General Osteopathic Council

**4**

**Policy Advisory Committee**
**9 March 2017**
**Review of the *Osteopathic Practice Standards***

| | |
|---|---|
| **Classification** | Public |
| **Purpose** | For discussion |
| **Issue** | An update on the review of the *Osteopathic Practice Standards* |
| **Recommendation** | To consider the progress and development of the *Osteopathic Practice Standards* review as set out in the paper and the issues highlighted at paragraph 29. |
| **Financial and resourcing implications** | The review so far has been within budget allocations. Consultation and engagement, including the preparation of documentation will be accounted for in the 2017-18 budget. The equality impact assessment advice has also been accounted for within the budgets. |
| **Equality and diversity implications** | A draft equality impact assessment is being prepared ahead of consultation by an independent consultant. |
| **Communications implications** | The draft revised *Osteopathic Practice Standards* will be subject to a public consultation later in 2017 (September to December). A communications strategy will be developed to promote feedback to the consultation with all our stakeholders including patients and the public. A communications strategy to introduce the revised standards before implementation in 2018 will also be developed. The process of revising the standards will be regularly reported in the osteopathic media to ensure wide awareness, as well as through channels that encourage other stakeholders to be involved. |
| **Annex** | Initial working draft of revised *Osteopathic Practice Standards* |
| **Author** | Steven Bettles |

## Background

1. At its meeting of 13 October 2016, the Policy Advisory Committee was given an update on the review of the *Osteopathic Practice Standards* (OPS) including an analysis of responses to the initial call for evidence and an initial outline of what revised standards might look like.

2. The Committee expressed concern that the scope of the review remained consistent with the principles outlined in the November 2015 Council paper, namely:

| | |
|---|---|
| 1. Overarching values/ principles | Possible inclusion of a set of high-level over-arching values/principles. Alternatively, reflect those developed and owned by the profession (e.g. Patient Charter'). |
| 2. Standards | The existing 37 standards with modifications where required. |
| 3. Guidance | Revision and strengthening of the current guidance, incorporating revisions identified in the review. |
| 4. Learning resources | A range of material explicitly linked to the OPS, providing more explicit explanation of why standards are in place/how they apply in practice. In support, also additional resources, or sign-posting to relevant external resources, case studies, and interactive educational material, etc. This would largely be provided online. |

3. The distinction between 'guidance' and 'resources' was discussed, and the Committee indicated that:
   - The distinction between guidance and resources, and the scope of these would need to be clear to osteopaths, particularly if some areas of guidance were to be published separately from the OPS document.
   - If any guidance was to be published separately, then the reasons for doing this should be made clear.
   - Whatever was published within the OPS should be the critical information required to support good practice.

4. Some areas were drawn to the Committee's attention, as having arisen from the initial call for evidence and review process so far. These included:
   - Inclusion of osteopathic principles and philosophy in the standards (Standards B1, B2, C1, C2);
   - The osteopaths role in public health (Standard D11);
   - The contribution of other healthcare professionals (Standard D1);
   - The requirement for the production of high quality material and data and being capable of retrieving, processing and analysing data (Standards D2 and D3).

5. The Committee considered that these issues should be referred to the Stakeholder Reference Group, established to collaborate on the revision of the OPS.

6. At its meeting on 2 November 2016, Council noted the progress made on the review of the OPS so far. It was agreed that the progress of the review was consistent with the principles agreed by Council referred to in 2 above, and a revised timetable was agreed as follows:

| **Activity** | **Date** |
|---|---|
| Multi-stakeholder working group established to collaborate on the development of revised OPS and supplementary guidance documents. | January to May 2017 |
| Report to Policy Advisory Committee | June 2017 |
| Council approval of draft OPS and guidance for consultation | July 2017 |
| Consultation | September to December 2017 |
| Publication and introduction | Spring 2018 |
| Preparation for revised OPS coming into force | Spring 2018 to Autumn 2019 |
| Standards come into force | Autumn 2019 |

7. An initial meeting of the Stakeholder Reference Group took place on 30 January 2017. This paper outlines key outcomes of this meeting, and reports on an initial working draft of revised OPS which has been developed as a result of input from the group.

**Discussion**

*General*

8. The Stakeholder Reference Group met on 30 January 2017. This was chaired by Jane Fox, and included representatives of:
   - The Council of Osteopathic Educational Institutions
   - The National Council for Osteopathic Research
   - The Institute of Osteopathy
   - The Osteopathic Alliance

   The group also has two patient representatives, though neither were able to attend the initial meeting. Both will give feedback on the information supplied, and on the draft as it develops.

9. An initial outline of what revised OPS might look like was included with a paper to the Policy Advisory Committee on 13 October 2016. This 'suggestion' document was used as the basis for discussions at the initial meeting of the Stakeholder Reference Group. In accordance with the review principles outlined by Council, the document was prepared on the basis that the four themes of the current OPS will remain. These are:
    - Communication and patient partnership
    - Knowledge, skills and performance
    - Safety and quality in practice
    - Professionalism.

10. Following the Stakeholder Reference Group meeting, the initial document has been developed into a first draft of revised OPS, which is annexed to this paper. This draft is very much a work in progress and has not yet been circulated to the Stakeholder Reference Group members for comment. It is provided in order to facilitate the input of the Policy Advisory Committee at this stage of development, prior to a first draft being circulated to the group. The language suggested is provisional, and will be tested during the development process.

11. Feedback in response to the initial call for evidence, and internal review processes, indicated that there were some areas of repetition within the standards, and some standards that seemed better suited in a different theme. The initial draft addresses this. Some of the existing standards from 'Safety and quality in practice' (current C3-5), related more to 'Communication and patient partnership', and have been moved to or combined with standards from that theme. Similarly, some current standards from 'Professionalism' seemed to relate more to 'Safety and quality in practice' (current D2, D12, D13).

12. The draft shows the current OPS, suggested revisions to these, and suggested guidance. Commentary and notes are shown in relation to each of the standards. Current guidance is not shown, though changes are referred to in the commentary in relation to each. For a full comparison, it is suggested that the draft be compared to the current OPS[1]

13. Key issues were discussed by the Stakeholder Reference Group which are summarised in the following paragraphs. Where these discussions led to revisions in the draft OPS, this is highlighted.

*Integration of the Standard of Proficiency and Code of Practice*

14. The Group discussed the suggestion that the Standards of Proficiency and the Code of Practice, which are currently separately differentiated within the OPS, be integrated more closely. The suggestion is to have one set of standards which, simultaneously, represent both the Standard of Proficiency and the Code of Practice. Legal advice from Fieldfisher solicitors confirms that this is possible

[1] Available at: http://www.osteopathy.org.uk/standards/osteopathic-practice/

within the provisions of the Osteopaths Act 1993, provided it is clearly stated that this is the case. The group were supportive of this suggestion.

*Consent guidance*

15. The group considered whether, in relation to consent (Standard A4), the current extensive guidance published within the OPS document could be reduced, with more detailed guidance being published separately. The general feeling of the group was:
    - It would be more convenient to have one single document with standards and guidance, as separate guidance may act as a barrier to engaging with this.
    - There was a strong feeling that standards and guidance should be available and easily accessible online, although it was acknowledged but that many would also rely on a hard copy.
    - The overarching aim, however guidance was published, would be to ensure optimum accessibility and engagement.

16. In the draft revised OPS this, as now, is referred to in Standard A4. In the light of discussions with the Stakeholder Reference Group, guidance has been included within the initial draft, rather than as a separate document at this stage. Some of the more detailed guidance regarding the treatment of children has been removed, however, in an attempt to focus the guidance on key issues. These aspects are already covered, to an extent, in separate guidance published on the **o** zone (Obtaining consent[2]) and this will be reviewed to ensure that all relevant areas are adequately covered. Headings have also been added to the consent guidance to improve navigability.

*Reference to osteopathic principles in the standards*

17. The current standard B1 states; 'You must understand osteopathic concepts and principles, and apply them critically to patient care'. This drew some critique within responses to the initial call for evidence with respondents stating that osteopathic principles are not universally agreed, understood or applied, nor unique to osteopathy. In response to this, the suggestion was that B1 and B2 be combined into one; 'You must have sufficient and appropriate knowledge and skills to support your work as an osteopath'.

