,315 (2024 - £148,273)

8. Intangible and Tangible Fixed Assets

Intangible assets

	Intangible assets £
Cost	
At 1 April 2024	**20,000**
Additions	**213,962**
Disposals	–
At 31 March 2025	**233,962**
Depreciation	
At 1 April 2024	**20,000**
Charge for the year	–
Disposals	–
At 31 March 2025	**20,000**
Net book value	
At 31 March 2024	–
At 31 March 2025	**213,962**

All intangible assets related to Computer Software.

Tangible Fixed Assets

	Office furniture £	Computer hardware £	Freehold building £	Total £
Cost				
At 1 April 2024	114,970	24,648	2,244,172	**2,383,790**
Additions	–	12,164	–	**12,164**
Disposals	–	–	–	–
At 31 March 2025	114,970	36,812	2,244,172	**2,395,954**
Depreciation				
At 1 April 2024	85,243	13,944	737,332	**836,519**
Charge for the year	10,354	7,815	38,185	**56,354**
Disposals	–	–	–	–
At 31 March 2025	95,597	21,759	775,517	**892,873**
Net book value				
At 31 March 2024	29,727	10,704	1,506,840	**1,547,271**
At 31 March 2025	19,373	15,053	1,468,655	**1,503,081**

9. Investments

	2025 £	2024 £
At the start of the year	1,269,682	**1,167,992**
Income reinvested	22,466	**19,677**
Fees taken	(11,218)	**(12,548)**
Investment gain	36,630	**94,561**
Total portfolio	1,317,560	**1,269,682**

Investments are managed by Brewin Dolphin and are held in a medium risk diversified portfolio incorporating a mix of equities (£641,121), bonds (£465,916), and other assets, including cash (£210,523).

10. Debtors

	2025 £	Restated 2024 £
Trade debtors	21,173	**10,622**
Prepayments and accrued income	170,886	**117,855**
Other debtors	1,252	**904**
Total debtors	193,311	**129,381**

11. Creditors

	2025 £	Restated 2024 £
Trade creditors	**49,968**	47,308
Deferred income	**702,322**	621,893
Accruals	**97,133**	77,445
Other creditors	**8,134**	6,794
Other tax and social security	**47,252**	37,361
Total creditors	**904,809**	790,801

12. Deferred income

	2025 £	Restated 2024 £
As at 1 April	**621,893**	818,067
Amount deferred during the year	**702,322**	621,893
Amount released to the financial statements	**(621,893)**	(818,067)
Total deferred income	**702,322**	621,893

Income from annual registration fees is deferred and released to the statement of financial activities on a straight-line basis over the period to which the registration fee relates. All deferred income brought forward from the previous year is released to the statement of financial activities in the following year.

13. Reserves

	At 1 April 2024 £	Income £	Expenditure £	Transfer £	At 31 March 2025
General reserves	2,386,217	3,030,088	(3,311,444)	(39,476)	2,065,385
Designated reserves					
- IT investment	152,093	–	–	–	152,093
- Values Project	10,000	–	–	(10,000)	–
- Registrant Perceptions	34,120	–	–	(30,348)	3,772
- General legal	150,000	–	–	(26,969)	123,031
- NCOR infrastructure costs	150,000	–	–	(26,500)	123,500
- Website development	–	–	–	136,005	136,005
- iO Convention 2023	–	–	–	(2,712)	(2,712)
Total reserves	2,882,430	3,030,088	(3,311,444)	–	**2,601,074**

The designated reserves relate to the increased Information Technology ("IT") investment to streamline our activities (£152,093), the Values Project (shared decision making) (reserve fully utilised in the year), the Registrant Perceptions Survey to capture views and gain insight from registrants (£3,772), a general legal fund to mitigate unforeseen costs (£123,031), a fund to support the ongoing work of the National Council for Osteopathic Research ("NCOR"); five years of infrastructure costs have been ringfenced (£123,500), a reserve for the website development project (£136,005). There was also an overspend in the year relating to a previous reserve for contributions to the iO convention in 2023.

Prior year comparative

	At 1 April 2023 £	Income £	Expenditure £	Transfer £	At 31 March 2024
Reserves					
General reserve	2,636,671	3,018,256	(2,994,590)	(274,120)	**2,386,217**
Designated reserve	222,093	–	–	274,120	**493,213**
	2,858,764	3,018,256	(2,994,590)	–	**2,882,430**

14. Related party transactions

Matthew Redford, Chief Executive and Registrar, is a Trustee of the National Council for Osteopathic Research.

Dr Daniel Bailey, Council Member, is a Research Fellow of the National Council for Osteopathic Research.

There are no outstanding high-court cases.

15. Contingent liabilities

We have considered the Somerville v Nursing and Midwifery Council (NMC) judgment, where Mr Somerville was found by the Employment Tribunal to be a worker, as to whether it is likely we may face similar liabilities. No claims have been made against the GOsC to date, and so no liability has been included within these accounts.

General Osteopathic Council

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General Osteopathic Council

Annex C to Item 11

HaysMac LLP
10 Queen Street Place
London
EC4R 1AG

15 July 2025

Dear Sirs,

During the course of your audit of our financial statements for the period ended 31 March 2025, the following representations were made to you by management and trustees of the charity.

1 We have fulfilled our responsibilities as trustees under the Charities Act 2011 ("the Act") for preparing financial statements, in accordance with FRS102 and the Act, that give a true and fair view and for making accurate representations to you as auditors.

2 We confirm that all accounting records have been made available to you for the purpose of your audit, in accordance with your terms of engagement, and that all the transactions undertaken by the charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and trustees' meetings, have been made available to you. We have given you unrestricted access to persons within the charity in order to obtain audit evidence and have provided any additional information that you have requested for the purposes of your audit.

3 We confirm that the methods, significant assumptions and source data used by us in making accounting estimates and their related disclosures are appropriate to ensure compliance with the recognition, measurement and disclosure requirements of FRS102.

4 We confirm that all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with FRS102 and the Act.

5 We confirm that we have informed you of the details of all correspondence with the charity's regulators during the year and, in particular, the details of all Serious Incident Reports that we have made to the Charity Commission/OSCR.

6 We confirm that there have been no events since the balance sheet date which require disclosing or which would materially affect the amounts in the accounts, other than those already disclosed or included in the accounts.

7 We confirm that we are aware of the definition of a related party set out in FRS102. We confirm that the related party forms have been completed by all trustees and made available to you as part of the audit.

8 We confirm that the related party relationships and transactions set out in the declarations provided to you are a complete list of such relationships and transactions and that we are not aware of any further related parties or transactions and the transactions have been accounted for and disclosed in accordance with FRS102 and the Act.

9 We confirm that the financial statements correctly disclose the Trustees' remuneration and reimbursement of expenses, and are drawn up in accordance with the Statement of Recommended Practice *Accounting and Reporting by Charities*.

10 We confirm that the charity has not contracted for any capital expenditure other than as disclosed in the financial statements.

11 We confirm that we are not aware of any possible or actual instance of non-compliance with those laws and regulations which provide a legal framework within which the charity conducts its business and which are central to the charity's ability to conduct its business, namely the Osteopaths Act 1993.

12 We acknowledge our responsibility for the design and implementation of controls to prevent and detect fraud. We confirm that we have provided you with the latest copy of our risk assessment. We confirm that we have considered the risk of fraud and disclosed to you any actual or suspected instances of fraud involving management or employees who have a significant role in internal control or that could have a material effect on the financial statements. We also confirm that we are not aware of any allegations of fraud by former employees, regulators or others.

13 We confirm that we have reviewed the control procedures governing payments to overseas territories and that the charity has conducted appropriate due diligence procedures to ensure that such payments are used in accordance with the purposes for which they were given.

14 We confirm that, having considered our expectations and intentions for the next twelve months and the availability of working capital, the charity is a going concern.

15 We confirm that in our opinion the effects of unadjusted misstatements as listed in the Audit Findings Report are immaterial, both individually and in aggregate, to the financial statements as a whole.

16 We confirm that in our view, the treatment of the contingent liability relating to unpaid holiday pay within the accounts accurately reflects the likelihood of such payments being made as at 31 March 2025.

17 All grants, donations and other incoming resources, receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms and conditions in the application of such incoming resources.

18 We confirm that there is no audit information of which you as auditors are unaware, and that each trustee has taken steps to make themselves aware of any relevant information and to establish that you are aware of that information.

We confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and expertise (and, where appropriate, of supporting documentation) sufficient to satisfy ourselves that we can properly make these representations to you and that to the best of our knowledge and belief they accurately reflect the representations made to you by the trustees during the course of your audit.

Yours faithfully

Signed on behalf of the Board of Trustees by:

Jo Clift
Chair of Council

General Osteopathic Council

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Council
15 July 2025
Equity, Diversity, Inclusion and Belonging Annual Report 2024-25

Classification	Public
Purpose	For discussion
Issue	The paper presents our Annual Report to Council on the work we have undertaken on equity, diversity, inclusion and belonging in the year 2024-25.
Recommendation(s)	To consider the Equity, Diversity, Inclusion and Belonging Annual Report 2024-25.
Financial and resourcing implications	The budget approved by Council includes funds for EDIB activity.
Equality and diversity implications	These are set out in the paper.
Communications implications	We ensure our communications reflect the diversity of the profession and wider society.
Annex(es)	Equity, Diversity, Inclusion and Belonging Annual Report 2024-25
Author	Matthew Redford, Stacey Clift

Key messages from the paper:

- Council receives an annual report on our work relating to equity, diversity, inclusion and belonging, which is presented at Annex A.
- The paper also sets out our progress against those activities we had aimed to have completed by July 2025, as recorded in the Equity, Diversity, Inclusion and Belonging Framework.

Background

1. The General Osteopathic Council (GOsC) is a designated public authority and is subject to the public sector equality duty under the Equality Act 2010.
2. Council receives an annual report on our activities over the last year relating to equity, diversity, inclusion and belonging. The report is set out at Annex A.

Discussion

Equity, Diversity, Inclusion and Belonging Annual Report 2024-25

3. In the year, we have undertaken a range of activities which support, enhance and demonstrate our ongoing commitment to equity, diversity, inclusion and belonging across the full range of our business. We are continuing to collect evidence to demonstrate that our activities are having a positive impact and this is described in detail within the Annex to the paper.
4. Looking ahead to 2026, we will plan to develop a new EDIB Report which can be published, akin to our Annual Report and Accounts and Fitness to Practise Reports.

Equity, Diversity, Inclusion and Belonging (EDIB) Framework, 2024-30

5. Last year we published our EDIB Framework, 2024-30. It outlined our policy and legal duties, our governance arrangements around EDIB and the actions we intended to take to progress our work in this area. We report to Council our progress against those actions we had outlined in the EDIB Framework which we had aimed to have completed by July 2025.
6. Progress against our published actions is as follows:

Published action	Progress
Progressed the website technical scoping activity which will pave the way for a new and more accessible public website. (December 2024)	Completed.
Completed the specification for the new CMS and for the development and build of a new and more	Completed.

Published action	Progress
accessible website, which better meets the needs of our all who use it. (July 2025)	
Implemented a new CRM system and be ready to begin the collection of equality monitoring data across the full range of protected characteristics. (December 2024)	Incomplete. The CRM implementation has been delayed; due for completion late 2025.
Collected six months of osteopath equality monitoring data through the new CRM system (NB: we do not have a single point in time where every osteopath renews their registration, so renewal happens monthly) (July 2025)	Incomplete. This has been delayed due to the CRM project. We are now taking a different approach to collecting EDI monitoring data and a survey has been developed and issued to the profession.
Published for consultation the draft guidance for students with a disability or health condition, and have started analysis of the consultation responses. (December 2024)	Completed.
Published the final version of the guidance for students with a disability or health condition. (July 2025)	Council approval, due for publication is imminent.
Completed the 2024 staff survey and started analysis of the results. (December 2024)	Completed.
Reported on the results of the staff survey to People Committee and to the GOsC staff team. (July 2025)	Completed.
Carried out a comprehensive review, and made amendments to, all fitness to practise guidance both at the initial and hearings stages of the fitness to practise process, to ensure the guidance adequately addresses allegations that involve racist and discriminatory behaviours.	Completed.
Started a review of our staff and non-executive recruitment processes to ensure our approach is inclusive and does not contain avoidable barriers to entry.	Completed.

Recommendations: To consider the Equity, Diversity, Inclusion and Belonging Annual Report 2024-25.

Report on Activities in 1 April 2024 - 31 March 2025

EDI theme	Main activities
1. Service provision	**A. We will ensure that information is available (or can be made available) in accessible formats, whether in hard copy or online.** We ensure all documents intended for external use are offered in accessible, easy to use, formats. We post out printed copies of online materials where requested. Our Register is available online and we answer registration queries by telephone for those who cannot access the Register online. We have information about accessibility on the website and we aim to meet level 2. (See osteopathy.org.uk/accessibility). We will explore whether can reach AA status as part of our future website development project. We continue to seek to incorporate in our website high standards of accessibility and readability as we have an increase in traffic to our website. We ensure that our resources are designed to meet a range of learning styles and draw upon best practice in use of typefaces, fonts and colours to enhance accessibility. We will constructively challenge those we work with to ensure that their materials, which we may publish, are accessible for our service users. We ensure that we utilise images (photos and illustrations) to reflect diversity in our recruitment materials and through our social media, print publications and on our website. We are also diversifying how we communicate information, for example, through the use of animations with subtitles and video clips, which are reflected on our websites although we have more to do in this space. This ensures that information is available for osteopaths and others in different, accessible formats.
	B. We will use a wide variety of channels to communicate and engage with a diverse range of stakeholders. We continued to utilise our own channels including our monthly news ebulletin, websites and social media. We have continued to engage with the profession and other stakeholders using online

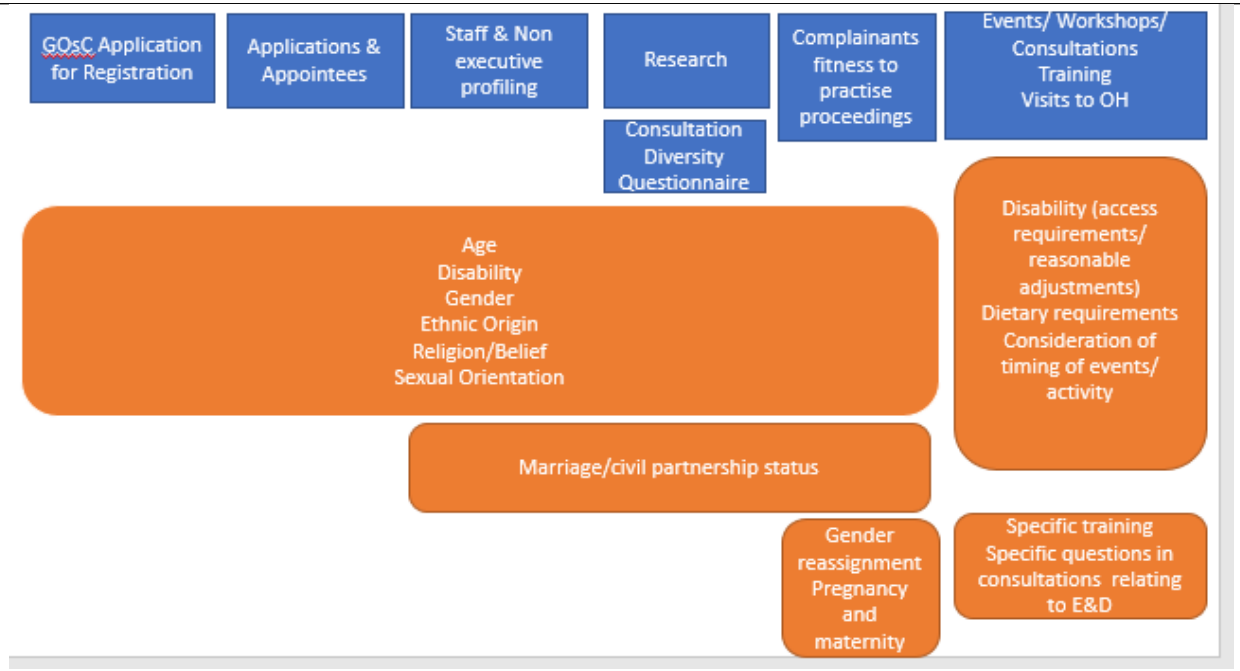
EDI theme	Main activities
	communications such as webinars (small and large scale). During the year we have undertaken engagement activities with osteopaths in-person. We have also introduced a new WhatsApp channel, video calls and weekly drop-in sessions where osteopaths can meet staff online to ask questions. We remain committed to communicating and engaging with a diverse range of stakeholders, for example, during consultations, so that we take their needs into account in order to maximise the interaction we have with them. During the year we held online recruitment webinars in order to demonstrate our commitment to inclusion within recruitment of non-executive positions. These events were well attended and led to a significant number of applications being received for our lay and osteopathic vacancies. We have expanded the Cymraeg section of our website to offer a broader range of information to Welsh speakers. This included publishing our patient animation, Visiting an Osteopath, in Welsh with Welsh subtitles. We promote our Welsh language services in Welsh in our ebulletins regularly, and in March we sent out our first student ebulletin in both Welsh and English to students in Wales. In the year we have positively promoted awareness of equity, diversity, inclusion and belonging through our social media which included Pride month and mental health awareness campaigns. We have also recognised many religious festivals in the year so we can appreciate the diversity of the profession, patients and the stakeholders we work alongside. In 2024-25 we again attended Pride in London and walked in the parade alongside osteopaths, patients and stakeholder colleagues from the Institute of Osteopathy and the educational institutions.
	C. We will ensure that Osteopathy House and any GOsC external events are accessible. We maintain an ongoing commitment to ensuring Osteopathy House is accessible for meetings and events, including a hearing loop for use in the Council Chamber if required. We continue to ensure that the headquarter building is secure for when staff and visitors have been in attendance in our post

EDI theme	Main activities
	pandemic environment. This has included: risk assessments, signage, office protocols, enhanced ventilation systems, additional cleaning materials and desk screens.
	D. We will ensure that complainants, witnesses and osteopaths are effectively supported through the fitness to practise process. We provide comprehensive guidance for all participants in fitness to practise hearings, whether they are witnesses or registrants. Guidance for witnesses: https://www.osteopathy.org.uk/standards/complaints/hearings/attending-a-hearing/witness-guidance/ Guidance for registrants: https://www.osteopathy.org.uk/news-and-resources/publications/guidance-for-osteopaths/ During the reporting period we have continued to make available the Independent Support Service for complainants, witnesses and osteopaths which is run by Victim Support and to publicise its availability to the profession and to patients involved in fitness to practise. This service is free for any party of a fitness to practise process and ensures that in addition to the support GOsC can provide, there is an independent service for individuals to use. We ensure this service is known to all parties who are subject to a fitness to practise process and we have also communicated with the wider profession on the availability of the service. We will continue to raise awareness of this service. Our website also reflects our approach to raising concerns and individuals may raise concerns by either sending the GOsC a hard-copy form or they can make use of the online concerns form. To supplement this, we have continued the Fitness to Practise ebulletin as well as being open to running online webinars to explore and explain our approach to handling concerns. These new communication activities act as 'myth-busters' and enable the GOsC to demonstrate our approach is one that is accessible as well as fair and proportionate.

EDI theme	Main activities
	Following the DJS registrant and stakeholder survey we have developed visuals around the timeline of a fitness to practise complaint process and visual around myth-busting which can be publicised through social media. We have a process in place to make sure that Welsh speaking complainant, witnesses and osteopaths can take part in our hearings in Welsh if they wish. Our hearings guidance for witnesses and osteopaths reflects this position.
	E. We will meet our duties under the Welsh Language Act. We submitted our annual monitoring report to the Welsh Language Commissioner following the Annual Report to Council in July 2024. In the current reporting year (2024-25), the Register included 34 practices where the Welsh language can be used with patients, which was an increase on the previous year (27). In total we had 164 registrants practising in Wales, which was an increase on the previous year (158). In order to ensure the Welsh Language is treated as favourably as the English Language our Equality Impact Assessment (EIA) ensures that any changes to existing policies/guidance, or the introduction of new policies/guidance, consider the Welsh Language. We have also ensured that our consultation approach includes reference to the Welsh Language. In the previous reporting period we received a compliance notice from the Welsh Language Commissioner on 6 June 2023 which outlined 67 standards, including policy-making, operational, service delivery and record-keeping standards. These standards supersede GOsC's previous Welsh Language Scheme, implemented in response to the Welsh Language Act 1993.

EDI theme	Main activities
	We were able to meet all Standards bar one, which requires that applications/renewals to join/renew our Register be facilitated and processed in Welsh in the same manner as applications in English. When the new CRM system is implemented we will be compliant with this standard.
2. Policy development and implementation	**A. We will assess the equality and diversity implications of all new policy development and operational activities.** Council approved a new Equity, Diversity, Inclusion and Belonging Framework, 2024-30, at the July 2024 Council meeting. An update on our progress against published actions is set out within the July 2025 paper on equity, diversity, inclusion and belonging. In the reporting period we have undertaken a number of equality impact assessments and these have been reported in papers to the Policy and Education Committee, Audit Committee, People Committee and to Council. All papers presented to Council and Committees take equality, diversity and inclusion EDIB issues into account, especially our CPD Evaluation papers with discussions at Council and Committee including a greater focus and attention on matters of EDIB. Additionally, the budget for the year ahead has ensured that funds are available for activities which will help our commitment to making EDIB pervasive throughout everything we do. Our work in seeking external input into our policy work has been recognised as good practice by the Professional Standards Authority in their performance review report for 2024-25, specifically around the Guidance for Pre-Registration Education.
	B. We will publish formal equality impact assessments on all major projects. See response to A.

EDI theme	Main activities
	• **We will seek to ensure that our consultations, surveys and research projects address equality and diversity issues, and that there is an appropriate diversity of respondents.** In the reporting period we undertook the following public consultations: • Draft Guidance about Professional Behaviours and Student Fitness to Practise. • Draft Guidance for Applicants and Students with a Disability or Health Condition. • CPD Guidance and PDR template. In all our consultations we seek to involve not just registrants but a full range of stakeholders, using a range of approaches including written consultation, focus groups and one-to-one meetings. The consultations have been conducted in accordance with our consultation principles.
3. Data collection and analysis	**A. We will collect and record equality and diversity data from those we interact with including: respondents to consultations and research surveys; and complainants and others involved in fitness to practise proceedings.**

EDI theme	Main activities
	 Figure 1: E&D Data Collection Process. We collect and record equality and diversity data across the full range of our business activities – see figure 1 – for a range of different purposes. We are currently working towards the implementation of a new CRM system which will facilitate the easier and greater collection of EDI monitoring data from registrants, by requesting the information at the point of online renewal. We see this as an important development which will ensure we are capturing a dataset that has greater breadth and depth and which will allow us deeper insight into the demographics of our registrant base.

EDI theme	Main activities
	We collected EDI monitoring data from staff and non-executives and reported the results to People Committee and Council.
	B. We will collect and record equality and diversity data in relation to consultation responses and research surveys and evaluate the data where possible. We collect and record equality and diversity data in relation to consultation responses, the CPD Evaluation survey and focus group activities now include each participant completing a short survey before joining a focus group, which includes recording equality, diversity and inclusion monitoring information. In the reporting year we ran consultations which were supplemented with a diversity monitoring form. Data collected is evaluated and reflected upon to inform the purpose for which it collected. We also work with our education stakeholders to provide student enrolment data for the osteopathic profession as whole on the following protected characteristics: age, sex, ethnicity and race (which also includes country of origin) and disability.
	C. We will collect and record equality and diversity data on all applicants and appointees to non-executive and executive posts. We have continued to collect and record equality and diversity data in relation to staff and non-executive applications and appointments. In the year under report, equality monitoring statistics have been collated and reported to the People Committee for the appointments made in year. We are able to say with confidence that our recruitment campaigns are generating a diverse set of applicants across a range of protected characteristics. With our recruitment campaigns we took specific steps to enhance the diversity of the applications we received. This included a review and changes to the recruitment materials to make them more inclusive and welcoming; we were more active with our social media promotion, and we ran online recruitment

EDI theme	Main activities
	webinars. In previous reporting years we expanded the EDI monitoring data we collected from applicants through our new online application process and this has continued in the reporting period. This new online process has meant that it has been much easier to review the EDI data we collect and to analyse the findings, particularly in terms of completed, incomplete and shortlisted applications.
	D. We will analyse data collected through these processes and ensure that it is used to inform the equality and diversity aspects of our work. Data collected is analysed and reflected upon to inform the purpose for which it collected.
4. Partnerships and the implementation/ promotion of standards	**A. We will seek to work in partnership with others to ensure best practice in equality and diversity (for example, with the osteopathic educational institutions and others in the implementation of the Osteopathic Practice Standards).** *CPD Consultation* In the reporting year we have run a CPD consultation that, as part of the discussions, considered strengthening the CPD requirement on Boundaries and equity, diversity, inclusion and belonging (EDIB). In running the consultation we held a focus group with osteopaths with an interest in EDIB. We also discussed the proposed changes with members of our patient involvement forum. They highlighted the distinction between equality and equity and suggested the need for practical scenarios to be included in any supporting material. Of those who completed the survey, most osteopaths agreed that boundaries and EDIB should become mandatory elements to the CPD scheme (77.5% and 63% respectively). Although, this was higher for boundaries than for EDIB. We have also begun initial discussions with the National Council for Osteopathic Research (NCOR) about ways in which we might be able to progress the EDIB evidence base for the profession, with the idea

EDI theme	Main activities
	being that we could possibly commission NCOR to conduct a cultural humility survey with the profession (as the UrGEnt study did with the osteopathic students). *Signposting resources:* We have taken steps to ensure that we have provided signposts to resources for registrants to support them. Through the GOsC ebulletin and social media we have provided signposts around matters such as looking after one's mental health, and through the fitness to practise ebulletin and webinars we have referenced the support provided by the Independent Support Service for those who are subject to a fitness to practise process.
	B. We will seek to ensure that equality and diversity considerations are taken into account in any projects undertaken jointly with others (for example, with our Osteopathic Development Group (ODG) partners on development projects). We continue to work with ODG partners including on the importance of recognising equality and diversity aspects of ODG projects and the development of its strategy.
5. Employment and governance	**A. We will ensure that our HR policies are up to date and represent best practice in equality and diversity, and we will monitor their effects on staff recruitment and retention.** We have a range of flexible policies in place to ensure that staff are provided with equal opportunities to undertake their work. The People Committee monitors staff recruitment and retention and are made aware of any new flexible working arrangements which have been introduced, particularly around reasonable adjustments. We have maintained our hybrid working patterns ensuring staff who required reasonable adjustments in the office have been able to work from home without any difficulties.

EDI theme	Main activities
	B. We will ensure that all non-executives and executives receive appropriate and regular equality and diversity training. We have maintained a focus this year on our employees mental health and their awareness of mental health which has been of particular importance. All new non-executives and new members of staff are required to undertake online training on equality, diversity and inclusion and we will continue to consider what further training might be required. We developed plans for the collection of EDI data from those who work within our Governance model and from staff and we rolled that out, albeit outside of this reporting period. With the significant non-executive recruitment undertaken, we have ensured our recruitment panels receive training to support members make the interview an inclusive environment for applicants. We have run a Tone of Voice workshop with staff which considered the need to think about how we communicate with a diverse range of stakeholders and what steps we can take to ensure our communications meet different needs.
	C. We will seek to improve the diversity of applicants and appointees to non-executive roles. In addition to the response we have set out at Section 3C, this year saw the continuation of our Council Associate Programme. The Council Associate Programme has allowed the GOsC to offer development opportunities to osteopaths who have considered applying for governance positions, but who perhaps do not yet have the full set of skills. The Council Associates position shadow Council and its Committees and we value the perspectives that our Associates bring to these roles.

EDI theme	Main activities
	In the reporting year we considered how we might ensure the patient voice is central to strategic decision-making and two new Partner Partners will join Council in the next reporting period.
	D. We will keep ourselves up to date and share best practice in equality and diversity through our participation in the joint regulators' equality and diversity forum. Members of the executive continue to attend the regular meetings of the joint regulators' equality and diversity forum.

General Osteopathic Council

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Council
15 July 2025
Annual Report to the Welsh Language Commissioner

Classification	Public
Purpose	For discussion
Issue	Under the Welsh Language Standards (No.8) Regulations 2022, the General Osteopathic Council (GOsC) is required to publish an annual report to the Welsh Language Commissioner on the ways in which it has complied with the Welsh Language Standards. This paper introduces the annual report for 2024-25 which is attached as an annex.
Recommendation(s)	To consider the second Annual Report to the Welsh Language Commissioner and to agree that the report be published to GOsC's public website.
Financial and resourcing implications	The costs of complying with the Welsh Language Standards are provided for in the 2024-25 budget.
Diversity implications	The purpose of the report is to demonstrate the ways in which we have complied with the Welsh Language Standards, ensuring we treat the Welsh language no less favourably than the English language. The report therefore takes into account the needs of Welsh speakers and those living in Wales.
Communications implications	The report will be published in Welsh and English once agreed by Council, and will then be submitted to the Welsh Language Commissioner. We will promote the report externally across our channels in both Welsh and English, in accordance with the standards.
Annex(es)	General Osteopathic Council's Annual Report to the Welsh Language Commissioner (1 April 2024 – 31 March 2025)
Author	Jessica Davies, Matthew Redford

Key messages from the paper:

- In December 2023, GOsC implemented the new Welsh Language Standards in accordance with the compliance notice received from the Welsh Language Commissioner in June 2023.

- GOsC is expected to implement standard 20 (the provision of an online registration process available to registrants in Welsh) by the end of 2025 due to unforeseen delays from our current website provider causing delays to the implementation of our new CRM system.

- The reporting period for GOsC's second Annual Report to the Welsh Language Commissioner under the Welsh Language Standards covers 1 April 2024 – 31 March 2025.

- As of 31 March 2025, there are 164 osteopaths living and/or practising in Wales, and 138 students studying and/or living in Wales.

Background

1. The Welsh Language (Wales) Measure 2011 is the legislation that created the Welsh Language Standards. The standards aim to promote and facilitate the Welsh language, and ensure that the Welsh language is not treated less favourably than the English language in Wales.

2. GOsC is under duty to comply with the Welsh Language Standards (No.8) Regulations 2022. In accordance with our compliance statement from the Welsh Language Commissioner, we implemented all except one of the 67 standards, including policy-making, operational, service delivery and record-keeping standards.

3. Standard 20 requires that applications to join our Register be facilitated and processed in Welsh in the same manner as applications in English. Progress is being made to implement this standard as part of GOsC's project to implement a new CRM system, which will ensure we have the system capability to process Welsh applications in the same manner as English applications.

4. While we have not been able to meet the deadline of 6 December 2024 for implementing standard 20, we have been in contact with the Welsh Language Commissioner to reiterate that this is still on track, and that in the meantime, Welsh osteopaths looking to renew their registration can do so using a standalone form on our website, which we then manually process. So far we have not received any renewal registrations in Welsh.

5. As part of the compliance notice, GOsC is required to publish an annual report to the Welsh Language Commissioner explaining the ways in which GOsC has complied with the standards with which we are under a duty to comply during that year.

6. The report must include the following:

    - the number of complaints that GOsC received during the year in question which related to compliance with the standards with which GOsC is under a duty to comply

    - the number of employees who have Welsh language skills at the end of the year in question

    - the number of new and vacant posts that you advertised during the year which were categorised as posts where:

        - Welsh language skills were essential

        - Welsh language skills needed to be learnt

        - Welsh language skills were desirable

        - Welsh language skills were not necessary

7. The reporting period for this first annual report to the Welsh Language Commissioner covers 1 April 2025 to 31 March 2024.

Discussion

8. We are seeking Council's agreement to publish the report attached as an Annex. If agreed, the report will be published on our website in both Welsh and English, and promoted externally across our channels in both Welsh and English. The report will then be submitted to the Welsh Language Commissioner.

9. In the report we outline the compliance activities we have delivered during this period relating to:

    - Consultations
    - Correspondence
    - Promoting our Welsh language services
    - Providing information in Welsh on our website

10. The report details the numbers of osteopaths and osteopathic students in Wales as of 31 March 2025. We hope this can provide useful context for Council and the Commissioner regarding our decision to take an approach to implementing the standards that is proportionate to our size and reach as an organisation.

Recommendation: to consider GOsC's Annual Report to the Welsh Language Commissioner and to agree to publication of the report to GOsC's website.

General Osteopathic Council

General Osteopathic Council's Annual Report to the Welsh Language Commissioner

April 2024 – March 2025

Contents

Introduction

This annual report explains how the GOsC has sought to comply with the Welsh Language Standards (No.8) Regulations 2022 between 1 April 2024 and 31 March 2025.

We are committed to treating the Welsh language no less favourably than the English language, recognising the significance and history of the language and doing our best where possible to facilitate the use of Welsh across our services.

This report provides an overview of the activities we have undertaken to facilitate the use of Welsh both now and in the future. We continue to take a proportionate approach to compliance with the standards, aligned with the size and reach of our organisation, as well as the number of osteopaths and students currently living, studying and practising in Wales.

Wherever possible we look at ways we can improve our Welsh language services to meet the needs of osteopaths, patients, students and members of the public in Wales. We do this through our equality impact assessments and as part of our pre-consultation planning and engagement activity, liaising with stakeholders in Wales where possible and relevant. The provision of Welsh services is part of our vision to be an inclusive regulator, trusted by all.

We continue to encourage feedback from Welsh speakers on the services and information we provide in Welsh. Any feedback we receive will be used to inform how we deliver our services and comply with the standards in the future. If you are a Welsh speaker and would like to contact us in Welsh, you are welcome to email us at: info@osteopathy.org.uk

About the GOsC

The General Osteopathic Council (GOsC) is the regulator for osteopathy in the United Kingdom, including Scotland, Wales and Northern Ireland. Osteopaths must be registered with the GOsC to legally practise osteopathy in the UK.

Our overarching objective is to protect the public, maintain public confidence in osteopathy and promote proper professional standards and conduct for osteopaths.

Our responsibilities include:

- keeping a Register of all osteopaths permitted to practise
- working with the public and the osteopathic profession to promote patient safety by registering qualified professionals and setting, maintaining and developing standards of osteopathic practice and conduct
- helping patients with concerns about an osteopath, and removing from the Register any osteopaths who are unfit to practise
- assuring the quality of osteopathic education
- setting the requirements for osteopaths in relation to their continuing professional development

As of 31 March 2024, there are 164 osteopaths living and/or practising in Wales, and 138 students studying and/or living in Wales. Swansea University is currently the only osteopathic education provider in Wales.

The GOsC is a small organisation with less than 30 members of staff and our office is based in London, England. We are governed by our Council which has a statutory requirement to include at least one Welsh member (a person based wholly or mainly in Wales who may be lay or osteopathic) to help us consider and support the needs of Welsh osteopaths, patients and Welsh members of the public when making strategic regulatory decisions.

We currently do not have any Welsh speaking members of staff.

Our compliance activities

Between 1 April 2024 and 31 March 2025 our compliance activities focused on the following areas:

- Consultations
- Correspondence
- Promoting our services
- Providing information on our website in Welsh

We did not receive any requests from Welsh-speaking individuals to facilitate hearings in Welsh, or to provide correspondence or information relating to a fitness to practise investigation in Welsh. While we promote these services as part of our correspondence with individuals in these circumstances, the relatively low number of osteopaths in Wales suggests a low likelihood that Welsh-speaking registrants or patients would need to use this service.

Consultations

During this period we received guidance from the Welsh Commissioner on standards 45-47 explaining the need to demonstrate a conscious effort, where possible, when seeking views on the impact of our policy decisions on opportunities to speak Welsh, as part of our consultations. The Commissioner explained the need to demonstrate, as part of our consultation document, how we have assessed the impact on opportunities to speak Welsh and the outcome of our assessment, including any suggested changes to our approach.

This is the approach we took in all public consultations delivered during this period, which included a consultation on our health and disability guidance for students, and a consultation on our Continuing Professional Development (CPD) guidance and Peer Discussion Review template – a template osteopaths are required to use to facilitate a conversation with another healthcare professional. The completed template must be stored as part of an osteopath's CPD records.

When we completed our impact assessment in preparation for the consultation on our CPD guidance and PDR template, we realised that we did not currently provide the template in Welsh, and that doing so would support Welsh-speaking osteopaths to have their conversation with other healthcare professionals using the Welsh language. This was a clear action we suggested taking as part of our consultation outcome to increase or improve opportunities to use Welsh. The revised guidance and templates are due to be published before the end of 2025, subject to approval from our Council.

Correspondence

The Welsh Language Standards require us to provide correspondence in Welsh to those acting in their capacity as residents of Wales, including osteopathy students. To comply, we sent out all four issues of our quarterly student ebulletin during this period in both Welsh and English to students either studying or living in Wales (Swansea University).

During this period we also launched WhatsApp as a method for receiving communication from osteopaths and students. As part of our promotion of this service we specified that messages received in Welsh, whether as texts or voice messages, will receive text responses in Welsh. This is because we do not have a Welsh-speaking member of staff to respond with voice notes, and unless an individual messaging us specifies that they speak Welsh or reside in Wales, we would not be able to identify whether they are a resident of Wales. Our proportionate response was to therefore be clear that we invite and facilitate correspondence in Welsh, without providing this automatically for all.

We received no correspondence (emails, phone calls, letters or WhatsApp messages) in Welsh during this period.

Promoting our services

To be consistent in the way we promote our services, we include a bilingual feature in every monthly ebulletin to our registrants promoting one of our Welsh language services. As engagement on our social media channels is much lower, we promote our services in Welsh less regularly (on average every three months), and we aim to increase this going forward.

We also promote our Welsh language services in our email signatures (specifically inviting correspondence in Welsh), in our online presentations to students in their final year, and on our website.

Providing information on our website in Welsh

During this period we have published the following information in Welsh on our website:

- Fitness to Practise Annual Report
- Annual Reports and Accounts
- Annual report to the Welsh Language Commissioner
- Guidance for Students on Fitness to Practise and Professional Behaviours
- Equity, Diversity, Inclusion and Belonging framework
- Our Strategy

We also regularly update the information on the Cymraeg section of our website to mirror updates on our English pages. This included information about our Council and Committee members, research from the National Council for Osteopathic Research and our concerns process.

Further information about our compliance with the Welsh Language Standards

The number of complaints GOsC received from December 2023 – March 2024 that relate to GOsC's compliance with the standards:	None
The number of employees who have Welsh language skills as of 31 March 2024:	None
The number of new and vacant posts that GOsC advertised (excluding governance/non-executive posts) where Welsh language skills were essential:	None
The number of new and vacant posts that GOsC advertised (excluding governance/non-executive posts) where Welsh language skills were essential:	None
The number of new and vacant posts that GOsC advertised (excluding governance/non-executive posts) where Welsh language skills were essential where Welsh language skills needed to be learnt:	None
The number of new and vacant posts that GOsC advertised (excluding governance/non-executive posts) where Welsh language skills were desirable:	None
The number of new and vacant posts that GOsC advertised (excluding governance/non-executive posts) where Welsh language skills were not desirable:	7

How to contact us in Welsh

Queries in Welsh can be sent to GOsC by email, WhatsApp or post and will receive a written response in Welsh. Queries sent to us through any of our social media channels (Facebook, Twitter/X or LinkedIn) will also receive a response in Welsh. We usually aim to respond to emails and contact through social media within 5 working days. On WhatsApp, we aim to respond within 24 hours.

As we do not currently have a Welsh speaking member of staff, we are unable to answer phone calls in Welsh.

If you would like to contact us about our Welsh language services or the content of this annual report, you can do so by emailing info@osteopathy.org.uk

General Osteopathic Council

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Council
15 July 2025
Marjon – Renewal of Recognition of Qualification (RQ)

Classification	Public
Purpose	For decision
Issue	Consideration of the Recognised Qualification (RQ) review at the Marjon in relation to: • Master of Osteopathy (MOst) (4 years full time) • Master of Osteopathy (MOst) (6 years part time)
Recommendations	1. To recognise the Master of Osteopathy (MOst) (4 years full time) and Master of Osteopathy (MOst) (6 years part time) awarded by Marjon from 1 February 2026 with no expiry date subject to the approval of the Privy Council. 2. To note the conditions to be addressed within a published action plan as outlined.
Financial and resourcing implications	The RQ Visit was included in the 2024-25 financial schedule, with a budget of c£20,000.
Equality and diversity implications	Equality and diversity issues are reviewed as part of the RQ renewal process.
Communications implications	We are required to maintain and publish a list of the qualifications which are for the time being recognised in order to ensure sufficient information is available to students and patients about osteopathic educational institutions awarding 'Recognised Qualifications' quality assured by us.
Annexes	A. The Marjon review specification B. The Marjon RQ Visit Report
Authors	Steven Bettles and Banye Kanon

Key Messages

- The visitor report contains recommendation for renewal of the recognition of Marjon qualifications with two specific conditions.
- This was reported to the Policy and Education Committee on 10 June 2025.
- The Committee made a recommendation that the programmes be recognised without an expiry date. On this basis, the specific conditions recommended by the visitors alongside the general conditions applying to all recognised qualifications will be dealt with within a published action plan.

Background

1. A draft RQ specification was approved by the Committee at its March 2024 meeting and the Committee agreed a team of three Education Visitors under s12 of the Osteopaths Act 1993 to undertake the review. The RQ Specification is included at Annex A to this paper.

2. The visit took place in December 2024.

3. The final visitors' report is attached at Annex B. The recommendation of the Visitor for the programmes is approval with two specific conditions. When we recognise an RQ, we also recognise in accordance with the general conditions which are also specified below.

Discussion

Strengths and good practices

4. The visitors identified several specific areas of strength and good practices in the final report, including:

    - Clarity in admissions procedures and variations in interviews opportunities (i.e. face-to-face or video) are seen as examples of good practice. This allows prospective students to have clarity on admissions expectations and provides equal opportunities to overseas students or distance learners.
    - Use of a QR code to access feedback is an example of good practice, providing patients with an easily accessible method for providing feedback.
    - The integration of the OPS and the pillars of the ACP is a strength of the new programme and whilst the ACP focus will only take place at level 7, this could provide an added level of employability for graduates.
    - The University actively supports all teaching staff in their professional development needs. The peer review rationale is considered to be a strength of the provision and is made possible by the location of the institution within the University itself as opposed to a remote site, and by the integration of

osteopathic staff as a whole. The interprofessional collaboration planned within the new clinic facilities should build upon this and if managed appropriately, the MDT approach will filter into the student's clinical experience.

- The supportive and compassionate culture inherent and strongly focussed upon within the University is a strength and this creates a safe space for quality learning.

- The introduction of the individual student's presentations, observed during the first year teaching session, at an early point of the programme is an example of good practice, enabling a sense of ownership in their exchange of knowledge and building self-confidence.

- The extended opening hours of the library and library staff's highly proactive approach to engaging with students and staff is a strength which supports the students' needs, academic study skills development and enables them to become more autonomous in their learning.

- Having a student led clinic where students are responsible for administration, reception and have input into the marketing of the clinic adds an additional dimension to their training, allowing these important aspects of practice to be taught and experienced in a more comprehensive manner.

