Annex A to 2

MOTT MACDONALD

General Osteopathic Council

Quality Assurance Handbook

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Quality Assurance Handbook

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Contents

Executive summary

As the regulator for Osteopaths in the UK, the General Osteopathic Council (GOsC) are responsible for:

- Setting standards
- Assuring the quality of pre-registration education
- Maintaining a register of osteopaths who are able to practise in the UK
- Removing or restricting the registration of osteopaths who do not meet standards

This quality assurance (QA) of pre-registration education ensures that students who enter the register can demonstrate that they are able to meet the Osteopathic Practice Standards (OPS). This is important to ensure that the public remain confident that care provided will allow them to be safe and know what standard of practice is expected of the profession.

Mott MacDonald (MM) provide QA services on behalf of GOsC. The handbook sets out the purpose and processes of QA, allowing for transparent decision making about delivery of osteopathic education courses.

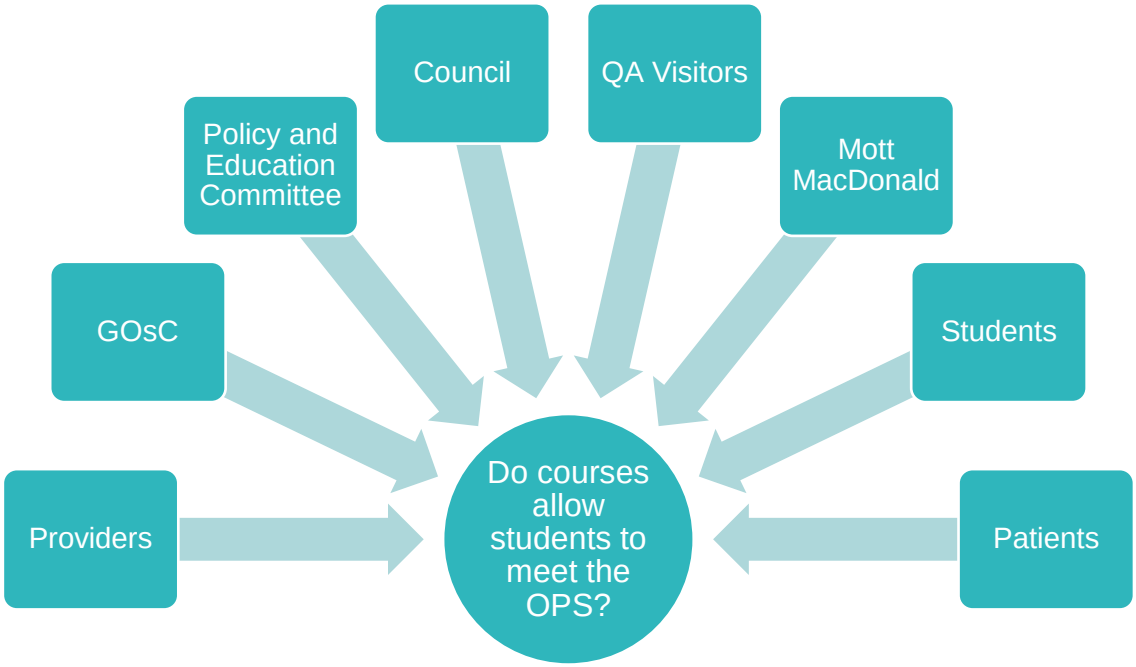
This handbook outlines:

- The roles and responsibilities within QA
- The QA process
- Details of initial recognition, renewal and monitoring visits
- The annual reporting process

The handbook considers all aspects of the QA process and is a tool for both providers and QA visitors.

1 Roles and responsibilities

The following section describes the roles and responsibilities for those involved in the QA process.



1.1 Providers

Providers are responsible for ensuring their programmes allow graduates to meet the OPS, maintaining patient safety and the protection of the public. In order to provide this assurance, providers must have appropriate internal governance mechanisms which enable them to maintain quality and to identify, manage and monitor issues which may affect the quality of their provision. This ensures that only students meeting the OPS are awarded a recognised qualification (RQs) which entitles the graduate to apply for registration with GOsC.

There are a number of mechanisms in place to provide assurance to GOsC that the qualifications offered by the provider meet the legal requirements ensuring that they are only awarded to graduates who meet the OPS. These include: a continuous cycle of review; informing GOsC of any changes in provision which may impact on standards including the ways in which they identify these and are managing and monitoring risks; renewal visits every four to six years, unless an earlier visit is required; reporting against specific and general conditions or other requirements if applicable; annual reports to GOsC (reporting on a variety of issues including data about students, educators, student fitness to practise findings and external sources of data including external examiner reports and internal annual quality monitoring reports, feedback from stakeholders including staff, students and patients); managing concerns and information from third parties about quality issues, supporting and sharing good practice and ongoing engagement and dialogue GOsC, amongst other ways in which assurance is provided. Where appropriate GOsC may request further updates from the provider to give the required assurance.