18. The group considered referring to osteopathic principles within the standard itself was not necessary, but that these could be referenced within the guidance to the standard, where an outline is given as to the knowledge necessary to meet this standard. It was acknowledged that the recent *Guidance for Osteopathic Pre-registration Education*[3], introduced since the current standards

[2] (**o** zone log in required to access this) http://www.osteopathy.org.uk/news-and-resources/document-library/osteopathic-practice-standards/consent-guidance-for-osteopaths-practising-in-england-and-wales/

[3] http://www.osteopathy.org.uk/training-and-registration/becoming-an-osteopath/guidance-osteopathic-pre-registration-education/

were implemented in 2012, now sets out the outcomes students are expected to meet in order to graduate with a Recognised Qualification, and there is therefore less need to be so explicit within the standards as to the nature of knowledge and skills required of registrants, so long as this is sufficient and appropriate to support their work.

19. In the draft revised OPS, the guidance to B1(You must have sufficient and appropriate knowledge to support your work as an osteopath) now includes a statement that this knowledge should include '*An understanding of osteopathic principles and concepts of health, illness and disease and the ability to critically apply this knowledge in the care of patients'.*

*Relationships with other healthcare professionals and the role of osteopathy*

20. In relation to standard D1 (You must consider the contributions of other healthcare professionals to ensure best patient care) feedback from the call to evidence indicated that this, and its guidance were not always clearly understood. The group was keen to emphasise that osteopaths are part of a larger community of healthcare professionals, and to reflect a respectful and collaborative approach with the patient at the centre.

21. The guidance to D1 within the draft revised OPS has been modified slightly to emphasise an understanding of the contribution of osteopathy within the context of healthcare as a whole, and a collaborative approach to care, where appropriate.

*Production of reports and data analysis*

22. Standard D2 states; 'You must respond effectively to requirements for the production of high-quality written material and data'. Feedback indicated that this standard and its guidance were not clearly understood. The group considered that this standard would be better placed within the Safety and Quality theme, and linked to the keeping of records. It was felt that guidance should refer to the production of reports and information to support patient care and effective practice management. This is reflected in the draft revised OPS, where this becomes a new C3 under 'Safety and quality in practice'.

23. Standard D3 states: 'You must be capable of retrieving, processing and analysing information as necessary'. Again, feedback indicated that this was not always well understood. The group approved the suggestion to modify the standard to reflect the need to 'have sufficient knowledge and ability to analyse and reflect upon information related to your practice in order to enhance patient care and your own professional development', and this is shown in the draft revised OPS, where this becomes D2 under 'Professionalism'

*Role of osteopaths in relation to public health*

24. Standard D11 states; 'Be aware of your role as a healthcare provider to promote public health'. The current guidance is not particularly helpful in explaining this, and, again, feedback indicated that the context of this standard was not always clear. The group considered this aspect, and felt that it was important that, as statutorily regulated healthcare professionals, osteopaths played a part in promoting public health. This should be reflected in terms of being aware of public health issues and concerns, being able to discuss these impartially with patients or referring them to others or to resources to support decision making.

25. In the draft revised OPS, this becomes standard D10. The suggestion is to modify the guidance to: 'You should be aware of public health issues and concerns, and be able to discuss these impartially with patients, or guide them to resources or to other healthcare professionals to support their decision making regarding these.'

*Next steps*

26. The draft revisions to the OPS and guidance will continue to be developed in collaboration with the Stakeholder Reference Group through the spring, and will be reported to the Committee in a more final form at its meeting on 8 June. A final draft will then go to Council at its meeting on 18 July for approval, prior to broader consultation.

*Consultation*

27. The final draft revisions of the OPS will be subject to consultation from August to October 2017, which is slightly sooner that the consultation period envisaged in the timetable referred to in 6 above (see timetable below). The initial call for evidence used a dedicated microsite (http://standards.osteopathy.org.uk/), and it is intended to adapt this to facilitate the consultation process. Consideration is currently being given as to the best means of achieving this to encourage ease of response in relation to the proposed revisions.

*Presentation of the Osteopathic Practice Standards*

28. Consideration is also being given as to a variety of means of publishing revised OPS and any supporting guidance and learning resources. As well as a hard copy or PDF version of the standards as now, this might include a better navigable website (or app) which would facilitate a more interactive and engaging experience for users.

*Timetable*

29. The suggested timetable below is as agreed at Council and referred to in paragraph 6 above, with a slightly earlier consultation period.

| Activity | Date |
|---|---|
| Multi-stakeholder working group established to collaborate on the development of revised OPS and supplementary guidance documents. | January to May 2017 |
| Report to Policy Advisory Committee | June 2017 |
| Council approval of draft OPS and guidance for consultation | July 2017 |
| Consultation | Early August to end October 2017 |
| Post consultation analysis | November 2017 |
| Publication and introduction | Spring 2018 |
| Preparation for revised OPS coming into force | Spring 2018 to Autumn 2019 |
| Standards come into force | Autumn 2019 |

30. Whether the post-consultation OPS is considered again by the Policy Advisory Committee in March 2018, will depend on the extent of post-consultation changes. This will also determine whether the final version is submitted for approval to Council in February or May 2018.

**Issues for consideration**

31. At this stage in the OPS development process the Committee is asked to consider the following issues:

    a. The approach proposed in the minor rearrangement of certain standards between the four themes of the OPS.

    b. The presentation of consent guidance within the standards document as suggested in the initial draft (A4).

    c. The approach to making reference to osteopathic principles within the guidance (B1).

    d. The suggested interpretation of osteopaths' public health role. (current D11, revised D10).

    e. The overall direction of travel of the review and whether there are any issues or concerns at this stage to inform the further development of a draft for consultation.

General Osteopathic Council

**Draft revisions to Osteopathic Practice Standards**

Note – we have highlighted the current standard in the left column, and any suggested revision in the central column. Where some standards have been consolidated or moved sections, the reference to these may have changed (for example – from D4 to A6). In the notes and comment section in each case the revised standard is referred to.

## Theme 1: Communication and patient partnership

| **Introductory statement - notes and comments** | |
|---|---|
| We've mentioned 'putting patients first' in the revised version. | |
| **Current introductory statement** | **Suggested revisions** |
| **The therapeutic relationship between osteopath and patient is built on trust and confidence. Osteopaths must communicate effectively with patients in order to establish and maintain an ethical relationship.** | **The therapeutic relationship between osteopath and patient is built on trust and confidence. Osteopaths must put patients first, and communicate effectively to establish and maintain ethical patient partnerships.** |

| **Revised A1 Notes and comments** | | |
|---|---|---|
| The suggested A1 is a combination of the current A1, plus elements of the current A5, with C3 becoming point 1 of the guidance. It seems that all of these standards underpin the formation of an effective patient partnership, so having this andhere as a primary standard seems to make sense, rather than separating it out as it is currently.<br><br>We have added Para 2 of the guidance in response to a disability consultant's comments on disability issues. This is adapted from the current guidance to A1.<br><br>Para 4 of the guidance is from the current guidance to A5. | | |
| **A1 Current standards** | **A1 Suggested revisions** | **Suggested guidance** |
| A1. You must have well-developed interpersonal communication skills and the ability to adapt communication strategies to suit the specific needs of a patient. | A1. You must work in partnership with patients, effectively adapting your communication approach to take into account the particular needs of the patient. | 1. You must care for your patients and do your best to understand their condition and improve their health.<br>2. You should be sensitive to the specific needs of patients, and be able to select and utilise effective forms of communication, which take these into account.<br>3. You should share with patients, accurate and relevant information and encourage them to ask questions, and to take an active part in decisions about their care.<br>4. The most appropriate treatment for patients will sometimes involve:<br>4.1. Referring them to another osteopath or other healthcare professional.<br>4.2. Providing advice on self-care.<br>4.3 Not treating them at all. |

**Revised A2 Notes and comments**

The revised A2 incorporates also the current C4 (being polite and considerate), and C5 (acknowledging patients' individuality).

In point 3. We've added physical and mental health and disability to the existing wording.

Current guidance includes:

> 5. Good communication is especially important when you have to examine or treat intimate areas. You should first ensure you explain to the patient clearly and carefully what you need to do and why you need to do it. The patient needs to understand the nature and purpose of the examination or treatment proposed. Intimate areas include the groin, pubis, perineum, breast and anus, but this is not an exhaustive list.
>
> 6. If you are proposing to undertake a vaginal or rectal examination or technique, you should offer to conduct the procedure at a subsequent appointment. Some patients may not have come prepared for such a procedure and may prefer to return at another time.