Recommendations

5. Recommendations may be made by visitors when they consider that '*there is an opportunity for improvement, but a condition is not necessary. These areas should be monitored by the provider and the recommendations implemented, if appropriate.*'

6. The visitors in this case made a number of recommendations within the report.

7. These areas should be monitored by the provider and implemented if appropriate with updates reported in the next annual report process. Marjon will be asked to provide a progress update with regard to these specific areas as part of their 2024-25 Annual Report submission.

Conditions recommended by the Visitors.

8. Two specific conditions were proposed in the report by the Visitors. These are:

    - The University must immediately update their consent forms and privacy policy to ensure patients are fully aware of who can access their clinical information.

    - In order to effectively manage the risk to patient data, the University must carry out an urgent review of the risks associated with the use of students'

own IT equipment to access and record patient data both on site and off site as well as the risks associated with allowing students from other programmes access to osteopathic patient records. This should be done in conjunction with staff at the university who have expertise in IT and data protection. The University must develop and carry out a plan to implement the recommendations from the review.

9. An action plan in relation to the above recommended conditions has been developed and sent to us by Marjon and was reported to the Committee. Appropriate actions have taken place so far in addressing the conditions, and an update on these will be provided to the Committee at its October 2025 meeting.

Recognition period

10. The interim Quality Assurance handbook[1] sets out the current criteria regarding the period of RQ approvals stating:

"The maintenance of the RQ status currently follows a cyclical process. Where required, PEC may apply an expiry date to the RQ. This decision will be made based on anticipated level of risk that the RQ presents."

GOsC will usually recognise qualifications for a fixed period of time in the following circumstances:

- A new provider or qualification
- An existing provider with a risk profile requiring considerable ongoing monitoring.

For existing providers, GOsC will usually recognise qualifications without an expiry date in the following circumstances:

- an existing provider without conditions or
- an existing provider with fulfilled conditions and without any other monitoring requirements or
- an existing provider who is meeting all QA requirements (providing required information on time) or an existing provider with outstanding conditions, an agreed action plan and which is complying proactively with the action plan and
- an existing provider engaging with GOsC.

This will be subject to satisfactory review of the providers annual report."

11. Marjon programmes are currently recognised with an expiry date of 31 January 2026.

[1] Mott MacDonald GOsC Interim Quality Assurance Handbook - General Osteopathic Council (osteopathy.org.uk)

12. The Committee was asked to consider whether the Marjon programmes should be recognised with an expiry date, or whether the expiry date can now be removed.

13. The executive's recommendation was that Marjon is now an established provider, and that though conditions are recommended, Marjon is meeting QA requirements and engaging with the process positively in accordance with an action plan. It is our aim to remove the expiry date for all programmes that meet the above criteria, and we suggested that Marjon qualifies on this basis for an expiry date removal. This gives greater flexibility in arranging the timing of the next RQ visit, and of monitoring conditions by way of a published action plan.

14. The Committee agreed to recommend that Council recognises the Master of Osteopathy (MOst) (4 years full time) and Master of Osteopathy (MOst) (6 years part time) awarded by Marjon from 1 February 2026 with no expiry date subject to the approval of the Privy Council

15. The conditions set out below (1-2 being specific conditions as recommended by the visitors in their report, and 3-5 being general conditions that apply to all Recognised Qualifications) will be addressed in a published action plan.

Conditions to be addressed in a published action plan	
1	The University must immediately update their consent forms and privacy policy to ensure patients are fully aware of who can access their clinical information. (2i, 9vi)
2	In order to effectively manage the risk to patient data, the University must carry out an urgent review of the risks associated with the use of students' own IT equipment to access and record patient data both on site and off site as well as the risks associated with allowing students from other programmes access to osteopathic patient records. This should be done in conjunction with staff at the university who have expertise in IT and data protection. The University must develop and carry out a plan to implement the recommendations from the review. (2i, 9vi)
3	Marjon must submit an Annual Report, within a three month period of the date the request was first made, to the Education Committee of the General Council.
4	Marjon must inform the Education Committee of the General Council as soon as practicable, of any change or proposed substantial change likely to influence the quality of the course leading to the qualification and its delivery, including but not limited to: i. substantial changes in finance

	ii. substantial changes in management iii. changes to the title of the qualification iv. changes to the level of the qualification v. changes to franchise agreements vi. changes to validation agreements vii. changes to the length of the course and the mode of its delivery viii. substantial changes in clinical provision ix. changes in teaching personnel x. changes in assessment xi. changes in student entry requirements xii. changes in student numbers (an increase or decline of 20 per cent or more in the number of students admitted to the course relative to the previous academic year should be reported) xiii. changes in patient numbers passing through the student clinic (an increase or decline of 20 per cent in the number of patients passing through the clinic relative to the previous academic year should be reported) xiv. changes in teaching accommodation xv. changes in IT, library, and other learning resource provision xvi. any event that might cause adverse reputational damage xvii. any event that may impact educational standards and patient safety
5	Marjon must comply with the General Council's requirements for the assessment of the osteopathic clinical performance of students and its requirements for monitoring the quality and ensuring the standards of this assessment. These are outlined in the *Graduate Outcomes for Osteopathic Pre-registration Education* and *Standards for Education and Training*, 2022, General Osteopathic Council. The participation of real patients in a real clinical setting must be included in this assessment. Any changes in these requirements will be communicated in writing to Marjon giving not less than 9 months notice.

Recommendations:

1. To recognise the Master of Osteopathy (MOst) (4 years full time) and Master of Osteopathy (MOst) (6 years part time) awarded by Marjon from 1 February 2026 with no expiry date subject to the approval of the Privy Council.

2. To note the conditions to be addressed within a published action plan as outlined.

Review Specification for University of St Mark and St John (Marjon) - Renewal of Recognised Qualification Review.

Background

1. Marjon currently provides the following qualifications which are due to expire on 31 January 2026:

   - Master of Osteopathy (MOst) (4 years full time)
   - Master of Osteopathy (MOst) (6 years part time)

2. The last RQ review visit report was from January 2020. The programmes above were recognised for a period of five years from 1 February 2021 to 31 January 2026. In accordance with the Mott MacDonald Handbook, this is a visit to ensure that our standards are being maintained. A copy of the current Recognised Qualification award and the last Quality Assurance Agency for Higher Education (QAA) report is attached for information. All Education Committee papers are available on request.

3. A review visit is being scheduled for early 2025.

Review Specification

4. The GOsC requests that Mott MacDonald schedules a monitoring review for Visitors to report on the following qualification:

   - Master of Osteopathy (MOst) (4 years full time)
   - Master of Osteopathy (MOst) (6 years part time)

5. The aim of the GOsC Quality Assurance process is to:

   - Put patient safety and public protection at the heart of all activities
   - Ensure that graduates meet the standards outlined in the Osteopathic Practice Standards
   - Make sure graduates meet the outcomes of the Guidance for Osteopathic Pre-registration Education.
   - Identify good practice and innovation to improve the student and patient experience
   - Identify concerns at an early stage and help to resolve them effectively without compromising patient safety or having a detrimental effect on student education
   - Identify areas for development or any specific conditions to be imposed upon the course providers to ensure standards continue to be met
   - Promote equality and diversity in osteopathic education.

6. The format of the review will be based on the interim Mott MacDonald Handbook (2021) adapted appropriately by the Visitors for the purposes of this specification and Graduate Outcomes and Standards for Education and Training. In addition to

the usual review format for a renewal of recognition review (appropriate to the stage of development of this course), the Committee would like to ensure that the following areas are explored:

- The implementation of the update MOst curriculum, and the management of this with some students on the former curriculum as it is taught out.
- The impact of the clinic move, and the delivery of clinical education in this context, meeting the requirements of the Graduate Outcomes and Standards of Education and Training.
- The recording of students' clinical hours and experience of patients to ensure that sufficient depth and breadth of clinical education is delivered during the digital review.
- How the University's interprofessional learning strategy is implemented, and the impact of this on learning outcomes.
- How students are made aware of and familiar with key guidance and policy documents, including the student code of conduct, student fitness to practise guidance, and guidance in relation to the management of health and disability.
- Mechanisms for encouraging and enhancing the process by which students provide feedback.
- Ongoing monitoring of the actions identified in response to student feedback and NSS scores and the processes by which actions are identified, managed and monitored.
- Ongoing monitoring of the actions identified from patient audits and to ensure that those actions continue to be identified, managed and monitored.
- The review and updating of the safeguarding policy.
- Identification and maintenance of innovative and good practice.

Provisional Timetable

7. The provisional timetable for the Nescot Part-time programme review will be as follows, but is subject to review:

- **RQ visit in January 2025**

Month/Year	**Action/Decision**
March 2024	Committee agreement of initial review specification and statutory appointment of visitors
10 weeks before the visit	Submission of mapping document
December 2024	Review takes place
5 weeks following visit	Draft Report to Marjon for comments - statutory period.
Following receipt of final report	Preparation of Action Plan to meet proposed conditions (if any)
June 2025	Recommendation from the Committee to Council whether to make changes to the RQ programme approval (e.g., conditions or addition of an expiry date)
July 2025	Recognition of Qualification ongoing by the General Osteopathic Council
July-September 2025	Privy Council Approval

This timetable will be the subject of negotiation with Marjon, GOsC and Mott MacDonald to ensure mutually convenient times that fit well with the quality assurance cycle.

GOsC Education Quality Assurance

Renewal of Recognised Qualification Report

This report provides a summary of findings of the providers QA visit. The report will form the basis for the approval of the recommended outcome to PEC.

Please refer to section 5.9 of the QA handbook for reference.

Provider:	Plymouth Marjon University
Date of visit:	3 -5 December 2024
Programme(s) reviewed:	Master of Osteopathy (MOst) (4 years full time) Master of Osteopathy (MOst) (6 years part time)
Visitors:	Dr Brian Mckenna, Melanie Coutinho, Mark Foster
Observer:	William Shilton

Outcome of the review

Recommendation to PEC:

☐ Recommended to renew recognised qualification status

☒ Recommended to renew recognised qualification status subject to conditions being met

☐ Recommended to withdraw recognised qualification status

Programme start date:

Date of expiry (if applicable):

Date of next review:

Abbreviations

ACP	Advanced Clinical Practice
AER	Annual Equality Report
AI	Artificial Intelligence
APR	Annual Programme Review
BCAP	British Association for Counselling and Psychotherapy
CV	Curriculum Vitae
DBS	Disclosure and Barring Service
EC	Extenuating Circumstances
EDI	Equality, Diversity & Inclusivity
EDIC	Equality, Diversity & Inclusivity Committee
EE	External Examiner
EV	Electric Vehicle
FHEQ	Frameworks for Higher Education Qualifications
FtP	Fitness to Practise
GDPR	General Data Protection Regulation
GOPRE	Guidance for Osteopathic Pre-Registration Education
GOsC	General Osteopathic Council
GP	General Practitioner
HE	Higher Education
HEA	Higher Education Academy
HEE	Health Education England
HR	Human Resources

IT	Information Technology
MDT	Multi-Disciplinary Team
MEF	Module Evaluation Forms
MLO	Module Learning Outcomes
MOst	Integrated Masters
MSK	Musculoskeletal
NHS	National Health Service
NSS	National Student Survey
OEI	Osteopathic Education Institution
OEIs	Osteopathic Education Institutions
OPS	Osteopathic practice Standards
PDR	Personal Development Review
PDT	Personal Development Tutor
PEC	Policy and Education Committee
PG	Post Graduate
PhD	Doctor of Philosophy
PL	Programme Lead
PMU	Plymouth Marjon University
PSRB	Professional, Statutory and Regulatory Bodies
PVP	Programme Voice Panel
QA	Quality Assurance
QAF	Quality Assessment Framework
QR	Quick Response

RPCL	Recognition of Prior Certificated Learning
RPL	Recognition of Prior Learning
SEC	Student Experience Council
SEOP	Student Engagement Outcome Panel
SET	Standards for Education and Training
SEV	Student Experience Voice
SMT	Senior Management Team
SOE	Staff Osteopathic Enrichment
SRF	Student Regulations Framework
SSLC	Staff Student Liaison Committee
SVP	Student Voice Panel
UCAS	Universities and Colleges Admissions Service
USP	Unique Selling Point
VLE	Virtual Learning Environment
VPN	Virtual Private Network

Overall aims of the course

Plymouth Marjon University confirmed the following aims of the MOst course within the mapping tool:

1) Develop advanced clinical skills: To equip students with in-depth knowledge and advanced clinical skills required for diagnosing, managing, and treating MSK and systemic health conditions in alignment with the OPS and statutory regulation.

2) Foster a culture of life-long learning and evidence-informed practice: To cultivate a critical understanding of information and evidence-informed practice, empowering graduates to contribute to the advancement of osteopathic healthcare delivery through clinical reflection and professional development.

3) Embody the University's values of humanity, ambition, curiosity, and independence: To inspire students to integrate PMU's core values by fostering compassionate patient care (humanity), striving for excellence in their practice (ambition), engaging in lifelong learning and innovative approaches to healthcare (curiosity), and developing the confidence to work autonomously and ethically as osteopathic practitioners (independence).

Overall Summary

The visit to Plymouth Marjon University was undertaken over three days at the university campus in Plymouth. Visitors were able to meet with a range of relevant groups to support work in relation to the visit specification. These groups included staff, students, SMT, clinic administration staff and patients. Meetings held across the three days were held in an open and honest way to support the visitors with triangulation.

Strengths and good practice

Clarity in admissions procedures and variations in interviews opportunities (i.e. face-to-face or video) are seen as examples of good practice. This allows prospective students to have clarity on admissions expectations and provides equal opportunities to overseas students or distance learners. (1i)

Use of a QR code to access feedback is an example of good practice, providing patients with an easily accessible method for providing feedback. (1vi)

The integration of the OPS and the pillars of the ACP isa strength of the new programme and whilst the ACP focus will only take place at level 7, this could provide an added level of employability for graduates. (1vii)

The University actively supports all teaching staff in their professional development needs. The peer review rationale is considered to be a strength of the provision and is made possible by the location of the institution within the University itself as opposed to a remote site, and by the integration of osteopathic staff as a whole. The interprofessional collaboration planned within the new clinic facilities should build upon this and if managed appropriately, the MDT approach will filter into the student's clinical experience. (1ix)

The supportive and compassionate culture inherent and strongly focussed upon within the University is a strength and this creates a safe space for quality learning. (3iv)

The introduction of the individual student's presentations, observed during the first year teaching session, at an early point of the programme is an example of good practice, enabling a sense of ownership in their exchange of knowledge and building self-confidence. (3vi)

The extended opening hours of the library and library staff's highly proactive approach to engaging with students and staff is a strength which supports the students' needs, academic study skills development and enables them to become more autonomous in their learning. (5i, 6ii)

Having a student led clinic where students are responsible for administration, reception and have input into the marketing of the clinic adds an additional dimension to their training, allowing these important aspects of practice to be taught and experienced in a more comprehensive manner. (7i)

Areas for development and recommendations

The University should review the osteopathy web pages to ensure that the University's EDI strategy is sufficiently reflected to encourage applications from all potential students. (1ii)

The University should continue to monitor student feedback regarding the effectiveness of the current formative assessment procedures and if necessary, should consider implementing these under examination conditions, especially for practical modules. Alongside this, all formative feedback opportunities should be explicitly included in module guides, and students informed of the role and benefits of formative assessment within their learning. (1v, 1viii, 6iv)

The University should ensure consistency by explicitly mapping MLOs to the OPS, the 'threads' and the four pillars, ensuring students can locate this and staff understand all and have embedded them into their teaching. The mapping should also be included in module guides to ensure mapping of OPS to MLOs can be consistently applied in all modules so that students and other stakeholders are clear as to which educational and professional attributes each module enables acquisition of. (1vii, 6i)

The University should have a realistic plan in place for the integrated interprofessional operation of the clinic, in advance of the osteopathic clinic move. This should include clear practitioner roles and responsibility (for patient care) aspects and should demonstrate the integration with classroom teaching and learning and OPS. The plan – which should be clearly displayed in the clinic and/or on the clinic webpage – should have a clear rationale of the clinic and patient management protocols which will enable students, clinic staff and particularly patients to have reassurance in the planned healthcare to be provided. This would be beneficial to avoid ambiguity in the management of the new clinic and would provide transparency for students, staff and patients. (1vii)

Students commented that the support provided by personal development tutors could be inconsistent and dependent on who they were assigned to. Therefore, the University should ensure that the training and support which is provided for this role enables students and staff to appreciate of the remits of the role, including a practical knowledge of the scope of support available, commitment to a minimum number of diarised meeting opportunities (taking into account tutor availability), and a review process which ensures consistent and equitable support for all students. (3iii)

The University should ensure that procedures for complaints are explicit and easily accessible both in hard copy at clinic and online for the Clinic patients. Similarly, there should be information posters within the clinic areas to remind patients (and others) of the University's culture of mutual respect, and its response to unacceptable behaviours towards students, clinical staff or other service users. (3iv)

The University should continue its search for software or develop its own bespoke software that will allow closer monitoring of student experience. (7ii)

The University should develop a consent form for those with parental or other devolved responsibility that standardises necessary information they require to make an informed decision. (9ii)

The University should provide additional training and support for students with regards to exercise prescription and rehabilitation. (9vii)

Conditions

The University must immediately update their consent forms and privacy policy to ensure patients are fully aware of who can access their clinical information. (2i, 9vi)

In order to effectively manage the risk to patient data, the University must carry out an urgent review of the risks associated with the use of students' own IT equipment to access and record patient data both on site and off site as well as the risks associated with allowing students from other programmes access to osteopathic patient records. This should be done in conjunction with staff at the university who have expertise in IT and data protection. The University must develop and carry out a plan to implement the recommendations from the review. (2i, 9vi)

Assessment of the Standards for Education and Training

1. Programme design, delivery and assessment

Education providers must ensure and be able to demonstrate that:

i. they implement and keep under review an open, fair, transparent and inclusive admissions process, with appropriate entry requirements including competence in written and spoken English.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The University has explicit and easily understandable admission criteria, including English language requirements. Details of these and of the interview process can be found on the website and is included in the admissions policy and within the programme specification. All entry routes including RPCL and RPL follow the comprehensive admissions policy and procedure. Admission of students via these routes has not been used for this programme as of yet. The admissions procedures are aligned with other providers in the sector.

The University offers both face-to-face and online interview opportunities to enable students from distance or overseas to apply. The standard UCAS application route is in place. The majority of students spoken to as part of the visit confirmed that the location of the University was the deciding factor in their choice of OEI.

Whilst the small class sizes lend themselves to a strong, supportive, inclusive atmosphere in the classroom, consideration must also be given to the need for a compelling marketing strategy to increase student applications in order to secure continuation of the programme and provide students sufficient peers to work with.

Based on the evidence seen and discussions held, we are assured that this standard has been met and that adequate processes are in place to ensure fair and transparent admissions procedures are in place.

Strengths and good practice

Clarity in admissions procedures and variations in interviews opportunities (i.e. face-to-face or video) are seen as examples of good practice. This allows prospective students to have clarity on admissions expectations and provides equal opportunities to overseas students or distance learners.

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. there are equality and diversity policies in relation to applicants, and that these are effectively implemented and monitored.

☒ MET

☐ NOT MET

Findings and evidence to support this

The University provided documentation to support alignment with this standard, and discussions with the SMT further assured the University's strong EDI policy, and their specific aim to integrate students from diverse cultural and social backgrounds into the University. The policy is reviewed annually and the outcomes are reported to the EDI Committee. However, despite their commitment to inclusivity and diversity, the annual programme review and discussions with the SMT during the visit highlighted that student recruitment continues to be an issue, with numbers lower than desired seen in the last two years.

SMT members confirmed that a minimum 8-10 student registrations were necessary for programme viability. Whilst in the previous year they had between 15-18 initial applications, the SMT acknowledged a concern in the drop in application numbers, acknowledging that running the programme with minimal numbers (8-10), would compromise the students learning experience in terms of fewer opportunities for peer work in practical classes and may also require reconsideration in managing student availability in the clinic. The target is for 20 students per cohort. However, they could not confirm application numbers at the time of the visit as the UCAS application date had changed.

The University is able to provide a range of support options to students with seen and unseen disabilities.

The University assured the visitors that marketing of the programme has been focussed upon within the University's normal annual marketing strategy. They believe that the continued link with local GPs, sports clubs, and the proposed new interprofessional clinic facility will generate interest in the programme.

We are confident that this standard has been met and is effectively monitored to ensure it conforms to the University's EDI policy.

Strengths and good practice

None reported.

Areas for development and recommendations

The University should review the osteopathy web pages to ensure that the University's EDI strategy is sufficiently reflected to encourage applications from all potential students.

Conditions

None reported.

iii. they implement a fair and appropriate process for assessing applicants' prior learning and experience.

☒ MET

☐ NOT MET

Findings and evidence to support this

The University has clear and effective processes in place for assessing RPCL and RPL which are evident in the admissions policy and procedures and underpinned by the SRF. The evidence provided confirms that these processes all follow standard expectations for prior learning assessment procedures. Discussions with staff confirmed that this process can be utilised if necessary. The support staff acknowledged that the processes are in place and staff are trained on applying the procedures if an applicant requires to use this

route. However, the University has confirmed that this route has not yet needed to be utilised, as all recent applications for the osteopathy programme have followed the normal entry route.

The University has explicit policies and procedures in place which can be evoked for assessing prospective applicants' learning experience and therefore we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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iv. all staff involved in the design and delivery of programmes are trained in all policies in the institution (including policies to ensure equality, diversity and inclusion), and are supportive, accessible, and able to fulfil their roles effectively.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Robust and well supported staff induction and development opportunities exist relating to the University policies and procedures. Staff confirmed that all staff were required to undertake induction and training in areas such as Prevent and EDI expectations. Initial induction was followed up at SOE and other annual training events. Discussions with SMT confirmed that specific topics were run over several different days and times to allow all staff an opportunity to attend.

Staff confirmed that there is support for undertaking further training – to support development of their teaching skills or enhance their professional development. Mentoring and peer support are integral parts of the teaching strategy, and newly appointed staff confirmed that they had received this and felt it was effective and supportive for their development and had helped them to effectively fulfil their roles. The University has set clear completion expectations for annual training topics. Staff are also encouraged and supported in undertaking research either as part of attaining further academic qualifications or with the aim of data publication. From reviewing the staff training list, we have seen that the University's training includes EDI, Fire safety, GDPR, safeguarding, and Prevent training are carried out regularly.

However, the agenda for the staff training days run by the programme team suggest that these days are largely utilised as programme review opportunities with little or no training taking place. This was confirmed in the discussion with staff at the visit, and some staff are yet to complete any training in expected areas.

The University provides a thorough range of training in all of its policies, and in areas which effectively support and encourage the individual's personal and academic development. Staff are also supported to acquire certification and fellowship of the HEA and or undertake research, all of which enhances their teaching skills.

Staff and SMT confirm that a robust and well supported training programme is in place and takes into consideration part-time availability of osteopathic tutors. Further staff reported being able to access peers

and mentors if required. Discussions provided assurance of the expertise utilised in programme design, and as such we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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v. curricula and assessments are developed and evaluated by appropriately experienced and qualified educators and practitioners.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Semester reports are carried out on individual modules by the PL. Generally, they demonstrate a good spread of assessment marks obtained, though poor student feedback continues to be a common thread running through them. The differences in approach in clinical teaching which had been highlighted in a report from the previous year, were addressed in the teaching staff meeting. We were assured that following the teaching team's annual module reviews, more consistency in the approach adopted by staff teaching in the clinical environment had been embraced.

The External Examiner's report confirms that threshold standards in modules have been reached in line with the FHEQ, the subject benchmark statement and that student performance is in line with sector expectations. Lectures now adopt round-robin style teaching in practical modules, as requested by students to facilitate group working and this appears to have been well received.

All module guides contain details of the summative assessments, however formative assessments appear mainly to be informal both in scheduling and operation. Staff mentioned that in practical classes for example, questions are given in a round-robin style, to the whole class for them to respond to in their working pairs. Feedback would then be provided by peers. Whilst this is commendable, there appears to be few, if any, opportunities for formative assessments structured under summative assessment (exam) conditions, with feedback being provided by tutors normally involved in summative marking.

We are assured that this standard has been met, the curricula and assessments have been externally verified by the External Examiner and via the validation process as fulfilling educational expectations. Ongoing annual verification by the External Examiner ensures the programme continues to meet these expectations.

Strengths and good practice

None reported.

Areas for development and recommendations

The University should continue to monitor student feedback regarding the effectiveness of the current formative assessment procedures and if necessary, should consider implementing these under examination conditions, especially for practical modules. Alongside this, all formative feedback opportunities should be explicitly included in module guides, and students informed of the role and benefits of formative assessment within their learning. (1v, 1viii, 6iv)

Conditions

None reported.

vi. they involve the participation of students, patients and, where possible and appropriate, the wider public in the design and development of programmes and ensure that feedback from these groups is regularly taken into account and acted upon.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Staff have been consulted during the annual module review and the new programme development phase. Student feedback was also considered and utilised. Students confirmed that they are encouraged to provide feedback, and some do; however this is usually related to module content or delivery only. There does not appear to be any documented formal feedback from students or staff in programme development or design.

Patient feedback can be provided via the online form accessed using a QR code, but the impact of this feedback on future programme design or delivery as opposed to the day to day running of the clinic is not explicit. Patients are being sought for forum groups; however, this is related more to the healthcare provision as a whole. There are no information posters in the Clinic's teaching or waiting areas that encourage patients, students or other stakeholders to provide feedback on the service, programme delivery or design. There are no posters that inform patients how previous feedback has impacted on the programme design or clinic provision.

Patients whom visitors met with were highly supportive of providing feedback if asked. No hardcopy feedback forms were shown or available. In discussions with students, staff and support staff we heard that that the University has implemented a number of committees or groups where students' comments and concerns can be addressed, or feedback can be given. These include the SSLC, SEV, teaching staff, patient and student meetings, Clinic observation, Clinic QR code accessing online form and feedback committees. Students responded positively on the University's rapid response to student feedback regarding the provision of additional equipment in the clinic. Similarly, the extended opening of the library facilities to 24 hours a day, 7 days a week following student feedback has been welcomed by all students.

Based on the evidence seen, we are assured that this standard has been met.

Strengths and good practice

Use of a QR code to access feedback is an example of good practice, providing patients with an easily accessible method for providing feedback.

Areas for development and recommendations

None reported.

Conditions

None reported.

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).

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The new Most programme has been granted RQ status (and new students will continue to apply for this route). The aim of the MOst is to produce outstanding healthcare professionals who are able to surpass the remits of private practice or working within the NHS. The programme design reflects the GOPRE expectations, and it shows a cohesive and logical progression which enables students to acquire the expected standards of knowledge and skills, and demonstrate the professional values and attitudes expected by the GOsC.

There is a full understanding of health care inequalities and drive to ensure a non-biased approach in clinical care. The MLOs are found in each module guide and tutors reinforce these verbally at the commencement of each module. Within the programme specification, the University has mapped the modules to OPS, and has also subdivided the programme into eight 'threads'. The evidence provided confirms that the threads would enable the programme to have consistency and rationality.

The programme specification states that the programme adopts a critical approach to the theory and practice of osteopathy which will help develop complex problem-solving skills and criticality in students and that they would become familiar with the HEE Four Pillars of Healthcare. Our discussions with staff further verified that this was the planned strategy. Some students confirmed they were already familiar with the four pillars. The HEE pillars (clinical practice, leadership and management, education and research), are identified in the programme specification, but do not appear on any other programme documentation. However, it was clarified in our discussions with teaching staff and SMT that their teaching of the four pillars of the ACP will be focussed and relevant to Level 7 only.

It is acknowledged by the University that this could provide their graduates with added employability and in discussions staff proposed this was a USP for the provider. In the module guides some, but not all, of the MLOs are explicitly mapped to the OPS for students or other stakeholders to view. Furthermore, not all staff appear to be aware of the aspirations to integrate the ACP Pillars into the Level 7 of the programme. The teaching team strongly emphasised an integrated approach in interprofessional healthcare teaching within the programme and assured the visitors that this will strengthen the students' clinical expertise, values, attitudes and MDT-style working. However, this will only be fully operational once the osteopathic clinic has relocated to its new building. Whilst the programme does already allow students to become familiar with working in an interprofessional way. with some lectures being taken with other healthcare disciplines, e.g., sports massage, the full strategy is reliant on the new clinical facility being in operation when it is envisaged that sports massage and physiotherapy will be involved. The new building is planned to open in Autumn 2025.

The programme has not reached level 7 teaching, where the majority of the interprofessional learning is planned. Furthermore, the full implementation of this is dependent on the opening and running of the new clinic. However, the knowledge basis, attitudes and values required within GOPRE are already evident in the clinical and classroom teaching, as these attributes are essential in underpinning interprofessional learning. Based upon these observations and our discussions with the staff, we are assured that this standard has been met.

Strengths and good practice

The integration of the OPS and the pillars of the ACP isa strength of the new programme and whilst the ACP focus will only take place at level 7, this could provide an added level of employability for graduates.

Areas for development and recommendations

The University should ensure consistency by explicitly mapping MLOs to the OPS, the 'threads' and the four pillars, ensuring students can locate this and staff understand all and have embedded them into their teaching. The mapping should also be included in module guides to ensure mapping of OPS to MLOs can be consistently applied in all modules so that students and other stakeholders are clear as to which educational and professional attributes each module enables acquisition of. (1vii, 6i)

The University should have a realistic plan in place for the integrated interprofessional operation of the clinic, in advance of the osteopathic clinic move. This should include clear practitioner roles and responsibility (for patient care) aspects and should demonstrate the integration with classroom teaching and learning and OPS. The plan – which should be clearly displayed in the clinic and/or on the clinic webpage – should have a clear rationale of the clinic and patient management protocols which will enable students, clinic staff and particularly patients to have reassurance in the planned healthcare to be provided. This would be beneficial to avoid ambiguity in the management of the new clinic and would provide transparency for students, staff and patients.

Conditions

None reported.

viii. assessment methods are reliable and valid and provide a fair measure of students' achievement and progression for the relevant part of the programme.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

We were assured that University's assessment profile is fit for purpose and in accordance with their SRF. A wide range of assessment methods are used, which will enable the students' specific and transferable skills and knowledge to be obtained. External examiner reports, example assessment papers and moderated work have all been presented and demonstrate that expected standards for the sector have been reached. The University has a comprehensive and robust assessment policy in place to ensure assessment reliability and validity.

The assessments chosen within the programme provides assurance that MLOs and OPS are attained and align with those at other sector institutions. In our discussions, students confirmed that they were familiar with round-robin style assessments including peer feedback, but they could not recall structured formative assessments carried out under exam conditions and more significantly with individual tutor feedback.

Staff also confirmed that the round-robin questioning combined with peer feedback methodology was usually used. We heard from staff that recognised academic marking grids and rubrics were used and were shown examples of these. We were assured of due process being applied for marks at grade boundaries. Overall, we are assured by the documentary evidence which was further supported by our discussions with staff that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

The University should continue to monitor student feedback regarding the effectiveness of the current formative assessment procedures and if necessary, should consider implementing these under examination conditions, especially for practical modules. Alongside this, all formative feedback opportunities should be explicitly included in module guides, and students informed of the role and benefits of formative assessment within their learning. (1v, 1viii, 6iv)

Conditions

None reported.

ix. subject areas are delivered by educators with relevant and appropriate knowledge and expertise (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).

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Staff CVs provide reassurance that programme content is taught by appropriately qualified staff with teaching experience/certification, registered osteopaths and/or academically experienced as necessary for the specific module. In discussions, staff commented positively on the support they receive to attain academic qualifications (teaching certification or research) to support their skills and professional development. The rationale of the University's peer review policy is to foster a collaborative approach to professional development, and staff confirmed the merits of this approach in our meeting with them.

The University has as one of its four core priorities, a focus on 'research and knowledge exchange' and with this in mind, staff are encouraged and supported to undertake high level research and attain doctorates to support their teaching expertise.

A line management document was provided to demonstrate how the osteopathic staff are integrated into the School of Health Wellbeing and Social Science. In our discussions staff and students confirm their understanding of the roles and reporting lines of various personnel. The integration within the School of Health Wellbeing and Social Care substantiates the University’s aim to encourage knowledge exchange not only within the student body but staff too. In discussions with staff, we were assured that peer observations and mentoring was carried out for all new staff. Those who had been involved (as a mentor or a mentee), commented that it had made a positive impact on their teaching. Staff have access to the staff VLE 'Antler' to support their teaching and development of teaching skills.

Documentary evidence was provided to demonstrate that staff have the relevant knowledge, skills and certification to teach on the programme and in accordance with GOsC requirements and this was supported within discussions with staff. Therefore, we are assured that this standard has been met.

Strengths and good practice

The University actively supports all teaching staff in their professional development needs. The peer review rationale is considered to be a strength of the provision and is made possible by the location of the institution within the University itself as opposed to a remote site, and by the integration of osteopathic staff as a whole. The interprofessional collaboration planned within the new clinic facilities should build upon this and if managed appropriately, the MDT approach will filter into the student's clinical experience.

Areas for development and recommendations

None reported.

Conditions

None reported.

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x. there is an effective process in place for receiving, responding to and learning from student complaints.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

We were assured that the University has published complaints and whistleblowing policies, which can be found on the website, the SRF, the programme specification and in the student information handbook. In the meeting with students we were reassured that these policies were in place, and that they had been informed of them during their induction. They told us that they had not had necessity to use them, but would not feel apprehensive about doing so if necessary.

At the support staff meeting it was confirmed that staff were able to provide support to students wishing to complain if needed. The University tracks and reports on complaints as part of their annual reporting process, although to date, the programme has not had any recorded complaints.

Based on the evidence seen including in meetings with students and staff who demonstrated their knowledge of the complaints procedures, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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xi. there is an effective process in place for students to make academic appeals.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

We were assured that the University has in place an academic appeals policy and procedure which can be found on the website, the SRF programme specification and in the student information handbook. The policy is in line with education sector expectations.

Students attending the meeting were aware of an appeals process, those in the lower years less so, but none had had recourse to utilise it. One student commented positively on using the EC procedure.

Visitors were provided with documentary evidence of the procedure, and our discussion with students verified that they were aware of the procedure. Overall, we were assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

2. Programme governance, leadership and management

i. they effectively implement effective governance mechanisms that ensure compliance with all legal, regulatory and educational requirements, including policies for safeguarding, with clear lines of responsibility and accountability. This should include effective risk management and governance, information governance and GDPR requirements and equality, diversity and inclusion governance and governance over the design, delivery and award of qualifications.

☐ **MET**

☒ **NOT MET**

Findings and evidence to support this

The University has a well understood governance and management structure with effective lines of reporting, accountability and monitoring passing between the Board of Governors, the Senate and deliberative committees, the senior management team and the programme management overseeing the osteopathic programme. Independent audit reports confirm that there is an adequate and effective framework for risk management, governance and internal control.

Minutes of deliberative committee meetings of the Senate provide evidence that aspects of programme performance and development are considered and that policies are reviewed. The arrangements in place are sufficient to ensure that for the osteopathy programme, compliance with policies is effectively monitored and that the management is held to account. Updated policies, for example the assessment policy are presented by the policy owner to the teaching and learning committee who engages in scrutiny before the policy is confirmed and approved for dissemination. The minutes of the teaching and learning committee are presented to Senate by the Chair and members have the opportunity to discuss policy introduction or amendments further. Senate minutes are presented to the University Board of Governors.

In meetings with the University SMT, including the Vice-Chancellor, they explained the model of oversight. The Senate has established two oversight committees to facilitate scrutiny of the University's academic activities. The academic planning partnership committee oversees all aspects of new programme development and partnerships with external organisations. The teaching and learning quality committee considers reports and data prepared by academic senior managers related to individual programme performance and development plans. The reports prepared by programme senior managers highlight issues arising out of both regular and annual programme evaluation and includes progression and achievement data, External Examiner reports and NSS data and associated development plans. Development plans arising from programme annual reports, External Examiners reports and NSS data are monitored for implementation. The teaching and learning committee has a standing item on the agenda for PSRB issues to be discussed. Annual reports, including those prepared for GOsC are scrutinised before submission. Data is also considered on staff professional development including the completion of individual staff PDRs, staff research activity and publications. Minutes from the SEC are also considered by the teaching and learning committee. Actions arising are recorded in minutes and progress is tracked between meetings. Summaries of complaints and academic appeals are considered.

The Dean of School of Health meets regularly with the Programme Lead who in turn meets with the teaching team every one to two weeks. Teaching staff described the meeting as an effective way for senior staff to hear about programme delivery-related issues and for senior staff to update about University initiatives.

The University has a policy on GDPR and an information technology policy that are easily found and seem fit for purpose. Under the GDPR, medical records are classed as sensitive and as such require a greater degree of care when being handled. The information technology policy reflects this by making suggestions on how this should be handled. The visitors identified a concern that patient consent forms did not inform them that their records were accessible to staff working in other non-statutory regulated professional practice

clinics and that students used their own IT equipment both on and off site to access the patient records system.

Further documentation was requested such as the consent form signed by patients and the privacy notice used. A meeting was requested with the Programme Lead, Dean of School and two other members of the osteopathy department. They clarified that the psychotherapy and counselling students had their own standalone Cliniko programme which no one else could access. This had been specifically requested by the programme staff when setting up the course due to the nature of information shared with their therapist.

The team reported that they were aware that students from the sports therapy and rehabilitation programmes could access osteopathic clinical records. However, they stated that training is provided to students which discouraged them from accessing notes that are not their own patients notes. They said the situation had arisen as the original osteopathy clinic was housed in the sports facilities with sport therapy and rehabilitation.

The team stated that students using their own devices to access patients records both on and off site did not in their opinion pose any additional risk than was posed by any other osteopath using the same software. They reported that some mitigation takes place in that two-factor authentication is active on the software which provides some assurance. The team confirmed that students are not supplied with access to VPN or virus software. No data breeches have been reported regarding these issues.

They confirmed that student data is not allowed to be accessed off site by staff and could only be accessed when connected to the University network as the information is sensitive. There were, in the opinion of the visiting team, a number of issues with the way patient data is handled at the University. The first is regarding consent. The consent form nor the privacy policy do not inform patients that their clinical records may be seen by students on the BSc sports therapy and rehabilitation courses.

The second is that sports rehabilitation and therapy do not have statutory regulation. There is a system of voluntary regulation which does provide some reassurance. However, neither the visiting team nor the osteopathic team members have any oversight of the professionalism training undertaken on the sports therapy and rehabilitation courses and thus cannot provide any assurance that patient data is handled in an appropriate manner.

The use of the students' own IT poses a number of risks that are not being mitigated. The first is that there is no requirement for them to have virus software, the second is that there is no obligation for them to have a VPN to protect data whilst on public or Wi-Fi networks in shared housing. It also runs contrary to their own policies on data protection such as their IT code of practice which discourages the use of personal IT equipment as they could be infected by malicious software and that they recommend using a Marjon device and VPN when accessing confidential data off site.

Under the GDPR, medical records are classed as sensitive and as such require a greater degree of care when being handled. Staff are not permitted to access student data off site as it is considered sensitive. The same should apply to patient data.

We felt some reassurance after having met with the above representatives that this issue is being talked about and that staff and management felt the software in use did not meet their needs. However, we did not feel that it was a high enough priority for the university given the risks associated with it. This process needs to be expedited and patients need to be fully informed about who has access to their notes whether they are actually accessed or not.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

The University must immediately update their consent forms and privacy policy to ensure patients are fully aware of who can access their clinical information. (2i, 9vi)

In order to effectively manage the risk to patient data, the University must carry out an urgent review of the risks associated with the use of students' own IT equipment to access and record patient data both on site and off site as well as the risks associated with allowing students from other programmes access to osteopathic patient records. This should be done in conjunction with staff at the university who have expertise in IT and data protection. The University must develop and carry out a plan to implement the recommendations from the review. (2i, 9vi)

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ii. have in place and implement fair, effective and transparent fitness to practice procedures to address concerns about student conduct which might compromise public or patient safety, or call into question their ability to deliver the Osteopathic Practice Standards.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The University's general FtP policy focusses on supporting students before leading to steps intended to lead to a break or withdrawal from study. For osteopathy students, this process subsumes FtP requirements that reflect GOsC guidelines.

The FtP policy is published with other HE policies on the University website. Information about FtP is included in programme handbooks. Students and staff confirmed that they were aware of the policy and where they could find information. Students confirmed that information about FtP had been explained during programme and clinic inductions. No cases had been brought under the terms of the policy for the osteopathy programme.

We are confident that the University has in place, and implements fair, effective and transparent FtP procedures, and therefore are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iii. there are accessible and effective channels in place to enable concerns and complaints to be raised and acted upon.

☒ MET

☐ NOT MET

Findings and evidence to support this

The University's policy to deal with complaints is widely publicised to students, patients and staff through programme handbooks, the University website and clinic posters. In meetings with students, patients and staff, the visitors heard that there was good awareness of the policy and how they could raise an issue of concern. Staff and students emphasised the importance of direct communication in informal settings to resolve concerns and how this had been effective in resolving issues quickly.

The policy sets out the stages for dealing with a complaint beginning with an initial informal approach to a member of staff (or line manager if more appropriate), before embarking on formal procedures. Data on complaints is collated centrally by the Head of Quality and reported to the teaching and learning quality committee of the Senate. Data on complaints is also reflected upon during annual programme monitoring and in the annual report to GOsC.

The complaints policy sets out the process for escalating of concerns to GOsC and the Office of the Independent Arbitrator where individuals are dissatisfied by the outcome of their complaint.

Where issues arise involving a staff complaint the process is similar but managed by the human resources staff. There is a staff grievance procedure in place. Staff met by visitors indicated that they would prefer to adopt informal channels initially before following the formal procedure if a resolution could not be found.

There are arrangements in place to provide accessible and effective channels to enable concerns and complaints to be raised and acted upon by the University. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. the culture is one where it is safe for students, staff and patients to speak up about unacceptable and inappropriate behaviour, including bullying, (recognising that this may be more difficult for people who are being bullied or harassed or for people who have suffered a disadvantage due to a particular protected characteristic and that different avenues may need to be provided for different people to enable them to feel safe). External avenues of support and advice and for raising concerns should be signposted. For example, the General Osteopathic Council, Protect: a speaking up charity operating across the UK, the National Guardian in England, or resources for speaking up in Wales, resources for speaking up in Scotland, resources in Northern Ireland.

☒ MET

☐ NOT MET

Findings and evidence to support this

Information published on the public website and in programme handbooks indicates that the University seeks to promote a culture of openness and transparency. Minutes of the governing body and deliberative committees are routinely published on the website. A student and staff member are represented on the governing body.

The University has published policies on the website concerning the approaches to anti-bullying, harassment and whistleblowing, together with associated procedures. Relevant external sources of support are signposted in these policies. For example, the policy states that the complainant has the right to be accompanied by a friend, colleague or a trade union representative. The GOsC is also identified as an additional avenue for support.

Information about accessing policies is included in programme handbooks on the staff intranet and on the University web pages. The staff and student inductions provide information and signposting on these policies.

Meetings with staff, students and patients confirmed awareness on how to report formal concerns. In these meetings it was confirmed that wherever possible there was a preference to use informal approaches to quickly resolve issues, but also an understanding that the policies would be used for some issues. Students and patients confirmed that staff were approachable and that informal discussions could take place in public areas such as the clinic, or privately as appropriate. Staff provided confirmation that they intended to be available to meet students informally with a view to speedy resolution of difficulties and were aware that for some issues a referral would be necessary. Patients stated that they felt able to raise issues directly with a student treating them or with clinic staff.

