General Osteopathic Council

3

Policy Advisory Committee
13 October 2016
Review of the *Osteopathic Practice Standards* – 2016 call for evidence

Classification	Public
Purpose	For discussion
Issue	An update on the review of the *Osteopathic Practice Standards*
Recommendation	1. To consider the feedback analysis and the development of the *Osteopathic Practice Standards* review. 2. To consider the distinction between 'Guidance' and 'Resources' 3. To consider the options for the development of the *Osteopathic Practice Standards* and the impact on timelines.
Financial and resourcing implications	There will be a moderate cost incurred over the course of the 2016-17 financial year to prepare documentation for public consultation next year, which is contained within the Professional Standards and Communications budgets. The equality impact assessment advice has also been accounted for within the budgets. Consultation and engagement will be accounted for in the 2017-18 budget.
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 in 2017. 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	Work in progress revised *Osteopathic Practice Standards* showing how the revised standards are developing
Author	Steven Bettles

Background

1. At its meeting of 4 February 2016, Council approved fundamental principles to underpin the *Osteopathic Practice Standards* review. These principles are:

    a. The existing four themes for the *Osteopathic Practice Standards* should be retained, i.e. Communication and patient partnership; Knowledge, skills and performance; Safety and quality; Professionalism.

    b. The *Osteopathic Practice Standards* should continue to comprise both the *Code of Practice* and the *Standard of Proficiency*, standards specified in the Osteopaths Act 1993.

    c. A call for evidence, using a diverse range of communications, should target all our stakeholders. Evidence gathered in this way will inform proposed revisions to the *Osteopathic Practice Standards*, prepared for public consultation.

    d. A reference group comprising a range of stakeholders should be engaged to ensure a balanced approach to the analysis of pre-consultation feedback and the development of new draft standards.

    e. The scope of the review will embrace the four levels of standards and guidance 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.

2. On 16 June 2016, the Policy Advisory Committee noted the progress of the review of the *Osteopathic Practice Standards*. As part of that discussion the Committee discussed the following:

    a. The ambitious timetable – although they noted that it was feasible at this stage of the development of the review.

b. The robust and comprehensive engagement strategy.

c. The need to ensure that the extent of the proposed revision of the *Osteopathic Practice Standards* remained in line with the principles agreed by Council in February 2016. The Committee was concerned to ensure that there was not an unnecessarily and burdensome impact on the educational institutions, osteopaths and others because of the revision of the *Osteopathic Practice Standards*.

3. At its meeting of 12th July 2016, Council noted the outcome of preliminary analysis of the initial call for evidence in relation to the *Osteopathic Practice Standards* (OPS), as well as an overview of broader engagement with stakeholders.

4. This report provides an update on the review process to date, and outlines revised timetable options for consideration.

Discussion

General

5. Following the initial 'call for evidence', concluded on 31 May 2016, the feedback received has been analysed and considered. This has been coupled with researching of other healthcare regulators' standards (particularly the GCC, which has a new 'Code'[1]) and who have a similar professional context to osteopathy); in-house reflections of GOsC staff teams across our different functions; and consideration of other research, such as that by McGivern et al[2] on compliance with standards in practice. A considerable amount of material has been generated. Rather than provide all of this to committee members, selected examples of feedback received in relation to the current standards has been incorporated into the sections on the four themes of the standards, later in this report. This provides a flavour of the comments received, though further detail can be provided on request from Steven Bettles at sbettles@osteopathy.org.uk.

6. The review is underpinned by the assumption that the current four themes of the OPS will remain. This seems logical, as osteopaths have become used to these over the last four years, and the new CPD scheme requires CPD activities to be mapped to the themes.

7. Feedback indicates that there is a desire for greater clarity in terms of what the standards actually mean in practice. Some current standards, on closer examination, could be clearer and more precise, and some standards may benefit from more extensive guidance and/or learning resources.