The suggestion is to remove these comments from this section – having these on, effectively, page 1 of the OPS might give an alarming and inaccurate indication of what typical osteopathic treatment might include for patients reading the standards. This is covered in guidance to A4 in relation to consent.

| A2 Current standards | A2 Suggested revisions | Suggested guidance |
|---|---|---|
| A2. Listen to patients and respect their concerns and preferences. | A2. Treat patients courteously, respect their individuality and preferences, and recognise their concerns and expectations. | 1. Poor communication is at the root of most patient complaints. Effective communication is a two-way exchange, which involves not just talking but also listening with care.<br>2. You should be alert to patients' unspoken signals; for example, when a patient's body language or tone of voice indicates that they may be uneasy or experiencing discomfort.<br>3. Be aware that patients will have particular needs or values in relation to gender, ethnicity, culture, religion, belief, sexual orientation, lifestyle, age, social status, language, physical and mental health and disability. You must be able to respond appropriately to these needs.<br>4. Your patients should have your full attention, and you should allow sufficient time to deal properly with their needs. If you are in sole practice, you will need to develop strategies to minimise interruptions while you are with a patient. |

| **Revised A3 Notes and comments** | | |
|---|---|---|
| A3 has been reworded to refer to information that patients may 'want or need', rather than just 'need'. The aim is to make this more patient-centred, and avoid implying that it is the osteopath who decides what the patient needs (reflecting the Montgomery case).<br><br>Point 1 of the guidance: this has been slightly reworded, retaining the original essence.<br><br>Point 2 of the guidance: this has been slightly reworded. Reference is made to 'care options' (similar to the GCC Code), rather than 'alternatives to treatment', as this was a point of criticism in the feedback we received. We have also added 'benefits' to explanations, and a requirement to confirm patient's understanding of risks and benefits.<br><br>Point 3 of the guidance: this is in the current guidance. Some feedback highlighted the demand this places on the osteopath (e.g. to provide an interpreter) and questioned the need for this detail. Should this be retained? Our disability consultant pointed out that it's important osteopaths understand they must be legally compliant – where reasonable, they may need to provide an interpreter – certainly using a third party, or notes/engaging with someone effectively who needs to lip read. | | |
| **A3 Current standards** | **A3 Suggested revisions** | **Suggested guidance** |
| A3. Give patients the information they need in a way that they can understand. | A3. Give patients the information they want or need to know in a way they can understand. | 1. You should explain to patients what they can realistically expect from you as an osteopath, and their rights as a patient, including the right to have a chaperone present, and to stop the examination or treatment at any time.<br>2. Inform your patients of any material or significant risks associated with the treatment you are proposing, as well as anticipated benefits, and confirm their understanding of these. You should discuss care options and encourage patients to ask questions, dealing with these clearly, fully and honestly.<br>3. If you propose to examine or treat a patient who has difficulty communicating or understanding, you should take all reasonable steps to assist them. For example, make use of an appropriate interpreter if the patient cannot speak your language or relies on signing for communication. |

| **Revised A4 Notes and comments** | | |
|---|---|---|
| There was discussion with the Stakeholder Reference Group as to whether guidance on consent could be reduced, as it is currently more than two pages in the OPS document. Some felt it important to retain as much guidance as possible within the document itself. The question is likely to be more one of accessibility. In this suggestion, we have reformatted the current guidance with some changes to try and make it clearer to understand. We have grouped guidance under headings, for clarity. Some of the finer detail from the current guidance related to the treatment of children has been removed, and will be incorporated within separate guidance (as is the case now with our supplementary guidance on *Obtaining Consent*). | | |
| **A4 Current standards** | **A4 Suggested revisions** | **Suggested guidance** |
| A4. You must receive valid consent before examination and treatment. | A4. You must receive and valid consent for all aspects of examination and treatment and record this as appropriate. | 1. Gaining consent is a fundamental part of your practice and is both an ethical and legal requirement. If you examine or treat a patient without their consent, you may face criminal, civil or GOsC proceedings.<br><br>2. The gaining of consent is an ongoing process. You must make sure that patients are kept informed about the progress of their treatment, and are able to make decisions at all stages.<br><br>3. For consent to be valid, it must be given:<br><br>• Voluntarily.<br>• By an appropriately informed person.<br>• With the capacity to consent to the intervention in question.<br><br>**Voluntarily**<br><br>4. To be voluntary, the patient must not be under any form of pressure or undue influence to consent to osteopathic care. You should ensure that patients are given all the information they need in order to give their consent, and to reach their own decision on this.<br><br>5. Situations where you might question whether consent is voluntary might include patients being put under pressure by employers or relatives to accept osteopathic care, or where a patient might be vulnerable.<br>**By an appropriately informed person**<br><br>6. The patient needs to understand the nature, purpose and risks of the examination or treatment proposed. The patient must then be free to either accept or refuse the proposed examination or treatment. Some patients may need time to reflect on what you have proposed before they give their consent to it.<br><br>7. Where your diagnostic examination and treatment are carried out simultaneously, consent may be best obtained by explaining your approach, describing the types of treatment methods you might like to use and setting the parameters within which you will work. If the patient consents to you proceeding on this basis, you may do so. If the patient expresses concern that you are going outside the agreed treatment plan, you must |

| | | |
|---|---|---|
| | | stop the treatment.<br><br>8. Before relying on a patient's consent, you should consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed. This is more important than how their consent is expressed or recorded<br><br>9. It is particularly important to ensure that your patient understands and consents to the proposed examination or treatment of any intimate area before it is administered. Intimate areas include the groin, pubis, perineum, breast and anus, but this list is not exhaustive, and patients may regard other areas of their body as 'intimate'. Some patients may not have come prepared for such a procedure and you should offer to conduct this at a subsequent appointment.<br><br>**Capacity**<br><br>10. Capacity, in this context, relates to the ability of an individual to understand, retain and evaluate information to make a decision regarding their health needs and treatment options, and to communicate this[4] [5] [6].<br><br>11. You must not assume that a patient lacks capacity solely because of their age, disability, appearance, behaviour, medical condition, beliefs, or because they make a decision which you disagree with. The starting point should always be a presumption of capacity.<br><br>12. The law recognises that some patients – because of illness or mental capacity – are not competent to give consent for an examination or treatment. This is because they may not be able to absorb or weigh up the information and make an informed decision.<br><br>13. When an adult lacks mental capacity, decisions about their treatment must be taken in their best interests and in accordance with relevant legislation. Further details on the relevant legislation are provided in the GOsC guidance document *Obtaining Consent*.<br><br>14. Where an adult in England and Wales does not have capacity, The Mental Capacity Act enables someone who is over 18 to be authorised to make decisions on their behalf under a Lasting Power of Attorney (LPA). The LPA must hold explicit powers to make decisions regarding health and welfare issues. |

[4] Mental Capacity Act 2005 (England and Wales), available at: http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf
[5] Adults with Incapacity (Scotland) Act 2000
[6] Common law (Northern Ireland).