The culture at the University is one where it is safe for students, staff and patients to speak up about unacceptable and inappropriate behaviour, including bullying. External avenues of support and advice and for raising concerns are effectively signposted. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. the culture is such that staff and students who make mistakes or who do not know how to approach a particular situation appropriately are welcomed, encouraged and supported to speak up and to seek advice.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The University promotes an open and supportive environment that aims to empower students, staff and patients to promptly raise issues and to check for understanding regardless of the issue being experienced.

Students were familiar with who they should contact to deal with a range of issues, beginning with the personal mentor where appropriate to signpost students to a range of services to support. This might include

student services such as counselling, financial advice or learning support. Students were clear that they could access sources of advice and support independently. Relationships between students and clinic tutors are close and students are encouraged to reflect upon their experiences with patients, their tutor and peers in group settings. Students confirmed that teaching staff were supportive and available.

Students also have an opportunity to raise concerns through the SVP, attended by the senior management staff and staff from student support, including the library. Students are also represented on the governing body.

The culture of the University is open and supportive of both students and staff. Staff and students were clear that they knew who to approach and were encouraged and supported to speak up and to seek advice where appropriate. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

vi. systems are in place to provide assurance, with supporting evidence, that students have fully demonstrated learning outcomes.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Robust QA processes are in place overseen by the University Head of Quality. Externality provides a further degree of assurance in the form of the role of the External Examiner and involvement of external panel members at validations. The External Examiner's reports are positive and no issues or concerns have been raised about academic standards or the quality of assessment practice. The programme Examination Board provides the formal forum for staff delivering the programme to review assessment in terms of achievement of the programme and module learning outcomes. The External Examiner is present to provide feedback on their sampling of assessments and oversight of the process. Appropriate records are maintained about the outcome of module assessment, completion of levels of study and awards.

The programme regulations confirm that all learning outcomes for each module must be assessed and passed in order to complete the module. The External Examiner's report confirms that this requirement is met. Similarly, the programme regulations specify that all modules must be passed in order to complete the programme successfully. The External Examiner's report confirms that this requirement has been met.

The assessment strategy for learning outcomes is set out in the module guides. These articulate clearly with the programme specification which in turn maps to the professional education standards. Assessment instruments are developed internally and subject to process of internal moderation before being forwarded to the External Examiner for comment. Marking criteria are set out clearly in assessment rubrics seen on the Turnitin platform used for assignment submission and assessment by staff. A University grading matrix has

been developed and shared with students. Staff described approaches to contextualising the University grading criteria to relate more closely to the assessment. This work was informed by the External Examiner's feedback. This developing area of good practice assessment will be shared and developed as part of forthcoming staff development.

Examples of assessed work was made available to the visiting team. They were assured that assessment feedback related to the learning outcomes and was informed by the University grading criteria. The assessment briefs were clearly written and there was evidence that internal moderation had taken place. Students confirmed that they were clear about the assessment process and that the assessment clearly explained the grade awarded and what areas should be addressed in subsequent work.

Written work is internally moderated and the outcomes recorded, to be scrutinised by the External Examiner. The policy requires a reconsideration of marks where they differ between those marked by more than an indicated threshold. The sample size for moderation may include a relatively high proportion of marked work as is typical for a small cohort size. All referred work is reviewed along with pieces of work at grade boundaries. Practical work is moderated by a process of second marking of students. There is provision for the External Examiner to become involved if assessors and moderators are unable to reach an agreement.

External Examiner reports consistently confirm that students have demonstrated the required learning outcomes and they confirm that staff marking and feedback practices are robustly and consistently applied.

Module and programme results are monitored and confirmed at the Examination Board, with the External Examiner present together with staff responsible for assessment.

The University has effective systems in place, including External Examiner reports, to provide assurance that students have fully demonstrated learning outcomes. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

3. Learning Culture

i. there is a caring and compassionate culture within the institution that places emphasis on the safety and wellbeing of students, patients, educators and staff, and embodies the Osteopathic Practice Standards.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The University has confirmed that students are at the centre of their purpose, and they have a clearly defined set of values which are: humanity, curiosity, ambition and independence. These values can be seen to be reinforced on the website, via posters throughout the site and also in discussions in staff meetings. In discussions with the SMT and staff, it was made clear that the teaching and learning culture was one of support, compassion and empathy and that students, whilst being positively challenged to achieve programme and professional expectations, are concurrently provided with support to address any learning needs.

Posters and slogans are found all around the University to spur on constructive academic and personal development. However, the osteopathic clinic and classrooms walls appear to be scant on similar posters which could reinforce the OPS and other professional attitudes, values and expectations - only one set of OPS literature was observed in the clinic tutor room. Students confirmed that they were introduced to the professional expectations of the OPS at induction, and that these were reinforced throughout their learning journey.

We were assured that a raft of policies, procedures and services exist to ensure, support and enhance the experience of all students and staff. These include safeguarding, disability and inclusion, diversity, academic advice, student funding advice, FtP policy, health and safety policy, mental health wellbeing policy and strategy, Prevent policy, extensive counselling services, the Chaplaincy centre and an on-campus nursery

We were informed in discussions with staff that they are given training in all relevant policies at induction and these are revisited at intervals during their employment. The mission and vision statements within the strategic plan 'Marjon 2030', reinforces the University's commitment to adopting a caring and compassionate learning culture.

Our discussions with staff and students confirmed that the university adopts a caring supportive, nurturing and inclusive culture in which staff and students can safely work and learn.

We were assured from observations of the learning environment, and by positive statements from staff and students regarding the institution’s approach in its learning culture, that this standard has been met

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. they cultivate and maintain a culture of openness, candour, inclusion and mutual respect between staff, students and patients.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The University has a number of relevant guidelines in place to ensure that the behaviour of staff and students is within acceptable parameters. The SRF, FtP and student misconduct procedures clearly explain the expectations. It is available in hardcopy or online. Lesson and clinic observations and the meeting with patients conducted at the visit lay testament to the mutual respect that staff, students and patients have for each other. Patients commentated positively on the openness and approachability of their student osteopaths, and without exception they all felt their healthcare concerns were dealt with honesty and openness, which they expressed as refreshing.

Students confirmed a supportive and caring approach within the institution and went on to emphasise that they were happy with the friendly, easy, approachable attitude they had with tutors. The annual quality report places emphasis on equality, courtesy and respect towards all, and this approach was apparent in the meetings held and interactions observed. The University has an aim to integrate students from all cultures and social backgrounds, and whilst this is a commendable aspiration, they should reflect on their programme web page to ensure that it too fulfils the University's aim.

All individuals that the visiting team engaged with – students, staff and patients – commented positively on the welcoming, open nature of the institution. With patients especially, being complementary and supportive of the treatment received within the clinic. During our discussions with students, we were assured that they were fully aware of their responsibility under their Duty of Candour. Overall, we were assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iii. the learning culture is fair, impartial, inclusive and transparent, and is based upon the principles of equality and diversity (including universal awareness of inclusion, reasonable adjustments and anticipating the needs of diverse individuals). It must meet the requirements of all relevant legislation and must be supportive and welcoming.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

We heard that the University's learning culture is fair and impartial; students, staff and patients feel comfortable in their experiences with others. The annual equality report confirms that the University's

commitment to a diverse and equal community, respectful of, and valuing others and encouraging personal development. The EDIC is responsible for ensuring that the University's EDI strategy is implemented and that it complies with all required legislation and monitors all data on an annual basis, the outcomes of which are reported in the annual equality report.

Students informed us that they have the opportunity within the SVP to address concerns. However, the osteopathic students also acknowledged that as a group they do not interact as much with these groups as they could. Student support services confirm that reasonable adjustments can be made for any student should they need it, however this has not been necessary for osteopathic students to date. They also commented positively on the autonomous and mature nature of the osteopathic students in general.

Students confirmed that they all had a personal development tutor. However, some said they had not met with them throughout their learning journey and others mentioned that the quality of help and support they received from the PDTs varied depending on the tutor assigned to them. Most were not fully aware of what areas they could approach their PDT about. Staff training documents showed that two staff members do not appear to have completed their annual training programme. Discussions with SMT confirmed that this was an issue but in discussions with staff, it was confirmed that the institution was doing everything possible to support them in completing the annual training..

Observations of the institution and discussions with staff and students confirm that the institution places a strong emphasis on creating an equal, inclusive and nurturing environment, which enables students and staff to achieve their potential. We are assured that overall, this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

Students commented that the support provided by a personal development tutors could be inconsistent and dependent on who they were assigned to. Therefore, the University should ensure that the training and support which is provided for this role enables students and staff to appreciate of the remits of the role, including a practical knowledge of the scope of support available, commitment to a minimum number of diarised meeting opportunities (taking into account tutor availability), and a review process which ensures consistent and equitable support for all students.

Conditions

None reported.

iv. processes are in place to identify and respond to issues that may affect the safety, accessibility or quality of the learning environment, and to reflect on and learn from things that go wrong.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The SVP provides a formal route for students to raise concerns; these are held once per semester. During discussions with visitors, students confirmed that they felt confidence in being able to speak directly with tutors or programme leaders about any concerns. They emphasised that there was a culture of mutual respect and care which was apparent throughout the University. They felt that their opinions were valued and acted upon rapidly. Staff confirmed that despite having lecturers who had graduated from other OEIs, there

was a ‘Marjon’ approach within the teaching team, which emphasised the supportive cultural nature of the institution, and especially in practical tutoring. All staff were familiar with this approach and had mentors to support them in their early days as a new staff member.

During discussions with patients, they confirmed that they were easily able to voice concerns verbally to their practitioner or tutors on the day. However, they were unaware of a formal process for reporting this. They were also not aware of an explicit complaints section within the online form, accessed via the QR code.

The institution has a variety of policies and processes available through student services – both academic and pastoral, including disability and inclusivity, counselling, safeguarding, chaplaincy and mental health support and our discussions with support staff confirmed the easy access available for students needing any of these. Support staff also confirmed that access was anonymously audited in order to ensure the service provided was fit for purpose.

Staff confirmed in our meeting with them available training in Prevent, EDI and health and safety policies. The website also lists all policies and procedures. The programme team and PL confirmed that staff reflected on the previous years teaching and learning during their SOE day and that recommendations were acted upon. Based on the evidence seen and discussions held, we are assured that this standard has been met.

Strengths and good practice

The supportive and compassionate culture inherent and strongly focussed upon within the University is a strength and this creates a safe space for quality learning.

Areas for development and recommendations

The University should ensure that procedures for complaints are explicit and easily accessible both in hard copy at clinic and online for the Clinic patients. Similarly, there should be information posters within the clinic areas to remind patients (and others) of the University's culture of mutual respect, and its response to unacceptable behaviours towards students, clinical staff or other service users.

Conditions

None reported.

v. students are supported to develop as learners and as professionals during their education.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Our discussions with students and staff confirmed that the OPS are introduced during induction and are consistently revisited throughout various touch points of the programme, including their personal and professional development modules, the module guides, links to the GOsC within the student handbook or in the appropriate pages of Canvas. They were also expected to reference the OPS within their reflective assessments.

Clinic staff also confirmed their consistent reference to OPS within the clinical teaching sessions. Overall, the curriculum demonstrates a logical progression which supports and positively challenges learning through to level 7. This affords assurance that students will develop as learners and professionals during their education. We are therefore confident that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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vi. they promote a culture of lifelong learning in practice for students and staff, encouraging learning from each other, and ensuring that there is a right to challenge safely, and without recourse.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Staff confirmed the University's commitment and support for them to undertake further academic qualifications, and this aligns with their core priority of research and knowledge exchange. Staff confirmed during our discussions that this value applied not only to the learning environment for students but also in the teaching support given to staff. They appreciated the ongoing support provided by the university.

Classroom observations and further discussions with students in the clinic confirmed that peer group learning and feedback is an integral pedagogic approach used by the University. First year students were observed in an interactive and innovative lesson, presenting topics to their peers, there was scope to safely challenge and receive immediate feedback.

Following our discussions with staff, students and support staff, we are confident that this standard has been met.

Strengths and good practice

The introduction of the individual student's presentations, observed during the first year teaching session, at an early point of the programme is an example of good practice, enabling a sense of ownership in their exchange of knowledge and building self-confidence.

Areas for development and recommendations

None reported.

Conditions

None reported.

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4. Quality evaluation, review and assurance

i. effective mechanisms are in place for the monitoring and review of the programme, to include information regarding student performance and progression (and information about protected characteristics), as part of a cycle of quality review.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The University has put in place effective programme monitoring and review mechanisms. The Programme Lead is responsible for completing evaluations at an operational level and responding to feedback from teachers and students.

The annual evaluation cycle begins with the gathering of module feedback and information from the Board of Examiners, including student outcomes and progression data. The feedback from the External Examiner is also considered. The evaluation document is shared for consideration by the Dean of School or nominee. The programme evaluation document is considered by a deliberative committee, the teaching and learning quality committee of the University Senate. The report and accompanying development plan are confirmed prior to implementation. The development plan arising from specific feedback from the External Examiner's Annual Report and from the NSS is also considered and approved. The evaluation process informs the drafting of the annual report to the GOsC.

Data relating to protected characteristics is gathered, anonymised, collated, reported, and reviewed at programme level and University level. This data is reflected upon during the annual evaluation cycle at programme level and contributes to the annual reporting to the GOsC.

The University publishes a comprehensive equality and diversity report each year, including commentary on progress against external benchmarks and internal targets. The report monitors equality and diversity for both staff and students.

There are effective mechanisms in place for the monitoring and review of key aspects of the programme, to include information regarding student performance and progression. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. external expertise is used within the quality review of osteopathic pre-registration programmes.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The External Examiner process provides a valuable external reference to assure the University that academic standards are being met and that assessment QA processes are effectively operated. A single External Examiner is appointed for the programme. In their annual report they commented on the appropriateness of standards, both academic and professional. The reports scrutinised confirm that assessment practices are robust and fairly applied. By sampling assessment marking and records of moderation of marks, they are able to confirm the effectiveness of processes. External Examiners have access to all assessments and marks awarded through access to the VLE, Canvas. Reports arising from this scrutiny include commendations and suggestions for development and are overwhelmingly positive in their feedback. External Examiner reports are responded to by the Programme Lead and the progress made in addressing developments required is considered in the subsequent report. Scrutiny of the reports demonstrates that they are responded to in detail by the course team in accordance with the University procedures.

The University reviews External Examiner's reports across the institution to identify any themes for good practice or areas for development that can inform the planning for cross-college staff development.

The University uses external expertise within the quality review of the osteopathic programmes under review. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The management structure diagrams and committee structure terms of reference provided outline the University's line management and the committee structures and indicate that the reporting lines offer effective oversight.

University policies, including the academic framework, are available to staff, students and the External Examiner on the public website. Policies clearly define the ownership together with a record of review and approval. The student handbook provides information about policies including those related to assessment. Links in the handbook provide access to policies published on the website and serve to ensure consistency of published information.

There is good evidence of an effective management structure, and that relevant and appropriate policies and procedures are in place and are reviewed regularly to ensure they are kept up to date. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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iv. they demonstrate an ability to embrace and implement innovation in osteopathic practice and education, where appropriate.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Opportunities for educators to innovate in professional practice is encouraged by the University. The visitors heard that there are opportunities provided in the osteopathy department in a range of informal and formal settings. Staff have opportunities to discuss individual practice as part of the peer observation process. Innovative practice may be observed in theory, practical and clinical settings. Senior managers identified the interdisciplinary working policy as providing good opportunities to share effective learning and teaching strategies.

The osteopathy team meets regularly with the Programme Lead to discuss the delivery of the osteopathic programme. This provides good opportunities for staff to informally share information about new strategies for supporting effective learning. Formal staff development days have provided good opportunities to showcase examples of innovative professional practice from those present. Teaching staff shared with the visitors, examples of good practice shared at formal staff development days and they confirmed that they valued them. For example, staff described sharing of approaches to teaching of osteopathic techniques and the creation of interactive resources. Formal and informal sharing opportunities have enabled staff to share different approaches to developing osteopathic skills developed as a result of different professional routes into teaching. Students confirmed that they valued the range of experiences the staff brought to the programme and the insight specialisation brings to practice.

It is clear that staff demonstrate an ability to embrace and implement innovation in osteopathic practice and education and to share information with colleagues. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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5. Resources

i. they provide adequate, accessible and sufficient resources across all aspects of the programme, including clinical provision, to ensure that all learning outcomes are delivered effectively and efficiently.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The osteopathic medicine programme benefits from support from the University's onsite library. The library provides access to private and group study spaces arranged over three levels with areas zoned for quiet study. The book stock most relevant to the osteopathy programme is arranged on the second floor. Breakout rooms and group teaching areas are available on the ground floor. A help desk provides students with access to support from a professional librarian and an issue desk and self-service point enables students to borrow items. The University does not operate a 'subject librarian' system. Following adjustments made following student consultation, the library is open 24 hours a day, 7 days a week, to accommodate students with different working patterns. The professional services team operates within core hours, and the estates security staff manage access to the library outside of these hours. In meetings with students, they confirmed that the new arrangements met their requirements.

Library services are available online to students and staff 24 hours a day via a web-based portal. Electronic sources including e-books and journals are linked directly to module guide reading lists. The number of simultaneous users may be limited, dependent upon individual publishers' licence terms and conditions.

The library offers an extensive collection of books, e-books and journals. It offers access to relevant online databases such as Medline and Sport Discuss. A collection development policy is in place, setting out the strategy for the purchase of new resources to support University programmes. Professional librarians meet with subject specialists annually to review module reading lists and to identify additional resources that may be required. In meetings with teachers and students, the process of review and enhancement of subject-specific resources was considered to be effective. A further process was also available for individual staff and students to propose acquisitions for consideration within the terms of the collection development policy.

The library offers a comprehensive programme of support for study and academic skills development. This service is branded under the acronym 'AIM', standing for 'Acquire', 'Improve' and 'Master'. The programme sets out to develop study and academic skills such as critical reading, thinking skills and the use of AI in assessment. Group sessions are offered on a rolling basis throughout the academic year. Sessions are recorded and made available to students unable to attend in person. The AIM programme is advertised on the student portal where individual sessions may be booked. On occasion, sessions may be tailored to meet the needs of particular groups of students. The library offers scheduled 'drop-in' academic and study skills sessions for students who reported in meetings with visitors that it was a was a valued and useful service. Library staff attend programme voice panels and the student experience committee to collect feedback on services and proposals for enhancement.

The library provides a base for specialist one to one study skills provision for students with learning disabilities. The services are provided in small study rooms. A drop-in service is offered two days per week for students self-referring for screening for specialist assessment, those with new disability disclosure or identification and needing support with application processes for the Disabled Student Allowance. Staff delivering the support have specialist qualifications at an appropriate level. For example, staff delivering study skills for students with autistic spectrum issues are qualified at level 7 and those supporting dyslexia and co-occurring conditions such as dysgraphia have qualifications at level 5.

Library staff, including specialist study skills tutors, provide inductions for students at the beginning of each of the study levels. The 'study essentials' welcome event is a mandatory session for all first-year students. The programme introduces student support services including the development of independent study skills. For second-year students the focus is on information skills and academic skills. A tailored provision is delivered for late enrolling students. An induction programme is provided for new staff and refresher input for existing staff. There is a focus on reading list development and it is mandatory for new staff to complete the induction programme for new staff within one month of starting their employment. In meetings with students and staff, the visiting team were assured by the value of the induction to the library services.

Student support services, including counselling, financial advice and support for the use of appliances and adaptations provided for students with disabilities operates from a student facing 'welcome desk' single point of contact in the 'student life hub'. Staff providing counselling services are accredited by BCAP.

Programme handbooks for the osteopathic medicine programme comprehensively outline the various support services and opening times.

The osteopathy programme and the associated clinic is managed on a day-to-day basis by the Programme Lead who also manages clinic-only professionals and support staff. A newly appointed Associate Dean is responsible for the line management of the academic staff delivering the programme. Most teachers work both in the Clinic and in academic settings, providing good opportunities to link academic and clinical teaching aspects. All teachers are registered with GOsC and are practitioners. Teachers are drawn from a range of OEIs. Staff and students gave examples of how the learning experience was enhanced by the range of experience brought by academic osteopaths delivering the programme.

Academic development mentors are responsible for the academic and pastoral care of their designated students. They meet students periodically and seek to signpost students to a range of relevant University services and support. An 'open door' policy to supporting students was described by managers and was confirmed as beneficial in meetings with staff and students. This served to enhance informal channels of communication between managers, teachers and students. Students spoke positively about the approachability of staff and were able to give examples where steps had been taken to address concerns and issues.

The osteopathy department has access to teaching rooms of various sizes, with practical rooms furnished with plinths, interactive white boards and video recording facilities. The rooms are allocated using the University's central allocation services and are shared with other professional programmes. For existing cohort sizes there is sufficient space for theory and practical teaching

A good range of specialist anatomical models, skeletons and posters are available to support learning and teaching.

The onsite osteopathy clinic is well equipped and has eight newly fitted treatment rooms. Each treatment room contains a plinth, a desk and at least one chair. Each room is separated from the corridor by a curtain. The rooms allow sufficient space for at least two observers. Adjacent accommodation provides a tutorial and changing room with a reception desk in close proximity. Unoccupied treatment rooms may be used too for individual tutorials.

Students have access to a portal hub called 'MyMarjon' and access to the VLE, Canvas, is provided securely. The VLE provides access to essential course information including the programme handbook and is used by students for coursework submission and the similarity detection software, Turnitin is used to detect possible plagiarism.

During the visit, the Canvas was demonstrated by a course team member. The resource demonstrated was clearly laid out and provided access to programme information and module guides including assessments and grading descriptors. The VLE also provided a portal to enable students to upload assignments via a link to the similarity software 'Turnitin'. A feature for uploading lecture videos is available. Students and staff were able to provide instances where the resources published on Canvas were valuable and supported learning and programme organisation, for example key information such as assessments, e-books, handbooks, calendars, course material, reading lists, lecture notes, presentations and links to policies. In cases of planned student absence, students and staff confirmed that special arrangements can be made for lectures to be recorded and then viewed at a later date on this platform. Typically, lectures were expected to be delivered to students attending in person. Links are available in the programme handbook and in the VLE to the GOsC website where the Osteopathic Education Standards can be accessed.

The University provides adequate, accessible and sufficient resources across all aspects of the programme, including clinical provision, to ensure that all learning outcomes are delivered effectively and efficiently. Therefore, we are assured that this standard has been met.

Strengths and good practice

The extended opening hours of the library and library staff's highly proactive approach to engaging with students and staff is a strength which supports the students' needs, academic study skills development and enables them to become more autonomous in their learning. (5i, 6ii)

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. the staff-student ratio is sufficient to provide education and training that is safe, accessible and of the appropriate quality within the acquisition of practical osteopathic skills, and in the teaching clinic and other interactions with patients. ☒ **MET** ☐ **NOT MET**

Findings and evidence to support this

In accordance with the Benchmark Statement for Osteopathy (2019) and GOPRE requirements, the University maintain appropriate staff-student ratios to maintain effective and safe supervision in the clinical and classroom environments.

The University provides ratios of one tutor to 10 students in practical classes and one supervising tutor to six students in clinic, with one tutor to three students where they are actively engaged with patients. The published ratios were evidenced in the programme specification and the mapping to OPS and GOPRE and SET. Visitors observing lessons in classrooms and clinic settings confirmed that the ratios were maintained. The Programme Lead confirmed that a bank of sessional tutors was available. These tutors were prepared to cover sessions in periods of staff holiday or absence to ensure that the ratios are maintained. In exceptional cases, cover would be provided by the Programme Lead. Teaching staff confirmed that they understood that where necessary, substitute staff were available.

A review of staff with the Programme Lead and available CVs confirmed that the teachers are all trained and experienced osteopaths and bring experience from a range of UK osteopathic education institutes. Teachers

confirmed that there were good opportunities for learning and teaching to benefit from the range of experiences and approaches to osteopathic education brought by the team. Good opportunities were offered in a range of formal and informal settings to share ideas with colleagues.

Students confirmed that they had benefited from opportunities to be taught by staff with a range of different insights into treatment and this led to an enriched student experience. Students described in detail the high quality of support they received from staff at whatever level they were currently studying.

The Programme Lead and the academic team emphasised the importance of the relatively small cohort sizes in ensuring that there were good professional working relationships developed between both teachers and students. There were wide opportunities for informal communication to take place, for example small group discussions regularly took place in addition to regular scheduled supervision meetings.

Clinic-based students confirmed that they had good opportunities to treat a wide variety of patients of differing ages, gender and physiology types. Past graduates described some limitations in the range of patients they had had an opportunity to treat and expressed a wish that the programme had focussed more on rehabilitation protocols to prepare them for practice following graduation. The Programme Lead confirmed that some adjustments to the programme content with respect to rehabilitation had been included as part of the approval of the new programme.

The teaching observation carried out by osteopathic visitors confirmed that class activities were appropriate to the level and that learning outcomes were published for the lesson. Detailed lesson plans are not currently used. However, lesson summaries are made available to students and staff for each lesson through the VLE. There were examples observed of positive student engagement. There was good use made of specialist and general learning resources to support the lessons observed. The staff-student ratios quoted and observed provided by the University are sufficient to provide education and training that is safe, accessible and of the appropriate quality within the acquisition of practical osteopathic skills, and in the teaching clinic and other interactions with patients. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iii. 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.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

In meetings with specialist professional support staff and academic staff, we heard that effective exchange of information led to good support for individual and groups of students being delivered. Students were able to describe in detail the range of services available to support their learning. A 'welcome desk' offers students a single point of initial contact to enable them to access a range of specialist services including support for learning difficulties. Students were also aware of support available for students with physical and learning disabilities and could give appropriate examples. For example, they described arrangements for providing students with advance information prior to lectures and access to recordings.

Additional learning needs are generally disclosed by students at the admissions stage or during the induction process. Students confirmed that they have opportunities to make their needs known as part of the application process and during interview. On occasions, teachers may draw on their experience and training to become alert to students presenting in class or in written work with potential learning support needs. They may make an informal recommendation that contact is made with specialist support staff for further screening or assessment as necessary. Specialist support staff confirmed that they had undertaken assessments to identify learning disabilities for students already studying on the programme.

Specialist support staff are appropriately skilled to provide support for students with a range of learning disabilities. For example, level 7 trained specialist support teachers are available to facilitate necessary changes and adaptations for students and provide a programme of one-to-one sessions delivered to support conditions such as autistic spectrum issues. Level 5 trained staff are available to support students with dyslexia and other co-occurring disorders such as dysgraphia. In cases of a sensitive nature, the specialist support staff will discuss required adaptations on behalf of the student.

The specialist support staff attend programme voice panels and the University student experience committee to hear of concerns expressed by student representatives. An evaluation of support services is undertaken to identify areas for enhancement. Staff development has been provided for programme teachers to enable them to better understand the challenges faced by those with learning disabilities and to be aware of key indicators of challenges faced by some students when engaging with the programme.

The Programme Lead gave the example of where a student was unable to attend clinic on their specified time due to paid work schedules and an adjustment was agreed to enable required hours to be met.

The resources provided for students effectively take account of the diverse needs of students to support them in a range of practical and theory study settings. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. there is sufficient provision in the institution to account for the diverse needs of students, for example, there should be arrangements for mothers to express and ☒ **MET**

store breastmilk and space to pray in private areas and places for students to meet privately. ☐ NOT MET

Findings and evidence to support this

Students are made aware of additional facilities in their programme handbook and by participating in induction to the library and student support welcome desk. Osteopathic teachers are updated on changes to support services during professional development days, informally via the Programme Lead and staff delivering services.

When in clinic, unused rooms may be used by students and staff for discussion and practice activities. The library staff confirmed that a prayer room was available. Nursing mothers could easily be accommodated in private spaces should the need arise.

In addition to the dining areas and cafes at the University, there are a range of internal and external areas for students to socialise. For those interested in playing sport or physical activity, the University offers excellent sports facilities including playing fields, all weather pitches, swimming pool and fitness gym are available onsite.

There is sufficient provision to account for the diverse needs of students and overall, we are assured that this standard has been met

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. that buildings are accessible for patients, students and osteopaths. ☒ MET ☐ NOT MET

Findings and evidence to support this

The University is relatively easily accessed by car and public transport. Car parking is plentiful and secure with a designated parking areas for those with disabilities or those needing access to EV charging points. Students and patients are permitted to park onsite. Access into the teaching areas and the teaching clinic is via the main reception.

Students and staff receive a tour of the University facilities as part of their induction and site maps are posted throughout the campus.

Patients usually make their way independently to the dedicated clinic reception desk. The clinic reception is a student-led facility. Confirmation of initial appointment with the osteopathy clinic is made by email with guidance on their first visit and directions to the University.

Lifts are available for those unable to use stairs and all buildings have ramp options for wheelchair users. The clinic telephone number is given for those with mobility issues and for those who may need assistance from their car.

University buildings are accessible for patients, students and osteopaths. Overall, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

6. Students

i. are provided with clear and accurate information regarding the curriculum, approaches to teaching, learning and assessment and the policies and processes relevant to their programme.

☒ MET
☐ NOT MET

Findings and evidence to support this

There are a variety of methods by which students are provided with course information including Canvas, the programme handbook, student support inductions and University policy web pages. Evidence provided to support the OEIs assertions included the SRF and programme specification document (both of which are available to staff and students) and module guides. These all provide clear and accurate information regarding programme aims, the curriculum, teaching and learning approaches, learning and professional outcomes, and assessments.

The student clinical handbook provides all essential information regarding the clinical learning environment and expectations of professional behaviour are provided in the FtP policy. Students are directed to the available academic and personal support services on the VLE. Discussions with support staff confirm that they also provide any information requested in this area. Students confirmed their knowledge and ability to utilise these information sources, although not all access them regularly.

The VLE is well developed and provides support to the teaching and learning.

Student support services are able to offer adjustments to assessment to suit student's needs if necessary.

Documentary evidence to support this standard including module guides and programme specification is further supported by information provided on Canvas. All students and staff are fully aware of how to access this information. All the information provided is clear and concise. However, clarity within the module guides in terms of mapping of the MLOs to relevant OPS is inconsistent and requires finalisation. Overall, we are assured that this standard has been met.

Strengths and good practice

None identified.

Areas for development and recommendations

The University should ensure consistency by explicitly mapping MLOs to the OPS, the 'threads' and the four pillars, ensuring students can locate this and staff understand all and have embedded them into their teaching. The mapping should also be included in module guides to ensure mapping of OPS to MLOs can be consistently applied in all modules and so that students and other stakeholders are clear as to which educational and professional attributes each module enables acquisition of. (1vii, 6i)

Conditions

None reported.

ii. have access to effective support for their academic and welfare needs to support their development as autonomous reflective and caring Allied Health Professionals.

☒ MET
☐ NOT MET

Findings and evidence to support this

We were reassured that the student support services provide pastoral care and a range of services to support the students' welfare and academic needs including mental health wellbeing, student funding advice, a range of counselling services, a Chaplaincy centre, disability and inclusion advice and support. Student support services are introduced to students during programme induction and are available in the library.

As result of student feedback, the library now operates a 24/7 opening policy, which was instigated to support students with work or family commitments who were unable to use the facility during normal working hours. Students confirmed they were pleased with the University's response to this concern. Students mentioned that the effectiveness of PDTs as part of their programme, was inconsistent and could depend on the individual tutor assigned. Some senior students had not had many, if any, appointments with their PDT. Students expressed that the operation, role and scope of support offered by the PDT was not clear. The University has acknowledged that the PDT role is currently being adapted to support the osteopathic students.

Overall, our discussions provided reassurance that students' academic and welfare needs are supported sufficiently to allow them to become reflective and autonomous allied health professionals. Therefore, we are confident that this standard has been met.

Strengths and good practice

The extended opening hours of the library and library staff's highly proactive approach to engaging with students and staff is a strength which supports the students' needs, academic study skills development and enables them to become more autonomous in their learning. (5i, 6ii)

Areas for development and recommendations

None reported.

Conditions

None reported.

iii. have their diverse needs respected and taken into account across all aspects of the programme. (Consider the GOsC Guidance about the Management of Health and Disability).

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

We were informed during our meetings with SMT and other groups that it is an aspiration of the University to support diverse needs of students, and that the University welcomes students with disabilities and other health conditions. Discussions with student support services confirmed the University's commitment to providing a range of support mechanisms to facilitate this. The fitness to continue in study procedure details the University's support for students managing health issues. These are considered within the remits of current legislation. The osteopathy page on the website clearly states the University's approach.

Student support confirmed that, as yet no osteopathic student has required any additional support in this area. However, the policies and procedures which are in place mean that we are confident that students'

diverse needs can and will be met when necessary, and therefore we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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iv. receive regular and constructive feedback to support their progression through the programme, and to facilitate and encourage reflective practice.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The University has asserted that student feedback on their progression follows the University's normal protocols and provided evidence to demonstrate examples of written feedback given. The SRF outlines the process for receiving feedback. However, formative assessments tend to be run informally and feedback on them does not appear to be recorded. In practical classes, the use of round-robin teaching is frequently used, and peer feedback is the norm. This was also verified in discussions with staff.

Formative assessments under exam conditions do not appear to be held and there is no opportunity for students to receive constructive feedback on their performance from tutors who will be markers of the summative assessments. Students in the Clinic confirmed that at the end of each clinical session they were required to submit a reflection on their work during that session, including any tutor feedback. Once signed off by the tutor and submitted to their clinic log, these reflections could be accessed by the student for their learning purposes, but no changes could be made to the reflection itself.

Based on the evidence seen and discussions held, we are confident that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

The University should continue to monitor student feedback regarding the effectiveness of the current formative assessment procedures and if necessary, should consider implementing these under examination conditions, especially for practical modules. Alongside this, all formative feedback opportunities should be explicitly included in module guides, and students informed of the role and benefits of formative assessment within their learning. (1v, 1viii, 6iv)

Conditions

None reported.

v. have the opportunity to provide regular feedback on all aspects of their programme, and to respond effectively to this feedback.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The University employs a number of feedback routes for students to comment on the programme and these can be formal or informal including discussions with their PDT, or directly with other academic staff, or the PL, mid-module and end of Semester MEFs, SSLC, SEOP, SEC, the NSS, HEA Surveys and graduate outcome surveys. However, the University has recognised that student feedback within the osteopathy programme has been consistently low in the past two years. The reasons for this are unclear. The programme team have decided to emphasise programme-specific feedback. This has resulted in more meaningful feedback.

Students confirmed that they had experience of directly feeding back to the team and having their feedback addressed in a very timely fashion, in one case in advance of the next lecture for that module.

We were reassured that feedback obtained on the programme is listened to by the team and actioned if possible, therefore we are confident that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

vi. are supported and encouraged in having an active voice within the education provider.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The University places emphasis on students having an active voice within its operation, and to enable this there are a number of opportunities available for students to express their views through the QAF: student engagement and representation including PVP, SEC, SSLC, their PDT, discussions directly with academic staff, mid-module and end of semester evaluations.

Students confirmed their knowledge of these groups and committees and some testified to themselves or peers being members of these groups. They were able to confirm that issues raised at these meetings had been heard and acted upon, an example of which was the extension to 24/7 opening of the library.

Based on the evidence seen and discussions held, we are confident that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

7. Clinical experience

i. 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.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

There is a comprehensive student clinic handbook which sets out what is expected of students in the clinical environment. Clinic mentors and the Programme Lead confirmed that students receive training on the handbook as well as safeguarding, GDPR, complaints handling, FtP and their duty of candour before they enter the clinical environment each year. Induction agendas supplied to the visiting team demonstrate that students have timetabled induction sessions which include the running of the Clinic as well as safeguarding training.

The Clinic is said to be student led which means students take more responsibility for their patient, have responsibility for administration and for reception. They are also expected to contribute to the marketing of the Clinic. Tutors are advised that they should not treat patients unless they feel it is absolutely necessary. The team state that this allows students to become more autonomous and to use the skills they have rather than relying on tutors.

Whilst the principal method of achieving the required clinical hours is through the onsite Clinic, clinical scenarios are used widely in the osteopathic skills lectures to facilitate peer and group discussion around presentation, evaluation, diagnosis and treatment. This gives students an opportunity to discuss and approach clinical situations in a less pressurised environment where there are no expectations upon them from patients. These scenarios are also employed in Clinic if students are not seeing or observing patients.

There are no specialist clinics running. Students do see a wide range of patients and although paediatric patients are rare there is the expertise within the clinic team to be able to treat and manage them. If a paediatric patient needs an appointment they are booked in on the day when a clinic tutor who has the requisite experience is on duty and they take primary responsibility for the patient. This in effect acts as a demonstration clinic for the student so that they can observe and be involved with elements of the consultation.

Senior management and the osteopathic Programme Lead stated during the visit that the university offers opportunities to attend multi-disciplinary clinical placements. However, these ceased in 2020 due to the COVID-19 outbreak and are just now being reinstated. The first of these to be reinstated will be working with sports therapy in the chronic back pain service that is run from the University. This is timetabled to start in February 2025. Students act as observers' whist sports therapy provide exercises to those referred to the service. Osteopathic students get to interact with patients and those running the service but are not attending as osteopaths. The hours they attend these clinics do count towards their clinical hour's requirement. This provides students with a different perspective on healthcare provision that should be encouraged.

The visiting team were told of plans to move the osteopathy teaching rooms and clinic into a new building which is being developed. It is anticipated that osteopathy students will work and learn alongside physiotherapy, nursing, psychotherapy and counselling students. This is due to open in September 2025.

Students are further exposed to clinical scenarios in other classes such as osteopathic skills classes where clinical scenarios are used and discussed by the class. This allows them to explore more fully with their peers' differing perspectives and approaches further bolstering their professional identity development.

Students get the opportunity to observe more senior students with patients in clinic from year one; they do further observations in year 2 and start to interact with patients at the end of their second year. In Clinic they are allocated a patient list from that time. They may also observe other students if they do not have a patient and engage in discussions around written clinical scenarios with their peers and tutors if there are neither of the above.

The ability to observe students from other years, be involved in discussions with senior students and tutors and the opportunity to discuss clinical scenarios in other classes provide students with a good opportunity to identify with what it means to be an osteopath, professional behaviours and expectations, communication, dealing with patient expectation, record keeping, treatment and treatment planning. It allows them to practice and begin to integrate these necessary skills in a supported environment with real patients. Furthermore, being given responsibility for the administration, reception and contributing to the marketing of the Clinic gives an additional dimension to their training which might otherwise be dealt with in a less comprehensive manner.

Students are supervised by experienced osteopathic clinicians who also have qualifications and experience of osteopathic and more broadly in higher education. Students get the opportunity to work with a number of osteopaths with a range of experience and approaches. Affording students this variety of role model allows students to try out a number of ways of doing things. This allows them to form their own unique identity as osteopath. The variety of qualifications in osteopathy and education and the variety of experience provides assurance that students will receive a rounded clinical education from their educators.

The visiting team had the opportunity to speak with present students from a number of year groups and with past students of the course. Both groups felt that the clinical experience provided by the University does prepare them well for osteopathic practice. What was observed on site and in the evidence provided to the visiting team prior to the visit does in our opinion provide a suitably stimulating, nurturing and supportive environment to enable students to meet the outcomes set out in the GOPRE and SET. Therefore, we are confident that this standard has been met.

Strengths and good practice

Having a student led clinic where students are responsible for administration, reception and have input into the marketing of the clinic adds an additional dimension to their training, allowing these important aspects of practice to be taught and experienced in a more comprehensive manner.

Areas for development and recommendations

None reported.

Conditions

None reported.

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.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The course specification provided to the visiting team is the definitive document that details the programme outline, aims, learning outcomes, learning and teaching methods, modes of assessment, and work-based

learning (clinic) expectations and hours, academic progression, support, feedback and quality and enhancement.

The programme specification states that students are required to achieve 1000 clinical hours, and that each student needs to see 50 new patients over the four years of the course. This aligns with undergraduate osteopathic education expectations and norms for the sector and meets the requirements set out in the GOPRE and SET. This is mainly done by attending the onsite clinic, where students are supervised by experienced, registered osteopathic clinicians who also have experience and training in higher education.

Students are gradually exposed to patients throughout the four years of the course. Their clinical hours are allocated in the following way: 20 hours observation in year one, 80 hours observation from September to June in year two followed by 150 clinical hours in the summer holiday in June and July. They then do 450 hours clinical practice in year three, and 300 hours in year four. It is stated in the course handbook that this is designed to develop the student from novice to autonomous practitioner.

Students confirmed that they are primarily responsible for maintaining a log of their clinical hours, patient numbers, types of presentation and patient characteristics which are set out in the portfolio. This information is kept in their module portfolio. They are also required to undertake a reflective activity in the portfolio after each clinical experience. Clinical tutors monitor the portfolio during their supervision periods when students are seeing patients and sign off on the hours recorded. If students are not deemed to be seeing the requisite number or variety of patients then steps are taken to address this by funnelling patients to the student who is deemed to be in need. The portfolio is submitted to the Programme Lead at the end of each academic year for further checking.

If students miss clinic time, they are required to make it up by attending clinic at other times when they are not timetabled to have a lesson such as during holiday periods. Given the small cohort sizes of approximately 15 students per year group this is a pragmatic and low-tech way of managing a complex issue.

The student handbook states that the Clinic is student led. What this means is that students are responsible for all aspects of the running of the Clinic, including reception and administration as well as marketing. Students are rostered onto reception in their clinical time if they do not have patients booked in to that slot. They are responsible for answering the phone, responding to emails, booking and rebooking patients.

Each student who is allocated to see patients on a given day is assigned a patient list. Students who do not have a patient at a given time or those assigned to observe, attach themselves to a student practitioner and observe them whilst they undertake the consultation. If there are no patients allocated to them, or they are not in clinic students are expected to work through clinical scenarios which they can discuss with their clinic tutors.

Past and present students state feeling supported in the clinical environment through every aspect of the patient encounter and are afforded the freedom to do things in their own way within boundary norms for the profession monitored by their clinical supervisors.

Patient list numbers in the clinic software were consulted going back over the last year. It appeared that there are sufficient numbers of patients to meet student needs. Marketing of the Clinic is done in cooperation with the marketing department. Students are expected to assist with the marketing of the Clinic, and they confirm they do discuss this with their clinic tutors and do some low-level word of mouth marketing. Students state that they are happy with the number of patients that they are seeing in clinic. They state that they get to see a range of patients but that it is weighted towards other students. The patient group that the visiting team met with primarily consisted of older patients who stated that they primarily heard about the Clinic through

word of mouth which is the norm for the sector. The Clinic is marketed to university staff and in the sports facilities attached.

The University marketing department use a Google AdWords campaign which uses keywords for certain health conditions that they turn on and off as requested by the osteopathy team to boost numbers when necessary. They have also in the past written to all local GP practices advertising the service, but this has not been deemed necessary since the Clinic has been more established. Whilst this seems like a narrow view of marketing it does seem sufficient to sustain numbers.