[1] Available at: http://www.gcc-uk.org/good-practice/ This is worth looking at, as it has been very helpful in the consideration of our own standards. There is no guidance within the GCC Code any longer, and where this is published (also on their website) this is done separately.
[2] http://www.osteopathy.org.uk/news-and-resources/research-surveys/gosc-research/research-to-promote-effective-regulation/

8. There is a degree of repetition in relation to some of the current standards, necessitating considerable cross referencing. Queries and feedback from osteopaths suggest that this makes the current standards potentially more difficult to navigate, understand and perhaps apply with confidence.

Standards of Proficiency and Code of Practice

9. The *Osteopathic Practice Standards* combine the osteopathic *Standard of Proficiency* with a *Code of Practice*, and these are separately differentiated within the document. Although feedback received to date has not specifically raised this as an issue, there is a general sense that this arrangement contributes to some repetition of content and over-complicates the presentation of the standards. We are suggesting a more seamless integration so that the Standards of Proficiency and Code of Conduct are not differentiated within the Osteopathic Practice Standards at all. The GCC has achieved this within its new Code.

Stakeholder Reference Group

10. A Stakeholder Reference Group is being established to facilitate the collaborative development of revised standards for consultation in 2017. This will include representatives from The Council of Osteopathic Education Institutions (COEI), The National Council for Osteopathic Research (NCOR), The Osteopathic Alliance (OA) and The Institute of Osteopathy (iO), as well as a patient representative. The Group is expected to meet in the New Year and Jane Fox has been asked to chair it.

Equality impact assessment

11. We are working with an expert on equality issues in relation to the development of an equality impact assessment. We have shared some of the early thinking regarding the potential revisions to the standards, and will take her early feedback into account in the version we take to the Stakeholder Reference Group. We will continue to liaise throughout the development process to ensure that the version we take to consultation is robust from an equality and diversity perspective, and the equality impact assessment will be prepared during this process, with a final version to be published alongside the final revised OPS in due course.

Initial thoughts on revised OPS

12. As a result of the feedback analysis an initial outline of what revised standards might look like is shown in the annex. This sets out the current standards (current Standards of Proficiency are highlighted yellow, and those that have been moved between themes are highlighted orange). Suggestions as to revisions to the guidance have not been shown at this stage, but these, together with the suggestions as to revised standards, will form the basis of discussions with the Stakeholder Reference Group.

13. A summary of the feedback analysis is outlined below. Some general comments in relation to each of the themes of the OPS are highlighted together with some examples of feedback received.

Communication and patient partnership

Feedback examples

A1: "Understand what's being asked but need clarity e.g. an example of using different forms of communication, what do they consider is the range of patient friendly communication?....Cross-referencing this point, and cross-referencing throughout the standards in it's present form is 'waffly'. If more user friendly would refer to it more."

A2.3: "More direction/ advice, maybe on GOsC website, re points to know about concerning different religions, cultures and ethnicity that is relevant to us. In our area very little exposure to a variety of nationalities etc.

A2:"I have had to take work with a NHS community back pain clinic. This means although there are no interruptions I am only allowed a 15 minute list for reviews. These patients are frequently far more complicated than I see in private practice often with neurological symptoms and coexisting medical problems. I am expected to manage them not necessarily treatment them, they obviously are not paying for their visits. I frequently do not get enough time to do the job I would like to do for them."

A3: "In point 2, the sentence 'You should also explain any alternatives to the treatment' is problematic. If you go to see a neurosurgeon, you do not expect them to be informed regarding acupuncture or reiki. It seems inappropriate for the GOsC to require osteopaths to purport to knowledge outside of their profession."

A4: "Whilst this section is already very long, there should be something to indicate that patients should be reminded that they can withdraw consent at a subsequent visit. The most common example would be someone who does not like HVT and doesn't want it done again."

A5: "Surely this is just obvious. The tone of this sort of thing is very patronising and appears again to be aimed at NVQ level individuals, not medical professionals"

A6: "This guidance does not sufficiently support the standard. Informing the GP or healthcare practitioner will not particularly improve or maintain the patient's health. The guidance should be more focussed on providing advice and information to support and maintain good health."