| | | |
|---|---|---|
| | | **Treatment of children and young people**<br><br>Note that in the summary below a 'child' is a person under the age of 16 years and a 'young person' is a person aged 16 or 17 years.<br><br>15. Before you examine or treat a child or young person, you should ensure that you have valid consent. If you treat children, you must be aware of the law in this respect. Obtaining consent for treatment to be given to a child or young person is a complex issue: Further details are provided in the GOsC guidance document *Obtaining Consent*.<br><br>16. A child may have the capacity to consent, depending on their maturity and ability to understand what is involved. You will need to use your professional judgement in assessing the capacity of each patient under 16 years. You are strongly advised to involve the child's parent when seeking consent.<br><br>17. You should involve children and young people as much as possible in discussions about their care, even if they are not able to make decisions on their own.<br><br>18. A young person can be treated as an adult and can be presumed to have the ability to make decisions about their own care. Nevertheless, you will need to use your professional judgement to assess whether the young person in fact has the maturity and ability to understand what is involved in the treatment you are proposing for them because, as with adults, consent must be valid.<br><br>**Explicit or implied consent**<br><br>19. Patients can give consent orally or in writing (explicit or express consent), or they may indirectly give consent by complying with the proposed examination or treatment, for example, or by getting ready for the assessment or care (implied consent). Implied consent can be valid, provided this is voluntary, the patient has capacity, and has sufficient knowledge and understanding of what they are consenting to. If you are not sure whether you have valid consent, then you should seek explicit consent before proceeding.<br><br>**Records of consent**<br><br>20. You must record key elements of your discussion with the patient in their records. This should include information discussed, any particular concerns or requests for information raised by the patient, how you addressed these, and any decisions made. |

| | | |
|---|---|---|
| | | 21. The validity of consent does not depend on the form in which it is given. Written consent may serve as evidence of consent but if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not by itself make the consent valid.<br><br>22. Valid consent does not always have to be in writing. However, if you are proposing a vaginal or rectal examination or technique, written consent should be obtained. You should ask the patient to provide their valid consent in writing, by signing a consent form. This form should be placed in the patient's records. You may also ask patients to provide their consent in writing for other procedures.<br><br>**Sharing of information**<br><br>23. You must obtain specific consent from patients regarding the sharing of any information about them with others. |

| **Current A5 Notes and comments** | | |
|---|---|---|
| This has been combined with Standard A1 above, in an attempt to rationalise some of the standards and avoid undue repetition. | | |
| **A5 Current standards** | **Suggested revisions** | **Suggested guidance** |
| A5. Work in partnership with patients to find the best treatment for them. | N/A | N/A |

| **Revised A5 Notes and comments** | | |
|---|---|---|
| Feedback indicates a general lack of understanding around this standard. It reads as though it relates to the giving of broader lifestyle advice, but the current guidance says something different. The reference in the supporting guidance about encouraging patients to tell their GP they are seeing an osteopath was criticised by respondents as being unrealistic and unrelated to the standard. We have suggested some revised guidance, which avoids the current suggestion of encouraging patients to inform their GP that they are receiving osteopathic treatment, references broader lifestyle advice (similar to the GMC Good Medical Practice), and maintains the reference from the current guidance about allowing patients to make decisions about their care. | | |
| **A6 Current standards** | **Suggested revisions** | **Suggested guidance** |
| A6. Support patients in caring for themselves to improve and maintain their own health. | A5. Support patients in caring for themselves to improve and maintain their own health. | 1. Supporting patients in caring for themselves may include:<br>a. advising patients on the effects of their life choices and lifestyle on their health and well-being<br>b. supporting patients to make lifestyle changes where appropriate.<br><br>2. Allowing patients to make their own decisions about their care, even if you disagree with those decisions. |

| **Revised A6 Notes and comments** | | |
|---|---|---|
| It is suggested that the current standard (C6) is moved from *Safety and quality in practice* to *Communication and patient partnership*. | | |
| **C6 Current standards** | **A6 Suggested revisions** | **Suggested guidance** |
| C6. Respect your patients' dignity and modesty. | A6. Respect your patients' dignity and modesty. | 1. Patients will have different ideas as to what they need to maintain their dignity and modesty during a consultation, and you should be sensitive to those ideas.<br>2. Some of these ideas may have been shaped by a patient's culture or religion, but it is unwise to make assumptions about any patient's ideas of modesty. You should respect your patients' dignity and modesty by:<br>2.1. Explaining to patients in advance of their first appointment that they may be asked to undress for examination and treatment.<br>2.2. Allowing a patient to undress, and get dressed again, without being observed.<br>2.3. Explaining why (if you consider it necessary or helpful for the purposes of diagnosis or treatment) you wish to observe the patient undressing. If the patient does not wish to be observed, you must respect their wishes and find another way of establishing the clinical information you need.<br>3. Covering the parts of the patient's body that do not need to be exposed for examination or treatment. This can be achieved by providing the patient with a suitable cover or allowing them to remain partially dressed. If you need to see the patient undressed to their underwear, you should explain to the patient why this is, and ask them if they are comfortable about complying.<br>4. If you need your patient to remove underwear for an examination or treatment, you should encourage them to put their underwear back on at the conclusion of that particular examination or treatment and before you continue with any other procedure.<br>5. Wherever possible, patients should be allowed to remove underwear themselves. If it is genuinely necessary for you to assist them, you should have their consent to do so.<br>6. You should always ask a patient if they would like a chaperone when:<br>• You examine or treat an intimate area.<br>• You are treating a patient under 16 years of age.<br>• You are treating an adult who lacks capacity.<br>• You are treating a patient in their home.<br>A chaperone can be:<br>• 6.1. A relative or friend of the patient.<br>• 6.2. A suitable person from your practice but not your spouse or personal partner.<br>7. If the patient wishes to have a chaperone and neither you nor the patient is able to provide one, you should |

| | | |
|---|---|---|
| | | offer to re-arrange the appointment.<br>8. If a chaperone is present, you should record this in the patient records. If a patient within one of the categories in paragraph 6 declines the offer of a chaperone, you should record this in the notes. |

| **Revised A7 Notes and comments** | | |
|---|---|---|
| This standard was formerly in the Professionalism section of the current OPS, but was felt to be more relevant in terms of *Communication and patient partnership* with its emphasis on values.<br><br>The current guidance to this standard includes the following at the end of Point 3:<br><br>*'Good reasons for not accepting someone as a patient or declining to continue their care might arise where:*<br>• *They are or become aggressive.*<br>• *They seem to have no confidence in the care you are providing.*<br>• *They appear to have become inappropriately dependent on you.'*<br>This provoked comments in feedback from respondents, which questions its usefulness here. Some read it as implying that aggressive patients should be referred to other osteopaths. Our disability consultant suggested 'good' reasons would be problematic in this context (a language issue) and queried whether it would be unhelpful to specify reasons in case we indirectly discriminated against someone with, for example, Tourette's. We have suggested removing this wording and leaving the paragraph as shown below. | | |
| **D4 Current standards** | **A7 Suggested revisions** | **Suggested guidance** |
| D4. Make sure your beliefs and values do not prejudice your patients' care. | A7. You must make sure your beliefs and values do not prejudice your patients' care. | 1. The same quality of service should be provided to all patients. It is illegal to refuse a service to someone on the grounds of their gender, ethnicity, disability, religion or belief, sexual orientation, transgender status, age, marital status or pregnancy.<br>2. If carrying out a particular procedure or giving advice conflicts with your personal, religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and advise them they have the right to see or be referred to another osteopath.<br>3. You should maintain a professional manner at all times, even where a personal incompatibility arises with a patient.<br>4. You are not obliged to accept any individual as a patient (subject to the points raised in paragraph 1 above), but if having done so you feel you cannot continue to give them the good quality care to which they are entitled, you may decline to continue treating them. In that case, you should try to refer them to another osteopath or healthcare professional. |

## Knowledge, skills and performance

| **Notes and comments** | |
|---|---|
| We have revised the wording slightly. | |
| **Current introductory statement** | **Suggested revisions** |
| **Ethically, an osteopath must possess the relevant knowledge and skills required to function as a primary healthcare practitioner.** | **As an osteopath you must have the required knowledge and skills to practise as a primary contact healthcare practitioner, maintaining and developing these throughout your career** |

| **Current B1 Notes and comments** | | |
|---|---|---|
| Feedback was divided on this standard and called for more clarity. Some feedback supported the 'osteopathic concepts and principles' reference, but many challenged this, pointing out the general lack of agreement among osteopaths as to what these concepts and principles are, and how they should be implemented. Some also considered the guidance vague. Some regarded the reference to 'palpation' as being patronising (as it is written currently) and alluding to an aspect of practice that is unsupported by the evidence. | | |
| **B1 Current standards** | **Suggested revisions** | **Suggested guidance** |
| B1. You must understand osteopathic concepts and principles, and apply them critically to patient care. | See below | |