A snapshot audit is undertaken each year by the Programme Lead. This is usually undertaken in May and feeds into their development meeting. It looks at numbers and patient characteristics. Whilst monitoring of patient numbers and types is undertaken by students and staff in clinic, a more formal regular process is encouraged as this will allow programme management to better understand and address any issues with numbers and variety of patients on a more formal and ongoing basis.

The osteopathic team feel the current practice software (Cliniko) does not allow them to routinely audit patient characteristics or presentations which would allow for a more systematic process of ensuring students see a wide variety of patients and presentations. They are currently looking into alternatives and at the possibility of designing and building their own. However, no decisions have been made as of yet. The visiting team feel that the transition to a more flexible practice software system that would allow for closer monitoring of student experience would be preferrable.

Given the information provided and meetings with students, staff and management the visiting team are assured that the mechanisms in place are sufficient to ensure students gain sufficient access to the clinical experience required to meet the programme outcomes and the standards set out in the OPS. Therefore, we are confident that this standard has been met, however, further software development is encouraged to ensure this continues to be the case.

Strengths and good practice

None reported.

Areas for development and recommendations

The University should continue its search for software or develop its own bespoke software that will allow closer monitoring of student experience.

Conditions

None reported.

8. Staff support and development

i. educators are appropriately and fairly recruited, inducted, trained (including in relation to equality, diversity and inclusion and the inclusive culture and expectations of the institution and to make non-biased assessments), managed in their roles, and provided with opportunities for development.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The University's recruitment policy applies to the recruitment and selection of all staff. This was supplied to the visiting team prior to the visit. The policy states that all employees involved in recruitment and especially chairs of panels are required to attend a workshop on recruitment and selection. The policy also states that the selection process should be transparent, timely, cost effective, equitable, and free from conflicts of interest.

In the recruitment procedures document supplied by the University it states that any vacancy should go through the process mapped out within the document. This process includes a review of the requirements & role followed by the development of a job description and person specification. The role is then advertised.

Shortlisting is done by at least two individuals one of whom should be from HR. There is no mention of blind shortlisting in the recruitment procedures document but the Associate Dean for this area verbally recounted the process and without prompting confirmed that blind shortlisting is undertaken.

A variety of selection methods may then be employed, with interview being the preferred method. The policy again recommends that assessment panels should consist of at least two members of staff, one of which must be from HR. It is stated that where possible selection committees should be of mixed race and gender.

Each panel member completes an interview question matrix and are directed that any decision should be based on the application, measured against the information contained in the job description and person specification.

The three newest members of staff are managed by the course leader who is in turn managed by the Associate Dean for the school. All other members of staff in the department are directly managed by the Associate Dean for the school.

Documentation provided to the team and the Associate Dean who has management responsibility confirmed that staff have yearly performance reviews called PDR where the past year's performance is reviewed, and goals are set for the upcoming year. All new staff have to undertake mandatory induction and training in safeguarding, GDPR, EDI and Health and safety. Staff report that they are required to repeat this training every four years. However, there is a requirement for them to undertake the new safeguarding training yearly.

Staff report that a process of peer review is in pace and undertaken. This forms part of the PG Cert. in teaching in HE but also part of their development.

A new Safeguarding Lead has been appointed at the university. They have developed, in consultation, a new safeguarding policy that has been rolled out. All staff and students in the department have received bespoke safeguarding training this year which they state they found very useful and thought provoking.

Staff are encouraged to either have or to undertake a teaching in higher education qualification which is modular and to become fellows at the HEA. The academic promotion and career development procedure document was shared with the visiting team prior to the commencement of the visit. This document sets out

the academic career track and grade progression. It also states it is how talent, skills and experience is recognised and developed.

The document sets out the title name, grade and number of points needed to attain the grade from associate lecturer, lecturer, senior lecturer, associate professor and professor and as such is in line with university norms. It states that normal progression within grades will continue annually, subject to satisfactory performance until the top of the grade boundary but also sets out the expectations and routes for those wishing to progress.

Promotion is done through an annual application process that is considered by an academic promotion panel.

These opportunities are available to all academic members of staff including those employed on the osteopathy course.

In discussion with osteopathy teaching staff there were mixed experiences regarding progression. Some staff had experience from other universities and were engaged with the process and progressing through the career track. Others were either not interested in progression as they worked part time or have a career elsewhere and one admitted being a little confused by the process. However, all staff stated that if they did wish to engage with progression, they felt confident their line manager would be able to guide them and that they would be able to access the information they needed through the online system for employees called Antler.

As well as the certificate in teaching in HE, opportunities exist for staff to undertake master's degrees (level 7) and PhD (level 8) research studentships within the University. One member of staff was undertaking the PhD studentship when the visiting team were on site. It was confirmed by the Associate Dean who has line management responsibilities for the department and osteopathy teaching staff and by the staff themselves that they were aware of these opportunities.

The documentation supplied as well as verbal evidence gathered from management and staff means we are reassured that educators are fairly recruited, inducted and trained and there are systems in place to support staff in making unbiased decisions. The evidence gathered and what was observed on the visit indicates a supportive environment for educators, who are well managed and supported to progress if they wish. Overall, we are confident that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. educators are able to ask for and receive the support and resources required to effectively meet their responsibilities and develop in their role as an educator.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Documentation provided to the visiting team and verbal confirmation from the Programme Lead and Associate Dean for the area confirm that educators follow a PDR process where they meet with their line manager to discuss progress and set goals.

Two new members of staff were recruited in 2023. The course leader verbally set out the process which was followed. The two recruits were recent graduates of the course and had no teaching experience. They were employed as associate lecturers and were mentored for their first academic year, being given gradually more responsibility as they developed. They have both now started the University's certificate in teaching in HE, which when completed will allow them to apply for fellowship of the HEA. Verbal confirmation of this was obtained from one of the candidates.

Evidence provided in the form of a welcome letter and verbal confirmation from senior management confirm that induction and training takes place before new employees take up their roles.

The induction programme is designed to ensure new employees understand the working culture as well as all the important elements of your new role. This includes departmental induction, people team induction, warm welcome sessions, Marjon fundamentals, and other key training including Prevent, Cyber security, digital skills and iReview.

Further training in safeguarding and department-specific needs is also undertaken and was evidenced by training agendas and verbally with staff.

In meeting with the osteopathic team, they reported that they felt well supported. The small number in the department meant lines of communication were short and so they would go to the Programme Lead or their line manager if they felt they needed to access any help of support. Furthermore, they are able to access the staff intranet, Antler, which provides them with a host of resources such as library support for teaching, reporting concerns and accessing training should they need it.

We are assured from the meetings with staff and reviewing the documentation supplied that staff are provided with the necessary information, resource and support to effectively develop in their role, and therefore this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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iii. educators comply with and meet all relevant standards and requirements, and act as appropriate professional role models.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The job description for lecturer osteopathy practitioners and the clinic handbook provided to the visiting team set out what is required and desired of educators of that level joining the team. These include being a registered osteopath and having a postgraduate qualification in education. They are also required to have teaching and assessment experience.

CVs were provided for five of the nine members of staff. These detailed the qualifications and experience of those members of staff. All had or were working towards teaching in HE qualifications. All educators with a teaching qualification had a significant amount of teaching experience up to level 7.

All members of staff were reported to be registered osteopaths. This was checked against the GOsC registrant database, and all were found to be on the register.

When meeting with staff they confirmed all but two have teaching in HE certificates either from prior positions or from the university itself and were reported to be fellows of the HEA. The two new members of staff are enrolled on the university PG certificate in teaching in HE which will allow them to become fellows of the HEA.

Observation in clinic and the classroom evidenced that lecturers and clinic tutors acted in an appropriate and professional manner which added to the wealth of experience detailed in the CVs and verbally confirmed during the meeting with staff leads the visiting team to the conclusion that staff teaching on the programme meet all relevant standards and requirements and are appropriate role models for students on the course. Therefore, the visiting team are confident that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. 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.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The Programme Lead and teaching members of staff are familiar with the ratios necessary to manage the risks associated with undergraduate osteopathic education. These include teaching in practical classes and in the Clinic. Observations on site provided reassurance that these were being met with some spare capacity.

Educators are required to have experience of teaching and assessment which is set out in the job description. During meetings with staff and the CVs provided it was apparent that the team have the necessary skills to support, teach and assess students on the course.

Information from the course leader and documentation claimed that all educators on the programme have GOsC registration. This is written into the job description for lecturers and clinic tutors. This was checked against the online database.

The University is relatively geographically isolated, however, there are sufficient numbers of staff to cover all lessons; some are full time, and some are part time. This ensures some remain in and are familiar with practice. The University has recruited two new members of staff who are local. They initially worked as associate lecturers/tutors whilst gaining experience and are now working autonomously. This ensures that the programme is building capacity locally.

We are assured that there are sufficient numbers of staff with the necessary experience, qualifications and registration to meet the standard required.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. educators either have a teaching qualification, or are working towards this, or have relevant and recent teaching experience.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

CVs for five of the nine members of staff were provided. All had or were working towards teaching in HE qualifications. All of those with a qualification had a significant amount of teaching experience up to level 7.

When meeting with staff they confirmed all but two have teaching in HE certificates either from prior positions or from the University itself. The two new members of staff who joined the University in 2023 enrolled on the PG certificate in teaching in HE in September 2024 and are working through the course. It was reported that they were enjoying the course and found it very helpful with their teaching practice. Once completed this will allow them to become fellows of the HEA.

Given the information provided to the visiting team we are assured that educators have the necessary teaching experience and either have or are working towards a teaching in HE qualification. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

9. Patients

i. patient safety within their teaching clinics, remote clinics, simulated clinics and other interactions is paramount, and that care of patients and the supervision of this, is of an appropriate standard and based on effective shared decision making.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The sole means of students coming into contact with patients as osteopaths is through the on-site Clinic. Whilst opportunities for interprofessional learning are coming back online, students do not attend these as osteopaths but as observers and do not have responsibility for patient care.

Whilst in the Clinic the visiting team observed that patient safety was a high priority and consent processes were granular enough to allow patients to make informed decisions about their care. Patients are sent a consent form to sign when they make an appointment. They are given further information by students in the Clinic at each stage of the consultation process and verbal consent is gained.

When speaking with the patient group they felt assured that students and tutors had their best interests at heart. They commented on the good levels of communication and the information they were provided. Information of their clinic journey and what to expect is provided on the website so that patients can anticipate what will happen when they attend for the first time.

The clinic handbook sets out the process which should be gone through with each patient. This includes several safeguards to protect patients from harm. Clinic induction covers the process that needs to be followed with each new and returning patient so that at each step the student seeks tutor input. It was observed in clinic that students are encouraged to communicate what and why they are doing what they are doing with patients after each of these interactions.

In the clinic handbook, students are reminded they should not work outside of their capabilities and seek help when needed, they have a duty to inform clinic tutors if there are any factors they feel may negatively impact patients and inform tutors of any unusual or adverse incidents. For instance, it states that HVTs must be undertaken in the presence of a tutor.

Pre and post clinic sessions are held each day. These sessions help get students up to speed on their patient list for the day and plan interactions with the assistance of tutors. Post clinic meetings focus on reflecting on the patients they had responsibility for or were observing.

The handbook also covers areas such as FtP and infection control. Students are given a comprehensive clinic induction before they attend clinic in years three and four which includes safeguarding, clinic operating procedures, practice standards, values and communicating risk.

The visiting team feel assured that patient safety within the teaching clinics is paramount and that supervision is of an appropriate standard and based on shared decision making. Therefore, we are confident that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. 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.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

A new safeguarding lead was appointed to the University in 2023. They have developed a new safeguarding policy which was supplied. This covers the safeguarding of children and vulnerable adults and is in line with what is expected of such a policy.

Training regarding this has been rolled out with third- and fourth-year students receiving the training with their clinic tutors as part of their induction. Feedback sought during the visitor meeting with the staff and students was very positive, stating that the training had taken place in the Clinic and had been tailored to the programme. On questioning, staff and students report that they are aware of their duties regarding reporting and acting when necessary. The clinic handbook states that safeguarding training needs to be completed annually.

Safeguarding concerns can be raised by anyone; students report that they are most likely to report such concerns to their lecturer or tutor, if the concern was regarding their tutor or lecturer, they would report it to the Programme Lead or another member of staff. They also have the facility to provide anonymous feedback through the online chat back system or report it to the support services desk. Tutors said they would follow a similar route but can report concerns through their online portal for staff called Antler.

If a safeguarding concern is reported to the university, it is logged on the CPOMS which is a safeguarding and child protection management system. This ensures that all concerns are dealt with in the appropriate manner and that this can be audited. The Safeguarding Lead would then proceed with any investigation.

The consent process used in the Clinic is sufficiently granular to allow patients to make an informed decision regarding their care. However, there is no specific consent form for those under the age of 16 or for those who cannot consent for themselves. In discussion with tutors in the Clinic, those with parental responsibility or other devolved responsibility are asked to sign the standard consent form and verbal consent is given by the person with parental or other devolved responsibility at the consultation. This is then documented in the clinical notes. This is sufficient to gain informed consent. However, the addition of a consent form that summarises information for those who have to consent would make the process more robust.

We are confident that effective safeguarding policies are developed and can be 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. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

The University should develop a consent form for those with parental or other devolved responsibility that standardises necessary information they require to make an informed decision.

Conditions

None reported.

iii. the staff student ratio is sufficient to provide safe and accessible education of an appropriate quality.

☒ MET

☐ NOT MET

Findings and evidence to support this

In line with expected norms for the sector and GOPRE, the programme specification states that the staff to student ratio in clinic should be one tutor to four students. Observations carried out over the course of the on-site visit concurred with this. The Clinic is student led so tutors do not treat patients unless necessary. They do however supervise students whilst they carry out any treatment agreed with the tutor beforehand. In line with sector norms students are given more autonomy as they progress towards qualification at the end of the fourth year.

Student to teacher ratios in class were also observed with a maximum of one tutor to 10 students. In practice it is less as there are approximately 15 students in each year group meaning two tutors will have to be in attendance when the class is running to capacity. Again, this is in line with sector norms and the expectations set out in GOPRE.

The ratios above allow for close supervision when necessary but also give room for tutors to allow students more independence.

Documentation supplied, observations in practical classes and in clinic and discussion with staff provide us with the assurance that the ratios necessary to provide safe and accessible education are being met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. they manage concerns about a student's fitness to practice, or the fitness to practice of a member of staff in accordance with procedures referring appropriately to GOsC.

☒ MET

☐ NOT MET

Findings and evidence to support this

The FtP process which forms part of the student regulations framework were supplied to the visiting team.

The Programme Lead was aware of these documents and aware of their need to report concerns to the university and to the regulator when it was appropriate.

When speaking with students and osteopathy teaching staff they were aware of their duty to report concerns. Students reported that they raise such concerns to their tutor or if it was about their tutor to the Programme Lead. Staff members would go to the Programme Lead or to their line manager. All stated that they were aware they could raise concerns anonymously through other means such as the chat back service or at the support desk where there is a computer they can use to do this.

When asked when they would do this, they mentioned instances of inappropriate behaviour towards other staff and patients and when concerned about the health and wellbeing of a colleague, peer or student.

If the FtP of staff is raised, then it is reported to HR who initiate an investigation and follow university disciplinary procedures. If there is a case to answer, then professional codes would be checked and a referral made to the GOsC.

If a concern is raised about a student, they are lodged with the Dean of School who then manages the process. There are two stages; programme level is stage one where a discussion is had between the student and the Programme Lead. The student is then informed by letter of the concerns that have been raised.

The Programme Lead will convene and chair a meeting involving the student, their PDT and other appropriate members of academic staff. Where appropriate, the placement supervisor/mentor and a member of the institutional staff designated to support students during the placement period will also attend. At the meeting, the concerns and the student's progress will be discussed with a view to agreeing an action plan. If appropriate professional codes are used at this stage. This is agreed by all and put in place. The Programme Lead then monitors the case going forward.

If this fails to resolve the concern or if the concern is so serious it requires an immediate investigation, then stage two is triggered. The Dean of school with reference to colleagues who have expertise in the area such as osteopathy and with reference to those criteria for the profession instigates an investigation and appoints an investigator. If the Dean of School considers, in the light of the investigator's report, that the student's behaviour is serious or persistent enough to call their FtP in question, the case will be referred to a FtP panel.

Decisions are highlighted in the University's annual report and notified the regulatory body at the end of a hearing. Annual reports on FtP issues sent to the Senate and other appropriate committees for monitoring and to receive feedback.

Given the information supplied and when speaking with staff and student, we are assured that FtP issues would be handled in an appropriate manner with adequate reference to professional codes and the GOsC.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. appropriate fitness to practise policies and fitness to study policies are developed, implemented and monitored to manage situations where the behaviour or health of students poses a risk to the safety of patients or colleagues.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Students are required to undertake a DBS check on being accepted to the programme. They also need to be of good character and good health. Those responsible for the student's clinical placement are encouraged to flag concerns with the department head and to raise the issue informally in the first instance as additional support and guidance may resolve the issue. If this does not solve the issue, then it is raised formally.

The University supplied its FtP procedure which forms part of its student regulations framework. It covers all professional programmes at the University. It states that there may be regulator specific guidance that may also be needed to be taken into account. It includes information on contacting the regulator and informing them of decisions and in annual reporting. It states that if a FtP concern is raised which goes through the process, yet the student is allowed to continue on the course that the case will continue to be monitored. It also provides information on how the student should be supported through the process.

An annual report on recent FtP cases is submitted by the academic standards officer to senate each year. Senate then forwards any broad concerns they have to the relevant university committees.

The GOsC student FtP document is available to students and staff through Canvas.

The University also has a ‘continue to study’ procedure that can be found in the student regulations. This procedure is triggered if the University is concerned about a student’s mental or emotional well-being, health or behaviour, to the extent that this might have an adverse effect on the student, other students or staff.

Concerns are raised through student wellbeing and support welfare concerns group. It follows a similar process to the FtP procedure with reporting on an annual basis.

When speaking with programme management they were aware of these policies and when they would and should be triggered.

Overall, we are confident that there are sufficient policies and the knowledge of these policies in place and adequate monitoring to manage situations where the behaviour or health of students poses a risk to the safety of patients of colleagues. Therefore, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

vi. the needs of patients outweigh all aspects of teaching and research.

☐ **MET**

☒ **NOT MET**

Findings and evidence to support this

Our experiences at the Clinic, observing the taught classes and reading the relevant documentation demonstrate to us that patient need is paramount in nearly all situations. Students take their role seriously and tutors demonstrate the required qualities and skills to allow students to model from.

The training provided before entering clinic and the supervision in clinic would indicate the same. In every aspect apart from one we have no reservation in stating that patient needs are put above any other.

The one aspect that does not meet the standard necessary is in regard to patient records as noted in section 2i.

During the visit it became apparent that students were using their own devices in clinic to access the practice management and patient records system used at the Clinic. This system called Cliniko is widely used in osteopathy and other manual therapies. It then became apparent that students on other programmes such as sports therapy and rehabilitation also had access to the same software and could if they desired see osteopathic patients' records and vice versa.

Given that this has been known about by the university and runs contrary to several of the university's policies. The visiting team do not feel that on this issue patients' needs outweigh all aspects of teaching.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

The University must immediately update their consent forms and privacy policy to ensure patients are fully aware of who can access their clinical information. (2i, 9vi)

In order to effectively manage the risk to patient data, the University must carry out an urgent review of the risks associated with the use of students' own IT equipment to access and record patient data both on site and off site as well as the risks associated with allowing students from other programmes access to osteopathic patient records. This should be done in conjunction with staff at the university who have expertise in IT and data protection. The University must develop and carry out a plan to implement the recommendations from the review. (2i, 9vi)

vii. 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.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The patient record system used by the University allows the department to design their own new and returning patient consultation forms. The forms follow a logical sequence of collecting information from the patient and examination finding, diagnosis and treatment plan which includes aftercare advice. During our observations in the clinic, time was dedicated to aftercare which was delivered in an unhurried manner.

The patient group that we spoke with highlighted this aspect of their care as exemplary. They felt heard, could tell their unique story and found that the level of communication from students was excellent. This included aftercare advice, things they could do for themselves at home which is a vital part of any care relationship. Some had received ergonomic advice, general exercise advice and exercises that were designed to aid their condition.

When speaking with students, they felt supported to provide lifestyle and aftercare advice in nearly every way. They did share some concerns about the level of teaching and support they received for exercise prescription and rehabilitation. They did not know of any resources they could reliably point patients to for instance, support the patient in exercise prescription adherence.

We are assured that patients do feel able and supported to access additional help when appropriate but that this could be enhanced by implementing the recommendation set out below. Overall, we are assured that this standard has been met.

Strengths and good practice

None reported.

Areas for development and recommendations

The University should provide additional training and support for students with regards to exercise prescription and rehabilitation. (9vii)

Conditions

None reported.

A. Evidence

A.1 Evidence seen as part of the review

(JD) Lecturer Practitioner - Osteopathy.pdf
(TEMPLATE) - Warm Welcome Letter - June 2024.docx
20212824 OMEC 90 Assignment 3 Muscle Energy Techniques.docx (1).pdf
20212824 OMEC 90 Assignment 3 Muscle Energy Techniques.docx (1).pdf
20212824 OMEC 90 Assignment 3 Muscle Energy Techniques.docx.pdf
20212824 OMEC 90 Assignment 3 Muscle Energy Techniques.docx.pdf
Academic and Clinic Induction Year 4 September 2024 (1).docx
Academic and Clinic Induction Year 4 September 2024.docx
Academic Promotion and Career Development Procedure.pdf
Academic Structure.docx
Admissions Policy and Procedures.pdf
Annual Cycle of Business TLAQC 2024-25.xlsx
Annual Equality Report 2022-23_FINAL.docx
Annual Programme report Osteo v7 2023-24.docx
Annual Programme report Osteo v7 2023-24.docx
Appendix 1 MHW Privacy Policy 2024.docx
ASPPC 23-01 minutes APPROVED.pdf
ASPPC 23-02 minutes APPROVED.pdf
ASPPC 23-03 minutes APPROVED.pdf
ASPPC 23-04 minutes APPROVED.pdf
ASPPC 23-05 minutes APPROVED.pdf
ASPPC 23-06 minutes APPROVED.pdf
ASPPC Cycle of Business 2024-25.xlsx
Assessment Policy.pdf
Assignment 3 marking grid.docx
Assignment 3 marking grid.docx
assignment 3.docx
assignment 3.docx
Campus accessibility map.pdf
Case checklist-1.docx
Case study essay T2DM 20054704.pdf
Case study essay T2DM 20054704.pdf
clinical experience project.docx
clinical Induction Year 3September 2024.docx
Committee Structure.pdf
Committee Structure.pdf
Computing Services Circulation Policy.pdf
Cotton et al 2024.pdf
Cyber Security Policy.pdf

Data Protection Policy.pdf
Data Protection Policy.pdf
DGCV.doc
Digital and IT Code of Practice 13032024.pdf
Downey et al 2021.pdf
EDI Policy v2.2 2024.pdf
EGOlder CV Sept 2024.docx
ELT reporting structure updated June 2024 (1).pdf
ELT reporting structure updated June 2024 (2).pdf
ELT reporting structure updated June 2024 (2).pdf
ELT reporting structure updated June 2024.pdf
Essay Case Presentation 23-24.docx
Essay Case Presentation 23-24.docx
Essay Question and Marking Criteria.docx
Essay Question and Marking Criteria.docx
Expectations of PDTs & Students.pdf
Gabrielle Anderson - CV.pdf
gosc intro.pptx
GOsC response Quality.docx
HQAPEP.docx
Induction Year 4 September 2024.docx
interim report 2022-23_Osteopathic Medicine_M.Ost (Hume).docx
interim report 2022-23_Osteopathic Medicine_M.Ost (Hume).docx
interim report 2022-23_Osteopathic Medicine_M.Ost (Marshall).docx
interim report 2022-23_Osteopathic Medicine_M.Ost (Marshall).docx
JD CV.pdf
John-Evans-expansion Manager (1).docx
Learning and Teaching Strategy 2020-2025 (2).pdf
Learning and Teaching Strategy 2020-2025 (2).pdf
Line Management Structure AY 24-25 - final.pdf
Marjon Library Collection Development Policy.pdf
Marjon Library Collection Development Policy.pdf
Marjon new program paper.docx
Master in Osteopathic Medicine (OME) (Integrated Masters).pdf
Master in Osteopathic Medicine pre23.pdf
Master in Osteopathic Medicine pre23.pdf
Master's Thesis.docx (1).pdf
Master's Thesis.docx (1).pdf
Master's Thesis.docx.pdf
Master's Thesis.docx.pdf
Moderate OMEC90.xlsx
Moderate OMEC90.xlsx
Moderate OMEM03 Project (1).xlsx

Moderate OMEM03 Project (1).xlsx
Moderate OMEM03 Project.xlsx
Moderate OMEM03 Project.xlsx
Modules.zip
OMEC53 Personal and profesional development.docx
omec90 3.docx (1).pdf
omec90 3.docx (1).pdf
omec90 3.docx.pdf
omec90 3.docx.pdf
OMED04 2023 essay marking framework.docx
OMED04 2023 essay marking framework.docx
OMED54 Personal and Professional Development II.docx
OMEM03_thesis_Marking Framework (3) (1).pdf
OMEM03_thesis_Marking Framework (3) (1).pdf
Osteopathy Module Leadership.docx
Patient audit 24.docx
patient expereince project.pdf
Peer Review Policy.pdf
People Strategy 2020-2025 .pdf
Personal Development Tutor Expectations.pdf
Plymouth Marjon University ToR 2024-25 ASPPC.pdf
Plymouth Marjon University ToR 2024-25 SEC.pdf
Plymouth Marjon University ToR 2024-25 Senate.pdf
Plymouth Marjon University ToR 2024-25 TLAQC.pdf
PMU Policy and Procedure for Supporting Students Requiring Reasonable Adjustments in Practice and Simulated Practice Environments (2).pdf
PMU Policy and Procedure for Supporting Students Requiring Reasonable Adjustments in Practice and Simulated Practice Environments (2).pdf
PMU Simulation Based Education Strategy.pdf
PMU Student Pregnancy and Maternity Policy.pdf
Practice assessment doc 1 (1).docx
Practice assessment doc 1 (1).docx
PROFESSIONAL SERVICES STRUCTURE update.docx
Programme Specification_M.Ost.pdf
Recruitment Procedures Sep 19.pdf
Recruitment Policy (1).pdf
Recruitment Policy (1).pdf
Recruitment Policy.pdf
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Report 2021-22_Osteopathic Medicine_M.Ost (Marshall).docx
Report 2022-23_Osteopathic Medicine_MOst (Hume) (1).pdf
Report 2022-23_Osteopathic Medicine_MOst (Hume) (1).pdf
Report 2022-23_Osteopathic Medicine_MOst (Hume).pdf
Report 2022-23_Osteopathic Medicine_MOst (Marshall) (1).pdf

Report 2022-23_Osteopathic Medicine_MOst (Marshall) (2).pdf
Report 2022-23_Osteopathic Medicine_MOst (Marshall) (2).pdf
Report 2022-23_Osteopathic Medicine_MOst (Marshall).pdf
Report 2023-24_Integrated Masters in Osteopathic Medicine (M.ost) (Marshall).pdf
Research proposal.docx.pdf
Research proposal.docx.pdf
Response 2022-23_Osteopathic Medicine_MOst (Hume).pdf
Response 2022-23_Osteopathic Medicine_MOst (Hume).pdf
Response 2022-23_Osteopathic Medicine_MOst (Marshall).pdf
Response 2022-23_Osteopathic Medicine_MOst (Marshall).pdf
Response 2023-24_Integrated Masters in Osteopathic Medicine (M.ost) (Marshall) (1).pdf
Response 2023-24_Integrated Masters in Osteopathic Medicine (M.ost) (Marshall).pdf
Returning to Practice Following Sickness or Sick Leave .pdf
Risk Management Policy.pdf
RPRG 24-01-17 People Who Use Services Involvement Policy July 2024_New policy (003).docx
Safeguarding Policy (Children & Adults at Risk).pdf
Screenshot 2024-12-05 at 11.10.02.png
Screenshot 2024-12-05 at 11.10.18.png
Screenshot 2024-12-05 at 11.10.29.png
Semester B Report level 4.docx
Semester B Report level 4.docx
Semester B Report level 5.docx
Semester B Report level 5.docx
Semester B Report level 6.docx
Semester B Report level 6.docx
Semester B Report level 7.docx
Semester B Report level 7.docx
senate 22-05-23 Prevent Policy June 2023.pdf
senate 23-01-17 Safeguarding Policy.pdf
Senate CoB 2024-25_Approved v2.xlsx
Sept 2022 FINAL DBS POLICY & PROCEDURE (1).pdf
SHWB Interprofessional Learning Strategy.pdf
SHWB Interprofessional Learning Strategy.pdf
SHWB Interprofessional Learning Strategy.pdf
Simulated Practice Environments (2).pdf
SRF 2024-25 complete.pdf
SRF-2024-25-changes.pdf
staff day apr24.docx
staff list (1).docx
staff list training undertaken.docx
staff list.docx
Staff meeting agenda april24.docx
Staff meeting agenda april24.docx

Statement of Service.pdf
Student Clinic Handbook 2425 (1).pdf
Student Clinic Handbook 2425 (2).pdf
Student Clinic Handbook 2425.pdf
Student Clinic Handbook V2 2425.pdf
Student Code of Conduct for the School of Health and Wellbeing.pdf
Student Ethics Standard Operating Procedure.pdf
student liaison actions.xlsx
student liason nov 22.docx
student liason nov 22.docx
Student Regulations Framework 2024-25 - complete.pdf
Student Regulations Framework 2024-25 section 10 - Fitness to Practice Procedure (1).pdf
Student Regulations Framework 2024-25 section 10 - Fitness to Practice Procedure.pdf
Student Regulations Framework 2024-25 section 10 - Fitness to Practice Procedure.pdf
Student Regulations Framework 2024-25 section 12 - Assessment Practices.pdf
Student Regulations Framework 2024-25 section 12 - Assessment Practices.pdf
Student Regulations Framework 2024-25 section 16 - Academic Appeal Procedure.pdf
Student Regulations Framework 2024-25 section 17 - Complaints Procedure.pdf
Student Regulations Framework 2024-25 section 17 - Complaints Procedure.pdf
Student Regulations Framework 2024-25 section 9 - Support to Continue in Study Procedure.pdf
Student Regulations Framework 2024-25 section 9 - Support to Continue in Study Procedure.pdf
Support for Dyslexia and other Specific Learning Difficulties (SpLDs).pptx
TLAQC 23-01 Approved Minutes.pdf
TLAQC 23-02 Approved Minutes.pdf
TLAQC 23-03 Approved Minutes.pdf
TLAQC 23-04 Approved Minutes.pdf
TLAQC 23-05 Approved Minutes.pdf
TLAQC 23-05-10_GOsC Mapping Tool_MOst.xlsx
University-grade-descriptors (1).pdf
University-grade-descriptors (1).pdf
University-grade-descriptors.pdf
University-grade-descriptors.pdf

General Osteopathic Council

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Council
15 July2025
BCNO Group – Renewal of Recognition of Qualification (RQ)

Classification	Public
Purpose	For decision
Issue	Consideration of the Recognised Qualification (RQ) review at the BCNO Group in relation to: • BSc (Hons) Osteopathic Medicine (full-time three-year course)
Recommendations	To recognise the BSc (Hons) Osteopathic Medicine awarded by The BCNO Group subject to the conditions set out in paragraph 19, from 1 September 2025 to 1 January 2031 subject to the approval of the Privy Council.
Financial and resourcing implications	The RQ Visit was included in the 2024-25 financial schedule, with a budget of c£20,000.
Equality and diversity implications	Equality and diversity issues are reviewed as part of the RQ renewal process.
Communications implications	We are required to maintain and publish a list of the qualifications which are for the time being recognised in order to ensure sufficient information is available to students and patients about osteopathic educational institutions awarding 'Recognised Qualifications' quality assured by us.
Annexes	A. The review specification B. The RQ Visit Report
Authors	Steven Bettles and Banye Kanon

Key Messages

- The visitor report contains recommendation for initial recognition of the BSc (Hons) Osteopathic Medicine (full-time three-year course) with five conditions.

- The Policy and Education Committee considered the report and recommended that Council recognise the programme subject to conditions from 1 September 2025 to 1 January 2031.

- The Committee suggested the review of one of the conditions proposed by the visitors which is reflected in this paper.

Background

1. A draft RQ specification was approved by the Policy and Education Committee at its June 2024 meeting and in October 2024, the Committee agreed a team of three Education Visitors under s12 of the Osteopaths Act 1993 to undertake the review.

2. Following the BCNO Group's decision to cease recruitment to its London campus, the Committee agreed in January 2025 (via email) to proceed with the review, limited just to the proposed new three-year programme. The updated RQ specification as a result of this late change is attached as Annex A. A review of the remaining, existing provision will take place towards the end of 2025.

3. The visit took place in from 18-20 February 2025.

Discussion

4. The final visitors' report is attached at Annex B. The recommendation of the Visitor for the programmes is approval with five specific conditions. When we recognise an RQ, we also recognise in accordance with the general conditions which are also specified below.

Strengths and good practices

5. The visitors identified several specific areas of strength and good practices in the final report, including:

    - The appointment of the Student Engagement and Welfare Officer shows recognition of the importance of student welfare and well-being and has begun to lead to students feeling more supported and effectively signposted.

    - The BCNO Group has developed a strong, positive relationship with UoP where feedback is valued and acted upon.
    - The monitoring of student attendance is a good first step in leading to more effective engagement and support for students who may be struggling.

- Students really appreciate the opportunity to become involved in the specialist clinics at the Maidstone site.

- The clinical provision at the BCNO Group is of a very high standard. The levels of support offered by staff and attendance at specialist clinics affords students a host of opportunities to hone and develop their skills in all areas.

Recommendations

6. Recommendations may be made by visitors when they consider that '*there is an opportunity for improvement, but a condition is not necessary. These areas should be monitored by the provider and the recommendations implemented, if appropriate.*' The visitors in this case made a number of recommendations within the report. These areas should be monitored by the provider and implemented if appropriate with updates reported in the next annual report process. A request will be made for BCNO to provide a progress update with regard to these specific areas as part of their 2024-25 Annual Report submission.

Conditions recommended by the Visitors

7. Five specific conditions have been suggested in the report by the Visitors. These are:

    - In the continued design of the new three-year programme, the BCNO Group must ensure comprehensive engagement with all areas of the organisation involved in or affected by its delivery. This engagement must thoroughly address student concerns about the increased pressures associated with completing the course in a condensed format and ensure that adequate resources are available to support their studies. Additionally, the BCNO Group needs to consider the perspectives of support staff, teaching staff, clinic tutors, and patients to ensure that the programme's design encompasses all aspects of delivery. (1vi)

    - To allow staff and stakeholders to understand the changes that are taking place and to ensure there is a clear direction and milestones to increase accountability and the effectiveness of the management structure, the BCNO Group must produce a strategic plan document which gives an overview of their plans for development over the next three to five years showing clear timeframes, costings, and areas of responsibility. (2i, 4iii)

    - The BCNO Group must ensure that all relevant course materials have been reviewed, approved, and are in place before the commencement of the new three-year programme. (6i)

    - The BCNO Group must increase student welfare monitoring in order to provide assurance that students are coping with the new course, able to

engage in their clinical studies and ensure the BCNO Group can deal with any issues which may arise due to workload issues. (6ii, 7ii)

- A monitoring visit must be conducted during the second year of the new programme to review its delivery, with particular emphasis on meeting students' academic and welfare needs. This visit should include direct contact with students and staff to provide assurance beyond the requirements of the annual reporting process. (6ii)

8. The conditions reflect the particular nature of this new course, albeit from a very experienced provider. Compressing a programme in this way into a three-year delivery format is a new innovation within the sector, and it is hoped will be attractive for students enhancing accessibility and affordability. The conditions address some of the likely challenges, however, and provide a context within which monitoring can take place.

9. In relation to the condition proposing that a monitoring visit be carried out during the second year of the programme, the Committee felt that this was potentially onerous, and wished to keep the options open in this respect. As a result, we have redrafted the condition as follows, shown next to the original:

Original condition	**Modified condition**
A monitoring visit must be conducted during the second year of the new programme to review its delivery, with particular emphasis on meeting students' academic and welfare needs. This visit should include direct contact with students and staff to provide assurance beyond the requirements of the annual reporting process. (6ii)	*BCNO Group must provide ongoing assurance as the programme progresses (for example, through student and staff feedback and responses to this) that students' academic and welfare needs continue to be met, given the compressed delivery of the three-year programme. (6ii)*

10. This addresses the issue behind the condition, and seeks assurance as to how the academic and welfare needs of students continue to be met, but allows the Committee the flexibility to respond in a variety of ways which may or may not include a monitoring visit.

11. A draft action plan to outline how the conditions will be addressed and monitored has been submitted by the institution and at the time of the Policy and Education Committee was with the visitors for comment. The updated action plan will be reported to the Committee in October 2025.

12. The conditions therefore, as recommended by the Committee are as follows. These are four specific conditions as recommended by the visitors, a fifth one

modified from the visitors' suggestion as outlined above, and three more general conditions (6-8) which will apply to all recognised programmes.

CONDITIONS	
1	In the continued design of the new three-year programme, the BCNO Group must ensure comprehensive engagement with all areas of the organisation involved in or affected by its delivery. This engagement must thoroughly address student concerns about the increased pressures associated with completing the course in a condensed format and ensure that adequate resources are available to support their studies. Additionally, the BCNO Group needs to consider the perspectives of support staff, teaching staff, clinic tutors, and patients to ensure that the programme's design encompasses all aspects of delivery.
2	To allow staff and stakeholders to understand the changes that are taking place and to ensure there is a clear direction and milestones to increase accountability and the effectiveness of the management structure, the BCNO Group must produce a strategic plan document which gives an overview of their plans for development over the next three to five years showing clear timeframes, costings, and areas of responsibility.
3	The BCNO Group must ensure that all relevant course materials have been reviewed, approved, and are in place before the commencement of the new three-year programme.
4	The BCNO Group must increase student welfare monitoring in order to provide assurance that students are coping with the new course, able to engage in their clinical studies and ensure the BCNO Group can deal with any issues which may arise due to workload issues.
5	BCNO Group must provide ongoing assurance as the programme progresses (for example, through student and staff feedback and responses to this) that students' academic and welfare needs continue to be met, given the compressed delivery of the three-year programme. (6ii)
6	BCNO Group must submit an Annual Report, within a three month period of the date the request was first made, to the Education Committee of the General Council.
7	BCNO Group must inform the Education Committee of the General Council as soon as practicable, of any change or proposed substantial change likely to influence the quality of the course

CONDITIONS	
	leading to the qualification and its delivery, including but not limited to: i. substantial changes in finance ii. substantial changes in management iii. changes to the title of the qualification iv. changes to the level of the qualification v. changes to franchise agreements vi. changes to validation agreements vii. changes to the length of the course and the mode of its delivery viii. substantial changes in clinical provision ix. changes in teaching personnel x. changes in assessment xi. changes in student entry requirements xii. changes in student numbers (an increase or decline of 20 per cent or more in the number of students admitted to the course relative to the previous academic year should be reported) xiii. changes in patient numbers passing through the student clinic (an increase or decline of 20 per cent in the number of patients passing through the clinic relative to the previous academic year should be reported) xiv. changes in teaching accommodation xv. changes in IT, library, and other learning resource provision xvi. any event that might cause adverse reputational damage xvii. any event that may impact educational standards and patient safety
8	BCNO Group must comply with the General Council's requirements for the assessment of the osteopathic clinical performance of students and its requirements for monitoring the quality and ensuring the standards of this assessment. These are outlined in the *Graduate Outcomes for Osteopathic Pre-registration Education* and *Standards for Education and Training*, 2022, General Osteopathic

CONDITIONS	
	Council. The participation of real patients in a real clinical setting must be included in this assessment. Any changes in these requirements will be communicated in writing to BCNO Group giving not less than 9 months notice.

Recognition period

13. The interim Quality Assurance handbook[1] sets out the current criteria regarding the period of RQ approvals stating:

    "The maintenance of the RQ status currently follows a cyclical process. Where required, PEC may apply an expiry date to the RQ. This decision will be made based on anticipated level of risk that the RQ presents."

    GOsC will usually recognise qualifications for a fixed period of time in the following circumstances:

    - A new provider or qualification
    - An existing provider with a risk profile requiring considerable ongoing monitoring.

    For existing providers, GOsC will usually recognise qualifications without an expiry date in the following circumstances:

    - an existing provider without conditions or
    - an existing provider with fulfilled conditions and without any other monitoring requirements or
    - an existing provider who is meeting all QA requirements (providing required information on time) or an existing provider with outstanding conditions, an agreed action plan and which is complying proactively with the action plan and
    - an existing provider engaging with GOsC.

    This will be subject to satisfactory review of the providers annual report."

14. BCNO Group programmes are currently recognised with an expiry date of 31 August 2026.

15. The Committee considered our initial proposal, taking all of the above into account, of an expiry date of 1 January 2029. In discussion, it was felt that an expiry date of 1 January 2029 would need further review in early 2028, which seems potentially onerous. The Committee recommendation, therefore is for

[1] Mott MacDonald GOsC Interim Quality Assurance Handbook - General Osteopathic Council (osteopathy.org.uk)

approval for a period from 1 September 2025 to 1 January 2031, which provides flexibility to time a review according to the circumstances, and assurance for students entering the programme in 2025.

Recommendation: To recognise the BSc (Hons) Osteopathic Medicine awarded by The BCNO Group subject to the conditions set out in paragraph 19, from 1 September 2025 to 1 January 2031 subject to the approval of the Privy Council.

Draft Review Specification for BCNO Group - Renewal of Recognised Qualification Review. (As at 28 January 2025)

Background

1. The BCNO Group currently provides the following qualifications which are due to expire on 31 August 2026:

    - Masters in Osteopathy (M.Ost)
    - BSc (Hons) Osteopathy (modified attendance)
    - BSc (Hons) Osteopathic Medicine
    - Master of Osteopathy and BSc (Hons) Osteopathy, (validated by Buckinghamshire New University (BNU) awarded by the ESO)
    - Masters in Osteopathy (M.Ost) and Bachelors in Osteopathic Medicine (B.OstMed), (validated by University of Plymouth (UoP) awarded by BCOM)

2. A review of these programmes will be arranged later in 2025.

3. BCNO has further submitted a new Recognised Qualification application for the following course:

    - BSc (Hons) Osteopathic Medicine (three-year full time)

2. This programme underwent validation by the University of Plymouth in 2024. It is intended that students will commencing this course from September 2025 with the first cohort graduating in 2028. It is proposed that the new course will be delivered only at the BCNO's Maidstone campus.

3. The target first year cohort is 35 students, though the delivery would proceed even if the student numbers were lower than this. A copy of the Recognised Qualification (RQ) Initial Recognition Declaration of Intent and RQ Initial Recognition Application Questionnaire is attached for information along with supporting documentation outlined.