14. There is perceived to be some repetition and replication between the individual standards, and we have suggested combining some of these. It was felt that some of the standards from Safety and Quality in Practice (C3-6) and from Professionalism (D4), might fit better within this theme, which would focus the intent in each case, and attempt to avoid unnecessary repetition.

15. Standard A4 (*You must receive valid consent before examination and treatment*) This standard has more than two pages of guidance, and has drawn much comment and query from respondents. There seems to be a need for greater clarity. We will discuss with the Stakeholder Reference Group the suggestion that the current guidance to this standard be pared down, but replaced with more detailed supplementary guidance. This could support a more flexible approach to providing guidance; it could be updated as required, without the constraints of waiting for a five yearly review of our core standards.

16. In A6 (*Support patients in caring for themselves to improve and maintain their own health*) the current guidance refers to informing GPs that they are receiving osteopathic treatment (which some feedback highlighted as unrealistic) and allowing patients to make their own decisions about care. It does not, however, refer to advice about self-care, diet or exercise, for example. We will discuss these issues with the Reference Group – it may be that this issue is covered effectively, within aspects of Professionalism (or Safety and Quality in our work in progress draft at the Annex).

Knowledge, skills and performance

Examples of feedback
"B1 (1.1) refers to the principles and concepts of Osteopathy. What are these? What is their precise relationship to the Standards? Do they supervene over the Standards? If so, how, and when?"
B1: "1.1 Should there be mention here of an understanding of osteopathic PHILOSOPHY? As osteopathic principles are derived from osteopathic philosophy understanding of the latter is more important."
B1: "Stills philosophy and principles are distinct from the rigid evidence based practice mantra that we continually hear from our regulator."
B1: "How can one know if an osteopath understood and followed the principles and concepts of osteopaths when the principles and concepts are not clearly defined?"
B2: "Isn't this all relevant to us qualifying as osteopaths? and therefore as we can only call ourselves osteopaths if we have the relevant training this is a given?"
B2: "guidance 1.8 The ability to determine changes in tissues and joint movement by the appropriate use of observation, palpation and motion

evaluation. The reliability of these modalities have been shown to be poor and not valid. The clinical usefulness of these modes is highly speculative and this statement ought to be removed. Range of motion changes are not validated clinical outcome measures."

17. The reference to 'osteopathic concepts and principles and the critical application of these to patient care' (B1) has elicited much comment. Some wish to see the 'osteopathic' element enhanced, but many question this, pointing to differing views on the definitions of osteopathic concepts and principles, and how they should be applied. The relationship between osteopathic principles and the standards themselves has been raised.

18. In the draft at the annex, we have suggested, for consideration by the Committee, the Working Group and probably for consultation, combining B1 and B2 in a single standard (actually, the existing B2) to read 'You must have sufficient and appropriate knowledge and skills to support your work as an osteopath.' This removes the explicit but not the implicit reference to 'osteopathic principles'.

19. There are only four standards in Theme B currently, so combining two of them reduces this to three.

Safety and quality in practice

Examples of feedback

C1: "This seems very repetitious of Theme 2. Surely NOT doing the above would show gaps in knowledge, skills & performance? (And not doing things in Theme 2 would compromise safety & quality)."

C2: "The guidance for this standard does not seem to sufficiently support the patient partnership section A. This would benefit from being re-written with a focus on Shared Decision making and taking into account the patients values, preferences and expectations."

C4: "Does this not come under the 'communication' theme? And 'professionalism'?"

C5: "This standard could easily be combined with C1."

"C6.2 Need more advice on cultural and religious implications for dignity and modesty. Already noted under A2.3"

C7: "Section 1 is repetition of previous guidance, mainly under C1"

20. The inclusion of the qualifying term 'osteopathic' in C1 and C2 (i.e. references to 'osteopathic patient evaluation' and 'osteopathic treatment plan') raises similar issues to those in relation to B1 and B2. We have suggested combining these in a reworded standard, and propose to discuss this further with the Committee, the working group and probably a part of the formal consultation.