| **Revised B1 Notes and comments** | | |
|---|---|---|
| The suggestion here is that one standard is sufficient to determine that osteopaths must have sufficient knowledge and skills to support their work. The current guidance presents a long detailed list (10 bullet points) of necessary skills and knowledge, which are largely GOPRE (Guidance for Osteopath Pre-registration Education)[7] training outcomes. The GOPRE document was not available when the OPS were originally published. We have suggested some revision to the guidance here, which has been modified following the initial meeting of the Stakeholder Reference Group. We have included reference I the guidance to osteopathic principles and concepts of care, rather than 'osteopathic approaches'.<br><br>We have modified some of the guidance from the current B2 to take on board comments about the reliability of palpation, in the call for evidence. | | |
| **B2 Current standards** | **B1 Suggested revisions** | **Suggested guidance** |
| B2. You must have sufficient knowledge and skills to support your work as an osteopath. | B1. You must have sufficient and appropriate knowledge and skills to support your work as an osteopath | 1. These should include:<br>1.1 A knowledge of human structure and function sufficient to inform appropriate care.<br>1.2 An understanding of osteopathic principles and concepts of health, illness, and disease and the ability to critically apply this knowledge in the care of patients.<br>1.3 A knowledge of pathological processes sufficient to identify where osteopathic treatment may be contraindicated, and where patients may require referral to another healthcare practitioner for further investigation.<br>1.4 An understanding of the psychological and social influences on health, sufficient to inform clinical decision-making and patient care.<br>1.5 An awareness of the principles and applications of scientific enquiry and the ability to critically evaluate data to inform osteopathic care.<br>1.6 An understanding of the principles of biomechanics sufficient to apply osteopathic techniques safely and effectively.<br>1.7 Sufficient knowledge of the characteristics of the normal and abnormal functioning of different body tissues and systems to be able to interpret findings. The ability to determine changes in tissues and joint movement by the appropriate use of observation, palpation and motion evaluation.<br>1.8 Problem-solving and thinking skills in order to inform and guide the interpretation of clinical and other data, and to justify clinical reasoning and decision-making.<br>2. The ability to critically appraise osteopathic practice. For example, this could be achieved through:<br>2.1 Self-reflection.<br>2.2 Feedback from patients.<br>2.3 Feedback from colleagues.<br>2.4 Case analysis or clinical audit. |

[7] http://www.osteopathy.org.uk/news-and-resources/document-library/training/guidance-for-osteopathic-pre-registration-education/

| **Revised B2 Notes and comments** | | |
|---|---|---|
| Here the suggested guidance is a rewording of the existing guidance, to make this more focused.<br><br>Feedback suggested that the current guidance B3.3 and B3.4 (*3. You may be able to expand your training and competence, as outlined in standard B4 or through research, and 4. You also need to identify and work within your competence in the fields of education and research*) was unhelpful, and we have suggested deletion of these points. | | |
| **B3 Current standards** | **B2 Suggested revisions** | **Suggested guidance** |
| B3. Recognise and work within the limits of your training and competence. | B2. You must recognise and work within the limits of your training and competence. | 1. Be clear to patients about the limits of your knowledge and competence.<br>2. Refer to or seek support from other appropriate healthcare professionals when needed. |

| **Revised B3 Notes and comments** | | |
|---|---|---|
| This guidance here has been extracted from the existing B4 guidance which is arguably too detailed and over-prescriptive, providing suggestions for CPD which are probably best made in other contexts.<br><br>Para 3 is a new suggestion. | | |
| **B4 Current standards** | **B3 Suggested revisions** | **Suggested guidance** |
| B4. Keep your professional knowledge and skills up to date. | B3. You must keep your professional knowledge and skills up to date. | To achieve this, you should:<br><br>1. undertake professional development activities, and comply with statutory requirements regarding continuing professional development.<br><br>2. keep up-to-date with changes in the law, GOsC guidance, and other factors relevant to your practice.<br><br>3. Interact with others and seek feedback on your practice. |

## Theme 3: Safety and quality in practice

| **Notes and comments** | |
|---|---|
| We have suggested a revised wording of the introductory statement to better encapsulate this theme. | |
| **Current introductory statement** | **Suggested revisions** |
| **Osteopaths must deliver high-quality, safe, ethical and effective healthcare through evaluation and considered treatment approaches, which are clearly explained to the patient and respect patient dignity. Osteopaths are committed to maintaining and enhancing their practice to continuously deliver high quality patient care.** | **Revised introductory statement:**<br><br>**Osteopaths must deliver high-quality, safe, ethical and effective healthcare through considered and appropriate evaluation, treatment and management approaches, which are clearly explained to the patient and respect patient dignity and values. Osteopaths are committed to maintaining and enhancing their practice to continuously deliver high quality patient care.** |

| **Revised C1 Notes and comments** | | |
|---|---|---|
| We have suggested combining C1 and C2 as shown.<br><br>The guidance has been combined and reformatted from existing guidance to current C1 and C2. | | |
| **C1 and C2 Current standards** | **C1 Suggested revisions** | **Suggested guidance** |
| C1. You must be able to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan.<br><br>C2. You must be able to formulate and deliver a justifiable osteopathic treatment plan or an alternative course of action. | C1. You must be able to deliver safe, competent and appropriate osteopathic care to your patients. | 1. This should include the ability to:<br>1.1 Take and record the patient's case history, adapting your communication style to take account of the patient's individual needs and sensitivities.<br>1.2 Select and undertake appropriate clinical assessment of your patient, taking into account the nature of their complaint/s and their case history.<br>1.3 Formulate an appropriate working diagnosis or rationale for care, and explain this clearly to the patient.<br>1.2 Develop and apply an appropriate plan of care. This should be based on:<br>1.2.1 the working diagnosis<br>1.2.3. the best available evidence<br>1.2.4. the patient's values and preferences<br>1.2.5. your own skills, experience and competence, drawing on a range of osteopathic techniques and patient management approaches.<br>1.3 Monitor the effects of your care, and keep this under review. You should cease care if requested by the patient or if you judge that care is likely to be ineffective or not in the patient's best interests.<br>1.4 Recognise adverse reactions to treatment, and take appropriate action.<br>1.5 Recognise when errors have been made, and take appropriate action to remedy these, taking account of the patient's best interests.<br>1.6 Where appropriate, you should refer the patient to another healthcare professional, following appropriate referral procedures.<br>2 If providing care outside of your usual practice environment, you should note in your records where this took place, and apply the same standards, where possible, as you would apply in your usual practice. |

| **Current C3-5, C7 Notes and comments** | | |
|---|---|---|
| C3: This standard has been combined with A1 – see question in relation to that standard. The existing C3 guidance adds very little.<br><br>C4: This standard has been combined with A2 – see question in relation to that standard.<br><br>C5: This standard has been combined with A2 – see question in relation to that standard. The existing guidance to C5 is not especially useful.<br><br>C7: This standard adds little and in the current guidance seems to repeat what has already been said above. We recommend removing this, and relying on the preceding standards. | | |
| **C3-5 Current standards** | **Suggested revisions** | **Suggested guidance** |
| C3. Care for your patients and do your best to understand their condition and improve their health. | Combine with A1 | N/A |
| C4. Be polite and considerate with patients. | Combine with A2 | N/A |
| C5. Acknowledge your patients' individuality in how you treat them. | Combine with A2 | N/A |
| C7. Provide appropriate care and treatment. | N/A | N/A |

| **Revised C2 Notes and comments** | | |
|---|---|---|
| We have added the word 'legible' to the standard in relation to patient records.<br><br>The guidance here is largely as in the current standards, although reference to recording 'investigation' in *1.9. (The investigation or treatment you undertake and the results)* has been taken out, as this is felt to be covered under the recording of clinical findings. | | |
| **C8 Current standards** | **C2 Suggested revisions** | **Suggested guidance** |
| C8. Ensure that your patient records are full, accurate and completed promptly. | C2. Ensure that your patient records are full, accurate, legible and completed promptly. | 1. Records that are accurate, comprehensive and easily understood will help you provide good care to your patients. These records should include:<br>1.1 Date of the consultation.<br>1.2 Patient's personal details.<br>1.3 Any problems and symptoms reported by your patient.<br>1.4 Relevant medical, family and social history.<br>1.5 Your clinical findings, including negative findings.<br>1.6 The information and advice you provide, whether this is provided in person or via the telephone.<br>1.7 A working diagnosis and treatment plan.<br>1.8 Records of consent, including any consent forms.<br>1.9 Any treatment you undertake.<br>1.10 Any communication with, about or from your patient.<br>1.11 Copies of any correspondence, reports, test results, etc. relating to the patient.<br>1.12 Clinical response to treatment and treatment outcomes.<br>1.13 The location of your visit if outside your usual consulting rooms.<br>1.14 Whether a chaperone was present or not required.<br>1.15 Whether a student or observer was present.<br>2. Your notes should be contemporaneous or completed promptly after a consultation (generally on the same day).<br>3. The information you provide in reports and forms or for any other purpose associated with your practice should be honest, accurate and complete. |