Review Specification

4. The GOsC requests that Mott MacDonald schedules an initial recognition review for Visitors to report on the following qualifications:

    - BSc (Hons) Osteopathic Medicine (3 year full time)

5. The aim of the GOsC Quality Assurance process is to:

    - Put patient safety and public protection at the heart of all activities
    - Ensure that graduates meet the standards outlined in the Osteopathic Practice Standards
    - Make sure graduates meet the outcomes of the Guidance for Osteopathic Pre-registration Education.
    - Identify good practice and innovation to improve the student and patient experience
    - Identify concerns at an early stage and help to resolve them effectively without compromising patient safety or having a detrimental effect on student education
    - Identify areas for development or any specific conditions to be imposed upon the course providers to ensure standards continue to be met
    - Promote equality and diversity in osteopathic education.

6. The format of the review will be based on the interim Mott MacDonald Handbook (2022) and the Graduate Outcomes and Standards for Education and Training (2022). The Committee would like to ensure that the following areas are explored (account for new RQ):

    - Arrangements to manage the fallow year in recruitment to Year 1 at the Maidstone campus for 2024-25 and in subsequent years, including impacts on staffing and patients.
    - The provision of resources and facilities to accommodate the consolidation of Kent based teaching at the Tonbridge Road site following the recent sale of Boxley House.
    - How feedback from staff is gained to ensure that that staff needs are addressed appropriately.
    - How shared decision making with patients is embedded within the teaching clinics.
    - How the safeguarding policy is implemented and how patients are made aware of this.

- How feedback on students from staff is managed centrally to ensure actions are being addressed and resolved, to support their development as learners and professionals.
- How the outputs from student feedback mechanisms are cohesively reviewed to ensure actions are effectively identified, monitored and implemented.
- How data monitoring practices of student experience within the clinic is being fed back to relevant individuals for action, for example, to the marketing team to undertake targeted advertising for certain patient presentations.
- The processes by which the College reflects on student complaints to identify any required actions to ensure there is an effective process in place for responding to and learning from student complaints.

7. This timetable will be the subject of negotiation with BCNO Group, GOsC and Mott MacDonald to ensure mutually convenient times that fit well with the quality assurance cycle.

8. Visitors are also requested to particularly explore the following in relation to the planned new qualification. It will be important to have assurance that the planned curriculum meets the Graduate Outcomes and that intended delivery of the curriculum will evidence the appropriate quality and quantity of clinical experience as outlined in the Graduate Outcomes at paragraphs 22 to 28 and that there are sufficient resources to do this alongside the current qualifications delivered.

9. The following Standards for Education and Training are highlighted as particularly important to review in terms of the new three-year curriculum and plans for delivery to meet the Graduate Outcomes in an existing course provider but these are not inclusive and should be considered in the context of all the Standards for Education and Training and the whole provision:

a. **Programme design, delivery and assessment**

- All staff involved in the design and delivery of programmes are trained in all policies of the educational provider (including policies to ensure equality, diversity and inclusion and are supportive, accessible and able to fulfil their roles effectively)

- Curricula and assessments are developed and evaluated by appropriately experienced and qualified educators and practitioners
- They involve the participation of students, patients, and where possible and appropriate, the wider public in the design and development of programmes, and ensure that feedback from these groups is regularly taken into account and acted upon.
- The programme designed and planned for delivery reflects the skills, knowledge base, attitudes and values, set out in the Graduate Outcomes (including all outcomes including effectiveness in teaching students about health inequalities and the non-biased treatment of diverse patients)
- Assessment methods are reliable and valid and provide a fair measure of students' achievement and progression for the relevant part of the programme.
- Subject areas will be delivered by educators with relevant and appropriate knowledge and expertise

b. **Programme governance, leadership and management**

- They implement effective governance mechanisms that ensure compliance with all legal, regulatory and educational requirements…. This should include effective risk management and governance and ….governance over the design, delivery and award of qualifications.
- Systems will be in place to provide assurance with supporting evidence that students have fully demonstrated learning outcomes.

c. **Learning culture**

- Students are supported to develop as learners and professionals during their education
- External expertise is used within the quality review of osteopathic pre-registration programmes

d. **Quality evaluation, review and assurance**

- effective mechanisms are in place for the monitoring and review of the programme, to include information regarding student performance and progression (and information about protected characteristics), as part of a cycle of quality review.

- external expertise is used within the quality review of osteopathic pre-registration programmes

e. **Resources**

- they provide adequate, accessible and sufficient resources across all aspects of the programme, including clinical provision, to ensure that all learning outcomes are delivered effectively and efficiently.
- the staff-student ratio is sufficient to provide education and training that is safe, accessible and of the appropriate quality within the acquisition of practical osteopathic skills, and in the teaching clinic and other interactions with patients.

f. **Students**

- are provided with clear and accurate information regarding the curriculum, approaches to teaching, learning and assessment and the policies and processes relevant to their programme.

g. **Clinical experience**

- clinical experience is provided through a variety of mechanisms to ensure that students are able to meet the clinical outcomes set out in the Graduate Outcomes for Osteopathic Pre-Registration Education.
- 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

h. **Staff support and development**

- 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.

i. **Patients**

- patient safety within their teaching clinics, remote clinics, simulated clinics and other interactions is paramount, and that care of patients and the supervision of this, is of an appropriate standard and based on effective shared decision making.
- the staff student ratio is sufficient to provide safe and accessible education of an appropriate quality.

10. Visitors should consider the stage of development of the course in making their recommendations and should consider if further inspection should be recommended prior to the first cohort of students graduating in the context of this established provider.

Provisional Timetable

11. The provisional timetable for the review will be as follows, but is subject to review in discussion with the BCNO Group, Mott and the Visiting Team:

Month/Year	**Action/Decision**
March/June 2024	Committee agreement of initial review specification and statutory appointment of visitors
10 weeks before the visit c November / December 2024	Submission of mapping document
18-20 February 2025	Review takes place
5 weeks following visit c. March 2025	Draft Report to BCNO for comments - statutory period.
April / May 2025	Comments returned and final report agreed.
May 2025	Preparation of Action Plan to meet proposed conditions (if any)
June 2025	Recommendation from the Committee to Council whether to make changes to the

	RQ programme approval (e.g., conditions or addition of an expiry date)
July 2025	Recognition of Qualification ongoing by the General Osteopathic Council
September 2025	Privy Council Approval

GOsC Education Quality Assurance

Renewal of Recognised Qualification Report

This report provides a summary of findings of the providers QA visit. The report will form the basis for the approval of the recommended outcome to PEC.

Please refer to section 5.9 of the QA handbook for reference.

Provider:	BCNO Group
Date of visit:	18th - 20th February 2025
Programme(s) reviewed:	BSc (Hons) Osteopathic Medicine (full-time three-year course)
Visitors:	Dr Brian McKenna, Phil Stephenson, Stephen Hartshorn
Observer:	Hannah Warwick

Outcome of the review

Recommendation to PEC:

☐ Recommended to renew recognised qualification status

☒ Recommended to renew recognised qualification status subject to conditions being met

☐ Recommended to withdraw recognised qualification status

Programme start date:

Date of expiry (if applicable):

Date of next review:

Abbreviations

AGC	Academic Governance Committee
APCL	Accredited Prior Certificated Learning
APEL	Accredited Prior Experiential Learning
AQPC	Academic Quality and Planning Committee
BCNO	British College of Naturopathy and Osteopathy
BNU	Buckinghamshire New University
BSc (Hons)	Bachelor of Science (with Honours)
CEO	Chief Executive Officer
COEI	The Council of Osteopathic Education Institutions
CPD	Continuing Professional Development
CV	Curriculum Vitae
DBS	Disclosure Barring Service
EAP	Employee Assistance Programme
EDI	Equality Diversity and Inclusion
EE	External Examiner
EPR	Electronic Patient Records
ESO	European School of Osteopathy
FEG	Faculty Engagement Group
FtP	Fitness to Practice
FtS	Fitness to Study
GOPRE	Graduate Outcomes for Osteopathic Pre-Registration Education
GOsC	General Osteopathic Council
HE	Higher Education
HOD	Heads of Department
HR	Human Resources
IELTS	International English Language Testing System
iO	Institute of Osteopathy
MS Teams	Microsoft Teams
MSK	Musculoskeletal

NHS	National Health Service
NSS	National Student Survey
OPS	Osteopathic Practice Standards
PDR	Performance and Development Review
PEG	Patient Engagement Group
PPE	Personal Protective Equipment
PPH	Professional Practice Handbook
PT	Personal Tutor
QA	Quality Assurance
RA	Reasonable Adjustments
RAP	Reasonable Adjustments Policy
RQ	Recognised Qualification
SCOR	Student Characteristics Outcome Report
SCT	Senior Clinic Tutor
SEG	Student Engagement Group
SET	Standards for Education and Training
SEWO	Student Engagement and Welfare Officer
SIWAC	Student Inclusion and Welfare Committee
SMT	Senior Management Team
UCM	University Centre Maidstone
UoP	University of Plymouth
VLE	Virtual Learning Environment

Overall aims of the course

The BSc Osteopathic Medicine (three-year full time) course is a new course, validated by the UoP, currently recruiting for September 2025 enrolment. The course has been designed to condense the current four-year course into three. It is planned for the course to be delivered at the BCNO Group's Maidstone campus only.

The BCNO Group confirmed the following aims of the new three-year course within the mapping tool:

1) Equip students with knowledge, skills, and clinical training aligned with advancing healthcare standards in osteopathy.

2) Enhance students' competence in applying clinical skills in osteopathic practice.

3) Foster reflective, critical, and analytical skills for handling complex issues and making sound clinical judgments.

4) Develop reflective practice and communication skills for effective therapeutic partnerships with patients.

5) Improve the ability to communicate complex information appropriately for different audiences.

6) Cultivate critical thinking and research skills for evaluating evidence-based practice.

7) Prepare students for autonomous practice and effective teamwork.

8) Enhance problem-solving skills and adaptability to change.

9) Promote independent lifelong learning.

Overall Summary

The visit to the BCNO Group was undertaken over three days at the ESO campus in Maidstone. The RQ visit was limited in its purpose to undertake only an initial recognition review of the BSc (Hons) Osteopathic Medicine (three-year full time) course, which will be taught from the Maidstone campus.

Visitors met with a range of relevant groups to support their work in relation to the visit specification. These included SMT, teaching staff, clinic administration staff, support services, Trustees, students, recent graduates, UoP partner and patients. Meetings across the three days were held in an open and honest way to support the visitors with triangulation. The stakeholders which the visitors met with were generous with their time and candour, and were able to provide visitors with valuable information.

Strengths and good practice

The appointment of the Student Engagement and Welfare Officer shows recognition of the importance of student welfare and well-being and has begun to lead to students feeling more supported and effectively signposted. (2iv)

The BCNO Group has developed a strong, positive relationship with UoP where feedback is valued and acted upon. (2vi)

The monitoring of student attendance is a good first step in leading to more effective engagement and support for students who may be struggling. (3i)

Students really appreciate the opportunity to become involved in the specialist clinics at the Maidstone site. (4iv)

The clinical provision at the BCNO Group is of a very high standard. The levels of support offered by staff and attendance at specialist clinics affords students a host of opportunities to hone and develop their skills in all areas. (7i)

Areas for development and recommendations

The BCNO Group should review its policies to ensure alignment with recent structural and strategic changes within the organisation and to ensure all out of date policies are updated. Furthermore, efforts should be made to centralise policy access through a single repository, wherever feasible. (1i, 1iii, 1iv, 2ii, 4iii, 9v)

The BCNO Group should consider ways of incentivising students to become student representatives and attend all meetings to ensure their voice is more effectively heard and consider additional ways of significantly improving student response rates to surveys and module feedback. (1vi, 2i, 2iii, 3ii, 6v)

The BCNO Group should reinstate their formal yearly staff review process and provide staff with a process by which they can develop if they wish to. (1ix, 8i)

The BCNO Group should evaluate their current methods of engaging with the student voice and develop procedures to ensure that student concerns are effectively identified and directed to the relevant area within the organisation for resolution in a timely and effective manner. (1x, 6vi)

The BCNO Group should consider ensuring the risk register not just to be reviewed but also updated on a monthly basis and link this to the strategic development plan. (2i)

The BCNO Group should consider communicating with students more frequently upon their concerns and feedback and how this has been acted upon through a simple ‘you said we did’ format in order to encourage greater student engagement in the more formal feedback channels. (2iii)

The BCNO Group should gather feedback from staff and students on, and examine the effectiveness of, the personal tutor process, particularly with regard to engagement and frequency of meetings, to understand what is and is not working and to ensure that students have a suitable primary contact for their academic support and pastoral care. (3v, 6ii)

The BCNO Group should consider ways of incentivising stakeholders, including students, to regularly attend meetings so that their voice is consistently heard and is representative of the stakeholder views. This will be particularly important in order for stakeholders to give their views and suggestions to the new three-year programme as their involvement is not currently mentioned in the project schedule plan submitted. (4i)

The BCNO Group should consider implementing electronic patient records to adequately equip students for future roles in contemporary clinical practice. (5iii)

The BCNO Group should consider how they ensure that changes, made in response to identified problems, are monitored to ensure that they are effective. (6iv)

The BCNO Group should re-visit the policy of not requiring a DBS for osteopaths when they join the organisation in order to manage this risk associated with this and any impacts it may have on patients, students, and other staff. (8iv)

Conditions

In the continued design of the new three-year programme, the BCNO Group must ensure comprehensive engagement with all areas of the organisation involved in or affected by its delivery. This engagement must thoroughly address student concerns about the increased pressures associated with completing the course in a condensed format and ensure that adequate resources are available to support their studies. Additionally, the BCNO Group needs to consider the perspectives of support staff, teaching staff, clinic tutors, and patients to ensure that the programme's design encompasses all aspects of delivery. (1vi)

To allow staff and stakeholders to understand the changes that are taking place and to ensure there is a clear direction and milestones to increase accountability and the effectiveness of the management structure, the BCNO Group must produce a strategic plan document which gives an overview of their plans for development over the next three to five years showing clear timeframes, costings, and areas of responsibility. (2i, 4iii)

The BCNO Group must ensure that all relevant course materials have been reviewed, approved, and are in place before the commencement of the new three-year programme. (6i)

The BCNO Group must increase student welfare monitoring in order to provide assurance that students are coping with the new course, able to engage in their clinical studies and ensure the BCNO Group can deal with any issues which may arise due to workload issues. (6ii, 7ii)

A monitoring visit must be conducted during the second year of the new programme to review its delivery, with particular emphasis on meeting students' academic and welfare needs. This visit should include direct contact with students and staff to provide assurance beyond the requirements of the annual reporting process. (6ii)

Assessment of the Standards for Education and Training

1. Programme design, delivery and assessment

Education providers must ensure and be able to demonstrate that:

i. they implement and keep under review an open, fair, transparent and inclusive admissions process, with appropriate entry requirements including competence in written and spoken English.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group has an established admissions policy that has been developed for existing programmes, which will apply to the new three-year programme. The policy clearly details the various stages of the admissions process, from first point of contact through to final offer. This is made available via the BCNO Group website, where prospective students can also access information relating to the structure and content of the course. The admissions policy and procedure were last updated in November 2023 and would benefit from a review to ensure that it fully takes account of the recent structural changes to the BCNO Group.

At all points of contact, the faculty are keen to ensure that prospective students fully understand the specific demands of the course, including time commitment, whilst offering various mechanisms to allow prospective students to ask questions about the nature and delivery of the course.

The BCNO Group operates a structured interview process to objectively assess the suitability of prospective candidates. Interviews can take place online or face to face, depending on student preference, and participating staff are given training on the fair and consistent application of the interview process.

International students are expected to hold the equivalent of an IELTS certificate, with an overall score of 6.5. The BCNO Group undertakes a cyclical review of applicant information to drive strategies that ensure that the admission process can continue, where necessary, to evolve to maintain candidate inclusivity.

Based on our meetings with the SMT and documentation submitted as evidence we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should review its policies to ensure alignment with recent structural and strategic changes within the organisation and to ensure all out of date policies are updated. Furthermore, efforts should be made to centralise policy access through a single repository, wherever feasible. (1i, 1iii, 1iv, 2ii, 4iii, 9v)

Conditions

None reported.

ii. there are equality and diversity policies in relation to applicants, and that these are effectively implemented and monitored.

☒ MET

☐ NOT MET

Findings and evidence to support this

The BCNO Group maintains an EDI policy, which undergoes an annual review. This policy ensures that the admissions process is based on merit and objectivity. It aligns with the structured design of the interview process and underscores the BCNO Group's commitment to EDI as outlined in their admissions policy. The annual review of the EDI policy is conducted alongside the cyclical review of applicant data to inform the resourcing of future outreach programmes.

In cases where students believe themselves to be disabled, they are encouraged to speak to the Student Engagement and Welfare Officer, the registry team, or their personal tutor to ensure that, where possible, reasonable adjustments can be made. There are policies in place to guide students through the reasonable adjustment process and during our meetings with the student body, students indicated that the BCNO Group are effective in responding to requests for reasonable adjustments.

Based on the documentation submitted as evidence, we are assured that the standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iii. they implement a fair and appropriate process for assessing applicants' prior learning and experience.

☒ MET

☐ NOT MET

Findings and evidence to support this

Recognition of prior learning falls within the remit of the UoP's academic regulations and policies, which are available to prospective students via the BCNO Group's website. The UoP's policy for recognition of prior learning comprehensively sets out the process for consideration of APCL and APEL.

As part of the admissions process, applicants are encouraged to discuss the accreditation of prior learning with senior members of the faculty. Historically, senior members of faculty have reviewed any application for APCL/APEL and used a detailed form to map prior learning to the learning outcomes of the course. UoP audit all applicant qualifications at enrolment.

We were assured, in our meetings with SMT, that existing policies, procedures, and documentation were being repurposed. However, at the time of the visit, this mapping form was not available for the new three-year programme.

Based on our meetings with the SMT, and the documentation submitted as evidence, we are assured that overall, this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should review its policies to ensure alignment with recent structural and strategic changes within the organisation and to ensure all out of date policies are updated. Furthermore, efforts should be made to centralise policy access through a single repository, wherever feasible. (1i, 1iii, 1iv, 2ii, 4iii, 9v)

Conditions

None reported.

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iv. all staff involved in the design and delivery of programmes are trained in all policies in the institution (including policies to ensure equality, diversity and inclusion), and are supportive, accessible, and able to fulfil their roles effectively.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

During the visit, staff were able to confirm that they had access to all the BCNO Group policies via the VLE, MS Teams, and the BCNO Group website. Whilst staff were confident that they could find policies, it was noted that navigation across the various platforms could be slightly cumbersome, and consideration might be given to placing all policies into a single repository for ease of access.

During our meetings with various members of the faculty, it was evident that staff had received training on key policies, either as part of their induction or where key policies had been introduced. Where policies had been updated, changes were communicated to staff by email and via the staff newsletter.

Based on our meetings with members of the faculty and through access to the various BCNO platforms, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should review its policies to ensure alignment with recent structural and strategic changes within the organisation and to ensure all out of date policies are updated. Furthermore, efforts should be made to centralise policy access through a single repository, wherever feasible. (1i, 1iii, 1iv, 2ii, 4iii, 9v)

Conditions

None reported.

v. curricula and assessments are developed and evaluated by appropriately experienced and qualified educators and practitioners.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

It was evident during the visit that the BCNO Group has a vast amount of experience within its faculty. However, whilst the development of the new three-year course has been led by appropriately qualified and experienced educators, the group responsible for this task had been restricted due to the perceived pace of strategic change within the organisation. As such, there is work to be done to fully engage the broader BCNO Group academic community in the development of the course, prior to its inception in September 2025.

A recommendation to approve the new three-year programme had been made to the Senate of UoP and it was confirmed that this had been accepted when the visiting team met with the UoP's Partnership Manager for the BCNO Group.

Based on the evidence presented during the visit, and our meetings with the SMT, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

vi. they involve the participation of students, patients and, where possible and appropriate, the wider public in the design and development of programmes, and ensure that feedback from these groups is regularly taken into account and acted upon.

☐ **MET**

☒ **NOT MET**

Findings and evidence to support this

It was evident, during the visit that student, patient, and wider public participation in the design of the programme had been relatively limited. The new course has been presented to the patient engagement committee. Similarly, whilst most of the faculty were supportive of the new three-year programme, active involvement in the course design appeared to be limited to senior management and, to a lesser extent, course leaders.

The new three-year programme largely draws from existing programmes and the content is well understood. However, delivering it as a condensed programme poses challenges, especially with limited stakeholder engagement, which could hinder effective solutions. This is crucial due to the BCNO Group's recent decision to place their entire strategic focus on delivering the new programme at a single site.

Generally, the BCNO Group has made concerted efforts to engage with the student voice through membership in various committees. However, this engagement had seen limited success. In meetings with both students and alumni, the issue of response to student feedback was consistently raised as an area of concern. They also appeared sceptical as to the efficacy of current communication channels, with most of those present at the meeting with visitors were seemingly unaware of the process for reporting in to, and receiving information out of, their student representatives on these committees.

Given the condensed nature of the new three-year programme, the BCNO Group should consider how to better engage with its students within the broader context of the organisation's operational management. For instance, the BCNO Group has not yet fully consulted with support services in designing the new programme. This could help identify new ways of working or additional resource needs to support students during the intensive three-year period of study. Similarly, students report having a strong rapport with classroom and clinic tutors. The BCNO Group might explore these areas as potential channels of formal communication between the student body and the wider organisation.

In discussions with both students and alumni, the issue of "burnout" was frequently raised, with both groups expressing concerns about the additional pressures imposed by the new three-year programme. However, the faculty asserted that the condensed format of the course would yield significant benefits for future students. This situation highlights a disparity between the perceptions of the faculty and the students that should be examined before the implementation of the new three-year programme.

Levels of engagement in the programme design have, in part, been driven by the recent structural changes to the BCNO Group. Nevertheless, based on the evidence seen at the visit, we are of the opinion that this standard is not met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should consider ways of incentivising students to become student representatives and attend all meetings to ensure their voice is more effectively heard and consider additional ways of significantly improving student response rates to surveys and module feedback. (1vi, 2i, 2iii, 3ii, 6v)

Conditions

In the continued design of the new three-year programme, the BCNO Group must ensure comprehensive engagement with all areas of the organisation involved in or affected by its delivery. This engagement must thoroughly address student concerns about the increased pressures associated with completing the course in a condensed format and ensure that adequate resources are available to support their studies. Additionally, the BCNO Group needs to consider the perspectives of support staff, teaching staff, clinic tutors, and patients to ensure that the programme's design encompasses all aspects of delivery.

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).

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The new three-year programme is an abridged version of the existing programmes currently offered at the BCNO Group. Consequently, the majority of the content has been evaluated to ensure it aligns with the OPS, SET and the skills, knowledge base, attitudes, and values outlined in the GOPRE. The programme specification for the three-year programme is clearly mapped against programme intended learning outcomes, GOPRE and the OPS, as is programme module information.

There are well established mechanisms in place to monitor and ensure that students are exposed to a diverse range of patient presentations. The BCNO Group operates a range of specialist clinics that include sessions for headaches, paediatrics and balance and stability classes. There are also opportunities for students to explore interdisciplinary opportunities through collaborative initiatives with local dementia and physiotherapy services. Students reported that they were well supported into clinic and clinic staff were very adaptive to their individual needs. The mechanisms used for appropriately allocating specific patient types to specific students were effective and students have access to a suitable range and number of patients. However, some students raised concerns that they were not adequately prepared for some of the specialist clinics and only received the prerequisite training the week prior to beginning practice at those clinics.

Based on evidence submitted for the visit and our meetings with the SMT and faculty members, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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viii. assessment methods are reliable and valid, and provide a fair measure of students' achievement and progression for the relevant part of the programme.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group provides assessment criteria, weightings, and module descriptors for all assessment activities. These are shared with students and faculty through programme handbooks, module descriptors, and assessment briefs. This information is populated through the VLE and MS Teams. The new three-year programme is an abridged version of the existing programmes, so much of this information already exists. However, at the time of the visit, some modules required development and the programme quality handbook for the new programme, remains to be completed.

The faculty provides continuous feedback through tutoring and formative assessments. During meetings with student representatives, some concerns were raised regarding the timeliness and usefulness of certain feedback. Specifically, students reported difficulties in correlating feedback comments with the marks they received. This view was also expressed in our meetings with alumni.

The BCNO Group implements a moderation process, as outlined in their assessment setting, marking, and moderation policy. The forms employed during this moderation process are supplied to the external examiner, in accordance with the regulations of UoP. The UOP's Partnership Manager for the BCNO Group, has confirmed the appointment of an external examiner for the new three-year programme. Failed assessments, along with 20 percent of passed assessments, are subjected to anonymous double marking, as well as any work assessed by a new tutor.

Based on our meetings with the SMT and documentation submitted as evidence we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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ix. subject areas are delivered by educators with relevant and appropriate knowledge and expertise (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).

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group recruitment policy sets out a comprehensive framework to ensure that selection of new teaching staff is based on the specified criteria for skills, experience and qualifications set out in the job description and the role profile.

All osteopathic teaching faculty members are registered with the GOsC. During the visit, it was evident that the faculty members who met with the team were highly qualified and experienced. Several operational groups monitor the quality of teaching, and these efforts are reinforced through various feedback mechanisms, including a peer review process, the NSS and EE reports. Staff members who are new to teaching are supported into assistant roles within the classroom.

The BCNO Group keeps a register of all staff qualifications, which identified that over 20% of faculty have specific qualifications in teaching. During our meetings with the SMT we were informed that there was a limited budget for supporting staff development. However, in discussions with faculty, it became evident that there is no formal performance management process in place to identify areas for staff development. As

such, the BCNO Group should consider establishing a formal performance management process to identify areas for future staff development.

Based on the documentation submitted as evidence, and our meetings with the SMT and faculty, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should reinstate their formal yearly staff review process and provide staff with a process by which they can develop if they wish to. (1ix, 8i)

Conditions

None reported.

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x. there is an effective process in place for receiving, responding to and learning from student complaints.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

There are established procedures for managing student complaints, which are readily available. The SEG and programme committee meet regularly, providing a forum for student representatives to give feedback on areas of good practice or specific concerns. Meetings with the SMT indicated that student engagement can be challenging, and students mentioned feeling disconnected from their student representatives.

Overall, the BCNO Group have endeavoured to engage with the student voice and had established a number of processes to allow this to happen. However, both the BCNO Group and the student body recognised that this was not working as effectively as hoped. Therefore, the BCNO Group should reconsider how they engage with the student voice, potentially leveraging off the positive relationships at the classroom and clinic levels to create alternative, formal, lines of reporting.

Given the BCNO Group's resolve to find effective solutions in this area, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should evaluate their current methods of engaging with the student voice and develop procedures to ensure that student concerns are effectively identified and directed to the relevant area within the organisation for resolution in a timely and effective manner. (1x, 6vi)

Conditions

None reported.

xi. there is an effective process in place for students to make academic appeals. ☒ MET ☐ NOT MET

Findings and evidence to support this

The BCNO Group has adopted the UoP's appeals policy, which outlines the procedure for students seeking a review of decisions made by an academic board. For the new three-year programme, appeals will be submitted directly to the validating university. When necessary, students are able to seek additional support from the Student Union at the UoP.

During the 2023/24 academic year, there were two academic appeals. One of these appeals involved a UoP student and, at the time of the visit, this appeal remained outstanding.

Based on the evidence provided for the visit, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

2. Programme governance, leadership and management

i. they effectively implement effective governance mechanisms that ensure compliance with all legal, regulatory and educational requirements, including policies for safeguarding, with clear lines of responsibility and accountability. This should include effective risk management and governance, information governance and GDPR requirements and equality, diversity and inclusion governance and governance over the design, delivery and award of qualifications.

☐ **MET**

☒ **NOT MET**

Findings and evidence to support this

The BCNO Group committee structure consists of 16 committees and sub-committees including student, faculty and patient experience groups who are able to give their feedback to the Academic Board and SMT. In summer 2024 a survey with multiple sections covering organisation and understanding of role was undertaken to test the effectiveness of these current governance structures and mechanisms. Feedback from the surveys led to some changes including guidance on committee remit, quorum, responsibility for policies, training, and support. Details and updates were given in the student newsletter November 2024.

Following recent changes and the decision to teach out programmes in London, the Board is in the process of allocating workflows so that a new strategic plan for the next five years is agreed. The Board believes it has achieved its number one strategic objective by securing adequate financial resources to provide existing students with a full and enriching study experience and have the resources to deliver this. The Board told us that over the next five years, decisions will need to be made around educational delivery in the UK post-graduate and international options, plus identifying an economically viable future for the charity. They also intend to undertake another review of current operational and governance structures and measure their suitability within the current context.

The Board have provided a project schedule plan for the three-year programme which sets out targets and dates for the planning, development, implementation, and evaluation. Bearing in mind the considerable changes that have taken place it is felt necessary for the Board and SMT to expand this to produce a clear strategic development plan which would help staff and all stakeholders understand the BCNO Group's future direction. At the RQ visit on 11–13 January 2022, a recommendation was made for a similar plan to be developed but this was not undertaken. Extensive marketing information and financial oversight and predictions have been used to guide the Board's decision-making but a document giving clear strategic future planning over the next three to five years does not currently exist.

There are opportunities for all staff and students to be represented through the current governance structure but attendance at meetings is often quite low, particularly for student representation. This is recognised by SMT. Students tell us they feel their workload is such that representation at meetings and survey responses is not a high priority. In order for the BCNO Group to ensure greater engagement and a fuller student response, ways of incentivising them to become student reps should be considered.

The risk register is managed by the SMT and reviewed on a termly basis. The risk register provided identifies risks associated with governance, operations, finance, external factors, and students. Although each risk is scored for likelihood and impact, the current score dates varied from July 2020 to October 2024. Given the rapid pace of change within the BCNO Group and the impact of recent decisions it would be more useful for the risk register not just to be reviewed but also updated on a monthly basis.

Safeguarding is reported to a dedicated team who maintain a central repository. Processes and outcomes are reviewed annually through safeguarding audits. Safeguarding information and reminders are communicated via newsletters to staff and students on the VLE and on posters displayed in various locations, including clinics.

Although we were assured that the BCNO Group has a clear governance and management structure to ensure compliance with legal, regulatory and educational requirements with policies, guidance and terms of reference in place, we feel a clear strategic plan is needed to clearly show development plans over the next three to five years.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should consider ways of incentivising students to become student representatives and attend all meetings to ensure their voice is more effectively heard and consider additional ways of significantly improving student response rates to surveys and module feedback (1vi, 2i, 2iii, 3ii, 6v).

The BCNO Group should consider ensuring the risk register not just to be reviewed but also updated on a monthly basis and link this to the strategic development plan.

Conditions

To allow staff and stakeholders to understand the changes that are taking place and to ensure there is a clear direction and milestones to increase accountability and the effectiveness of the management structure, the BCNO Group must produce a strategic plan document which gives an overview of their plans for development over the next three to five years showing clear timeframes, costings, and areas of responsibility. (2i, 4iii)

ii. have in place and implement fair, effective and transparent fitness to practice procedures to address concerns about student conduct which might compromise public or patient safety or call into question their ability to deliver the Osteopathic Practice Standards.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BNU FtP policy was reviewed and approved via the BCNO Group committee structure in October 2024. FtP policies and procedures follow those set by the university with local adjustments made for the context and profession specific requirements. These are published to staff and students via the VLE and website. For the three-year course the policy will need to be aligned to the UoP, who will be validating the three-year programme, rather than BNU. The University notes that the UoP FtP is already in place for current UoP course students.

Students and staff told us they are aware of policies and procedures for FtP but access to the policies is not always straightforward. It was felt that it would be useful for all the policies relevant to the three-year programme to be placed together so that, for instance, policies shared with the UoP are more easily found.

The BCNO Group ensures that its students are not only familiar with its FtP procedures but also various GOsC guidance documents including applicants and students with a disability or health condition, student FtP guidance, and student guidance on professional behaviours and FtP for osteopathic students. The PPH also provides a repository of relevant information for staff and students while in clinic or practical classes with regard to conduct which may compromise public or patient safety.

The FtP policies, guidance, and procedures aligned to the UoP are in place. These are accessible and understood by staff and students so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should review its policies to ensure alignment with recent structural and strategic changes within the organisation and to ensure all out of date policies are updated. Furthermore, efforts should be made to centralise policy access through a single repository, wherever feasible. (1i, 1iii, 1iv, 2ii, 4iii, 9v)

Conditions

None reported.

iii. there are accessible and effective channels in place to enable concerns and complaints to be raised and acted upon.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group conducts an annual review of its complaint management procedures. In 2024, the BCNO Group identified the need to update the complaints procedure which has been approved through the committee structure and the UoP.

During meetings as part of the visit, students told us there are channels in place to raise concerns and offer feedback, but most feel they do not always have sufficient time to respond to some of the surveys or feel disillusioned that their feedback may not be listened to. They told us that concerns around clinical issues are resolved more effectively. Their experience of raising concerns about academic matters was that changes and responses were much slower and less forthcoming. Students told us that their student representatives find the additional demands on their time difficult to manage. During our visit it was noted that there were five vacancies on the SEG although a recruitment round was in process.

Students and staff informed us there are effective channels in place to enable concerns and complaints to be raised but have some reservations over how effectively they are acted upon.

Patients met with as part of the visit told us they are happy with the opportunities they have to raise concerns, complain, or make compliments either electronically, in person, or over the phone and do receive follow up from the clinic in a timely and respectful manner.

The AGC reviews complaints from students, staff, and patients at each meeting as a standing agenda item, which helps identify any recurring themes. Complaints and feedback through evaluations and surveys are used to review and improve teaching and learning but student engagement with this is low. For example, semester 1 and 2 module feedback varied from 0% to 41% with an average of 16% response rate.

Many students told us they prefer to chat with a member of staff rather than going along a more formal route so there is a danger that concerns, complaints, and feedback may not be logged and therefore a review of complaints will be incomplete. However, there is a log for HoDs to log complaints made formally. Students

were happy with the opportunities for giving feedback or raising concerns and complaints but were not always aware of whether they were acted upon so tended not to use them. It was felt that the BCNO Group could restore more confidence in the student body that they were acting upon their concerns and feedback by informing the students of any changes more effectively. This could be through regular 'you said we did' communications.

Overall, we found there were procedures and opportunities in place to enable concerns and complaints to be raised and acted upon. Our meetings with staff, students, and patients confirm this so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should consider ways of incentivising students to become student representatives and attend all meetings to ensure their voice is more effectively heard and consider additional ways of significantly improving student response rates to surveys and module feedback (1vi, 2i, 2iii, 3ii, 6v)

The BCNO Group should consider communicating with students more frequently upon their concerns and feedback and how this has been acted upon through a simple 'you said we did' format in order to encourage greater student engagement in the more formal feedback channels.

Conditions

None reported.

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iv. the culture is one where it is safe for students, staff and patients to speak up about unacceptable and inappropriate behaviour, including bullying, (recognising that this may be more difficult for people who are being bullied or harassed or for people who have suffered a disadvantage due to a particular protected characteristic and that different avenues may need to be provided for different people to enable them to feel safe). External avenues of support and advice and for raising concerns should be signposted. For example, the General Osteopathic Council, Protect: a speaking up charity operating across the UK, the National Guardian in England, or resources for speaking up in Wales, resources for speaking up in Scotland, resources in Northern Ireland.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Staff and students are informed about the BCNO Group's anti-bullying and harassment policy, sexual violence, and misconduct policies and procedures during induction. Through the dedicated VLE section there are a range of policies, learning resources, and guidance materials. Staff, students, or patients who feel they are being harassed are encouraged to follow the procedures outlined in these policies and the BCNO Group is committed to scrutinising any allegation of harassment with care and diligence. Staff, students, and patients told us they would feel confident to speak up if they witnessed unacceptable or inappropriate behaviour and are aware of procedures to follow.

There are also a number of current policies including the student code of conduct and dignity at work which emphasises the behaviour expected of the BCNO Group staff and students.

In addition to support available internally through personal tutors, the Student Engagement and Welfare Officer and student counsellors, students and staff have access to a number of external agencies who can provide additional support. This is signposted on the student welfare leaflet and VLE including access the Health Assured Programme and links to Samaritans, Shout and Stay Alive.

We found there were policies and procedures in place as well as key staff available to listen and signpost staff, students or patients if further support is needed. Our meetings with staff, students and patients confirm this so we are confident that this standard is met.

Strengths and good practice

The appointment of the Student Engagement and Welfare Officer shows recognition of the importance of student welfare and well-being and has begun to lead to students feeling more supported and effectively signposted.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. the culture is such that staff and students who make mistakes or who do not know how to approach a particular situation appropriately are welcomed, encouraged and supported to speak up and to seek advice.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Students tell us they have a number of informal and formal channels open to them to seek support and advice including personal tutors, the Student Engagement and Welfare Officer, or approaching a trusted member of staff. There are two student counsellors and 24 hour telephone support through the employee/student assistance programme. The full range of support is evidenced in the student welfare leaflet and student newsletter.

There have been a number of changes to the personal tutor system which is outlined in the personal tutor policy but most of the students we spoke to told us that they do not find the personal tutor system effective and many have not really engaged with their personal tutors more than once or twice throughout their course. The students have set up their own supportive WhatsApp group which they find useful in terms of sharing concerns or seeking advice or support particularly with their workload.

The BCNO Group has an ‘open door’ policy allowing staff and students to report concerns to a member of staff or faculty. Staff and students tell us they do feel confident to speak up and seek advice and support if needed.

Complaints from staff, students, and patients are centralised and presented to the SMT and then the AGC to help triangulate concerns which may need addressing strategically by the Trustees.

Students are asked to provide feedback on their clinical tutors every six weeks to ensure support for students and to flag any potential issues with tutors. Student engagement with this is variable with a recent response rate of under 20%. Tutors who have poor feedback meet with the Head of Clinical Education and undergo peer observation of their clinical teaching following induction for new clinic tutors. Clinic tutors have termly meetings chaired by the Head of Clinical Education to discuss updates and student progression, evidenced in the meeting agendas.

Lecturers undergo peer observation of teaching by heads of department and feedback is provided and where needed support is given. From discussions with staff, the frequency of these observations and quality of feedback offered is variable

We found there were channels and procedures for students and staff to follow with key staff available to listen and signpost further support if needed. Our meetings with staff and students confirm this so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

vi. systems are in place to provide assurance, with supporting evidence, that students have fully demonstrated learning outcomes.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

As part of the annual programme monitoring, assessment processes and outcomes are reviewed to ensure students are meeting the approved learning outcomes. This is evidenced in module outcome reports, student characteristics and outcomes reports, and EE reports. The BCNO Group already have a well-established, strong relationship with the UoP and have completed the validation process for the new three-year course.

Existing processes will be used for the three-year programme including academic teams marking and providing feedback using the marking rubric to help students identify areas for improvement. A rubric and marking criteria for each assessment is available for students, along with the marking criteria. There is also a guide for staff to assist in marking and an internal moderation for each assessment. Students told us the marking criteria and rubrics are useful but they feel there is still considerable variation in the quality of feedback offered and marks given.

The BCNO Group also use an internal approval process prior to the assessments being sent to the EE for approval. These steps are planned to aid internal and external scrutiny. EE reports provide feedback on and moderation of the assessments. Feedback from EE is largely positive but does indicate the need for more feedforward comments and indicates some variance in the quality and standards of marking. EEs also provide feedback to the SMT regarding the credibility of assessment and whether it meets the requirements

of the regulatory body. Our meeting with the UoP confirmed they have a very positive working relationship with the BCNO Group and a new EE is in the process of being appointed for the three-year programme.

We found there were systems in place to provide assurance that students have demonstrated their learning outcomes and evidence from EEs supports this, so we are confident that this standard is met.

Strengths and good practice

The BCNO Group has developed a strong, positive relationship with UoP where feedback is valued and acted upon.

Areas for development and recommendations

None reported.

Conditions

None reported.

3. Learning Culture

i. there is a caring and compassionate culture within the institution that places emphasis on the safety and wellbeing of students, patients, educators and staff, and embodies the Osteopathic Practice Standards.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group strives to maintain a culture of caring and compassionate leadership, recognising the importance of the safety and wellbeing of all the students, patients, and staff. This is backed up by a range of policies including; safeguarding, dignity at work, FtP, FtS, anti-bullying, EDI, prevent, whistleblowing and study and wellbeing.

Management and Board meetings have EDI, Prevent, health & safety, safeguarding, and training and development as standing agenda items.

The Head of HR takes a lead role in coaching managers to deal effectively with any issues that might arise and supporting those new to people management. Advice and more formal training is arranged if required, and students and staff can access the Health Assured assistance programmes if a situation arises that might be better supported externally.

Annual audits of safeguarding policies evaluate the effectiveness of processes and procedures and helps to identify any issues or recurring themes. The BCNO Group now use SharePoint as a central repository for safeguarding which, they feel, has enhanced their ability to manage information more efficiently.

Student attendance is carefully monitored by the Student Engagement and Welfare Officer who is notified if a student's attendance falls below 80%. Students whose attendance falls below 80% receive an email notifying them of this, with the welfare office copied, and offering support. Since this intervention there has been a marked improvement in attendance and increased engagement with both the registry and academic staff.

Safeguarding reminders are visible and accessible, with posters displayed in clinics, staff and student areas and regular updates sent through newsletters.

Staff have access to the EAP, which gives independent advice on various topics, including financial matters, and mental health and wellbeing support as well as providing a 24-hour helpline.

Stakeholders are currently reviewing a new staff policy on stress management dated November 2024. The BCNO Group believe this, together will additional resources offered will help foster an even more supportive work environment.

We found relevant policies are in place relating to the safety of staff, students, and patients. Our meetings with staff and students confirmed that a caring and compassionate culture is evident, so we are confident that this standard is met.

Strengths and good practice

The monitoring of student attendance is a good first step in leading to more effective engagement and support for students who may be struggling.

Areas for development and recommendations

None reported.

Conditions

None reported.

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ii. they cultivate and maintain a culture of openness, candour, inclusion and mutual respect between staff, students and patients.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group promotes a culture of openness and candour by providing staff, students, and patients with opportunities to voice their feedback and concerns through involvement in a number of committees and experience groups. Discussions about student-related issues are held during SEG meetings, and discussions about patient-related issues take place during PEG meetings. The FEG feed through to the programme leads who report back to the faculty. Student and staff representatives also form a key part of Board and governance meetings as well as being represented on the Board of Trustees.

SMT recognise that student engagement is quite low and are keen to improve this. Students acknowledge there are opportunities, but their perception is that workload and time issues hinder greater engagement and participation. The BCNO Group do create a range of opportunities for additional feedback including online surveys and informal meetings with programme leads or SMT to share their thoughts and concerns.

Faculty and support staff are members of the SIWAC which is a key forum for gathering feedback on the student population as a whole. Membership of this group includes the Student Engagement and Welfare Officer, personal tutors, heads of department, programme leads, and registry officers.

The BCNO Group has relevant guidelines for staff and student behaviour and expectations and tracks its complaints and disciplinaries for both students and staff annually.

We found relevant policies and processes are in place to encourage and monitor a positive respectful culture between staff, students, and patients. Our meetings with staff and students confirm a culture of openness, candour and respect is evident so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should consider ways of incentivising students to become student representatives and attend all meetings to ensure their voice is more effectively heard and consider additional ways of significantly improving student response rates to surveys and module feedback. (1vi, 2i, 2iii, 3ii, 6v)

Conditions

None reported.