21. As mentioned above, we have suggested moving and/or combining some of the current standards from this theme, into *Communication and patient partnership.*

22. Some of the standards which are currently in *Professionalism* seem to relate more to safety and quality, for example, standards regarding the spread of communicable diseases and hygiene. We have suggested moving these, accordingly.

Professionalism

Examples from feedback

D1: "Duh. Is this not obvious. What sort of professional would osteopaths be if this was not known or understood."

D1: "In response to a previous comment I feel that this is categorically not obvious to some in the osteopathic profession. I also feel that some osteopaths feel that they are above other care that the patient might be receiving which is a considerable risk."

"D2 1.1 and 1.2 - bit vague. Is it not ok to use paper?"

"D2&3. 1.3 and 1.4. Clarify please. Way written too ambiguous."

"D2/D3 - not that clear what specifically this is about. May need clearer examples in the guidance."

"D3: Retrieving, processing and analysing information – does this apply to all information e.g. haematology and imaging – Most Osteopaths act on the reports from these investigations rather than analysing."

"D4 4.3 Difficult to interpret. OK to keep treating if patient emotionally vulnerable and efforts have been made to acknowledge/explore dependency issues - and noted on records."

"Probably D6 hinders rather than supports good osteopathic practice as you have to comply with data protection"

D8: "so this is saying that the owner of the facility is responsible for the treatment of the patient, even when performed by another qualified and registered provider… just because they have less years being qualified ?"

"D8.6: Good idea (developing teaching skills) but is this really a regulatory

issue?"

D11: "The guidance does not match the statement.

D11: "Does the regulator have an opinion on osteopaths engagement / role in public health? eg vaccinations? (& obesity, smoking & alcohol cessation etc)"

D17: "I am curious about this section. Standards of a professional should be upheld certainly, especially during all interactions with the public when acting as an osteopath. But in this day and age of social media and blurring divide on ones private life, I feel that some of these points are too vague and could lead to spurious actions of others opening up opportunities for unwarranted investigations. "

23. This is the most extensive domain of the *Osteopathic Practice Standards*, currently comprising eighteen standards. Here there is a consistent call for much greater clarity in relation to many of the individual standards. We have attempted to address this in our suggestions, but have raised questions in relation to any such changes.

24. D1 (*You must consider the contributions of other healthcare professionals to ensure best patient care*), D2 (*You must respond effectively to requirements for the production of high-quality written material and data*) and D3 (*You must be capable of retrieving, processing and analysing information as necessary*) are particularly poorly understood. Issues raised include the need for greater clarity about the expectations of and relationships between osteopaths and other health professionals and the way that this is expressed in the OPS and also the need for greater context around the retrieval, analysis and production of information for others (perhaps including the regulator and other health professionals where expectations and needs may be different). These matters will be raised for discussion with the Committee, the working group and probably during formal consultation.

25. The D11 standard about being aware of 'your role as a healthcare provider to promote public health', was queried by a number of respondents, as there is perhaps a greater need for clarity about the expectations in this area for osteopaths. This will be a point for discussion for the Committee, the working group and probably an issue during formal consultation.

26. We have suggested moving the current D11, D12 and D13 to *Safety and Quality in practice.*

Questions for discussion

The Committee is asked to consider the feedback analysis and may wish to share its initial thoughts on the following areas:

a. What should be the osteopath's role in public health? Why?

b. Should the terms 'osteopathic principles', 'osteopathic evaluation' appear in the *Osteopathic Practice Standards*? Why?

c. What are our expectations of the osteopath's relationships with other health professionals and how should these be expressed in the standards. What else should we be doing in terms of guidance and learning resources to support osteopaths and other health professionals to support the patient journey?

d. What is the context within which osteopaths should be able to retrieve, analyse and produce information for others (regulator, patients, other health professionals, themselves). What are our expectations for osteopaths in these areas?

Supporting guidance and resources

27. The need for improved guidance and resources on a range of issues and more efficient signposting to other possibly external resources and websites has been identified.