| **Revised C3 Notes and comments** |
|---|
| This has been moved from D2 in professionalism, as the SRG felt that it related more to record keeping, and was thus a better fit in *Safety and Quality*. Feedback indicates these standards are not well understood, and the guidelines are not felt to be helpful. Consider what these actually mean (or should mean). We have reformatted the guidance and emphasised the need to be able to produce reports and present information to support patient care and practice management, rather than being proficient in IT. |

| D2 | C3 Suggested revisions | Suggested guidance |
|---|---|---|
| D2. You must respond effectively to requirements for the production of high-quality written material and data. | C3. You must respond effectively and appropriately to requests for the production of written material and data. | To achieve this you will need to:<br>1. Be able to produce reports and present information in an appropriate format to support patient care and effective practice management.<br>2. Develop mechanisms for storing and retrieving patient information, financial and other practice data to comply with legal requirements in relation to confidentiality, data processing and storage, and requests for information from patients or other authorised parties. |

| Revised C4 Notes and comments | | |
|---|---|---|
| Feedback indicates that the wording of this standard in the current text gives rise to confusion. We have tried to clarify this in revised guidance where safeguarding issues and procedures are referenced more clearly. | | |
| **C9 Current standards** | **C4 Suggested revisions** | **Suggested guidance** |
| C9. Act quickly to help patients and keep them from harm. | C4. You must act quickly to keep patients from harm | 1. You should have an awareness of current safeguarding procedures and follow these if you suspect a child or vulnerable adult is at risk.<br>2. You should ensure that you keep up to date information on safeguarding procedures relevant to your local area.<br>3. You should also take steps to protect patients if you believe that the health, conduct or professional performance of a colleague or other healthcare practitioner poses a risk to the patient. You should consider one of the following courses of action, keeping in mind that your objective is to protect the patient:<br>3.1. Discussing your concerns with the colleague or practitioner.<br>3.2. Reporting your concerns to other colleagues or the principal of the practice, if there is one, or to an employer.<br>3.3. If the practitioner belongs to a regulated profession, reporting your concerns to their regulatory body.<br>3.4. If the practitioner belongs to a voluntary register, reporting your concerns to that body.<br>3.5. Where you have immediate and serious concerns for a patient, reporting the colleague to social services or the police.<br>3.6. If you are the principal of a practice, ensuring that systems are in place for staff to raise concerns about risks to patients. |

| **Revised C4 Notes and comments** | | |
|---|---|---|
| We have suggested combining D12 and D13 in a new C4 (moving from *Professionalism* to *Safety and quality*)<br><br>We have deleted the words ' Promoting public health includes being aware of the following:' from the start of the guidance, as it was not felt to be helpful in relation to these standards. | | |
| **D12 and 13 Current standards** | **C4 Suggested revisions** | **Suggested guidance** |
| D12. Take all necessary steps to control the spread of communicable diseases.<br><br>D13 Comply with health and safety legislation. | C4. Ensure that your practice is safe, clean and hygienic, and complies with health and safety legislation. | 1. Your practice premises should be clean, safe, hygienic, comfortable and appropriately equipped.<br>2. There are detailed requirements in law for health and safety in the workplace. Further details can be found on the website of the UK Health and Safety Executive (http://www.hse.gov.uk/).<br>3. You should have adequate public liability insurance.<br>4. You should ensure that you have appropriate procedures in place in the event of a medical emergency. |

## Theme 4 – Professionalism

| **Notes and comments** | |
|---|---|
| We have suggested a revision of the wording to better encapsulate this theme. | |
| **Current introductory statement** | **Suggested revisions** |
| ***Osteopaths must deliver safe and ethical healthcare by interacting with professional colleagues and patients in a respectful and timely manner.*** | ***Osteopaths must deliver safe, ethical and professional healthcare by acting honestly and with integrity at all times, effectively maintaining public confidence and trust in the profession.*** |

| **Revised D1 Notes and comments** | | |
|---|---|---|
| Feedback on this standard and on the guidance indicated that some are not clear what this means. We have suggested some revisions following Stakeholder Reference Group discussions, aimed at emphasising the place of osteopathy within the broader healthcare environment, and a collaborative approach to care where appropriate. | | |
| **Current standards** | **Suggested revisions** | **Suggested guidance** |
| D1. You must consider the contributions of other healthcare professionals to ensure best patient care. | D1. You must consider the contributions of other healthcare professionals to ensure best patients care. | 1 To achieve this, you should:<br>2 1. Treat colleagues with respect, acknowledging the role that other practitioners may have in the care of your patients. Any comments that you make about other healthcare professionals should be honest, valid and accurate.<br>3 2. Understand the contribution of osteopathy within the context of healthcare as a whole.<br>4 3. Follow appropriate referral procedures when referring a patient, or one has been referred to you.<br>3. Where such approaches are appropriate and available, work collaboratively with other healthcare provider to ensure patient care. |

| **Revised D2 Notes and comments** | | |
|---|---|---|
| Feedback indicates these standards are not well understood, and the guidelines are not felt to be completely helpful. Currently, the guidance relates to both (current) D2 and D3, though these standards relate to different issues.<br><br>We have removed current D2 to Safety and Quality, as the SRG felt it was more focussed on information storage and related to record keeping.<br><br>D3 has been amended to relate more to the analysis of evidence to support patient care, and, in the guidance, to professional development. | | |
| **D3 Current standards** | **D2 Suggested revisions** | **Suggested guidance** |
| D3. You must be capable of retrieving, processing and analysing information as necessary. | D2. You must be able to analyse and reflect upon information related to your practice in order to enhance patient care. | To achieve this you will need to have sufficient knowledge and ability to collect and analyse evidence about your practice to support both patient care and your own professional development. |

| **Revised D3 Notes and comments** | | |
|---|---|---|
| With regard to the revised standard 3 we have expanded this from complying with equality and anti discrimination laws to include the more values based 'treat patients fairly and recognise diversity and individual values' (similar to GCC Code A4).<br><br>We have suggested expanding the guidance, including also a link to information on The Equality Act.<br><br>(Our disability consultant offered comments on this aspect. = Equality Act provisions go beyond promoting equal treatment, especially in the case of disability – they are strong provisions that require anyone providing a service to the public to make reasonable adjustments to policies, practices and procedures to overcome disability related disadvantage where it is reasonable to do so, even if extra costs accrue. Important that osteopaths are aware of this). | | |
| **D5 Current standards** | **D3 Suggested revisions** | **Suggested guidance** |
| D5. You must comply with equality and anti-discrimination laws. | D3. You must treat patients fairly and recognise diversity and individual values. You must comply with equality and anti-discrimination law. | 1. You should be familiar with the requirements that apply to you under The Equality Act 2010[8] [9].<br>2. It is illegal to refuse a service to someone on the grounds of their gender, ethnicity, disability, religion or belief, sexual orientation, transgender status, age, marital status or pregnancy. |