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iii. the learning culture is fair, impartial, inclusive and transparent, and is based upon the principles of equality and diversity (including universal awareness of inclusion, reasonable adjustments and anticipating the needs of diverse

☒ **MET**

☐ **NOT MET**

individuals). It must meet the requirements of all relevant legislation and must be supportive and welcoming.

Findings and evidence to support this

Through the recently reviewed EDI, RA and FtS policies, the BCNO Group seek to ensure students and staff are treated fairly. Students requiring RA are seen by the Student Engagement and Welfare Officer to enable a swift activation of the RA policy. Students confirm that this process is timely and supportive. Relevant faculty and staff are notified where appropriate and with consent of the student.

Students who struggle to engage with the course are highlighted through poor attendance and feedback from faculty. Informal meetings are arranged with the Programme Lead, Heads of Department, and the Student Engagement and Welfare Officer to support the students. The SIWAC oversees students' support and any trends affecting the attendance.

The BCNO Group has recently reviewed its policies and made a significant shift from focusing on equality to emphasising equity after discussions in SIWAC meetings. Student characteristics and outcomes are monitored, including learning differences, long-term health conditions, age, gender, disability, and ethnicity. This data helps the BCNO Group ensure that the learning culture remains fair, impartial, and inclusive. The approach is grounded in the principles of equity and diversity, promoting awareness of inclusion, reasonable adjustments, and anticipating the needs of diverse individuals.

A range of policies including those from the UoP are in place to meet all legislative requirements. Staff and students tell us that they feel supported, so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. processes are in place to identify and respond to issues that may affect the safety, accessibility or quality of the learning environment, and to reflect on and learn from things that go wrong.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Safety is closely monitored by the Operations Manager, who reports to the CEO, who, in turn, takes a lead role in health and safety matters as Chair of the health and safety committee. This committee meets every other month and considers all aspects of safety, including buildings, students, patients, and staff.

Key areas such as academic appeals, student complaints, and FtP are reported to the AGC. Patient complaints are also directed to the AGC, while whistleblowing incidents are escalated to the Board. This structured approach aims to ensure oversight and adherence to governance standards.

Students are encouraged to voice their concerns formally through SEG and informally through various channels, including meetings with faculty teams, personal tutors, or student representatives. Equally, if faculty note a particular issue, they can raise it directly with the facilities team or their line managers. Health and safety is a standing item on all committee agendas.

The Maidstone site has undergone refurbishment of student and patient areas with new flooring, decoration, new windows and furniture where needed. The refurbishment and modernisation is designed to ensure the learning environment is the best it can be and will provide suitable learning and clinic opportunities for the three-year course. There is also additional suitably equipped space available at the nearby UCM campus.

We found there are policies and procedures in place to reflect on aspects of safety and the learning environment. Discussions with staff, students, and patients confirm their awareness of this so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. students are supported to develop as learners and as professionals during their education.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The latest revision of the personal tutor policy attempted to ensure that all students have effective and suitable academic and professional development during their studies. Students are allocated a member of the academic staff as personal tutors where they can have one-to-one meetings to discuss matters related to their studies, academic professional, or personal support. The personal tutor handbook 2024/25 was produced as result of feedback from staff and was collated by the Student Engagement and Welfare Officer who interviewed personal tutors for feedback on the process. Changes include training for the personal tutors and greater clarity of roles. Personal tutors are expected to provide termly written reports and summaries to the Student Engagement and Welfare Officer, ensuring a support system is embedded across both campuses. These reports highlight any concerns about student engagement, which are followed up by the Student Engagement and Welfare Officer. The reports also help ensure that the personal tutors are engaging and meeting with their tutees. Although the Student Engagement and Welfare Officer reported that the policy is now more embedded and students have engaged well, feedback from students revealed most of them have not taken advantage of the personal tutor systems as stated in the policy. It was felt to be useful to gather more feedback from staff and students on why the personal tutor policy is not working as well as expected; students were surveyed at the end of semester 1 and the Student Engagement and Welfare Officer is reviewing the outcomes.

Students undertaking their research dissertations are allocated a research supervisor who supports the student through the research process. Students tell us they appreciate the range of support offered by the library.

In the clinical setting, students manage their own patients, ensuring they work within the scope of the OPS. Feedback from tutors is collected at the end of a six-week cycle. This information is collated and passed on to relevant tutors for the following six-week cycle to support individual development. Any areas that seem to be cohort related are addressed with tutorials delivered to support learning.

A wide range of study skills are offered through presentations, workshops, and use of the UoP resources, for example, literature searching, plagiarism, referencing, and paraphrasing. The VLE also offers valuable resources, including information on referencing. The study skills handbook has been thoroughly reviewed, updated, and distributed to all year groups.

Guest lectures cover various subjects related to the OPS and graduate outcomes, such as communication, consent, and telehealth.

Professionalism tasks are covered in class through problem-based learning and discussions using case examples on communication, consent, evidence-informed practice, and shared decision-making. Students are assessed through reflective pieces based on their clinic observations and understanding. Students are taught to handle complex cases in clinics under the supervision of qualified osteopaths.

The clinic portfolio is developed throughout the programme and applied to practice, using feedback from the clinic and classroom.

A careers day is organised for students to engage with professional osteopaths, learn about potential CPD and career pathways, and hear from osteopaths who have built successful practices.

Through a range of policies and support students are encouraged to develop as learners and professionals. Discussions with students and patients confirmed they develop their skills, knowledge and confidence throughout the course, so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should gather feedback from staff and students on, and examine the effectiveness of, the personal tutor process, particularly with regard to engagement and frequency of meetings, to understand what is and is not working and to ensure that students have a suitable primary contact for their academic support and pastoral care. (3v, 6ii)

Conditions

None reported.

vi. they promote a culture of lifelong learning in practice for students and staff, encouraging learning from each other, and ensuring that there is a right to challenge safely, and without recourse.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Students are encouraged to become reflective learners through their use of the clinic portfolios, reflective logs, plus a range of additional resources such as anatomy workbooks. In the clinical settings, pre and post session debriefs and tutorials encourage students to question and discuss cases and differential diagnoses.

There is a culture of questioning and challenge where students are encouraged to reflect on their own learning and learn from each other through problem-based approaches, reflective portfolios, lectures, and tutorials.

The BCNO Group's aim is for students to become reflective independent learners and for that to continue throughout their career as osteopaths. Students on the three-year course will have a range of opportunities to learn with and from each other and work in the specialist clinics at the Maidstone campus including those for paediatric, sports, headaches, and MSK ultrasound scans.

Discussions with students confirmed that they do enjoy learning from and with each other and feel well supported by staff to develop as lifelong learners and so we are confident this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

4. Quality evaluation, review and assurance

i. effective mechanisms are in place for the monitoring and review of the programme, to include information regarding student performance and progression (and information about protected characteristics), as part of a cycle of quality review.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group has developed a good relationship with the UoP with well-defined procedures for approving, monitoring, and reviewing academic programmes. Our meeting with the UoP confirmed that the validation process for the three-year programme had gone smoothly. For the coming months there is a project plan which shows the four stages of planning and development, development and preparation, implementation and evaluation. For each phase, start and end dates are shown alongside the person responsible for that area. The BCNO Group has experience of annual review of module and assessment elements, these reviews are conducted and discussed through committee meetings and culminate in the joint Board of Studies meetings. The UoP tell told us that staff are receptive to suggestions and change.

As most stakeholders were not involved in the development of the new programme it would seem prudent to ensure further monitoring and review of the programme includes all stakeholders attending the various committee or project meetings. In order to ensure better representation at future meetings, additional measures should be considered to incentivise attendance. Opportunities for stakeholder views are not currently evident in the project schedule plan submitted. It was noted that there is considerable variance in those attending meetings so there is a danger that full representation, for instance from the student body, may not always be possible.

An earlier analysis of student characteristics revealed that some students with reported disabilities were not succeeding at their first attempt on assignments and certain assessments. This insight prompted the BCNO Group to outsource training on neurodiversity, demonstrating a proactive approach to addressing these challenges. The Student Engagement and Welfare Officer is committed to providing an inclusive learning environment for neurodiverse learners and those who require additional learning support. There are also suitable policies and procedures in place if a student is affected by a disruption in their studies due to personal circumstances.

Our discussions with SMT, the programme team and the UoP confirm that there are mechanisms in place for the monitoring and review of the three-year programme, so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should consider ways of incentivising stakeholders, including students, to regularly attend meetings so that their voice is consistently heard and is representative of the stakeholder views. This will be particularly important in order for stakeholders to give their views and suggestions to the new three-year programme as their involvement is not currently mentioned in the project schedule plan submitted.

Conditions

None reported.

ii. external expertise is used within the quality review of osteopathic pre-registration programmes.

☒ MET

☐ NOT MET

Findings and evidence to support this

The EEs have a key role in quality assurance and enhancement processes and their quality review is used in the annual monitoring of courses. The three-year programme has been through the UoP validation process and a new EE is being appointed prior to the course starting. The validation of these programmes follows the UoP processes, which incorporate external experts from the profession to ensure thorough course reviews.

The UoP confirmed that the BCNO Group are receptive to suggestions and change and are keen to improve and enhance the student learning experience.

Historically EE reports have been used to drive change in earlier courses for example: increasing teaching observations, reviewing the use of rubrics for written feedback, and providing more informal feedback opportunities and feedforward comments.

The use of external expertise in evaluating the quality of osteopathic pre-registration programmes at the BCNO Group also includes Board level involvement and then moves through the formal process of validating programmes with the university. The Board becomes the critical reader overseeing the business model and the plan for the new three-year programme.

The project schedule plan combined with discussions held with SMT, the Board, and the UoP assure us that external expertise has been used with regard to the three-year programme, so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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

☐ MET

☒ NOT MET

Findings and evidence to support this

Management flow chart diagrams provided an outline of the line management structure from experience groups and committees through to Board level. These operate at both strategic and operational levels. Although the management structure aims to ensure transparency by including members with expert knowledge plus input from staff, patients and the student voice, the new programme development only seemed to include senior staff members. The opportunity for most stakeholders to give their input into the new three-year programme was not taken at the development stage and should be addressed at the earliest opportunity. Additionally, attendance at a variety of meetings seemed to include a high number of apologies so there is a danger that true representation, for instance from the student body, may mean the staff and stakeholder voice is diluted.

Although there is a clear management structure there is currently no written strategic development plan which means that the various committees up to Board level may find it difficult to assess progress towards goals or milestones. The current project schedule plan for the three-year programme is a beginning towards this approach but the absence of a strategic plan in all other areas may inevitably lead to difficulties in accountability and financial planning.

The BCNO Group is in the process of ensuring all policies are reviewed in a timely manner and checking they align with HE regulations in accordance with the validating university and GOsC requirements. Students and staff have access to the BCNO Group policies and procedures plus those developed by the validating university through the VLE.

Some staff and students told us the policies are quite difficult to access. It is recommended that access to all policies is more clearly organised for the course the student is undertaking and as a matter of priority all out of date policies are updated. A number of the submitted policies had passed their review date.

There is a clear management structure and a wide range of policies available to all. Our discussions with SMT, the Board, staff, students and patients inform us that the structure works but in order for a clear vision of where the BCNO Group is heading a clear strategic plan with timings, responsibilities, and costings is needed.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should review its policies to ensure alignment with recent structural and strategic changes within the organisation and to ensure all out of date policies are updated. Furthermore, efforts should be made to centralise policy access through a single repository, wherever feasible. (1i, 1iii, 1iv, 2ii, 4iii, 9v)

Conditions

To allow staff and stakeholders to understand the changes that are taking place and to ensure there is a clear direction and milestones to increase accountability and the effectiveness of the management structure, the BCNO Group must produce a strategic plan document which gives an overview of their plans for development over the next three to five years showing clear timeframes, costings, and areas of responsibility. (2i, 4iii)

iv. they demonstrate an ability to embrace and implement innovation in osteopathic practice and education, where appropriate.

☒ MET

☐ NOT MET

Findings and evidence to support this

Innovation is encouraged, shared and developed by the BCNO Group. Good practice and innovation is identified in lesson observations and research activities shared within the department. There are strong links with the London site and considerable possibilities to develop more innovative opportunities in terms of education and practice which would benefit the new three-year course.

From the Maidstone site students will also have opportunities to be involved in specialist provision including paediatrics, sports, headaches, MSK ultrasound clinics and with NHS links to observation in orthopaedic surgery.

Documentation and discussions with staff and students assure us that opportunities for innovation are sought by the BCNO Group and appreciated by the students. We are confident that this standard is met.

Strengths and good practice

Students really appreciate the opportunity to become involved in the specialist clinics at the Maidstone site.

Areas for development and recommendations

None reported.

Conditions

None reported.

5. Resources

i. they provide adequate, accessible and sufficient resources across all aspects of the programme, including clinical provision, to ensure that all learning outcomes are delivered effectively and efficiently.

☒ MET
☐ NOT MET

Findings and evidence to support this

The BCNO Group has centralised the delivery of the new three-year programme to a single location at Tonbridge Road in Maidstone. The clinic area spans two floors and includes disabled access at the rear of the building and patient hoists for those with mobility issues. The clinic rooms are well-equipped and there are designated breakout areas that provide suitable spaces for interactions between students and tutors.

There are three teaching areas, which are designed as versatile spaces that can facilitate both practical and academic instruction. These areas are equipped with screens capable of projecting information from the VLE and other media sources.

The premises include good catering services, and designated areas are available for students to socialise. Following the recent closure of the Boxley House site, the Tonbridge Road site has undergone significant refurbishment, including the consolidation of library services. The library provides comprehensive access to textbooks, journals, interactive media, and support services, such as literature searches. Additionally, students can access resources and facilities at the UoP.

The BCNO Group has leased additional space at the UCM. This site, located 5 minutes from the Maidstone campus, is designated for accommodating staff and conducting future teaching or student assessments. Based on our observation during the visit, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. the staff-student ratio is sufficient to provide education and training that is safe, accessible and of the appropriate quality within the acquisition of practical osteopathic skills, and in the teaching clinic and other interactions with patients.

☒ MET
☐ NOT MET

Findings and evidence to support this

The BCNO Group adheres to an educator-to-student ratio of 1:10 for practical classes and between 1:4 and 1:8 in clinical environments. This is consistent with relevant guidance documents, including the GOPRE and SET. Academic tutors are typically assisted by teaching assistants in the classroom.

During the visit, it was observed that both academic lessons and clinic sessions consistently followed these ratios, and discussions with student representatives indicated that they received sufficient support during their lectures and clinic sessions.

In meetings with the SMT we were assured that the BCNO Group would maintain similar staff to student ratios for the new three-year programme. However, at the time of the visit, roles within the restructured organisation were not fully agreed.

Based on these observations, and information provided to us during the visit, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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iii. 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.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group has a RA policy which states that students who declare a disability, either at the point of offer or as soon as they become aware of it, will receive support from the Student Welfare Officer to find appropriate solutions. During discussions with student representatives, it was noted that when such disabilities were declared, the BCNO Group has historically been very responsive in addressing their needs.

The BCNO Group uses hydraulic couches in their clinical and teaching area but none of these are electronically operated. In our discussions with support services staff, we were informed that adjustments for visually impaired students, such as the use of tablets for recording notes, could be accommodated. However, it was reported that there were no immediate plans to move from manual records to EPR.

The BCNO Group provides disabled access to the clinic, and classrooms are located on the ground floor. The administration has indicated that it will accommodate student requests for preferred seating arrangements in class, and room allocations in the clinic, where reasonable. During our meeting with support service staff, the Student Engagement and Welfare Officer reported that they had initiated training on neurodiversity to offer an additional level of support to both students and staff.

Whilst the BCNO Group might consider making some adjustments, such as the adoption EPR, overall, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should consider implementing electronic patient records to adequately equip students for future roles in contemporary clinical practice.

Conditions

None reported.

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iv. there is sufficient provision in the institution 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.

☒ **MET**
☐ **NOT MET**

Findings and evidence to support this

During the visit, the team observed that students had access to quiet study areas, private meeting rooms, and social spaces. It was evident that students were able to utilise the space and equipment to form study groups to practice techniques and discuss their studies.

The BCNO Group can provide quiet, contemplative, spaces for prayer if necessary. Returning new mothers are supported in their studies with accommodations such as access to refrigerators for breastmilk storage if needed.

Based on our observations during the visit, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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v. that buildings are accessible for patients, students and osteopaths.

☒ **MET**
☐ **NOT MET**

Findings and evidence to support this

The Maidstone campus offers disabled access to ground floor areas for wheelchair users and individuals with disabilities. Whilst treatment rooms are based over two floors, there are several that can be found on the ground floor, which offers ease of access for patients, students, and staff.

There are three classrooms that can also be found on the ground floor but other areas of the campus, such as the library, can only be accessed via a staircase, which could prove challenging for people with mobility issues. However, there are well established processes for managing RA, which have proven effective in the management of these types of issues, and students have extensive access to library resources online.

The BCNO Group conducts thorough risk assessments, in accordance with insurance requirements, to ensure that the premises are safe for patients, students, and staff. This process is overseen by the health and safety committee which meets on a quarterly basis.

Based on our observations during the visit, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

6. Students

i. are provided with clear and accurate information regarding the curriculum, approaches to teaching, learning and assessment and the policies and processes relevant to their programme.

☐ MET
☒ NOT MET

Findings and evidence to support this

Prospective students can obtain detailed information about the course on the BCNO Group website. The website provides an overview of the course, including an outline of the modules over the three years of study. Additionally, it offers a breakdown of the study hours, thereby providing prospective students with an understanding of the expected levels of study commitment.

The UoP partner student information handbook provides students with a basic overview of the organisation, including key personnel, facilities, and resources. The new three-year programme specification provides students with a more detailed breakdown of the modules to be studied, and includes information on module content, module assessment, module aims and learning outcome. However, at the time of the visit, this document was in draft form and will need to be signed off prior to the September 2025 start date for the new three-year programme.

The new three-year programme is primarily based on a condensed version of existing programmes, so much of the content for the module handbooks already exists. However, some modules need to be developed specifically for the new three-year programme. Additionally, programme documentation, including the programme handbook, must be approved before the modules can be officially implemented.

All enrolled students have access to the VLE, which serves as a repository for course information, processes, and policies related to their studies. However, considering the recent strategic changes to the BCNO Group, it is recommended that this content is reviewed to ensure its completeness, consistency, and relevance.

Based on the evidence seen at the visit we are of the opinion that this standard is not met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

The BCNO Group must ensure that all relevant course materials have been reviewed, approved, and are in place before the commencement of the new three-year programme.

ii. have access to effective support for their academic and welfare needs to support their development as autonomous reflective and caring Allied Health Professionals.

☐ MET
☒ NOT MET

Findings and evidence to support this

The support services team offers pastoral care and assistance to students, addressing both academic and welfare needs. Students receive detailed information about support services and are assigned a personal tutor as their first contact for academic and pastoral issues during the initial weeks of their studies. The personal tutor role is coordinated through the Student Engagement and Welfare Officer and the role is detailed in the personal tutor handbook.

The personal tutor handbook is intended to clarify the responsibilities of the role and states that personal tutors should meet with first year students at least five times through the year and at least once per semester with students in their second, third, and fourth year. It also stipulates that meetings should be recorded, with agreed actions forwarded to the Student Engagement and Welfare Officer at the end of each term.

Discussions with student representatives highlighted differences in their experiences with the personal tutoring system. Some students reported meeting their tutor only once or twice over four years. This finding contrasts with the intended design of the personal tutor policy and warrants examination to understand why it is not functioning as planned. Student representatives also spoke about the workload during the four-year course. They stated that the holidays were vital to their physical and mental health. They also shared their concerns about the new three-year course and the impact on student welfare

During our meeting with support services staff, it was noted that they had not been consulted on the design of the new three-year programme. As student welfare is likely to present a particular stress point for a condensed three-year programme, it should be thoroughly considered in the programme's design and delivery.

During meetings with the SMT and support services, we learned that students have access to a 24-hour helpline offering legal support and up to six free counselling sessions, if needed. Attendance policies are established to identify students who may be "at risk" and to implement early intervention strategies. However, student representatives report that some “at risk” students are being missed, so the BCNO Group may need to reassess the efficacy of their policies/processes in this regard.

Based on the evidence presented at the visit, and our meetings with Students and support services, we feel that without additional welfare monitoring in place for the new course this standard is not met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should gather feedback from staff and students on, and examine the effectiveness of, the personal tutor process, particularly with regard to engagement and frequency of meetings, to understand what is and is not working and to ensure that students have a suitable primary contact for their academic support and pastoral care. (3v, 6ii)

Conditions

The BCNO Group must increase student welfare monitoring in order to provide assurance that students are coping with the new course, able to engage in their clinical studies and ensure the BCNO Group can deal with any issues which may arise due to workload issues. (6ii, 7ii)

A monitoring visit must be conducted during the second year of the new programme to review its delivery, with particular emphasis on meeting students' academic and welfare needs. This visit should include direct

contact with students and staff to provide assurance beyond the requirements of the annual reporting process.

iii. have their diverse needs respected and taken into account across all aspects of the programme. (Consider the GOsC Guidance about the Management of Health and Disability).

☒ **MET**
☐ **NOT MET**

Findings and evidence to support this

Students are encouraged to disclose disabilities either on their applications or when they first become aware of them. The Student Engagement and Welfare Officer will assess their needs and make suitable adjustments where possible. Students can discuss their needs throughout their studies, and systematic checks allow for declaring changes in health or learning needs. Meetings with student representatives indicated that the BCNO Group effectively responds to requests for reasonable adjustments.

During the meeting with the support services team, it was noted that they had initiated neurodiversity training for staff. Furthermore, there is a SIWAC that monitors student performance to identify potential issues early and provide appropriate support. Based on our meetings with Support Services, and documentation presented as evidence for the visit, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. receive regular and constructive feedback to support their progression through the programme, and to facilitate and encourage reflective practice.

☒ **MET**
☐ **NOT MET**

Findings and evidence to support this

Feedback is given for both formative and summative assessments, enabling students to utilise this information to reflect on strengths and weaknesses, and to direct their future learning. An EE report identified that the feedback provided lacked feedforward opportunities and student representatives stated that they sometimes had difficulty in correlating feedback comments with the marks they received. This view was also expressed in our meetings with alumni. Whilst the BCNO Group have attempted to address the subject of feedback through staff development days, it may be necessary to re-explore this area to ensure the efficacy of training.

Whilst there are areas that the BCNO Group should consider in order to improve the consistency and relevance of constructive feedback, based on the evidence presented for the visit we were assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should consider how they ensure that changes, made in response to identified problems, are monitored to ensure that they are effective.

Conditions

None reported.

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v. have the opportunity to provide regular feedback on all aspects of their programme, and to respond effectively to this feedback.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Several formal channels exist for student feedback. The student body is represented on the SEG, which convenes once a term, separately under both UoP and BNU cohorts. However, the BCNO Group acknowledges challenges in engaging with the student body and recognises the necessity to evaluate the effectiveness of student representatives. In meetings with student representatives, there was scepticism as to the efficacy of current communication channels, with most of those present at the meetings seemingly unaware of the process for reporting in to, and receiving information out of, their student representatives on these committees. As such, the BCNO Group might consider exploring other channels for formal feedback, such as leveraging off the positive relationships between students and academic/clinic tutors.

More generally, students reported that feedback was effectively implemented in the clinic, however, they noted delays in addressing concerns related to the academic components of the course. These delays resulted in changes being made in subsequent years rather than promptly.

Students indicated that they had a clear understanding of the processes available to them for raising concerns. They expressed confidence in their ability to report issues related to breaches in the OPS without facing prejudice and believed that such concerns would be handled appropriately.

Whilst there are areas that the BCNO Group should consider in order to improve their engagement with the student body, based on the evidence presented for the visit we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should consider ways of incentivising students to become student representatives and attend all meetings to ensure their voice is more effectively heard and consider additional ways of significantly improving student response rates to surveys and module feedback. (1vi, 2i, 2iii, 3ii, 6v)

Conditions

None reported.

vi. are supported and encouraged in having an active voice within the education provider.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

It was evident that the BCNO Group has made concerted efforts to engage with the student voice through membership in various committees. However, this engagement had seen limited success. In meetings with both students and alumni, the issue of effective engagement with the BCNO Group as an area concern and students reported using informal lines of communication through, for example classroom tutors, to raise issues.

Given that current processes for engaging with the student voice have not functioned as intended, the BCNO Group might explore alternative methods of engagement. For example, periodic structured interviews conducted in the classroom could be used to gather student opinions.

Whilst there are areas that the BCNO Group should consider in order to improve their engagement with the student body, based on the evidence presented for the visit we are assured that this standard is being met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should evaluate their current methods of engaging with the student voice and develop procedures to ensure that student concerns are effectively identified and directed to the relevant area within the organisation for resolution in a timely and effective manner. (1x, 6vi)

Conditions

None reported.

7. Clinical experience

i. 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.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The clinical provision for the new three-year course will solely be based at the redeveloped Maidstone campus which incorporates teaching and clinic provision. There are a number of specialist on-site clinics which students get the opportunity to attend, observe, and gain hands on experience with discreet groups. These include clinics in paediatrics and maternity, sports, headache, MSK ultrasound clinics, as well as balance classes.

The tutor induction handbook currently quotes the student to teacher ratios in clinic as being ten students per tutor and an aim for a maximum of three patients at a time for year 3 and four patients at a time for year 4.

Management stated that the ratios of students to tutors on the new three-year programme will remain broadly the same at eight students per tutor and a maximum of three patients per student in year 2 and four in year 3. For specialist clinics the ratios are one tutor to three students.

Both the student and staff groups spoken to confirmed that the ratios in clinic are maintained, and lower ratios were observed in clinic.

The Head of Clinic informed us that though telehealth consultations are now very rare students do receive tuition on how they should be conducted. The team also witnessed clinically orientated classes using patient scenarios where they get the opportunity to discuss these as a group and with their tutor.

The professional practice handbook states that pre and post clinic sessions happen each day in clinic, students are encouraged to discuss their cases for the day before and after and seek tutor feedback. This was not observed but confirmed by both students and tutors.

Students are rotated every six weeks so that they work with different tutor groups each time. This is to ensure they gain exposure to different ways of practicing.

Students currently undertake other clinically relevant activities such as taking a dummy case history and discussing signs and symptoms with student practitioner and tutors. They also have to fill out their clinic portfolio and reflective log which acts as a learning tool and record of the types of cases and patients seen by the student. This must be signed by the tutor at the end of the day and submitted to the Head of Clinical Education or module leader when their clinical observation is completed. Management informed us that this is expected to remain the same for the new three-year course.

Current students have one week of lectures in the summer of year 2 in what is called clinic induction. This is undertaken before they enter clinic in year 3. During this week they have a number of lessons that include taking a case history, clinic administration, and treatment. For the new three-year course this will be extended to five weeks and is aimed to accelerate students' learning to the point where they can effectively start to interact with patients in a more meaningful way.

In line with the BCNO Group's other courses and guidelines set out in GOPRE, students on the three-year course will be required to undertake 1000 clinical hours in order to graduate. These hours are more

condensed due to the reduction in length of the course. Due to this it will impact reading weeks and holidays at Christmas, Easter, and in the summer.

A professional practice handbook sets out the expectations of students whilst studying at the BCNO Group and in whilst in clinic. It states that the clinical component is split into three broad areas. These are:

- Observation clinic, which commences in year 1 and 2 when students observe clinical students whilst the clinical students manage patients under supervision.
- Teaching clinic, which commences in year 3 when students start to manage patients under close supervision from tutors.
- Experiential clinic, which commences in year 4 when students, under supervision, start to take on increasing responsibility whilst managing patients.

Management stated that for the new three-year programme, students would still observe in year 1 and the first semester of year 2. In the second semester of year 2 the students will undertake a clinical assessment (summative or formative) based on the results of this assessment some students will be allowed to manage patients under close supervision. Once students have undertaken the five-week clinical preparation course in the summer, they will start to take increasing responsibility whilst managing patients.

The professional practice handbook has not been updated for the new three-year programme as of yet. Management stated that this would be done in the summer of 2025 in preparation for the planned course start date in September 2025.

BCNO Group has a well-documented approach to clinical learning which clearly sets out what is required of students from each year and provides students with the structure necessary for them to effectively learn. There is the opportunity to observe other students and interact with a wide variety of tutors, which provides fertile ground for students to develop their professional identity as an osteopath.

The clinical provision provided at the Maidstone campus is of very high quality. What is expected of students is well documented, the Clinic is well managed, staff are knowledgeable and experienced. Both the current student and past student groups consistently praised the levels of knowledge and engagement of staff and the support they received. What was witnessed during the visit supported that view.

We believe that this will be translated to the new condensed three-year course and so have no hesitation in stating that this standard is met.

Strengths and good practice

The clinical provision at the BCNO Group is of a very high standard. The levels of support offered by staff and attendance at specialist clinics affords students a host of opportunities to hone and develop their skills in all areas.

Areas for development and recommendations

None reported.

Conditions

None reported.

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.

☐ **MET**

☒ **NOT MET**

Findings and evidence to support this

The staff, management, and professional practice handbook state that students are expected to undertake 1000 hours of clinical practice and see 50 new patients in order to graduate. This will not change for the new three-year programme and meets the expectations set out by the GOsC in the GOPRE and SET and norms for the sector.

The clinical hours for the new three-year course will be divided up in the following way:

- Year 1: 96 hours
- Reading week year 1: 6 hours
- Year 2 semester 1: 64 hours
- Year 2 semester 2: 128 hours
- Year 2 Easter holidays: 32 hours
- Year 2 summer holidays: 140 hours
- Year 2 reading weeks: 8 hours
- Year 3 semester 1: 224 hours
- Year 3 Christmas holidays: 16
- Year 3 semester 2: 224
- Year 3 Easter holidays: 32
- Year 3 reading weeks: 30

As stated, the sole means of gaining clinical experience for the new three-year course is at the onsite clinic in Maidstone. The professional practice handbook states that for observation sessions in years 1 and 2 students are responsible for booking their own clinic time. This is done through the Clinic administration team. In years 3 and 4 when students start to take responsibility for patients, clinic hours are allocated to them by clinic management. When students attend clinic, they are required to sign the Clinic register to ensure their clinical hours are recorded. These are kept on reception, collated and sent to the Head of Clinic. Clinic absence forms help keep track of absences and time that needs to be made up.

Students who are falling behind in their clinical hours are met with and a plan of how they will make this up is agreed with them and monitored.

Ensuring students see the required number of new patients and see a wide variety of patients and presentations is done in the following way. Reception staff book patients into the computerised booking system; this is usually done in person or on the telephone. When they do this, they ask the patient which body area they are consulting about and note this. They then assign the patient to a student. If this is a new patient, they will allocate them to a student who either has seen less new patients than their colleagues or who has seen less of the particular area the patient is consulting about. This ensures that students see a wide variety of patients and presentation.

The team had the opportunity to see the register and the number of new patients seen by each year group, this was well above expectations for each student.

There are a number of specialist clinics which are staffed by clinic tutors with expertise in those areas. Students undertake observation and practical placements in those clinics which affords them an opportunity to gain specialist experience.

The opportunities and processes described will not change for the new three-year programme and so the visiting team believe that there are currently sufficient means of ensuring students gain access to a clinical experience that will develop and integrate their knowledge and skills, meet the programme outcomes, deliver the OPS, and thus meet this standard. However, whilst speaking with the past and present student groups, they consistently spoke about the academic and clinical load that they had to bear during the four-year course. They stated that the holidays provided them with an opportunity to decompress and spoke about how important they felt this was to their health. They shared their concerns about the new three-year course and the impact on student welfare. They also reported that they formed close bonds with their clinic tutors, often closer than their personal tutors, and relied on them for support and guidance.

Speaking with staff regarding this they felt differently. They felt that the shorter breaks in the new course would keep students focussed and felt they would have to spend less time getting students up to speed when they returned from breaks.

Whilst the visiting team can understand both positions, we have concerns that compressing the course to three years will increase this load and provide fewer opportunities to decompress and focus on something other than their studies. We feel it is vitally important that the BCNO Group increase student welfare monitoring for the new three-year programme in order to provide assurance that students are coping with the new course, are able to access and engage in clinic, and deal with any issues which may arise due to workload issues. Due to the bond spoken about with clinic tutors, this may be a good area to gain formal and informal feedback on student welfare, especially as the course runs through it first student cohort.

Overall, without the additional monitoring in place we believe this standard is not met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

The BCNO Group must increase student welfare monitoring in order to provide assurance that students are coping with the new course, able to engage in their clinical studies, and ensure the BCNO Group can deal with any issues which may arise due to workload issues. (6ii, 7ii)

8. Staff support and development

i. educators are appropriately and fairly recruited, inducted, trained (including in relation to equality, diversity and inclusion and the inclusive culture and expectations of the institution and to make non-biased assessments), managed in their roles, and provided with opportunities for development.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group provided the visiting team with their recruitment policy. The policy includes some core principles which include reference to EDI. The process for recruitment is set out as follows. The first stage is the preparation stage. This includes an evaluation of need, followed by the development of the job and person specification. The documents states that care should be taken when developing the person specification to ensure it does not indirectly discriminate against certain groups of applicants. It does not provide any guidance on how this would be achieved.

The role is then advertised. This is initially done internally with external advertising done if no applicants are forthcoming. Applicants are asked to provide equal opportunities details when making their application.

The selection process involves a member of the HR team and the line manager for the position reviewing the applicant CVs, which are matched against the role and person specifications. Candidates who meet the criteria are asked to attend an interview. There is no mention of blinding during the selection process.

Interviews are undertaken by at least two people, one of whom should be a member of the HR team. Interviewers are reminded that questions should be applied consistently to all interviewees. It is suggested that the format of the interview and interview questions should be discussed with HR prior to it being agreed. This process is quite robust. However, ensuring the reviewers are blinded during this process would be more robust.

The BCNO Group have a new starter induction checklist which is designed to ensure that new staff receive a comprehensive induction. This includes mandatory reading of their policies and procedures on EDI, data protection, anti-corruption and bribery, the employee handbook, safeguarding, email, health and safety, and osteopathic treatment. This is available to staff through the VLE. A form is signed by the new employee once it has been completed.

Additionally, e-learning on health and safety, display screen equipment, GDPR, fire safety, and manual handling through their e-learning portal PeopleHR. As with the necessary reading, employees are required to sign to say this has been completed and they are asked to note any additional training that they may require.

Junior lecturer and clinic tutor positions are available for those with less experience. More senior members of staff lead the lecture or are on hand in clinic to provide advice and support when necessary.

Staff are managed in their roles by their head of department. Staff reported that they are not aware of a personal development review process and whilst they did meet with their line manager it was inconsistent with some departments meeting yearly and others not. Staff did report, however, that they feel supported by their manager and by the organisation.

Staff reported that they were not aware of any documented process for development or progression with some very experienced staff being on the same pay grade and level as much more junior staff.

When explored with senior management and HR they confirmed that no personal development review process or documented process for progression existed. They reported that a PDR process was followed

prior to 2020 but since the pandemic it has not been reinstated. They reported that rather than staff putting themselves forward for promotion senior staff brought people to the attention of HR who they believed to be talented and had the desire to progress. They stated that this was done as in most instances staff worked very part time and did not wish to progress, so it was difficult to find people with the rights sets of skills and desire to progress. Some of this was borne out by the staff group that was spoken to by the visiting team who also reassured us that if they did want to progress, they felt happy to speak with their line manager.

The processes in place do fairly recruit, induct and train staff. Staff are provided with opportunities to develop, and they are managed in their roles. To this extent, we are assured that this standard is met. However, we recommend that the formal staff yearly review process is reinstated, and that staff are provided with a formal process by which they can develop if they wish to.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should reinstate their formal yearly staff review process and provide staff with a process by which they can develop if they wish to. (1ix, 8i)

Conditions

None reported.

ii. educators are able to ask for and receive the support and resources required to effectively meet their responsibilities and develop in their role as an educator.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The visiting team met with a group of teaching staff during the visit who taught on both the academic and clinical components of the course. They reported that they did feel supported in their roles. They felt they were able to ask for support and that they received what they needed to carry out their duties.

Whilst there is currently no formal process for meeting with their line managers, some departments do schedule regular catch ups to ensure staff have everything they need to carry out their duties. Staff and managers both stated that due to the size of the BCNO Group and the close working relationships, they did not feel incumbered in any way to ask for help when necessary.

Teaching rooms were well resourced with models, plinths, and screens. PPE and other infection control measures were available such as hand sanitiser and sprays for treatment couches. The VLE was well populated and contained all the information you would expect and need as an educator. This was well used in observed classes.

Seeing the resources on offer to staff, listening to staff and managers regarding support and resources means we feel confident that staff are well supported and have the resources necessary to carry out their roles. We therefore feel this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iii. educators comply with and meet all relevant standards and requirements, and act as appropriate professional role models.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group provided documentation detailing the qualifications of all faculty members currently employed at the organisation.

Senior management stated that it is the BCNO Group policy that all those who are involved in clinical or technique teaching roles must be registered with the GOsC or with another healthcare professional body. A sample from the faculty list that was provided to the visiting team was checked against the GOsC database and all were registered.

A number of mechanisms exist to ensure staff embody and model the OPS.

There is a peer review process in operation for all members of the teaching staff. We were provided with redacted examples of the peer review documentation that had been filled out by those involved. The process is designed to provide external feedback to faculty members which includes information on professionalism. This process currently happens once per semester and is carried out by a more senior member of staff such as a line manager. Feedback is provided in a timely manner in written and verbal formats.

Students have a number of ways they can feed back about staff members. Student feedback is sought in module evaluations at the end of each module and feedback is sought from students on clinical tutors at the end of each six-week rotation. This is then fed back to staff by the Head of Clinic or department with the aim of ensuring standards are maintained. Students can also feedback through the student voIce panels and through their student representatives.

The staff who we met with in meetings and during observations in class and clinic demonstrated all the qualities you would hope and expect to be modelled to students. This along with necessity to be registered, the broad experience of the faculty and the feedback provided to staff by peers and students assures us that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. 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.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

There are currently approximately 134 members of faculty working across both sites. They have a broad range of experience, 28 of whom have a teaching in higher education qualification. There is a range of specialist knowledge and expertise in a number of areas that ensure students receive a diverse education.

Currently there are enough members of faculty with the right qualifications and experience to ensure the delivery of a RQ course.

Management informed us that those who do not have a teaching qualification or teaching experience are initially employed as assistant tutors and if they wish after they have done a minimum of six months as an assistant tutor/lecturer they can start to take responsibility for student learning, eventually becoming a lecturer / tutor and teaching their own classes.

All staff who work in a clinical supervision role or in practical classes are registered with the GOsC or with another healthcare regulator, such is the case with the ultrasound imaging demonstration clinic.

We sought reassurance from management and trustees that they have appropriate plans and monitoring in place to effectively reduce the risk of maintaining enough adequately qualified staff to ensure that students receive the necessary support and education in order to meet the graduate outcomes and OPS.

Management stated that there are consultations currently ongoing with 44 members of staff who will be impacted by the recent decision to close the London site to undergraduate education and teach out the existing provision on both sites. Management stated that staff usually undertake a number of roles in the organisation and so the majority of the 44 will be retained in some way in the organisation.

When asked, the Head of HR stated that there would be an inevitable reduction in overall staff numbers as they teach out courses on both sites. They stated that this should not affect the expertise within the organisation and would work if necessary to retain it when they move to solely to the Maidstone site by offering vacant positions in Maidstone in the first instance to staff from London.

It was fed back to the team that osteopathic members of staff do not currently undergo a DBS check when they are employed as they will have done this through the GOsC when they registered, after which time any legal events that would affect their teaching status would be flagged to the GOsC and appropriate action taken. However, for a number of years after the register was opened it was not a requirement for osteopaths to undergo any form of check such as the DBS. This means a significant number of osteopaths from that time may not have had a DBS or equivalent. We therefore recommend that the organisation re-visit this policy to manage this risk and any impacts it may have on patients, students, and other staff.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should re-visit the policy of not requiring a DBS for osteopaths when they join the organisation in order to manage this risk associated with this and any impacts it may have on patients, students, and other staff.

Conditions

None reported.

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v. educators either have a teaching qualification, or are working towards this, or have relevant and recent teaching experience.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The faculty qualifications document supplied by the BCNO Group showed that 28 of the 134 members of faculty have a teaching in higher education qualification. Staff can apply for funding to undertake external courses. However, the funding available is limited and is not specific to teaching qualifications but to support wider staff development. Two members of staff who met with the visiting team said they had been supported to undertake further degrees. Other members of staff showed a good range of qualifications and experience.

We feel assured that educators have the relevant teaching experience and qualifications to ensure that students receive the necessary education to meet the graduate outcomes and OPS, and thus, feel this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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9. Patients

i. patient safety within their teaching clinics, remote clinics, simulated clinics and other interactions is paramount, and that care of patients and the supervision of this, is of an appropriate standard and based on effective shared decision making.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

A number of documents that relate to patient safety within the clinic were provided during the visit. These include the BCNO Group's safeguarding policy, student fitness to practice policy, and their professional practice handbook. The professional practice handbook covers a number of issues that are related to patient safety such as confidentiality, health and safety, and managing the patient encounter. Together these comprehensively cover patient safety. When speaking with clinic staff and students they were aware of these policies and received training on them.

Within the Clinic there are a number of physical patient safety measures in place. There is a defibrillator and first aid box. There are information posters on how to provide feedback and how to raise safeguarding concerns. These are in both student/tutor facing areas and patient facing areas.

Students in the Clinic are supervised by experienced osteopaths. Students gradually gain more autonomy as they move through the course. Observing in years 1 and 2 and gaining hands-on experience in years 3 and 4. Tutors are present for each element of the consultation but to different degrees based on the students experience and the presentation of the patient. For instance, tutors stated they would usually observe more of the patient student interaction and be more involved in specialist clinics where the student's specialist knowledge and skill may not be as developed.

Student to teacher ratios are currently six students to one tutor. However, the handbook and Clinic Manager stated that they can go to a maximum of ten students to one tutor with a maximum of three patients in year 3 and 4 patients in year 4. We were assured by management and staff that this will be the same for the new programme where the ratios will be ten in year 1 and specialist clinic with a maximum of three patients per tutor to four patients per tutor in year 3.

The professional practice handbook sets out how consent and shared decision making should be handled within the clinic. This was observed in clinic and was of a level that would be expected within this environment. The patient group who the visiting team met with confirmed that they felt valued, listened to, and included in their care.

Considering the documentation provided and interactions with staff and students. this provides assurance that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. 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.

☒ MET
☐ NOT MET

Findings and evidence to support this

We were provided with the BCNO Group's safeguarding policy, safeguarding audits for 22-23 and 23-24, a safeguarding presentation which is delivered to students, and safeguarding posters which are displayed around campus prior to attending.

The safeguarding policy meets sector norms for its scope and content. The new starter induction checklist was supplied which confirmed that new staff are required to read the policy as part of their induction. The staff group who we met with during the visit stated they were aware of the policy and its contents and received training on it.

Students also receive training on safeguarding which is timetabled and delivered by the Student Engagement and Welfare Officer This is done before students attend clinic. The presentation provided to the team covers the content of the policy and students confirmed that they received training on it when asked.

Safeguarding issues are reported to the SMT through a yearly safeguarding audit which was supplied to the visiting team for 2022 – 2024.