28. The feedback analysis showed that the following aspects of practice have been identified as potentially requiring clearer guidance or links to additional support and resources:

- Consent
- Capacity
- Candour
- Cultural elements and influences on the therapeutic relationship
- Risks of treatment
- Safeguarding
- Case notes and record keeping
- Mentoring/supporting colleagues
- Equality/diversity issues
- Maintaining boundaries
- Managing complaints and seeking patient feedback are issues identified in the external environment that may require further work as part of the review.

29. We would draw a distinction between 'guidance' and 'resources' – but what do we mean by 'guidance' and 'resources'?

30. We suggest that guidance, though in a separate document, would support interpretation of standards, and would need to be consulted on prior to publication. Guidance would elaborate, explain in more detail and contextualise the standards, would have a status as 'official' GOsC Guidance and would be referred to as such by external stakeholders. This guidance would be developed, consulted on and approved by Committee and Council in the same way that we would expect to produce standards.

31. Recommendations from the McGivern research included:

    'The GOsC should provide further communication and training about the OPS, particularly the standards osteopaths complained about most, relating to:

    - Communicating risks and gaining consent from patients – clarifying how osteopaths can communicate risks of osteopathic treatments to patients in ways that do not alarm them or undermine their confidence in osteopathy.
    - Keeping patient notes – addressing osteopaths' concerns about what constitutes adequate note-keeping and why notes are necessary.
    - Patient dignity and modesty – Clarifying what is expected in relation to these standards to prevent some osteopaths interpreting them in 'black and white' terms, which do not reflect the intent of the OPS and undermine their confidence in the OPS more generally.'

32. The McGivern research suggests it is not just the 'what' but the 'how' and the 'why' which is important in supporting implementation of standards. However, some of this 'how' and 'what' is not suitable for guidance, and might best be demonstrated through, for example, e-learning or videos, or 'think pieces' published in our magazine to help to implement, describe or explain a particular aspect of the OPS or guidance. Such resources wouldn't necessarily be 'official GOsC' guidance, developed by a working group, consulted on and approved by Committee and Council, but would help to support the implementation of Standards and Guidance already approved by the Committee and the Council.

33. We suggest that 'learning resources', therefore, would be a range of material specifically linked to the OPS, providing more explicit explanation of why standards are in place and how they might apply in practice. We envisage that these would include a much more dynamic range of additional resources, or sign-posting to relevant external resources, case studies, and interactive educational material, largely provided online.

Question for discussion

What are the Committee's thoughts about the distinction between 'Guidance' and 'Learning Resources'?

34. If the Committee were content with the distinction between 'Guidance' and learning resources, an initial suggestion would be that detailed and official guidance should be provided on consent (including capacity); maintaining boundaries and managing patient information. Other advice would be provided in supporting resources as is the case now. The detail of this can be explored further with the Stakeholder Reference Group. These items have been selected because they are areas which have features strongly in the detailed feedback analysis, and are of key importance in terms of patient protection.

35. It is intended that the revised OPS will be consistent with the feel and intent of the current document but will seek to address the issues outlined above, so that the revised OPS document is up to date, clearer, easier to navigate, understand and implement, and thus contribute more effectively to patient safety and quality of care supported by strengthened guidance and learning resources.

36. The OPS should also be consistent with the standards issued by other healthcare regulators, which, although varying in terms of the professions they apply to, contain very similar themes, and should be acceptable to key stakeholders. A detailed mapping of the new GCC Code to the initial suggested revisions of the OPS has been carried out to ensure that there are no obvious gaps at this stage of development (on the basis that the professional context and scope of chiropractic is arguably the closest to osteopathy). This is also supported by an analysis of the standards of all the other healthcare regulators. This analysis is available on request from Steven Bettles at sbettles@osteopathy.org.uk.

37. The potential impact of the revised OPS on stakeholders will continue to be explored, and the inclusion of stakeholder representatives on the reference group will help to ensure that this process is effectively managed and consensus is achieved through the formal consultation planned next year and the agreement of the final standards and guidance.

38. Alongside agreement to the final standards, implementation of the standards will be key. For example, the osteopathic educational institutions (OEIs) will need to re-map their curricula to the new standards by the time they come into force. The GOsC Professional Standards team will be able to support, advise and work with OEIs on this process.