[8] https://www.citizensadvice.org.uk/Documents/Advice%20factsheets/Unclassified/equlity-act-2010-overview.pdf
[9] https://www.equalityhumanrights.com/en/equality-act-2010/what-equality-act

| **Revised D4 Notes and comments** | | |
|---|---|---|
| We have suggested broadening the scope of this standard from maintaining patients' privacy and confidentiality to also maintaining and protecting patient information.<br><br>In this suggestion, we have retained the existing guidance, though amended this in some areas, and added sub headings to enhance clarity. This is an area where we considered reducing the guidance in the document, and publishing some separately. We will explore this further with the stakeholder reference group, though the initial view was to ensure that relevant information was readily accessible, largely in one place.<br><br>In relation to the storage of records, we have made reference to the fact that osteopaths should have a policy for retention beyond the minimum requirement.<br><br>We've added mention of 'incapacity' as well as death in para 4 of the suggested guidance.<br><br>We've also added a para 10, to require a record to be made where a patient has not been informed in circumstances where information is disclosed about them without their consent. | | |
| **D6 Current standards** | **D4 Suggested revisions** | **Suggested guidance** |
| D6. Respect your patients' rights to privacy and confidentiality. | D4. You must respect your patients' rights to privacy and confidentiality, and effectively maintain and protect patient information. | **Confidentiality**<br><br>1. Maintaining patient confidentiality includes:<br><br>1.1. Keeping confidential your patients' identity and other personal information, and any opinions you form about them in the course of your work.<br><br>1.2. Ensuring that your staff keep such information confidential.<br><br>1.3. Ensuring that the information is kept confidential even after the death of a patient.<br><br>1.4. Not releasing or discussing medical details or information about the care of a patient with anyone, including their spouse, partner or other family members, unless you have the patient's consent to do so.<br><br>1.5. Ensuring that such information is securely protected against loss, theft and improper disclosure.<br><br>2. Patients are entitled to see their notes and you should assist them with this if such a request is made.<br><br>**Storage and retention of records**<br><br>3. You should have adequate and secure methods for storing patient information and records. Patient records should be kept:<br><br>3.1. For a minimum of eight years after their last consultation.<br><br>3.2. If the patient is a child, until their 25th birthday. |

| | | |
|---|---|---|
| | | 3.3. You should have a policy regarding retention of records if it is your practice to retain them beyond eight years, or, in the case of a child, beyond their 25th birthday. Your patients should be made aware of this.<br><br>4. You should make arrangements for records to continue to be kept safely after you finish practising, or in the event of your death or incapacity. Patients should know how they can access their records in such circumstances.<br><br>5. You must comply with the law on data protection. For further information on data protection, please refer to the website of the UK Information Commissioner's Office.<br><br>**Disclosure of confidential information**<br><br>6. There may be times when you want to ask your patient if they (or someone on their behalf) will give consent for you to disclose confidential information about them; for example, if you need to share information with another healthcare professional. In that case, you should:<br><br>6.1. Explain to the patient the circumstances in which you wish to disclose the information and make sure they understand what you will be disclosing, the person you will be disclosing it to, the reasons for its disclosure and the likely consequences.6.2. Allow them to withhold permission if they wish.<br><br>6.3. If they agree, ask them to provide their consent in writing or to sign a consent form.<br><br>6.4. Advise anyone to whom you disclose information that they must respect the patient's confidentiality.<br><br>6.5. Disclose only the information you need to. For example, does the recipient need to see the patient's entire medical history, or their address, or other information which identifies them?<br><br>**Disclosure of confidential information without consent**<br><br>7. In general, you should not disclose confidential information about your patient without their consent, but there may be circumstances in which you are obliged to do so; for example:<br><br>7.1. If you are compelled by order of the court, or other legal authority. You should only disclose the information you are required to under that order.<br><br>7.2. If it is necessary in the public interest. In this case, your duty to society overrides your duty to your patient. This will usually happen when a patient puts themselves or others at serious risk; for example, by the possibility of infection, or a violent or serious criminal act.<br><br>7.3. If it is necessary, in the interests of the patient's health, to share the information with their medical |

| | | |
|---|---|---|
| | | adviser, legal guardian or close relatives, and the patient is incapable of giving consent.<br><br>8. If you need to disclose information without your patient's consent, you should inform the patient, unless you are specifically prohibited from doing so (for example, in a criminal investigation) or there is another good reason not to (for example, where a patient may become violent).<br><br>9. Any disclosures of information should be proportionate and limited to the relevant details.<br><br>10. If a patient is not informed before disclosure of confidential information takes place, you should record the reasons why it was not possible to do so, and maintain this with the patient's records. |

| **Revised D5 and D6 Notes and comments** | | |
|---|---|---|
| On reflection, we felt that this standard actually dealt with two elements – complaints and candour, and we have suggested splitting these into the two separate elements. The candour guidance has been expanded to reflect the joint regulators statement on candour, including reference to openness with colleagues/employers and the taking part in reviews and investigations if required.<br><br>With regard to new D7, our disability consultant asks should we also specify that this must be accessible, for example, via a clinic website, and we have added the word 'visible'. Currently, the guidance to this standard just says 'you should operate a procedure for considering and responding to any complaints about your practice…….'<br><br>In Point 5 of the D7 guidance: we have removed 'you should inform your professional association' from the current wording, as not every osteopath is a member of the professional association. | | |
| **D7 Current standards** | **D5 and D6 Suggested revisions** | **Suggested guidance** |
| D7. Be open and honest when dealing with patients and colleagues and respond quickly to complaints. | D5. You must be open and honest with patients, fulfilling your duty of candour. | 1. If something goes wrong with a patient's care which causes, or has the potential to cause harm or distress, you must tell the patient, offer an explanation as to what has happened and the effects of this, together with an apology and a suitable remedy or support.<br>2. Where appropriate, you must also be open and honest with your colleagues and/or employers, and take part in reviews and investigations when requested. |
| | D6. You must have a visible policy in place by which you manage patient complaints, and respond quickly and appropriately to any which arise. | 1. You should make sure that your staff are familiar with any complaints policy and know to whom they should direct any patient complaint.<br>2. You should provide information to patients about how they can make comments, including compliments, about the service they have received.<br>3. If you act constructively, allow patients the opportunity to express their dissatisfaction, and provide sensitive explanations of what has happened and why, you may prevent the complaint from escalating.<br>4. A complaint is an opportunity to reflect on the communication and standard of care that was given and it may highlight areas of your practice that could be improved. A complaint which is handled well can also result in a stronger bond of trust between you and your patient, leading to improved patient care.<br>5. You should inform your professional indemnity insurers immediately if you receive a complaint.<br>6. You should ensure that anyone making a complaint knows that they can refer it to the GOsC and you should cooperate fully with any external investigation. |

| Revised D7 Notes and comments | | |
|---|---|---|
| Current guidance to this standard (shown above) is extensive, and drew some comment and challenge from respondents. It is also quite prescriptive in some areas .<br><br>In this suggestion, we have removed the section relating to teaching and training in the practice, and student observers (Current D8.5-9). This could be modified for separate publication, but we will consult with the osteopathic educational institutions as to whether the current wording adequately deals with likely scenarios. We are not aware of undergraduate courses where students undertake such external clinic placements. | | |
| **D8 Current standards** | **D7 Suggested revisions** | **Suggested guidance** |
| D8. Support colleagues and cooperate with them to enhance patient care. | D7. You must support colleagues and cooperate with them to enhance patient care. | 1. 1. Where the care of patients is shared between professionals, you should consider the effectiveness of your handover procedures. Effective handovers can be done verbally, but it is good practice to make a note of the handover in the patient's osteopathic records.<br><br>2. 2. You are responsible for all the staff you employ in your clinic (including administrative staff ) and for their conduct, and any guidance or advice they give to patients. You should make sure that staff understand the importance of:<br>2.1. Patient confidentiality.<br>2.2. Retention of medical records.<br>2.3. Relationships with patients, colleagues and other healthcare professionals.<br>2.4. Complaints.<br>2.5. The work environment.<br>2.6. Health and safety.<br>2.7. Equality duties.<br><br>3. 3. If you are responsible for an associate or assistant, you should provide professional support and adequate resources for them so that they are able to offer appropriate care to their patients. You should not put them under undue pressure, or expect them to work excessive hours. You should not expect them to provide treatment beyond their competence.<br><br>4. 4. If your practice employs support staff, you should ensure that they are effectively managed and are aware of any legal obligations necessary to fulfil their role. |

| **Current D9 Notes and comments** | | |
|---|---|---|
| This was felt to be better included within the guidance to D1 above. | | |
| **D9 Current standards** | **Suggested revisions** | **Suggested guidance** |
| D9. Keep comments about colleagues or other healthcare professionals honest, accurate and valid. | N/A | N/A |

| **Revised D8 Notes and comments** | | |
|---|---|---|
| This standard has been modified to indicate that the osteopath should not rely on their own assessment of their risk to patients. | | |
| **D10 Current standards** | **D8 Suggested revisions** | **Suggested guidance** |
| D10. Ensure that any problems with your own health do not affect your patients. | D8. You must ensure that any problems with your own health do not affect your patients. You must not rely on your own assessment of the risk to patients. | 1. If you know or suspect that your physical or mental health is impaired in a way that might affect the care you give to patients, you must:<br>1.1. Seek and follow appropriate medical advice on whether you should modify your practice and in what way.<br>1.2. If necessary, stop practising until your medical advisor considers you fit to practise again.<br>1.3. Inform the GOsC so your registration status can be amended on the Register.<br>2. If you are exposed to a serious communicable disease, and you believe that you may be a carrier, you should stop practising until you have received appropriate medical advice, and follow any advice you are given about suspending or modifying your practice. You should take all necessary precautions to prevent transmission of the condition to patients. |