We were assured that the same policies, processes, and training will continue into the new three-year course. Overall, we feel that safeguarding is embedded into the organisation with policies, training and feedback loops to ensure patients are protected and thus we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iii. the staff student ratio is sufficient to provide safe and accessible education of an appropriate quality.

☒ MET
☐ NOT MET

Findings and evidence to support this

Student to teacher ratios in practical teaching classes are currently 10:1 which is in line with expectations and sector norms. Teaching observations during the visit confirmed that these ratios are observed with two tutors being present in each practical class where there were a maximum of thirteen students.

In clinic we observed six students to one tutor. However, the handbook and clinic manager stated that they can go to a maximum of ten students to one tutor with a maximum of three patients in year 3 and four patients in year 4. The visiting team were assured by management and staff that this will be the same for the new programme where the ratios will be a maximum of ten students per tutor and in year 1 and specialist clinic with a maximum of three patients per tutor to four patients per tutor when students are more autonomous in year 3.

Given the levels observed and the professionalism of the teaching staff, the visiting team feel assured that this standard is, and will continue to be, met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. they manage concerns about a student's fitness to practice, or the fitness to practice of a member of staff in accordance with procedures referring appropriately to GOsC.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The staff and student groups who we met with were all aware of the need to report issues and concerns regarding the fitness to practice of a student or tutor. They knew of the policies and knew where to find them if necessary. All commented that they would report it to a trusted tutor or their line manager and if it was about their line manager to a member of the SMT. They all commented that the lines of communication are quite short and that they could find someone trusted to go to if they needed to.

A safeguarding audit is undertaken each year and includes issues regarding fitness to practice as well as safeguarding issues. The audit lists the incident that occurs and the event that triggered the raising of the issue. It reports the action taken as well as the outcome and date that it was completed. It then rates the issues on a scale on one to five with one being not related to the operation of the school, two being no safeguarding controls in operation, three safeguarding concerns/weakness to be addresses, four identified safeguarding concerns/weakness, and five being concerns fully addressed.

The safeguarding audit that was shared raised some concerns with the visiting team that some issues listed on the audit should have triggered the FtP processes. This was queried with the BCNO Group prior to the visit, and we were provided with a response that satisfied the team that the matters had been dealt with appropriately.

One issue raised was to do with a member of staff and the other issue in relation to a student. It appeared from the audit and response that these issues were dealt with in accordance with their documented procedures. No referral to the GOsC was necessary in either case. However, staff were aware of the need to include the regulator if necessary or appropriate.

The same mechanisms and policies will be in place for the new three-year programme. We feel that the policies in place are followed appropriately with feedback mechanisms in place to learn from the issues and so are confident this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. appropriate fitness to practise policies and fitness to study policies are developed, implemented and monitored to manage situations where the behaviour or health of students poses a risk to the safety of patients or colleagues.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BNU fitness to practise policy, the UoP support for study policy and BNU fitness to study policies were shared with the visiting team prior to attending. All meet current expected standards for the sector. For the three-year course policies will need to be aligned to the UoP, who will be validating the three-year programme, rather than BNU. A safeguarding audit is undertaken each year and reported to the SMT this includes issues that affect fitness to practise and study. The audit demonstrated that proper procedures are undertaken, and issues investigated in line with their policies.

Overall, we are assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should review its policies to ensure alignment with recent structural and strategic changes within the organisation and to ensure all out of date policies are updated. Furthermore, efforts should be made to centralise policy access through a single repository, wherever feasible. (1i, 1iii, 1iv, 2ii, 4iii, 9v)

Conditions

None reported.

vi. the needs of patients outweigh all aspects of teaching and research.

☒ MET

☐ NOT MET

Findings and evidence to support this

Communication and consent are themes that run through the clinic documentation including the professional practice handbook and clinic case history sheets. Students receive training on it in their pre-clinic course and what was witnessed in the Clinic would support this. The patient group who we met with stated that they felt very included in their care, informed at all stages and felt able to ask questions without fear. This would indicate that shared decision-making is embedded and as such patients needs outweigh the learning environment.

The Head of Research confirmed that undergraduate research does not happen in the Clinic or with patients and this would remain the same for the new three-year course. Some data is collected from patients in the form of post treatment questionnaires which can be filled out on the premises, but most patients opt to receive it electronically and as such do not feel pressured to participate or to provide information that they feel uncomfortable with. This was confirmed by the patient group met with as part of the visit.

Overall, we feel assured that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

vii. 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.

☒ MET

☐ NOT MET

Findings and evidence to support this

The Clinic documentation such as the Clinic case notes, and the professional practice handbook detail the information necessary to take a thorough case history. This includes information on the patient's lifestyle and how to provide aftercare advice.

The time allotted to patients allows them to do this in an unhurried and relaxed manner and to explore areas of the patient's life that may not seem directly related to the reason they have attended. The patient group we met with as part of the visit echoed this and valued it as an opportunity to try to get to the bottom of things rather than just treating symptoms. They appreciated the time, levels of communication, they felt heard,

listened to and that their opinions mattered. They appreciated the aftercare advice as they wanted to be included in their treatment and ultimately help themselves.

The visiting team witnessed students discussing aftercare advice with tutors and then providing it to patients. The student group who we met with felt well prepared to provide this advice and stated that they had access to exercise prescription software which aided them in this. Some had signposted patients to their GP or other healthcare professionals for help with things like imaging and psychological support.

Based on the evidence seen, we feel that this standard is met and will continue to be met with the new three-year programme.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

A. Evidence

A.1 Evidence seen as part of the review

1.Student numbers teach out Kent and London 3 plus 1 launch 2025-26.xlsx
2.Summary of Phased Plan costs 24-27.xlsx
2022 BCNO Strategic Planning workshop.pptx
24-25 CashModellingPreBudgetApproval.xlsx
3.TestingBCNO Kent Teach out CommercialStrength.xlsx
4.Financial planning 2028-29 notes.docx
5.London Infrastructure Costing review 2024.xlsx
6.BSc - London Only SMT final costings.xlsx
7.Modified - London Only SMT update costings.xlsx
8.BSc - SMT final costings Kent only.xlsx
9.Kent Infrastructure Costing review 2024.xlsx
AR23-10a EEID-04630_BussStephenReport23.docx
AR23-10b MariaHayesUoPAnnualSubjectReport_22-23.docx
AR23-10c WildmanAnnualUoPAwardReport_22-23.docx
AR23-10d MeadowsS_IntegratedMaster'sDegreeInOsteopathy(ESO)22-23.pdf
AR23-10e BNU_EE School Response 2023_ESO Final.pdf
AR23-11 UKPartnersJBSAgenda.docx
AR23-12 EXTRACTfromModuleHandbook.docx
AR23-13a ClinicAuditCourseworkGuidelines.doc
AR23-13b ClinicalAuditReportTemplate.docx
AR23-14 Assessment - ChecklistForWrittenPapers.pdf
AR23-15a UoPStudentComplaintsPolicy.pdf
AR23-15b BNUStudentComplaintsPolicy.pdf
AR23-16a Minutes_ SEGwithUoPstudents07June23.docx
AR23-16b Minutes_SEGwithBNUstudents13June23.docx
AR23-17 SafeguardingPolicy.pdf
AR23-18 PosterA4SafeguardingBCOM_ESO.pdf
AR23-19 StudentInclusionWelfare&Attendance_ToR2023.docx
AR23-1a BNU mapping.xlsx
AR23-1b Copy of MOST UoP modules mapped to graduate standards (002).xlsx
AR23-1c Copy of BCNO modules mapped to graduate standards (002).xlsx
AR23-2 AdmissionsPolicyAndProcedure.pdf
AR23-20 BCNOPersonalTutorPolicy.pdf
AR23-21 BCNOPersonalTutorTraining.pdf
AR23-22 PersonalTutorHandbook23-24.docx

AR23-23 PersonalTutorSessionTemplate.docx
AR23-24 StudentFeedbackTemplate_CEx_Clinical.pdf
AR23-25 IT StrategyListAcademicYear23-24.docx
AR23-26a PhysiologyIn-classTestFormativeQ+A.pdf
AR23-26b AnatomyFormativeQuiz.pdf
AR23-26c OSCE QuizAndReadingWeekRevision.pdf
AR23-27a BCOMRepThankYouLtr2023.docx
AR23-27b ESORepThankYouLtr2023.docx
AR23-28 NSSDataOEIComparison 2023.pdf
AR23-29 SafeguardingAudit22-23.docx
AR23-3 AdmissionsTermsAndConditions.pdf
AR23-4 InterviewFormTemplate23-24.docx
AR23-5 ReasonableAdjustmentProcedure.pdf
AR23-6 StudentWelfareLeaflet.pdf
AR23-7a BCNO StudentSafeguardingAndPreventPresentation.pptx
AR23-7b BCNO StressManagementWorkshop.pdf
AR23-7c BCNO MentalHealthWorkshop.pdf
AR23-7d BCNO ExamRevisionWorkshop.pdf
AR23-7e BCNO StudentInductionWelfareWorkshop.pdf
AR23-8a Patient Complaints Procedure_London.pdf
AR23-8b Patient Complaints Procedure_Kent.pdf
AR23-9 FacultyDevelopmentDayFeb 2023.pdf
BCNO BSc & MSc Osteopathic Medicine Module Records.pdf
BCNO BSc Osteopathic Medicine Programme Specification.pdf
BCNO Budget Work 24-25.xlsx
BCNO Ltd Strategic Planning 2024 - Company Secretary copy.pptm
BCNO student welfare leaflet.pdf
BNCO - approved minutes of Board meeting 11.06.2024.pdf
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Board Strategy_DavidTasker.pdf
Copy of indicative timetable BSc three year (003).xlsx
Dates for Courses_BCNO.docx
Draft12+0 Cash Modelling.xlsx
ESO Clinic extra activities.docx
Financial Modelling Summary.docx
FOC Commentary 12+0.docx
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ICO Ltd_Strategic Decisions and Implementation Update 3.21.pptx

ICO note.docx
Jan2025 Slimline Operation consideration IF.pdf
MACs 12+0.xlsx
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ProjectSchedulePlan_BScHonsOsteopathicMedicine.xlsx
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RQ25-002 BCNO_Programme Spec_MOst.pdf
RQ25-003 BCNO_Programme Spec_BSc(Hons) Osteopathic Medicine_Draft.pdf
RQ25-004 BCNO Applicant Report.pdf
RQ25-005 Offer Holder Email Invite.pdf
RQ25-006 Equity Diversity And Inclusion_ Policy.pdf
RQ25-007 Recognition_of_Prior_Learning_Policy.pdf
RQ25-008 Recognition of Prior Learning Mapping Form.docx
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RQ25-010 Academic Policy Update for Staff - Autumn Term 2024.pdf
RQ25-011 BCNO Staff Newsletter_Issue6.pdf
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RQ25-013a Policy Audit.xlsx
RQ25-013b UoP Policies Page.docx
RQ25-013c BNU Policies Page.docx
RQ25-014 Policy Audit Process.docx
RQ25-015 Quality Mapping Document.xlsx
RQ25-016 BSc (Hons) Osteopathic Medicine Approval Report.docx
RQ25-017 Information for New course.pdf
RQ25-018 Programme Quality Handbook M.Ost teach out.pdf
RQ25-019 Programme Quality Handbook_BSc(Hons)Osteopathy.pdf
RQ25-020 Programme Quality Handbook MOst.pdf
RQ25-021 Programme Quality Handbook BSc Osteopathic Medicine draft.pdf
RQ25-022 OfS Sector-recognised-standards.pdf
RQ25-023 Assessment Approval Record (2).docx
RQ25-024 Assessment brief eg Functional Nutrition BCNO 5001.pdf
RQ25-025 Assessment Brief eg MOST7007 gynae 2024-25.pdf
RQ25-026 UoP Joint Board of Studies Agenda.docx
RQ25-027 PatientExperienceCommittee_subreport (1).pdf
RQ25-028 UoP Teach out Mapping document for Graduate outcomes.xlsx
RQ25-029 BNU -teach out Mapping Doc Graduate Outcomes.xlsx
RQ25-030 iO Screenshot iO news _3-12-2024_111427_www.iosteopathy.org.jpeg
RQ25-031 Potential Physiotherapy Placement and Interdisciplinary clinic at BCOM.pdf

RQ25-032 Moderation Form (003).docx
RQ25-033 UoP Assessment Setting Marking_and_Moderation_Policy_2023-24 (1) (002).pdf
RQ25-034 BNU Assessment and Feedback Policy v1.1 Sep-23_with_AI.pdf
RQ25-035 Module Outcome Report.pdf
RQ25-036 FCCA Email 2024.pdf
RQ25-037 Student Characteristics and Outcomes Report 2023-24.pdf
RQ25-038 UoP-Student-Complaints-Policy.pdf
RQ25-039 BNU-ESO Students Complaints Policy.pdf
RQ25-040 Email from BNU re policy.pdf
RQ25-041 AGC Agenda.docx
RQ25-042 Faculty Development Day 23-24.PNG
RQ25-043 Committee Survey_July 2024.pdf
RQ25-044 BCNO Staff Newsletter_Issue5.pdf
RQ25-045 CommitteeSurvey_CoverEmail&TeamsMessage.pdf
RQ25-046 GovernanceAndManagementStructure170924UpdatesProposedforAB.pdf
RQ25-047 GovernanceAndManagementStructure_2024-25ApprovedVersionAB.pdf
RQ25-048 Staff Survey Committee Outcome.pdf
RQ25-049 Effective Management of Committee Meetings.pdf
RQ25-050 UoP Referral Board Minutes 2024 _Redacted.pdf
RQ25-051 BNU Exit Strategy.docx
RQ25-052 Retention Scheme Email.pdf
RQ25-053 Safeguarding Audit 23-24.docx
RQ25-054 Student Newsletter November2024.pdf
RQ25-055 Safeguarding Posters BCOM ESO (003) (1).pdf
RQ25-056 UCM survey.pdf
RQ25-057 ESO-BNU FitnessToPractisePolicy_.pdf
RQ25-058 Mins Academic Board Committee Nov24 Redacted.pdf
RQ25-059 BCNO4002 MOst Module Guide 2024-25 (2).pdf
RQ25-060 Professional Practise Handbook.pdf
RQ25-061 Dignity at Work Policy.pdf
RQ25-062 Anti-bullying-policy.pdf
RQ25-063 StudentCodeOfConductAndDisciplinaryProcedure-1.pdf
RQ25-064 Student-sexual-violence-misconduct.pdf
RQ25-065 Whistle-blowing-Policy.pdf
RQ25-066a Student-Tutor Feedback London.pdf
RQ25-066b Student- Tutor Feedback Kent.pdf
RQ25-067 Clinic Peer Teaching Observation 24 (003).pdf
RQ25-068 Clinic Tutor Induction.pdf
RQ25-069 Clinic Team Meeting Agenda.docx
RQ25-070 Personal Tutor Policy.pdf

RQ25-071 BCNO Student Welfare Leaflet.pdf
RQ25-072 Student Newsletter.pdf
RQ25-073 External Examiner Report and Response S Buss 2023-24.docx
RQ25-074 External Examiner Report & Response M Hayes 2023-24.docx
RQ25-075a BNU External examiner Report 2023-24.pdf
RQ25-076 BCNO Safeguarding Presentation.pdf
RQ25-077 Attendance Registers- redacted.xlsx
RQ25-078 PEG Chair Email.pdf
RQ25-079 BCNO Prevent Risk Register and Action Plan.pdf
RQ25-080 BCNO Prevent Return 2024.xlsx
RQ25-081a HA_Assistance Programme leaflet.pdf
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RQ25-082 Stress Management Policy_BMG&HS Draft.pdf
RQ25-083 Faculty Engagement Agenda for meeting on 24 September 2024.docx
RQ25-084 S Student Engagement ENDA FOR MEETING ON 19 FEBRUARY 2024 - BNU STUDENTS.docx
RQ25-084 Student Engagement agenda for meeting on10 October 2024.docx
RQ25-085 20240919PEGFinalAgenda.docx
RQ25-086 SIWAC Extract from Minutes.pdf
RQ25-087 Reasonable Adjustment Policy.pdf
RQ25-088 BNU Exam Board 2022-23.pdf
RQ25-089a Personal Tutor report redacted example 1.pdf
RQ25-089b Personal Tutor report redacted example 2.pdf
RQ25-090 Personal Tutor handbook 2024-25.pdf
RQ25-091 Study skills presentation 2024.pptx
RQ25-092 Anatomy Workbook The regions of the spine.pdf
RQ25-093 Anatomy Workbook The thorax.pdf
RQ25-094 Anatomy Workbook Introduction to the spine.pdf
RQ25-095 Anatomy Workbook The abdomen and pelvis.pdf
RQ25-096 Anatomy Workbook The thoracic contents.pdf
RQ25-097 Updated Study Skills Handbook.pdf
RQ25-098 Pre-Clinic Course Time-Table 2024.docx
RQ25-099 Clinic tutorials BCOM 24-25.doc
RQ25-100 CLINIC TUORIALS.doc
RQ25-101 Year 1 BCNO4002 Portfolio Notebook.docx
RQ25-102 Year 2 Portfolio and Reflective Log.docx
RQ25-103 Year 3 Portfolio and Reflective Log.docx
RQ25-104 Year 4 Portfolio and Reflective Log.docx
RQ25-105 MOST7004 Audit Example.pdf
RQ25-106 UoP ADPC form.docx
RQ25-107 UoP Approval process.doc

RQ25-108 UoP External Advisor Nomination Form_Approvals_24-25.docx
RQ25-109 UoP External Examiner nomination form.docx
RQ25-110 ACTION PLAN 24-25 EE response.pdf
RQ25-111 Main Poster - Silver Sunday (1).pdf
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RQ25-113 VLE Audit.xlsx
RQ25-114 Health Questionnaire (Preview) 2024.pdf
RQ25-115 Example Student Risk Asssessment Redacted.pdf
RQ25-116 Re-enrolment Form 2024 v2.pdf
RQ25-117 BCNO5007 MOst Module Handbook 24-25.docx
RQ25-118 MOST7007 Module Handbook 2024-25.pdf
RQ25-119 BNUESOHandbook24-25_VLECopy(2).pdf
RQ25-120 UoP Partner Student Institution Handbook BCNO 2024-25_- BCOM teach out (2).pdf
RQ25-121 UoP PartnerStudentInstitutionHandbookBCNO 2024-25_BCOMESO(2).pdf
RQ25-122 BSc Communication Weekly.pdf
RQ25-123 BNU Year 4 Drop in for writing support.pdf
RQ25-124 Year 1 Workshops.pdf
RQ25-125 Mini Cex Level 6_CEx_Clinical (1).pdf
RQ25-126 Attendance & Engagement Policy.pdf
RQ25-127 Email Attendance Redacted.pdf
RQ25-128 SIWAC Agenda for 1st October 2024 meeting.docx
RQ25-129 Faculty development day lecture-Practical assessments.pptx
RQ25-130 MOST7004 Audit-Form.docx
RQ25-131 OS746 Assessment Brief.pdf
RQ25-132 Student Rep Training_2024-25.pdf
RQ25-133 Student Rep ThankYouLtr_Redacted.pdf
RQ25-134 NSS comparisons (003).docx
RQ25-135 Module Feedback Report.docx
RQ25-136 Students perception questionnaire.docx
RQ25-137 ACTION PLAN 24-25.pdf
RQ25-138 Joint Board of Studies Minutes 2024_Redacted.pdf
RQ25-139 Portfolio Focus Group Questions 24.docx
RQ25-140 Portfolio Focus group Summary July 2024.docx
RQ25-141 Patient Case History Sheets.pdf
RQ25-142 Clinical Integration Presentation.pdf
RQ25-143 CCA Presentation.pptx
RQ25-144 Patient Mapping Kent Redacted.xlsx
RQ25-145 Patient Mapping London Redacted.xlsx
RQ25-146 Poster_BCOM_Sports Clinic_.pdf
RQ25-147 Flyer Mock Exams_2024 (2).pdf

RQ25-148 Applied Clinical Medicine Template.doc
RQ25-149 Applied Clinical Medicine Example.pdf
RQ25-150 Learning & Development Policy.pdf
RQ25-151 Learning & Development Funding Contract.docx
RQ25-152 HR Code of Conduct Policy.pdf
RQ25-153 BCNO Organisational Chart.pptx
RQ25-154 BCOM Patient Feedback Poster.pdf
RQ25-155 ESO Patient Feedback Poster.pdf
RQ25-156 UoP Support_for_Study_Policy_.pdf
RQ25-157 BNU Support to Study Procedure_ Jul_2023.pdf
RQ25-158 NHS Advice 0523-shoulder-pain.pdf
RQ25-159 Student Progress- Results- Feedback redacted.xlsx
RQ25-160 Tutor feedback from student eg 1 - redacted.pdf
RQ25-161 Tutor feedback from student eg 2- redacted.pdf
RQ25-162 Tutor feedback from student eg 3- redacted.pdf
RQ25-163 Tutor feedback from student eg 4- redacted.pdf
RQ25-164 SEG MEETING UoP Redacted.pdf
RQ25-165 SEG MEETING BNU Redacted.pdf
RQ25-166 Peer observation of teaching example 1 -redacted.pdf
RQ25-167 Peer observation of teaching example 2 redacted.pdf
RQ25-168 Peer observation of teaching example 3 redacted_v1_Redacted.pdf
RQ25-169 Peer observation teaching example 4 redacted.pdf
RQ25-170 BNU Annual report 2022-23.pdf
RQ25-171 BNU Annual Report 2023-24.pdf
RQ25-172 UoP Annual Report 2022-23.docx
RQ25-173 UoP Annual Report 2023-24.docx
RQ25-174 HoD Action Plan example.pdf
RQ25-175 Student response rate.pdf
RQ25-176 WiP_BCNO Policy Register (2).xlsx
RQ25-177 Complaints Themes 2023-24.pdf
RQ25-178 BSc(Hons) Osteopathic medicine presentation.pdf
RQ25-179 BSc(Hons) Osteopathic medicine financial modelling.xlsx
RQ25-180 SPP.pdf
RQ25-181 SIWAG minutes May 2024.pdf
RQ25-182 SIWAG minutes Oct 2024.pdf
RQ25-183 Example of email to student re attendance -redacted.pdf
RQ25-184 Student numbers 5.01.25.pdf
RQ25-185 Proposed Student feedback 2024-25 Semester 1 Year 1.pdf
RQ25-186 -Proposed Student feedback 2024-25 Semester 1 M.Ost Year 2.pdf
RQ25-187 -Proposed Student feedback 2024-25 Semester 1 BSc Year 2.pdf

RQ25-188a Example of Guest lectures LGBTQ+ and Healthcare.pdf
RQ25-188b Example of Guest lectures Skills & CV.pdf
RQ25-188c Example of Guest lectures- Telehealth.pdf
RQ25-188d Example of Guest lectures - NHS careers.pdf
RQ25-188e Example of Guest lectures-Osteopathic Communities.pdf
RQ25-188f Example of Guest lectures-Pain management.pdf
RQ25-189 Career Day 2024-25.png
RQ25-190 Example of Completed clinic Portfolio year 1- Redacted.pdf
RQ25-191 Example of Completed clinic Portfolio year 2- Redacted.pdf
RQ25-192 Example of Completed clinic Portfolio year 3- Redacted.pdf
RQ25-193 Joint Board of Studies Minutes 2022-23 - Redacted.pdf
RQ25-194 BNU periodic review.pdf
RQ25-195 Disability leaflet.pdf
RQ25-196 Institutional Risk Register October 2024.xlsx
RQ25-197 indicative timetable for BSc Hons Ost Med.xlsx
RQ25-198 Recruitment policy.pdf
RQ25-199 New starter induction checklist.docx
RQ25-200 Induction Clinic Tutors.docx
RQ25-201 Induction H&S.docx
RQ25-202 Faculty Qualifications.xlsx
RQ25-203 FTP response.pdf
RQ25-204 Research Ethics Policy.pdf
RQ25-205 REC Application Template.docx
RQ25-206 REC Membership.docx
RQ25-75b BNU External Examiner ESO Response 2024.pdf
Sale of Boxley House report to FSC Aug 2024.docx
Strictly Confidential HR Board update.pptx
StudentFees-Undergrad 2024-25.xlsx

General Osteopathic Council

Council
15 July 2025
Committee Annual Reports

Classification	Public
Purpose	For noting
Issue	Each Committee is required to report annually on its work to Council.
Recommendations	To note the Annual Reports of the: a. Policy and Education Committee b. People Committee c. Audit Committee
Financial and resourcing implications	These are set out in the papers.
Equality and diversity implications	Each committee considers matters relating to equality and diversity and these are set out in more detail within the Committee Annual Reports.
Communications implications	None arising.
Annexes	A. Policy and Education Committee Annual Report B. People Committee Annual Report C. Audit Committee Annual Report
Author	Matthew Redford

Annual Report of the Policy and Education Committee 2024-25

Introduction

1. The role of the Policy and Education Committee is to contribute to the development of Council policy across the breadth of its work including in education, professional standards, registration and fitness to practise.

2. The Committee performs the role of the statutory Education Committee under the Osteopaths Act 1993. The Committee has a 'general duty of promoting high standards of education and training in osteopathy and keeping provision made for that training under review'. It also has a key role in giving advice to the Council about educational matters including the recognition and withdrawal of 'recognised qualifications' (see Sections 11 to 16 of the Osteopaths Act 1993).

3. The terms of reference of the Committee can be found at the end of the report at the annex.

Membership

4. The Committee consists of five members of Council and four appointed external members. In addition, the key osteopathic sector organisations are invited to send an observer with speaking rights to each meeting. Observers may not take part in any part of the meeting where the business is that reserved to the statutory Education Committee.

5. These observer with speaking rights members are:

   - the Council of Osteopathic Education Institutions (COEI)
   - the Institute of Osteopathy (iO)
   - the National Council for Osteopathic Research (NCOR)
   - the Osteopathic Alliance (OA)

6. Whilst specifications for visits and visit reports are considered in public, other matters related to educational institutions are considered in private due to the commercial nature of the osteopathic educational institutions.

Quality assurance of 'recognised qualifications'

7. During the year, as part of its role to assure the quality of osteopathic recognised qualifications (RQs) which entitle applicants to register with GOsC and practise as an osteopath, and to offer advice to Council about the recognition of qualifications, the Committee considered the following:

Activity	**2024-2025**
Consideration of RQ specifications / appointment of Visitors	Five OEIs (including one new RQ)
Consideration of Education Visitor RQ reports (including new RQs, renewal of RQs and monitoring visits)	One OEI

Activity	**2024-2025**
RQ change notifications and consideration of reports and evidence submitted in relation to general and specific conditions or annual report follow ups	Three OEIs
Consideration of annual report analyses (including external examiner and internal annual monitoring reports, and information about student fitness to practise.)	Seven OEIs
Recommendation of withdrawal of RQ	No OEIs

Quality Assurance: Annual Report and themes

8. The purpose of the RQ annual reports is to assist the Committee confirm the maintenance of the Osteopathic Practice Standards and the Standards for Education and Training including the Graduate Outcomes, and patient safety and public protection in pre-registration education. The report process also enables us to be assured that issues are being identified for action and monitored on an annual basis or more frequently as appropriate. Finally, the annual report provides a regular consideration of good practice for sustaining and sharing across the sector. This approach requires a focus on the institution's management of risk and enhancement of practice. The reports provide both self-reported and third-party data and information – such as external examiner reports. Our approach is not undertaken in isolation, but is part of the wider picture of quality assurance and enhancement.

9. A number of areas of good practice were identified including using technology to support student learning and clinical practices, enhancement of equity, diversity and inclusion and creation of safe spaces for students, enhanced guidance for patients on their rights, encouraging peer to peer support and improved opportunities for student feedback. However there were also challenges including: student recruitment, student staff ratios and educator training and development. The findings were discussed with OEIs and this year's annual report will include further data to understand and contextualise the maintenance of standards in a challenging environment whilst also ensuring a focus on patient safety, maintaining standards and programme of work on stakeholder recruitment and retention.

Quality Assurance Services from 2025

10. The Committee considered the next steps following the planned conclusion of the quality assurance contract with Mott MacDonald in June 2025. Following extensive consideration of the detailed business cases for going to tender and taking the quality assurance services in house, the Committee concluded that quality assurance services should be taken in house and recommended this to Council.

11. The Committee has continued to monitor the progress of work to bring the quality assurance services being brought in house.

Continuous quality assurance process improvement

12. The Committee has had a strong focus on improvement of the quality assurance process this year to ensure an efficient and effective process. Changes as a result of feedback have included:

    - Piloting a values, culture and behaviour document for educational providers and for Visitors, developed in collaboration with Visitors and educational providers to ensure that the tone of the visit is explicit and clear to aid communication

    - More clarity about the context of a recommendation and the link to the relevant standard to enable it to be responded to appropriately.

    - Strengthened expectations on the role of the new QA Visit Manager in relation to the management of the visit and the report writing.

    - Building in more explicit links to evidence in relation to RQ visit reports as the process is moved in house

    - Additional pre-visit meetings to improve clarity around expectations on both sides and outcomes

    - Updating the process of raising concerns about the quality assurance process during the visit

    - Ensuring that conflicts of interest with Visitors are checked against staff lists.

    - A workshop with the OEIs to explore good reflection in an annual report narrative.

Potential new courses updates

13. The Committee noted updates about potential new course providers.

Student Forum Pilot

14. The Committee considered and discussed the approach to establishing a Student Forum pilot and to launch the student forum pilot.

Student placements

15. The Committee considered provided feedback on the benefits and challenges of student placements to inform next steps.

Transition into Practice

16. The Committee considered a research report about experiences of the transition into practice. The report noted some consensus in enablers, barriers and further

support and the opportunity for GOsC to develop guidance with stakeholders in these areas. Further discussion with stakeholders was wide ranging and noted that there were opportunities for stakeholders to take actions too. The Committee agreed a collaborative approach including principles for working together and co-creation of the agenda for a workshop with stakeholders and to work jointly with the Institute of Osteopathy.

Osteopathy Apprenticeships

17. The Committee noted the Institute of Osteopathy in conjunction with others leading on this process are trying to develop an apprenticeship standard for osteopathy, recognised by the Institute for Apprenticeships and Technical Education (IfATE) and that they were liaising with educational providers.

18. The Committee noted that they would be asked to confirm that the draft Apprenticeship Standard was capable of meeting the Graduate Outcomes prior to final submission to the Institute for Apprenticeships and Technical Education in July 2025.

19. The Committee noted that once the standard was approved, any qualifications developed would need separate 'recognised qualification' status and would be subject to quality assurance to assure that the Graduate Outcomes were met.

Advanced clinical practice

20. The Committee noted the update in developments in regulatory issues related to advanced practice.

Continuing Professional Development Evaluation

21. The Committee considered the implications from the CPD evaluation survey findings and agreed the approach to updating the CPD and associated guidance which were to:

- Strengthening CPD on Boundaries as an important part of the communication and consent requirement
- Strengthening and encouraging CPD in the area of EDI.
- Addressing the paperwork challenges expressed by osteopaths by performing a review/ edit of the current forms and templates, particularly the PDR form, so as to make this more manageable for osteopaths to complete.
- Strengthening the focus on the aims of the CPD scheme about promoting community and encouraging opportunities to engage with colleagues
- Strengthening guidance about range of practice and adjunctive therapies ensuring that people are up to date in their adjunctive therapies and explaining this as part of the Peer Discussion Review with supporting

resources and case study examples (based on specific feedback from insurers and the Institute of Osteopathy

- Consider guidance on use of artificial intelligence.

22. The Committee agreed to recommend the consultation documents to Council for publication for consultation.

Artificial Intelligence (AI) and implications for osteopathic regulation

23. The Committee considered artificial intelligence in health care and implications for osteopathy and agreed to further engagement with the osteopathic and wider healthcare sectors.

24. The Committee considered stakeholder views on the use of AI in osteopathic practice and implications for the GOsC approach to regulation including education and standards.

25. The Committee considered the feedback received to date from stakeholders, provided feedback on the Draft Artificial Intelligence in osteopathic practice statement and requested that some interim guidance be issued as soon as possible in the meantime.

26. Agreed: Committee agreed the approach to next steps which were to:

    a. To consider and further develop a proposal to explore current and future use of AI in osteopathic practice to inform our approach to ensuring patient safety and public confidence.
    b. To agree to consult on our Draft Artificial Intelligence in Osteopathic Practice Statement.
    c. To continue to work with educators and other stakeholders to further explore a statement on AI in osteopathic education.
    d. To continue to engage with other regulators and the Professional Standards Authority to ensure an aligned approach on AI in health professional regulation.

Workforce issues: recruitment and retention and our regulatory responses

27. The Committee considered the work being undertaken to support workforce issues this included:

    a. patterns of data identified from 24/25 academic year;
    b. feedback from work ongoing with the ODG data subgroup;
    c. update on the National Council for Osteopathic Research (NCOR research projects (enablers and barriers to undertaking an osteopathy course; reasons for leaving the register including the impact of ill health and understanding the journey of leaving the register.
    d. international relationships update and

e. An update about work being undertaken to compare the core documents in the French and UK systems to understand gaps and explore next steps.

Student fitness to practise guidance

28. The Committee noted the update on the outcome of the consultation on Guidance about professional behaviours and student fitness to practise in osteopathic education and noted the proposal to convene a stakeholder working group to consider the GOsC response to the feedback and further updates to the draft guidance as a result.

29. The Committee considered the outcome of the consultation analysis, stakeholder working group feedback and the Equality Impact Assessment. The Committee agreed to recommend the Guidance about Professional Behaviours and Student Fitness to Practise to Council for publication.

Guidance on the Management of Health and Disability for students and osteopathic educational institutions

30. The Committee considered the outcome of the consultation on updated guidance:

- Studying osteopathy with a disability or health conditions: guidance for applicants and students
- Students with a disability or health condition: Guidance for Osteopathic Educational Providers
- Easy Read versions of each

31. The Committee noted the publication and implementation plans and the updated Equality Impact Assessment.

32. The Committee requested that the updated guidance documents be amended before recommending publication to Council.

Recognition of professional qualifications

33. The Committee noted the progress on our work on recognition of professional qualifications in terms of strengthening relations with other regulators and bodies internationally to raise awareness of our standards.

Quality Assurance – Annual Report template 2023-24

34. The Committee agreed the annual report template for 2023-2024, including the updated educator data collection proposals and the enhancements to the reflective examples.

Registrant and Stakeholder perceptions survey

35. The Committee considered the registrant and stakeholder perceptions survey and action plan and provided feedback.

Patients

Evaluation of the patient information forum

36. The Committee considered and provided feedback on the Evaluation of the Patient Involvement Forum Report, agreed to publish the Evaluation of the Patient Involvement Forum Report and agreed the approach to the action plan developed from the learning including activities such as:

- Feeding back the impact of their contributions
- Providing notes for activities
- Simplifying language in communications and being clearer about objectives for activities
- Training
- Being clearer about opportunities for reasonable adjustments
- Reviewing our payment policies

Strategic Patient Engagement

37. The Committee reflected on options for different models of strategic patient engagement with a diverse range of perspectives. The Committee recommended that Council consider the proposed models taking into account the discussion and elements raised by the members of the Committee.

Committee Development Day

38. The Committee undertook a development day. The evaluation showed that it had been a positive experience for attendees which achieved its goals in terms of:

- listening to stakeholders about current opportunities, challenges and priorities for the future in osteopathic education and for the osteopathic education sector in the context of promoting high standards of education.

- facilitating dialogue, greater understanding and improving trust, inclusivity between stakeholders and with stakeholders and the Committee about roles and context.

- reflecting on our strategic leadership in a context of change and uncertainty reflecting on innovation

- considering key priorities, key risks and mitigations for the coming year

39. However, there was less time available to focus on reflecting on next steps. We have shared the evaluation with key stakeholders and next steps will be considered by the Policy and Education Committee in June.

Conclusion of Terms

40. The Committee thanked Simeon London, Nick Woodhead, Dr Marvelle Brown, Professor Raymond Playford and Bob Davies for their service to the Policy and Education Committee.

Membership

41. During the period April 2024 to March 2025 the Policy and Education Committee membership comprised:

Name	Member details	Meetings attended
Daniel Bailey	Council registrant member	4 / 4
Dr Chris Stockport (resigned Feb 2025)	Council lay member	1 / 2
Gill Edelmann	Council lay member	4 / 4
Dr Marvelle Brown	External lay member	2 / 4
Bob Davies	External registrant member	4 / 4
Simeon London	Council registrant member	4 / 4
Professor Patricia McClure (Chair)	Council lay member	4 / 4
Professor Raymond Playford	External lay member	4 / 4
Nick Woodhead	External registrant member	4 / 4

42. Observers with speaking rights attended public meetings:

Name	Meetings attended
The Council for Osteopathic Education Institutions	3/4
The Institute of Osteopathy	1/4
The National Council for Osteopathic Research	3/4
The Osteopathic Alliance	3/4

Terms of reference and membership of the Policy and Education Committee

The role of the Policy and Education Committee is to contribute to the development of Council policy. To do this it will:

a. Advise Council on all matters of policy including:

   i. The standards required for initial registration and appropriate means for assessing those standards.

   ii. On all matters relating to pre-registration education and training of osteopaths, including the standards of osteopathic practice required for registration.

   iii. Post-registration education and training, including the requirements for ensuring osteopaths remain fit to practise.

   iv. The management, investigation and adjudication of concerns about the fitness to practise of registrants.

   v. Matters relating to the exercise of powers under section 32 of the act (protection of title).

   vi. The development of the osteopathic profession.

   vii. Measures to encourage research and research dissemination within the osteopathic profession.

   viii. Any research needs to support the GOsC's work.

b. Take into account the decisions of fitness to practise committees, information from the PSA and other relevant sources, and external legal or other requirements.

c. Ensure that policy development has been informed by effective engagement with the full range of the GOsC's stakeholders.

d. Make an annual report for Council on the work of the Committee.

The Committee will also undertake the statutory functions that are reserved to the Education Committee, which are to:

a. Advise Council on the recognition of qualifications in accordance with section 14(6) of the Act.

b. Appoint and manage the performance of visitors to conduct the evaluation of courses under section 12 of the Act.

c. Advise Council on matters relating to the withdrawal of recognition of a qualification in accordance with sections 16(1) and 18(5) of the Act.

d. Exercise powers to require information from osteopathic educational institutions in connection with its statutory functions in accordance with Section 18 of the Act.

Meeting Frequency

Three times yearly or more frequently if required. Some business may be conducted out of committee where required.

Membership

Ordinary members

- Five members of Council, of whom two shall be osteopaths and three shall be lay members. One of the lay members shall be appointed by Council to be Chair of the Committee.
- Four members who are not members of Council.

Co-opted members

The Committee may co-opt up to five members in accordance with Rule 3 of the Statutory Committee Rules.

Observers with speaking rights

The member organisations of the Osteopathic Development Group are invited to send an observer with speaking rights to each meeting.

Observers may not take part in any part of the meeting where the business is that reserved to the Education Committee.

Quorum

Five, of which:

- at least one must be a lay person and one must be an osteopath.
- at least two must be members of Council and two must be members who are not members of Council.

People Committee Annual Report 2024-25

1. The People Committee met on three occasions during 2024-25, being June 2024, October 2024 and March 2025.

2. The terms of reference of the PC are attached at Annex A.

Appointments

3. During the year, the Committee oversaw appointment and reappointment processes for 21 different positions across the GOsC Governance Structure, including Professional Conduct Committee, Investigating Committee, Policy and Education Committee, Council member from Wales and Council Associate. These were a mix of lay and osteopath positions.

4. The Council member appointment process is overseen by the People Committee, scrutinised by the Professional Standards Authority, with the appointments approved by the Privy Council. The Investigation Committee and Professional Conduct Committee appointment processes are overseen by People Committee with decisions made by Council.

5. The recruitment campaigns ran in 2024-25 generated 489 applications (lay and registrant) including 315 completed applications and 174 incomplete applications with an extremely diverse set of applicants across all of the protected characteristics. We have made significant progress in this area and it is a reflection on our standing as a modern healthcare regulator that we are attracting high-calibre and diverse applicants.

6. The work of the Human Resources and Communications team were instrumental in those campaigns running smoothly. In addition, the data analysis undertaken by colleagues within the Professional Standards team to analyse the equality monitoring data across all campaigns was recognised by the People Committee.

Reward and recognition

7. The Committee considered a paper which looked at an appropriate level for staff pay increases in 2025 and agreed this for 1 April 2025.

Non-Executive fees and allowances

8. In March 2025, the Committee considered the day rates payable to non-executive members and made a recommendation to increase day rates for Fitness to Practise and independent committee members by the same percentage increase as had been agreed for staff from 1 April 2025.

Staff survey and People Effectiveness survey

9. In October 2024 and March 2025, the Committee considered the planning and analysis of the results of the staff survey and People Effectiveness survey.

Human Resources update

10. At each meeting the People Committee received an update from the HR Manager on relevant HR matters and statistics, including staff turnover, recruitment, sickness absence and feedback from exit interviews.

Sickness absence

11. The Committee received papers reviewing the sickness absence days taken by staff at the GOsC in the reporting period and compared this to the previous year. During the year, the average sickness absence at GOsC was 16 sickness absence days per employee compared to 4 sickness absence days per employee the previous year. In 2024 the median number of days absence was 4.9 per employee (Brightmine, 24 April 2025).

Staff statistics

	2024-25	**2023-24**
Number of staff recruited	7 [1]	3
Overall staff turnover[2]	10%	7%
Number of days sickness absence per employee	16	4
Learning and development: all staff training/collaboration sessions	6	4
Use of EAP service	16%[3]	-

Staff Survey data

	2024	**2022**
Mental health and wellbeing support	79%	84.2%
Job satisfaction: work life balance	90%	52.6%
Job satisfaction: motivated by role	79%	63%
Trust, communication and collaboration: well managed in role	79%	58%

[1] This includes 2 fixed term contracts and 1 temp
2 All voluntary turnover
[3] Average is 5-7%

	2024	2022
Trust, communication and collaboration: manager encourages team to continuously review and improve	89%	74%
Trust, communication and collaboration: manager encourages team to continuously review and improve	89%	79%
Recognition and feedback: encouraged to share opinions	94%	74%
Recognition and feedback: manager values staff feedback	89%	74%
Recognition and feedback: frequency of recognition received	89%	63%
Recognition and feedback: celebration of accomplishments and learnings and recognition received is meaningful	79%	79%
Personal growth and development: freedom to decide how I do my work	94%	74%
Personal growth and development opportunities	58%	53%
Personal growth and development: GOsC make use of staff skills and knowledge	63%	79%

Exit Interview data

Exit Interviews	**2024-25**	**2023-24**
Reason for leaving	Career progression and retirement	Career progression
Recruitment and induction	Good – excellent	Excellent
Salary	Good	Good
Benefits	Good	Good
Relationship with Line Manager	Good – excellent	Good – excellent
Relationships across teams	Good – excellent	Good – excellent
Suggestions listened to	Good – excellent	Good – excellent
Recognition	Good – excellent	Good – excellent
Equity, Diversity, Inclusion and Belonging (EDIB)	Good	Good
Learning and development	Good	Good
Mental health support	Good	Good

Committee membership

12. Membership of the Committee during the year was as follows:

Name	Member details	Dates of membership	Meetings attended
Elizabeth Elander (Chair)	Council registrant member	All year	3/3
Sandie Ennis	Council registrant member	All year	3/3
Kate Husselbee	Independent lay member	All year	3/3
Harry Barton	Council lay member	All year	3/3
Vacancy	Council lay member	-	-

Cost of People Committee-related work

13. The table below reflects the cost of the People Committee and the GOsC employment costs.

Committee-related	Costs paid 2024-25 £	Costs paid 2023-24 £
Committee members: fees and expenses	413	682
Governance appointments	47,396	42,233
Total	**47,809**	**42,915**
Employment costs for all GOsC staff		
Wages and salaries	1,549,239	1,505,534
Social security costs	149,946	142,576
Other pension costs	134,315	148,273
Recruitment	17,106	14,017
Learning and development	21,802	33,871
Health support costs	-	1,944
Mediation costs	-	18,541
Other employment costs	26,029	18,282
Total	**1,898,437**	**1,883,038**

14. Salary costs are slightly higher than the previous year because of the pay award agreed by the People Committee in March 2024. Recruitment costs in 2024-25 are higher than the prior year as we recruited seven individuals compared to three in the previous year.