39. The new CPD scheme requires osteopaths to complete activities across all four of the themes of the *Osteopathic Practice Standards*. This does not require mapping of activities to specific individual standards, only the themes. It has always been envisaged that the four themes will remain the same, as osteopaths are largely already familiar with this structure and it works well in the context of the domains of the standards of other regulators. Much work will be aimed at publicising the new *Osteopathic Practice Standards* across the profession prior to their implementation, and we will collaborate with others, including regional groups and the Institute of Osteopathy to this effect.

Timetable

40. The timetable previously noted by Council was as follows:

Call for evidence – engagement with key stakeholders	February to May 2016
Desk research	February to July 2016
Review of evidence	Summer 2016
Specific patient group consultation	Late September 2016
Report to Policy Advisory Committee with initial structure of revised OPS based on review evidence and feedback – seek feedback regarding consultation draft	October 2016
Multi-stakeholder working group established to provide further comment on the preparation of the draft standards for public consultation	October to December 2016
Council approval of draft OPS for consultation	February 2017
Consultation	March to June 2017
Publication and introduction	Autumn 2017
Implementation/roll out	Autumn 2017 to Autumn 2018
Standards come into force	Autumn 2018

41. As the review process has developed, however, some matters have arisen which raise options regarding the timetable. In particular, the development of separate guidance in particular topic areas as referred to in paragraphs 28 to 34 above.

42. The feedback analysis suggests that we need to develop extended guidance in the areas highlighted. The nature of the development process for the Guidance is such that it would not be ready for consultation by spring 2017 as outlined in the timetable agreed by Council.

43. There are, therefore, two options.

- Option 1: It would be possible to go to consultation on the revised standards on the existing timetable. During this period, we could develop guidance documentation which would be consulted on at a later stage (probably

autumn / winter 2017. This would have the advantage of keeping to the original timetable with publication of the final standards still taking place in autumn 2017 and the standards themselves coming into force in autumn 2018. Guidance would be finalised in spring / summer 2018 along with a series of resources, so that the final 'package' would be ready to come into force in autumn 2018 as envisaged. However, there are risks to this approach. For example, if the process of developing and consulting on the guidance took longer than planned, it could mean that the *Osteopathic Practice Standards* would have some gaps when they came into force.

- Option 2: An alternative, however would be to delay the consultation process for both the standards and the guidance by approximately six months, so that the guidance documents could be developed, and consulted on at the same time as the OPS. The advantage of this is that the full suite of revised OPS and guidance documents could be seen at the same time, potentially leading to the generation of more meaningful feedback – it also avoids the risk of 'gaps' if there were delays in the development of the comprehensive suite of guidance to support the standards. A revised timetable to support this option is outlined below:

Activity	**Date**
Multi-stakeholder working group established to collaborate on the development of revised OPS and supplementary guidance documents.	November 2016 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

44. This option would lead to the revised OPS coming into force a year later than originally envisaged, but would also give a longer period between publication and implementation. An additional advantage of such an approach is that this would ensure that stakeholders (such as the osteopathic educational institutions)

had more than enough time to prepare for the implementation and map their curricula accordingly ready for the 2019-20 academic year.

45. If the new CPD scheme becomes fully mandatory from August 2018, then those commencing their three year CPD cycle could be advised to map their activity to the new OPS from the start, which would also support effective implementation of the revised standards.

46. The Committee is requested to consider the options for the revisions of the OPS and the associated Guidance and to advise Council.

Recommendations:

1. To consider the feedback analysis and the development of the *Osteopathic Practice Standards* review.
2. To consider the distinction between 'Guidance' and 'Resources'
3. To consider the options for the development of the Osteopathic Practice Standards and the impact on timelines.

Work in progress to Osteopathic Practice Standards showing how the revised standards are developing

Current standards are show in the left column, with suggested revisions on the right. Those that currently constitute the Standard of Proficiency are highlighted in yellow. Some standards have been moved from one theme to another, where this is felt to represent a better fit. These are highlighted orange.