| **Revised D9 Notes and comments** | | |
|---|---|---|
| The current guidance is included. | | |
| **D14 Current standards** | **D9 Suggested revisions** | **Suggested guidance** |
| D14. Act with integrity in your professional practice. | D9. You must act with honesty and integrity in your professional practice. | 1. A lack of integrity in your practice can adversely affect patient care. Some examples are:<br>1.1. Putting your own interest above your duty to your patient.<br>1.2. Subjecting a patient to an investigation or treatment that is unnecessary or not in their best interest.<br>1.3. Deliberately withholding a necessary investigation, treatment or referral.<br>1.4. Prolonging treatment unnecessarily.<br>1.5. Accepting referral fees.<br>1.6. Putting pressure on a patient to obtain other professional advice or to purchase a product.<br>1.7. Recommending a professional service or product solely for financial gain.<br>1.8. Borrowing money from patients, or accepting any other benefit that brings you financial gain.<br>2. Allowing misleading advertising and information about you and your practice. You should make sure that:<br>2.1. Your advertising and promotional material, including website content, conforms to current guidance, such as the UK Code of Non-broadcast Advertising, Sales Promotion and Direct Marketing (the CAP Code).<br>2.2. The information you provide about your professional qualifications, practice arrangements and the services you provide is of a high standard and factually accurate.<br>2.3. You do not use any title that implies you are a medical practitioner (unless you are a registered medical practitioner). This does not prevent you from using the title 'Doctor' if you have a PhD or other doctorate and it is clear that the title relates to this.<br>2.4. You do not generate publicity so frequently or in such a manner that it becomes a nuisance or puts those to whom it is directed under pressure to respond. |

| **Revised D10 Notes and comments** | | |
|---|---|---|
| For consideration: This standard was discussed at the stakeholder reference group meeting. It was one that feedback indicated was not well understood, and the current guidance related more to health and safety issues than public health. The suggested guidance here attempts to explain what is meant, with a focus on informed, impartial discussion or appropriate referral to facilitate informed choice. | | |
| **D11 Current standards** | **D10 Suggested revisions** | **Suggested guidance** |
| D11. Be aware of your role as a healthcare provider to promote public health. | D10. Be aware of your role as a healthcare provider to promote public health. | 1. You should be aware of public health issues and concerns, and be able to discuss these impartially with patients, or guide them to resources or to other healthcare professionals to support their decision making regarding these. |

| **Revised D11 Notes and comments** | | |
|---|---|---|
| This is the existing guidance with slight modifications. | | |
| **D15 Current standards** | **D11 Suggested revisions** | **Suggested guidance** |
| D15. Be honest and trustworthy in your financial dealings, whether personal or professional. | D11. You must be honest and trustworthy in your professional and personal financial dealings. | 1. You should charge fees responsibly and in a way which avoids bringing the profession into disrepute.<br>2. It will help you avoid disputes about fees if you have clear and visible information available on patient fees and charging policies.<br>3. You should not place pressure on a patient to commit to unjustified treatment.<br>4. You may recommend products or services to patients only if, in your professional judgement, they will benefit the patient.<br>5. You should declare to your patients any financial or other benefit you receive for introducing them to other professional or commercial organisations. You should not allow such an organisation to use your name for promotional purposes.<br>6. You should maintain sound financial records for your practice. |

| **Revised D12 Notes and comments** | | |
|---|---|---|
| The wording of this standard has been updated to include the establishing and maintenance of clear professional boundaries with patients.<br><br>This is an area where we are considering publishing more detailed separate learning resources, rather than 'official' guidance. | | |
| **D16 Current standards** | **D12 Suggested revisions** | **Suggested guidance** |
| D16. Do not abuse your professional standing. | D12. You must establish and maintain clear professional boundaries with patients, and must not abuse your professional standing and the position of trust which you occupy as an osteopath. | 1. You should be aware of the risks of engaging in or developing social relationships with patients, and the challenges which this might raise to the therapeutic relationship. You should also be aware of the risk of patients developing an inappropriate dependency upon osteopathic treatment, and be able to manage these situations appropriately.<br>2. Abuse of your professional standing can take many forms. The most serious is likely to be the failure to establish and maintain appropriate boundaries, whether sexual or otherwise.<br>3. Failure to establish and maintain sexual boundaries may, in particular, have a profoundly damaging effect on the patient, is likely to bring the profession into disrepute and could lead to your removal from the GOsC Register.<br>4. When establishing and maintaining sexual boundaries, you should bear in mind the following:<br>4.1. Words and behaviour, as well as more overt acts, may be sexualised, or regarded as such by the patient.<br>4.2. You should avoid any behaviour which may be construed by a patient as inviting a sexual relationship.<br>4.3. Physical contact for which valid consent has not been given can amount to an assault leading to criminal liability.<br>4.4. It is your responsibility not to act on feelings of sexual attraction to or from patients.<br>4.5. If you are sexually attracted to a patient, you should seek advice from, for example, a colleague or professional body on the most appropriate course of action. If you believe that you cannot remain objective and professional, you should refer your patient to another healthcare practitioner.<br>4.6. You should not take advantage of your professional standing to initiate a relationship with a patient. This applies even when they are no longer in your care.<br>5. Osteopaths who practise in small communities may find themselves treating friends or family. In such cases, establishing and maintaining clear professional boundaries will help you ensure that your clinical judgement is objective and that you can provide the treatment your patients need. |

| **Revised D13 Notes and comments** | | |
|---|---|---|
| The suggested revision of this standard confirms that upholding the reputation of the profession can relate to behaviour in and out of the workplace. | | |
| **D17 Current standards** | **D13 Suggested revisions** | **Suggested guidance** |
| D17. Uphold the reputation of the profession through your conduct. | D13. You must uphold the reputation of the profession at all times through your conduct, in and out of the workplace. | 1. The public's trust and confidence in the profession, and the reputation of the profession generally, can be undermined by an osteopath's professional or personal conduct. You should have regard to your professional standing, even when you are not acting as an osteopath.<br>2. Upholding the reputation of the profession may include:<br>2.1. Acting within the law at all times (criminal convictions may be evidence that an osteopath is unfit to practise).<br>2.2. Not abusing alcohol or drugs.<br>2.3. Not behaving in an aggressive or violent way in your personal or professional life.<br>2.4. Showing compassion to patients.<br>2.5. Showing professional courtesy to those with whom you work.<br>2.6. Not allowing professional disputes to cause you to fall below the standards expected of you.<br>2.7. Not falsifying records, data, or other documents.<br>2.8. Behaving honestly in your personal and professional dealings.<br>3. Maintaining the same standard of professional conduct in an online environment as would be expected elsewhere. |

| **Revised D14 Notes and comments** | | |
|---|---|---|
| The standard has been modified to require the informing of the GOsC 'as soon as is practicable', and a requirement to then cooperate with requests for further information and a catch-all compliance with all regulatory requirements.<br><br>This guidance is a slight modification of the existing guidance, making it more general. The current guidance requires the GOsC to be informed if the osteopath is charged anywhere in the world with an offence relating to violence, sexual offences or indecency, dishonesty or alcohol/drug abuse. This has now been modified with the catch-all 'criminal proceedings'. | | |
| **D18 Current standards** | **D14 Suggested revisions** | **Suggested guidance** |
| D18 You must provide to the GOsC any important information about your conduct and competence. | D14. You must inform the GOsC as soon as is practicable of any important information regarding your conduct and competence, cooperate with any requests for information, and must comply with all regulatory requirements. | 1. Such information regarding your conduct and competence would include:<br>1.1. Being subject to criminal proceedings anywhere in the world.<br>1.2. Being subject to regulatory findings by an organisation responsible for regulating a healthcare profession anywhere in the world.<br>1.3. Accepting of a police caution.<br>1.4. Receiving a conditional discharge for an offence.<br>2. Being suspended or placed under a practice restriction by your employer or a similar organisation, because of concerns about your conduct or competence. |