15. Learning and development costs were higher in 2023-24 due to one-off costs such as appointments panel training and £6,122.58 invested into a series of intensive Leadership and Change Management training courses across the management team.

16. Other employment costs were higher in 2024-25 because of a one-off cost of £7,505 for a temporary member of staff to undertake a review of historical registration files relating to osteopaths who registered during the Transition Period.

People Committee

Terms of Reference

The People Committee oversees appointment, performance and remuneration policy in relation to Council, non-executives[4] and staff of the GOsC and makes recommendations to Council. To do this it will:

a. Advise Council on the arrangements for the appointment, induction and performance review of the Chair and members of Council in accordance with the PSA's standards.

b. Appoint the panel, including independent members, for appointing the Chair and members of Council.

c. Provide assurance of high standards in the appointment and performance review of all other Council appointees including non-Council members of committees and other Council appointees.

d. Advise Council on its structure, composition and competencies.

e. Make arrangements for the performance review process for Council as a whole.

f. Make arrangements for the appointment of the Chief Executive and make a recommendation to Council.

g. Following appointment, make arrangements for the formal review of the probation period of the Chief Executive and Registrar to be informed by feedback from Council, staff and stakeholders.

h. Advise Council that the formal review of the probation period of the Chief Executive and Registrar has been completed and clarify whether the probation period has been successfully passed or whether the probation period has been extended.

i. If required, oversee a performance management process for the Chief Executive and Registrar, which will ensure feedback is provided to them by the Chair of Council supported by two members of the People Committee.

j. If appropriate, make recommendations to Council concerning the removal of the Chief Executive and Registrar.

k. Consider and approve the remuneration of the Chief Executive on an annual basis.

[4] Non-executives are defined as members of Council, statutory and non-statutory committees and any other individuals, other than the Chief Executive and the executive team, appointed from time to time to undertake tasks on behalf of Council.

l. Receive an annual report from the Chief Executive on HR strategy.

m. Consider and approve recommendations of the Chief Executive in relation to pay, performance and reward of all other staff.

n. Consider any issues in relation to the remuneration of non-executives (including the requirements of the Charity Commission), review the remuneration of non-executives annually and make recommendations to Council.

o. Consider any issues in relation to the performance review of non-executive members and make recommendations to Council.

p. Consider the Equality, Diversity and Inclusion Framework as it relates to GOsC staff and non-executives.

q. Consider issues of health and wellbeing as they relate to Executive and Non-Executives.

r. Make an annual report to Council on the work of the Committee.

Meeting Frequency

Four times yearly or more frequently if required. Some business may be appropriately conducted out of committee. Any such activity will be reported formally to the next meeting of the committee with a record made in the minutes.

Membership

Two lay members and two osteopath members of Council and one external lay member with appropriate expertise.

There are no co-opted members.

Quorum

Three members - two lay members (Council or external) and one osteopath member.

Audit Committee Annual Report 2024-25

1. The Audit Committee met on four occasions in the year; April 2024, June 2024, October 2024 and March 2025.

New Public Website Development Project

2. An additional meeting was held in April 2024 to discuss the new website and to recommend that Council approve the designation of £200k of reserves for the project.

3. The members discussed various aspects of the website project proposal, including the needs of the end user, the blocks of funds to be spent, and any contingencies. They also discussed external consultancy expertise and timelines, and asked the Executive to consider risks of the project and how it would link into the new CRM system being implemented.

4. The Committee recommended that Council designate up to £200k for the scoping work and for the development and delivery of the website project.

Financial Audit, auditor evaluation, Annual Report

5. During the year the Audit Committee considered the Audit Findings Document and draft Annual Report and Accounts for financial year 2023-24. The document set out the key issues affecting the financial results of the GOsC including the preparation of the financial statements. The Committee agreed the audit, which was the second undertaken by HaysMac (formerly Haysmacintyre), had been completed satisfactorily, the only concern identified being the use of the incorrect materiality level when requesting adjustments.

6. The Committee considered an auditor evaluation framework for evaluating the performance of the external financial auditors. Audit Committee met with the external auditors in private and questioned the Executive and the external auditors before noting the evaluation document.

7. The Committee received HaysMac's external financial audit plan for 2024-25 at the March 2025 meeting. The document was approved.

Statement of internal financial controls

8. Audit Committee received the statement of internal financial controls for review in March 2025. The Audit Committee noted the control framework which is in operation, with some comments regarding version control so any changes are more easily identifiable.

Review of principal accounting policies

9. Audit Committee received the principal accounting policies for annual review in March 2025 which were noted.

Risk Register

10. At each meeting the Audit Committee reviewed the Risk Register which included a report presented by the Chief Executive and Registrar highlighting any movements in the risk level and discussion of action to manage risks.

11. During the year Audit Committee discussed refreshing the risk register as well as engaging firms to carry out Internal Audit and a Board Effectiveness review.

12. The Value Proposition, as outlined in the Annual Report and Accounts, was also discussed. There were thoughts around unpicking the three strands of the Value Proposition and to consider what is contained in the value chain, and the elements which allow us to generate value.

13. In the October meeting, heat maps were introduced to the risk register for Audit Committee to review and comment on. One positions the eight strategic risks on a heat map, with the second positioning the three strategic priorities. The members commented that it was particularly important to link back to objectives or core function. They also suggested summarising the tables, annotating which member of the executive the risks were allocated to and assessment whether the mitigating activities were working.

Performance Measurement

14. The Committee received the annual performance measurement matrix and recommended it to Council for noting. It was noted that the organisation performed well against its performance objectives.

Professional Standards Authority (PSA) Performance Review and consultation

15. The Audit Committee discussed the PSA Performance Report for the period covering 2023-24. The Committee noted that the GOsC had met all standards for the 14th year in succession.

CRM IT project

16. The Audit Committee has received regular updates on the CRM IT Project which has been progressing during 2024-25. The external IT consultant has been in attendance at each meeting to provide updates and answer any questions from the members.

17. Audit Committee noted in June 2024 that post-implementation there will be an ongoing managed service meaning that GOsC will have support for future problem solving.

18. The members were advised in October 2024 of some delays in the work relating to the way Integra works with Ozone and the Public Register. ClearCourse, the external supplier that hosts GOsC's public website, have done the initial work however they have been unresponsive since then which held matters back.

19. The Audit Committee were concerned regarding ClearCourse not delivering in a timely manner and wanted to clarify that this was the biggest risk. Both the Chief Executive and Project Manager responded that the first two phases were going to plan and that it was only this hold-up in relation to ClearCourse that had any risk attached to it.

20. The March 2025 update mentioned that the build out of the Salesforce platform was 97% complete with final checking and testing underway, and the external IT consultant recognised the efforts of the Registration team for the testing they have undertaken. In addition, the relationship with ClearCourse had improved following meetings with the Chief Executive and Registrar.

IT security

21. The Audit Committee received reports at each meeting on the GOsC IT infrastructure and approach to security, receiving assurance as to the steps being taken to maintain Cyber Essentials Certification and work towards achieving Cyber Essentials Plus Certification. Penetration testing was carried out in April 2024, with the results presented to Audit Committee in the June 2024 meeting.

22. The majority of resolutions to this testing can only be completed once the new CRM is implemented. The Audit Committee has been provided with an update at each meeting, and noted the fact it has other dependencies before it can be resolved.

Banking mandate

23. Audit Committee noted that the banking mandate, reflecting the change in Council membership from April 2024, was updated during December 2024.

Internal audit

24. In the October 2024 meeting, Audit Committee approved the launch of an Invitation to Tender for Internal Audit services. Interviews were held in February 2025 and the appointment of TIAA was approved by the members in March 2025.

25. Members discussed an outline internal audit plan with TIAA in the March 2025 meeting, and agreed that the finalised plan would be approved in the June 2025 meeting once TIAA had worked on this with the Executive.

Board effectiveness

26. The Audit Committee also approved the launch of an Invitation to Tender for a Board Effectiveness review in the October 2024 meeting. It was reported in the May 2025 Council meeting that the review is underway.

Development of a medium term financial and asset plan

27. In the June 2024 meeting, the Financial and Asset Plan was introduced which outlined the need to implement a plan to interrogate areas of the balance sheet, such as tangible assets, reserves, the investment portfolio, along with income and expenditure. Members noted the development of the plan.

28. In October 2024, members discussed a more fully-formed Draft Financial and Asset Framework covering the 2025-2030 period. This included some financial modelling on various scenarios, which were discussed by the Committee. Reserves levels were benchmarked against other regulators to give an idea of GOsC's standing.

Monitoring report

29. The Committee received a report at each meeting from the Executive on any serious events including fraud notification, data breaches and corporate complaints.

30. In 2024-25, the Executive reported to the Committee five corporate complaints (six in the prior year), three data breaches (one 'major' severity, and two 'low') (one 'low' severity in the prior year), one serious event (none in the previous year), no attempted fraud (none in the previous year) and no learning points received from the PSA (none in the previous year).

Forward work plan

31. At each meeting, the Committee received a report from the Executive which set out what items were likely to appear on future Audit Committee agendas. Audit Committee was able to comment upon the proposed future agendas and to influence its own workplans.

32. Updates on IT projects was added as a permanent item to all agendas until the various projects have been completed.

Membership

33. During the period 2024-25 the Audit Committee membership comprised:

Name	Member details	Dates of membership	Meetings attended
Harry Barton (Chair	Council lay member	All year	4/4
Graham Masters	External lay member	All year	4/4
Rob Jones	External lay member	All year	3/4
Caroline Guy	Council registrant member	All year	4/4
Sandie Ennis	Council registrant member	All year	3/4

Cost of the Audit Committee

34. It is estimated that the cost of the Audit Committee and its related activities, excluding staff time, is approximately £21k. This is calculated as follows:

Activity	**Cost £**
Committee members: fees and expenses	311
External financial audit fee (excl. VAT)	20,800
Total	**21,111**

Opinion of the Audit Committee

35. It is the opinion of the Audit Committee that its work during the past year is in line with the purpose and the Terms of Reference of the Committee. The Committee also believes Council can take assurance that the organisation has proper and appropriate systems in place to enable it to discharge its statutory responsibilities. The work reviewed by the Committee demonstrates the Executive has a mature approach to financial and non-financial control frameworks and a willingness to implement improvements where identified.

36. Council can take assurance that the controls upon which the organisation relies to manage risk are suitably designed, consistently applied and proportionate.

37. During the course of the year, the Committee has undertaken a wide range of activity as described in the report above. It is the view of the Committee that its approach has been supportive to the Executive while retaining the necessary rigour and challenge.

Audit Committee terms of reference

The role of the Audit Committee is to provide advice that the necessary internal and external systems and processes are in place for identifying, managing and mitigating the risks relating to the discharge of the GOsC's statutory duties, and make recommendations for any actions to Council and the Executive as appropriate. To do this it will:

a. Review and make recommendations to Council about the content and structure of the risk register at the start of each business planning cycle and keep it under review.

b. Review and make recommendations to Council about the effectiveness and proportionality of the risk management process.

c. Request and receive reports on the management of risk areas identified in the register and make recommendations to Council about improvements needed.

d. Review the internal financial controls and advise Council on these controls.

e. Make a recommendation to Council on the appointment of external financial auditors to conduct the annual financial audit.

f. Receive a report on preparations for the annual external financial audit.

g. Receive the audit report, Audits Findings Report (AFR), draft Annual Report and Accounts, and Governance Statement and make recommendations to Council on the approval of these, and monitor the implementation of agreed recommendations in the AFR.

h. Approve proposals for the commissioning of internal audits of key functions within the organisation and to recommend any areas where special investigation might be necessary.

i. Receive audit reports and the Executive's response and make recommendations to Council on the implementation of recommendations arising from such audits and investigations, and monitor the implementation of agreed recommendations.

j. Receive reports on any incidents reportable under the serious events framework, data breaches and corporate complaints or whistleblowing, and the Executive's response to them, and make any recommendations to the Executive and Council.

k. Receive reports on the Executive's approach to organisational performance management and corporate governance and make any recommendations.

l. Ensure that reports received across all aspects of the Committee's work consider the importance of equality, diversity and inclusion.

m. Make an annual report to Council on the work of the Committee and an overall opinion on the management of risk within the GOsC.

n. To review periodically its own effectiveness as a Committee.

Meeting Frequency

Four times yearly or more frequently if required. Some business may be appropriately conducted out of committee. Any such activity will be reported formally to the next meeting of the committee with a record made in the minutes.

Membership

Five members:

- Three Council members (one of whom is the Chair), of whom one must be an osteopath and the other a lay member.

- Two external members.

Council Associates

Council Associates may attend meetings of the Audit Committee and may participate in business at the discretion of the Committee Chair. Council Associates are not permitted to vote on any recommendations or decisions to be made by members of the Audit Committee.

Quorum

Three members – the Chair of the Committee (who is a Council Member) (or appointed deputy if unavailable), one Council member (which may be the co-opted member) and at least one external member.

General Osteopathic Council

17

Policy and Education Committee

Minutes of the 30th Policy and Education Committee held in public on Tuesday 10 June 2025, at Osteopathy House, 176 Tower Bridge Road SE1 3LU and Go-to-Meeting online video conference.

Unconfirmed

Chair: Professor Patricia McClure (Council, Lay)

Present:
Gabrielle Anderson (Council Associate)
Dr Daniel Bailey (Council, Registrant)
Gill Edelman (Council, Lay)
Professor Debra Towse (Council, Lay)
Arwel Roberts (Council Associate)
Kate Kettle (Independent, Lay)
Jayne Walters (Independent, Lay)
Andrew MacMillan (Independent, Osteopath)
Patrick Gauthier (Independent, Osteopath)

Observers with Speaking Rights:

Sharon Potter, Council of Osteopathic Educational Institutions
Santosh Jassal, Secretary to the Osteopathic Alliance, [online]
Matthew Rogers, Associate Director of Professional Development, Institute of Osteopathy.

In attendance:
Steven Bettles, Head of Education and Policy
Fiona Browne, Director, Education, Standards and Development
Nerissa Allen, Executive Assistant to the Chief Executive and Registrar
Lorna Coe, Governance Manager
Will Shilton, Mott MacDonald (QA provider)
Hannah Warwick, Mott MacDonald (QA provider)
Liz Niman, Head of Communications, Engagement and Insight
Darren Pullinger, Head of Resources and Assurance
Paul Stern, Senior Research and Policy Officer
Matthew Redford, Chief Executive and Registrar

Observers with No Speaking Rights:

Sally Gosling, Institute of Osteopathy [online]
Fiona Hamilton, Council of Osteopathic Educational Institutions
Neil Hayden, Chair, SCCO (online) [1000-1130]

Item 1: Welcome and apologies

1. The Chair welcomed all to the meeting and confirmed that all were happy that the meeting would be recorded.

2. Special welcomes were extended to:

   a. Lynne Chambers and Janet Rubin from Praesta, the company that has been undertaking the Board Effectiveness Review.

   b. The 4 new independent members who joined from 1 April 2025: Kate Kettle (Lay), Jayne Walters (Lay), Andrew MacMillan (Osteopath) and Patrick Gauthier (Osteopath).

   c. All members of the committee and staff present introduced themselves.

3. Apologies were received from:

   - Dr Jerry Draper-Rodi, National Council for Osteopathic Research.
   - Jo Clift, Chair of Council GOsC.
   - Banye Kanon, Senior Quality Assurance Officer

Item 2: Minutes and Matters arising.

4. The minutes of the meeting of March 2025 were agreed as an accurate record of the meeting subject to the following amendment:

   a. Typo on page 6, item 17 Paragraph P to be amended.

Item 3: CPD consultation analysis:

5. Stacey Clift, Head of Research, Data and Insight introduced the item. The key messages were:

   a. Most osteopaths understood the changes being proposed to the Continuing Professional Development (CPD) guidance and peer discussion review (PDR) Template and could not identify any gaps.

   b. It was considered that both the consultation version of the CPD Guidance and the PDR documents could be improved.

   c. The paper considered the findings of the consultation around fundamental elements of any CPD scheme: mandatory elements, reflective practice, sufficient evidence base for change and accessibility or inclusion considerations and some potential options for progressing in terms of an inclusive approach.

d. The paper asked the committee to consider a set of reflective questions (see paragraphs 16, 17, 22, 35 and 39 in the report) around implementation of next steps concerning:

   I. Strengthening trust among the contrasting views within the profession on this area.

   II. Mandatory, encouraged, building an evidence base for change or Right Touch elements (or a combination of these) for effective CPD and practice.

   III. Right touch reflective practice, which encompasses the individual Learner, inclusivity and innovative changes.

6. In discussing and considering the questions asked of it and considering next steps following the consultation which proposed introducing mandatory elements of CPD (in the areas of maintaining and establishing professional boundaries and equality, diversity, inclusion and belonging (EDIB)), the Committee looked at the 4 options provided in the report and debated extensively which was the most appropriate one:

   a. **Option 1**: Introduce these elements as mandatory elements in principle based on the statistical data collected as part of the consultation and use that as our evidence informed approach for them becoming mandatory elements of the CPD scheme under the theme of 'Benefiting patients'.

   b. **Option 2**: Introduce them as 'Encouraged elements only, in light of the unintended consequences which are highlighted by those that disagree with their mandatory introduction (educational evidence is cited by this group).

   c. **Option 3:** Introduce the Boundaries as mandatory and the EDIB as encouraged elements, given there is greater acceptance of the evidence base for the introduction of the boundaries element. Although we consider that the evidence base is strong for EDIB – we do think that there were some valid points made about process and outcome. We think that possibly framing a requirement about inclusive practice may be a way forward to better focus on successful outcomes. See Annex B for further detail.

   d. **Option 4:** Introduce both elements as 'Encouraged elements' while we work on developing resources and the narrative for EDIB evidence base beyond education and into practice, given some respondents cannot see the

correlation between the UrG[1]Ent project and wider practice as an osteopath with the view to introducing these elements as mandatory on a set date in the future.

7. The Committee debated the options and concluded that it agreed EDIB and boundaries were important elements but, in line with GOsC values, it needed more evidence about how the scheme would work for osteopaths to consider making them mandatory. It was noted that usually, the Committee would agree the guidance first and then would work on the package of resources to support osteopaths to do that. However, in this case, it was proposed that the team would bring back a more complete package of resources for both the boundaries and EDIB elements, developed collaboratively with osteopaths, students and others, so that the Committee could decide at that stage whether to make the elements mandatory. This would also include a more layered approach to the CPD guidance so that the requirements of CPD would be the same, but alongside the core guidance, there would be a number of different accessible ways for osteopaths with more or less detail as required. This layered approach would also incorporate appropriate reflection. The Committee agreed with this approach and therefore Option 4 was the preferred option however a decision to whether or not they would be mandatory in the future would be considered at the October meeting.

8. In coming to this conclusion, it was noted that involving students early in this process via the OEIs would be valuable.

9. It was pointed out that it would be how the materials around the CPD guidance would be presented that was layered and not the guidance itself.

Considered: Committee considered the CPD consultation analysis findings and the implications for next steps (There are specific questions for the committee to consider in paragraphs 16, 17, 22, 35 and 39).

Agreed: Committee agreed the approach to further development of the CPD Guidance and resources based on Option 4 outlined at paragraph 25 with consideration of whether or not it should be mandatory to be discussed at October Committee.

Agreed: Committee agreed the approach to the further development of the PDR template as outlined in paragraphs 36 to 39

[1] https://www.hsu.ac.uk/urgent-project/

Item 4: Standards Queries and Osteopathic Practice Standards (OPS) review call for feedback

10. The Senior Research and Policy Officer introduced the item and provided a summary which is start to the review of the Osteopathic Practice Standards (OPS). The key messages and following points were highlighted:

    a. The purpose of this paper was to provide an analysis of the issues raised with GOsC by osteopaths and other stakeholders and their application to the OPS over the past 13.5 months, as well as setting out the plan to start the review of the OPS through a call for feedback in late Summer/Autumn.

    b. The OPS was last reviewed and updated in 2018. Good practice suggests that standards should be reviewed at approximately 5-year intervals. Given the current standards are just over 5 years old, it was felt that it was right time to start the review process which was the reason for the paper to committee.

    c. As part of the preparatory work, Professional Standards have analysed the 91 ethical and standards queries received from osteopaths and members of the public between 23 March 2024 and 14 May 2025.

    d. The main issues raised were in relation to osteopaths' management of records, osteopaths' undertaking activities sitting outside the typical scope of practice and how to manage difficult situations with patients and colleagues.

    e. Consideration should be given as to whether there was anything further needed in these areas, whilst also considering issues such as, the rise of artificial intelligence (AI) and its impact on practice; boundaries issues between osteopaths, patients and their colleagues; and osteopaths' use of social media.

    f. In order to ensure a wide range of views and to hear from all stakeholders with an interest in osteopathy, the next step would be to launch a call for feedback later this year. Considering what was missing in terms of further guidance that might be helpful.

    g. There were a high number of queries on:

        I. Patient records and what registrants should do when they sell their business or retire, or members of the public asking how they could access their records in those instances.

        II. Patient confidentiality regarding AI transcripts or use of WhatsApp.

        III. Adjunctive therapies e.g. Injection therapy, Botox, infant feeding advice, diagnostic imaging.

    h. The Committee was asked for feedback on the research on the enquiries and whether it considered there were any gaps in the guidance.

11. In discussion, the following points were made and responded to:

    a. The Committee asked the executive if those responding to those queries felt able to answer the questions coming in or whether there were areas where there was no guidance or that were more challenging.

       It was also asked if, having responded, people were generally satisfied with the responses.

       The Senior Research and Policy Officer advised that in the main, the executive was able to respond to the queries and there was little that was not covered in the standards, however, there were a few that needed more consideration before responding e.g. how to deal with a challenging patient such as one who was breaking the boundaries and a registrant wanted to know their responsibilities. Responses were always sent with the offer to come back if there were more queries which the majority do not. Speaking in person was most helpful as it reduced any anxiety.

    b. The Head of Policy and Education pointed out that GOsC could not give legal advice and could not tell osteopaths what to do, rather, the executive would give them information and point them to legal advice or insurance etc. depending on the situation. The Committee suggested that the pre-engagement work would include other organisations such as the iO or insurers to triangulate what could potentially be a rich set of data on such queries and could inform GOsC's work on the review of standards of practice.

    c. The Committee queried where cultural competence within the delivery of practice would sit within the standards and questioned if it was missing because there were no queries coming from osteopaths on this or whether it was part of wider development of the profession.

       The executive advised they were not aware of specific queries coming through but there were communication and patient partnership elements in the guidance but GOsC would need to ask the patients what was missing.

    d. The Committee explored the issue with some members surprised to see non-surgical cosmetic treatments and feeding advice for example and wondered how a member of the public knew an osteopath was trained in those approaches, what was considered appropriate training and how the public knew it was safe practice.

       It was discussed that scope of practice was different for everyone with enhanced and advanced practice being very different than novice, therefore, the scope of practice needed to be wider to cover everyone.

       Committee concluded the guidance on adjunctive therapies would be included in the call to feedback to consider all the points made.

e. The Committee noted how this project was a great example of how GOsC was living its values as it was collaborative, respectful, evidence informed and it would be influential in changing practice by amending Osteopathic Practice Standards.

Noted: Committee noted the findings from the analysis of the queries received from osteopaths between March 2024 and May 2025.

Agreed: Committee agreed that GOsC launch a call for feedback in late Summer/Autumn 2025 and that this included the adjunctive therapies guidance.

Item 5: Quality Assurance

12. The Head of Education and Policy introduced and explained the process for new members of the Committee.

13. The key messages and following points were highlighted:

    a. The Committee were asked to agree an updated version of the annual report template for 2024-2025.

    b. The Committee should prescribe the format of the annual report requirement in good time in accordance with the 'general conditions' attached, the recognised qualification approvals or the agreed action plans (for OEIs without an expiry date) and in accordance with s18 of the Osteopaths Act 1993.

    c. The report will be sent out in August/September and returned in late November/early December for analysis. The analysis reports will be presented to the Committee in March 2026.

    d. The template was similar to previous years with a focus on delivery of the Standards for Education. Further detail was requested this year around student protection plans, the qualification and training/development approaches of education providers for teaching staff and curricula. In the data sheets, the question was asked about the ratio of clinical educators to patients, as well as students.

    e. The analysis would be carried out in-house for the first time.

14. In discussion, the following points were made and responded to:

    a. The Committee queried how GOsC would ensure, when moving the process in-house, that it was dealt with fairly, transparently with no bias etc. and whether it had approached the OEIs to involve them.

The Head of Policy and Education advised that GOsC had not firmed up on the moderation process yet but was considering using RQ visitors in a moderation capacity and that the template would remain the same as was used by Mott MacDonald. How the process developed over time would continue to be done with input from the OEIs.

b. The Committee discussed the requirement for a student protection plan, noting it was timely to include that. It was suggested that GOsC should clarify the intention and whether that was for institutions to share their standard student protection plan or whether it would be a specific plan to ensure students could transfer from one osteopathy course to another. The latter would negate potential issues of fairness for larger versus smaller institutions and if that was the intention it should be made very clear to institutions so they did not just share the larger student protection plan.

The Head of Policy and Education advised this would come out in the analysis. There was a duty on GOsC to support students in these situations and at the present time the focus was about making sure institutions had considered what they would do in the event a course was cancelled part way through.

Agreed: Committee agreed the annual report template for the 2024-2025 academic year, including the updated educator data collection proposals.

Item 6: Apprenticeship Standard

Due to conflicts of interest Patrick Gauthier, Daniel Bailey, Andrew MacMillan and Sharon Potter stepped out the room.

Caroline Guy, Member of Council had been co-opted for this particular item and had joined the call online. Approval had been received from Council.

15. The Director of Education, Standards and Development introduced the item. The key points were:

a. The paper asked the Committee to make the following decisions:

i. To agree that the draft osteopath apprenticeship standard attached at Annex A is aligned with and capable of delivering the Graduate Outcomes as demonstrated by the mapping and the overarching requirements statement.

ii. To note that any qualifications developed to deliver the osteopath apprenticeship standard will be subject to usual quality assurance arrangements to inform the Education Committee's statutory recommendations about recognition to Council in accordance with the Osteopaths Act 1993.

b. The paper explained that the development of the employer owned apprenticeship with the Institute for Apprenticeships and Technical Education (Ifate) is aligned with the GOsC strategy previously agreed by Council.

c. The paper explained that the decisions the Committee was being asked to make are in line with its statutory duties and roles as outlined in the Osteopaths Act 1993 and the General Osteopathic Council (Recognition of Qualifications) Rules 2000.

d. Matthew Rogers and Sally Gosling were present to answer any questions.

16. The following points were made and responded to in the discussion:

a. The Committee noted that GO70, 71 and 72 had not been mapped across to the apprenticeship standard and questioned the reasons for that.

Mathew Rogers, Associate Director of Professional Development, Institute of Osteopathy provided the background. The trail blazer group was putting together the apprenticeship standard which was the knowledge, skills and behaviours that employers told them they would want to see in an osteopath who had graduated through an osteopathy apprenticeship to demonstrate to show that they are employment ready.

In a regulated profession any provider would have to assure GOsC that those students who graduated out of an apprenticeship programme met the same graduate standards as other routes. It would not be in the same language though, as Ifate and Skills England had a language convention so they would not fully reflect the same wording in the Osteopathic Practice Standards (OPS) but the quality assurance process would be the same as for existing programmes.

The version presented was a draft version and there was time to make amendments.

b. The Director, Education, Standards and Development advised there were some of the Graduate Outcomes which were not capable of being translated into knowledge, skills and behaviours because they were experiential and therefore related to the delivery of the course rather than the content. They would instead be picked up as part of the QA process.

c. Sally Gosling, Institute of Osteopathy added there were a number of duties and knowledge, skills and behaviours that made overt reference to the GOsC Graduate Outcomes and then by definition the Osteopathic Practice Standards. Education providers' proposals to deliver an apprenticeship would go through GOsC RQ process.

The Chief Executive stated that this item should have been reserved (for Committee members only) and apologised for Observers with speaking rights that they could not contribute to the discussion on this item.

d. The Director of Education, Standards and Development advised that it was helpful for Committee to be aware that there was feedback from the ODG around specificity of osteopathy and whether there was sufficient osteopathy in the Apprenticeship Standard. She understood that this was being taken into account as part of the development process.

   The question for Committee was whether the draft Apprenticeship Standard presented mapped across to our Graduate Outcomes which did make reference and were agreed as sufficient in osteopathy (in particular paragraph 16). There was one view there was not enough osteopathy in the draft Apprenticeship Standard and this was now being updated to incorporate this. GOsC's view was that the draft was sufficient as it referenced the Graduate Outcomes both through the mapping document and through a 'catch all' statement. GOsC would review the delivery of the Graduate Outcomes as part of the quality assurance process. In order to be a 'recognised qualification (RQ) registrable with GOsC, subsequent qualifications developed in response to the Apprenticeship Standard must deliver the Graduate Outcomes and the Standards for Education and Training.

Agreed: Committee agreed that the draft osteopath apprenticeship standard aligned with and was capable of delivering the Graduate Outcomes.

Noted: Committee noted that any qualifications developed to deliver the apprenticeship standard would be subject to the usual quality assurance arrangements to inform recommendations about recognition to Council in accordance with the Osteopaths Act 1993.

BREAK 1136 - 1148

Item 7: BCNO Group – Initial Recognition of new RQ (reserved)

17. The Head of Policy and Education/ Senior Quality Assurance Officer introduced the item which was the visitor report that contained recommendation for initial recognition of the BSc (Hons) Osteopathic Medicine (full-time three-year course) with five conditions.

18. The key messages from the report were:

a. A draft RQ specification was approved by the Committee at its June 2024 meeting and in October 2024, the Committee agreed a team of three Education Visitors under s12 of the Osteopaths Act 1993 to undertake the review.

b. Following the BCNO Group's decision to cease recruitment to its London campus, the Committee agreed in January 2025 (via email) to proceed with the review, limited just to the proposed new three-year programme. The updated RQ specification as a result of this late change is attached as Annex A. A review of the remaining, existing provision will take place towards the end of 2025.

c. The visit took place from 18-20 February 2025.

d. The Action plan has been submitted to visitors for their comments so it is in hand and it was suggested that we request an update on all the conditions for the October meeting.

19. Hannah Warwick, Mott MacDonald added that there was a lot going on at BCNO at the time of the visit, but they were welcoming, very open and reflective about the areas that were identified. The visit focused on their readiness for change and the new programme. They had been thinking about some things that could cause issues for the student experience and making sure delivery of the programme would not negatively impact students.

20. A revised version of the report titled 'initial' rather than 'renewal' would be sent by Mott MacDonald.

21. In discussion, the following points were made and responded to:

a. The Committee suggested that condition 7 around advising GOsC of any proposed or substantial change should be higher up and questioned whether, for a new course, a change in student numbers should be advised sooner than a 20% variance, in order to be more of an early warning sign.

The Head of Policy and Education advised that there were general conditions, but the Committee could ask for much more detail on monitoring of student numbers if it wanted to.

The Director of Education, Standards and Development advised that there was an opportunity to reflect on the general conditions now that GOsC was taking Quality Assurance in-house and that the placement of each one could be reviewed as part of that.

b. The Committee discussed the requirement for a visit to be conducted in the second year of a new programme and whether that was proportionate

noting that there was one visit in February, another in November and a third the following year.

The Head of Policy and Education explained that the reason for the February and November visits was that BCNO had asked if the review visit could be done separately from the initial visit for the new programme.

The Director of Education, Standards and Development noted that the conditions should relate to the Standards of Education and Training and suggested the executive considered how to reword that to capture the concern rather than the process. The Committee could then make a decision on the visit at later date.

c. The Committee commented that in Annex B p5 regarding areas for development and recommendations regarding staff undertaking PDR should be compulsory rather than a recommendation.

d. The Committee commented on the requirement for all relevant course materials to be reviewed and questioned whether that was the validation documentation rather than all teaching and learning material which would be extensive and difficult to provide.

e. The Committee also raised a question in relation to condition 2 around producing the strategic plan for the next three to five years and wondered about the intent and proportionality of that request i.e. whether it was an action plan, a business continuity plan or a business case to support a new course showing how it would be delivered and sustained in the future.

f. The Director of Education, Standards and Development clarified for the Committee that its role was not to redo the visit as such as they had appointed Visitors to examine all the evidence at the schedule of the Report and triangulate this with live feedback from students, staff and patients. Rather it was for the Committee to check that the report justified the conclusions. For example, was there a disconnection or lack of consistency between the visit report and the evidence cited within it and the conditions and then question that.

g. The Committee discussed the proposed expiry date – the requirement was that there had to be a RQ visit one year before the expiry date of a new course but, if the Committee considered that another visit at the proposed time was disproportionate in this instance, noting it was an existing provider, it could decide to extend the expiry date to 1 January 2031 and review the position when they get the next RQ report towards end of 2026.

The Committee agreed to extend the expiry date to 1 January 2031.

Agreed: Committee agreed to recommend that Council recognise the BSc (Hons) Osteopathic Medicine awarded by The BCNO Group subject to the

conditions set out in paragraph 19, from 1 September 2025 to 1 January 2031 subject to the approval of the Privy Council. Subject to:

1. **The executive rewording the condition around the requirement for another visit in year 2 in line with Committee discussions.**

To request an update in relation to the action plan to be reported to the October 2025 Committee meeting. At that time the Committee will take a view about the date of the next visit.

Item 8: Swansea University – Renewal or continued recognition of RQ (reserved)

Jayne Walters and Sharron Potter stepped out the meeting for this item due to conflict of interests.

22. The Head of Policy and Education introduced the item and the key messages were:

    a. A renewal of recognition review took place in relation to the Swansea University M.Ost in February 2025.

    b. The visitor report contained recommendation for renewal of the recognition of the M.Ost qualification with no conditions.

    c. As there was no expiry date on the RQ, no decision by Council was necessary. However, the publication of the RQ report and the Action Plan would be reported to Council for information.

    d. Will Shilton of Mott MacDonald added it was a very detailed report and it had been a very successful visit in a very busy environment, lots of passionate students in osteopathy there and visitors saw state of the art resources. Lots of strengths of practice and whilst there were no conditions, the OEI responded really quickly to the recommendations.

23. The following points were made and responded to in discussion:

    a. The Committee commented on the areas of good practice and wondered if it could be highlighted specifically to the profession as an exemplar.

       The executive would consider how that could be done in a way that was fair and appropriate, ensuring that it was not promotion but that it could be used to show the profession the value of regulation.

Agreed: Committee agreed to publish the Swansea University RQ Visitor report which provides evidence to continue the recognition of the Masters

in Osteopathy (M.Ost) awarded by Swansea University with no conditions and no expiry date.

Agreed: Committee agreed that the action plan should be updated as outlined in paragraph 17 and published.

Item 9: Marjon – Renewal of Marjon RQ

Gabrielle Anderson left the meeting for this item due to a conflict of interest.

24. The Head of Policy and Education introduced the item and the key points were:

a. The visitor report contained a recommendation for renewal of the recognition of Marjon qualifications with two conditions.

b. A recommendation was made that the programmes be recognised without an expiry date. On this basis, the specific conditions recommended by the visitors alongside the general conditions applying to all recognised qualifications would be dealt with within a published action plan (Annex D).

c. Plan to update Committee in October as a lot of this would have happened by that point but team have been assured they are doing what they needed to do.

d. Will Shilton, Mott MacDonald added that the visitors were made to feel very welcome and teaching staff were very passionate, offering students a positive experience. The University benefitted from strong shared services and resources. There was evidence of good practice in supporting staff in their development needs. Although there was an ongoing discussion on one condition generally, they responded really quickly to the conditions.

e. The Head of Policy and Education explained there was an expiry date on the course despite the aim being to not have that as standard. The executive considered that the conditions to remove the expiry date had been met so suggested it be renewed with no expiry date.

Agreed: Committee agreed to recommend that Council recognises the Master of Osteopathy (MOst) (4 years full time) and Master of Osteopathy (MOst) (6 years part time) awarded by Marjon from 1 February 2026 with no expiry date subject to the approval of the Privy Council.

Agreed: Committee agreed to publish an action plan as set out in Annex D, subject to any further modifications to the Action Plan following Visitor feedback.

Requested: Committee requested an update from Marjon in relation to the implementation of the action plan for the two specific conditions recommended in the Visitors' report

Item 10: Exploring recognition pathways between the UK and New Zealand

25. **The Chief Executive introduced the item and the key points were:**

a. The GOsC has a three-stage international application pathway for any internationally qualified applicant wanting to register with GOsC.

b. The pathway cost an applicant £2,290.

c. Based on records from 2006, no applicant from New Zealand had failed the three-stage international application pathway.

d. New Zealand has a similar regulatory model to the UK and similar registration requirements to register.

e. The paper set out a comparison of the two models and suggestions of how to ensure that the systems always remained in line with each other.

f. The paper asked the question as to whether the GOsC and the Osteopathic Council of New Zealand could agree a system of mutual recognition of registration, reducing regulatory burden on osteopaths and streamlining the pathway making mobility between jurisdictions easier.

g. It demonstrated to regulators in other jurisdictions that progress could be made to ease the pathway to gain access to the register where the levels of regulatory systems were comparable. There are ongoing discussions in Australia around this point.

e. Questions for the committee to consider included the following:

a. How reasonable was it for GOsC and OCNZ to explore a system of mutual recognition of registration between our jurisdictions?

b. What would be the advantages and disadvantages of a system of mutual recognition of registration?

c. What were the mechanisms both GOsC and OCNZ could introduce to ensure our regulatory systems continued to align to support a system of mutual recognition of registration?

d. If a system of mutual recognition of registration was introduced, how frequently should such a system be reviewed?

f. In discussion, the following points were made and responded to:

a. Generally, the Committee felt this was a positive step and one that was innovative and fitted well with the GOsC values. It was felt that if this was successful it could serve as a template for other possibilities in the future but that there could be some resource implications longer term.

b. It was suggested that the GOsC consider a review process with a series of expiry dates so both parties had the opportunity to initiate a review as appropriate. Regular review of this item internally was also advised.

c. The Committee suggested looking for evidence that was already out there in other healthcare professions that could inform how GOsC takes this forward.

d. The Committee noted that one point of differentiation was that New Zealand had a clear scope of practice and pathways for advanced practice which the GOsC did not.

   The Chief Executive advised that in Section 4 New Zealand regulator had provided the wording around their competence authority pathway programme and GOsC was the only one that fitted within that. Therefore, they had not identified the scope practice and pathways for advanced practice as an issue.

e. Santosh Jassal, Secretary to the Osteopathic Alliance commented on the wider implications cost and longer-term effects in terms of costs and implementation of this with other countries. The OA had seen, through sister colleges in other countries, that there was a vast difference in basic standards in practice which would be a risk.

f. Santosh Jassal, Secretary to the Osteopathic Alliance also questioned what would happen with change – if regulators changed policies based on government, would the UK then have to align to international politics? It was suggested that another option would be to reduce the 3-year process to make that more user friendly rather than risk getting stuck in something that we cannot get out of if there is a change that GOsC did not like.

Discussed: Committee discussed the possibility of a system of mutual recognition of registration between the General Osteopathic Council and the Osteopathic Council of New Zealand.

Item 11: Policy and Education Committee Annual Report

27. The Director of Education, Standards and Development introduced the item and the key points were:

a. The role of the Policy and Education Committee was to contribute to the development of Council policy across the breadth of its work including in education, professional standards, registration and fitness to practise.

b. The Committee performed the role of the statutory Education Committee under the Osteopaths Act 1993. The Committee has a 'general duty of promoting high standards of education and training in osteopathy and keeping provision made for that training under review'. It also had a key role in giving advice to the Council about educational matters including the recognition and withdrawal of 'recognised qualifications' (see Sections 11 to 16 of the Osteopaths Act 1993).

c. The terms of reference of the Committee could be found at the end of the report at the annex.

d. The Director of Education, Standards and Development added that the executive would check the attendance records for observers with speaking rights as it had been highlighted that the OA had attended four out of four meetings.

Agreed: Committee agreed the Policy and Education Committee Annual Report to Council for 2024-25

Item 12: Update from Observers

28. COEI provided an update:

a. COEI Strategy Day, would be on 21st July 2025 in London and COEI would be reaching out to stakeholders with invites. The purpose was to look at how COEI could work with other stakeholders in a better way.

b. Redrafting COEI articles of association.

c. Relationship and strategy and how to invite other institutions to be part of meetings.

d. Noted thanks to GOsC for including COEI in the new QA process.

29. Matthew Rogers provided an update from the Institute of Osteopathy (iO):

a. The incumbent CEO had retired and Dr Alison Robinson Canham had been appointed as the new CEO and started on Monday 9th June. Her background was in education and PhD which linked to the educational role of professional bodies.

b. iO convention would be held on 21-22 November in London and would be a chance for the profession to come together and build the community. All were invited to consider joining this event.

c. The iO had been delivering a leadership course in conjunction with institute of leadership, 56 had joined and 5 had taken on non-executive roles as a result.

d. The iO had been working with GOsC on the transition to practise and was grateful to be involved in that process.

e. GOsC removed its CPD diary tool – the iO would now be providing a CPD tool instead and had been working with GOsC on that. Osteopaths could now upload their evidence that supported their CPD diary to that same platform.

29. OA provided an update:

a. The Osteopathic Children centre was piloting a paediatric Patient Recorded Outcome Measures (PROMS).

b. The OCC will be launching a new clinic as they are changing premises and there would be a launch party.

c. OA had undertaken a small study targeted at new graduates within the first three years of practice to explore how they felt about their practice, training and what gaps the OA could fill. The purpose was to provide some data on how the OA could support them better and it did provide some rich data in terms of practice, undergraduate training, what kind of things were supporting them in their current teaching at post-graduate level which included mentoring and teaching clinics.

30. Daniel Bailey provided an update in the absence of Jerry Draper-Rodi from NCOR:

    a. Dr Philip Bright was stepping down as Chair as he was taking a role at HSU but would remain on the Board for the transition of the incoming chair. New nominations had been invited.

Item 13: Any other business

31. The Committee thanked Mott for all work over the years and good team to work with and valuable contributions to the meetings and work on transition. Mott MacDonald would attend the next meeting.

Item 14: Date of the next meeting:

- Policy and Education Committee Wednesday 22 October 2025

Meeting closed at 1247