Please note: revised guidance is not shown in this document, only the standards themselves.

COMMUNICATION AND PATIENT PARTNERSHIP	
Current standards	**Suggested revisions**
Current introductory statement: **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.**	**Suggested revised introductory statement:** **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 effective patient partnerships.**
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, adapting your communication strategies to take into account the particular needs of the patient.
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
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
A4. You must receive valid consent before examination and treatment.	A4. You must receive and record valid consent for all aspects of patient care.
A5. Work in partnership with patients to find the best treatment for them.	
A6. Support patients in caring for themselves to improve and maintain their own health.	
C3. Care for your patients and do your best to understand their condition and improve their health.	
C4. Be polite and considerate with patients.	

C5. Acknowledge your patients' individuality in how you treat them.	
C6. Respect your patients' dignity and modesty.	A5. Respect your patients' dignity and modesty.
D4. Make sure your beliefs and values do not prejudice your patients' care.	A6. You must make sure your beliefs and values do not prejudice your patients' care.

Knowledge, Skills and performance	
Current standards	**Suggested revisions**
Current introductory statement: ***Ethically, an osteopath must possess the relevant knowledge and skills required to function as a primary healthcare practitioner.***	**Suggested revised introductory statement:** **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**
B1. You must understand osteopathic concepts and principles, and apply them critically to patient care.	
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
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.
B4. Keep your professional knowledge and skills up to date.	B3. You must keep your professional knowledge and skills up to date.

Safety and quality in practice	
Current standards	**Suggested revisions**
Current introductory statement: **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:** **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.**
C1. You must be able to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan.	C1. You must be able to deliver safe, competent and appropriate care to your patients
C2. You must be able to formulate and deliver a justifiable osteopathic treatment plan or an alternative course of action.	*C1 & C2 could be combined. Is there any value in two references to evaluation and treatment. Does the revised C1 encompass everything?*
C7. Provide appropriate care and treatment.	
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.
C9. Act quickly to help patients and keep them from harm.	C3. You should act quickly to safeguard patients and keep them from harm.
D11. Be aware of your role as a healthcare provider to promote public health.	C4. Be aware of your role as a healthcare provider to promote public health.
D12. Take all necessary steps to control the spread of communicable diseases.	C5. Ensure that your practice is safe, clean and hygienic, and complies with health and safety legislation.
D13 Comply with health and safety legislation.	

Professionalism	
Current standards	**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.***
D1. You must consider the contributions of other healthcare professionals to ensure best patient care.	D1. You must be respectful of the contributions of other healthcare professionals to your patients' care.
D2. You must respond effectively to requirements for the production of high-quality written material and data.	D2. You must respond effectively and appropriately to requests for the production of written material and data.
D3. You must be capable of retrieving, processing and analysing information as necessary.	D3. You must be able to analyse and reflect upon information related to your practice in order to enhance patient care.
D5. You must comply with equality and anti-discrimination laws.	D4. You must treat patients fairly and recognise diversity and individual values. You must comply with equality and anti-discrimination laws.
D6. Respect your patients' rights to privacy and confidentiality.	D5. You must respect your patients' rights to privacy and confidentiality, and effectively maintain and protect patient information.
D7. Be open and honest when dealing with patients and colleagues and respond quickly to complaints.	D6. You must be open and honest with patients, fulfilling your duty of candour.
	D7. You must have a visible policy in place by which you manage patient complaints, and respond quickly and appropriately to any which arise.
D8. Support colleagues and cooperate with them to enhance patient care.	D8. You must support colleagues and cooperate with them to enhance patient care.
D9. Keep comments about colleagues or other healthcare professionals honest, accurate and valid.	*(Note – it has been suggested that this be moved to guidance for D1)*
D10. Ensure that any problems with your own health do not affect your patients.	D9. 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.

D14. Act with integrity in your professional practice.	D10. You must act with honesty and integrity in your professional practice.
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.
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.
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.
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.

	Moved from one theme to another
	Current Standards of proficiency