Some of the key areas the provider is responsible for during the visit process and specifically covered in this handbook are:

- Identifying an appropriate range of dates for the visit to take place
- Confirming there is no conflict of interest with the visiting team allocated to the review
- Appointing a main point of contact for the review, for visitors, MM and GOsC to liaise with
- Completing the mapping tool and providing supporting evidence **ten weeks** before the visit
- Responding to the visiting teams request for further information **four weeks** before the visit
- Collaborating with MM to confirm the agenda
- Accommodating the visit at the required provider site, ensuring there is suitable space for the visiting team to work from
- Planning for the visit to ensure student and staff are available and teaching and learning observation has been arranged
- Arranging meetings for the visit
- Actioning follow-up post visit to mitigate potential conditions
- Provide comments on accuracy of draft report
- Develop action plan to address approach to fulfil conditions
- Provide feedback on review process
- Monitoring, manage and provide updates on conditions
- Annual reporting the maintenance of their RQ to GOsC

1.2 General Osteopathic Council (GOsC)

The General Osteopathic Council is established under the Osteopaths Act 1993 which sets out the legal duties and responsibilities of GOsC. These are to: To 'develop and regulate' osteopathy profession to ensure 'public protection'. Its objectives are:

- 'To protect, promote and maintain the health, safety and well-being of the public
- To promote and maintain public confidence in the profession of osteopathy
- To promote and maintain proper professional standards and conduct for members of that profession' As the professional regulator GOsC is responsible for scrutinising RQs, to ensure that through the provision of providers, graduates meet the OPS and practise safely.'

The Council also has specific statutory responsibilities including:

- Recognising qualifications that are or will evidence that students meet the OPS, subject to the approval of the Privy Council (attaching conditions or time periods to that recognition where appropriate). These qualifications are called 'recognised qualifications' (RQs).
- Withdrawing recognition of qualifications that are or will no longer be evidence that students meet the OPS, subject to the approval of the Privy Council.

For further information on the role of GOsC please see the GOsC website.

A key part of the process of recognising or continuing to recognise qualifications is the Visit process.

Some of the key aspects GOsC are responsible for during the visit process are:

- The initial scrutiny of the initial recognition application form
- Approval of the visiting team
- Approving request for changes to the QA review process
- Reviewing unsolicited information in collaboration with MM
- Reviewing the draft report
- Reviewing the final report post visitor comments and issuing back to provider
- Recommending the outcome of the review to the PEC

1.2.1 Policy and Education Committee (PEC)

The PEC performs the statutory role of the Education Committee under the Osteopaths Act 1993. It has a 'general duty of promoting high standards of education and training in osteopathy and keeping the provision made for that education and training under review'. Before making decisions about recommending the recognition of or withdrawal RQs, the Council must seek the advice of the PEC. The PEC also has wide statutory powers to require information to inform decisions about RQs and has specific powers about visits including appointment of visitors to undertake visits.

1.3 QA Visitors

The QA visitors have a responsibility to review evidence presented for delivery of qualifications and triangulate this at visits. They are responsible for providing a report that allows assurance to be provided to GOsC that the programmes allow graduates to meet the OPS, practise safely and ensure that RQs are only awarded to graduates meeting the OPS. If assurance can't be given, the visitors are responsible for ensuring that the report provides accurate findings as to why this cannot be given. The QA visitors must uphold the Code of Conduct when undertaking a visit, identified in the GOsC Governance Handbook, in annex 1.

During the visit process the visitors are responsible for:

- Providing availability to undertake a visit and identifying any conflict of interest prior to the visit
- Attending the annual mandatory visitor training and pre-visit briefing
- Working collaboratively across the visiting team to ensure the QA visit is conducted in line with the defined process
- Adhering to the QA visitor code of conduct
- Reviewing the mapping tool and evidence submitted by the provider and in conjunction with the visiting team to respond to the provider with additional requests. Additional requests should be made **six weeks** before the visit
- Agenda development, including adequate time to meet with students, staff and observe clinical settings. The final agenda will be agreed **three weeks** before the visit
- Attendance at the visit and agreeing the outcome with the other visitors
- Sharing high-level feedback with the provider at the end of the visit (see section 5.7)
- Identifying follow-up post visit for the provider and any conditions
- Producing a draft report in accordance with the specification provided and findings from the visit **one week** after the visit
- Review the collated visit report to confirm accuracy, making amendments accordingly
- Providing feedback on the action plan produced by the provider
- Reviewing providers responses to conditions where appropriate

1.4 Mott MacDonald

MM provide QA services on behalf of GOsC.

The MM team comprises of:

- Technical lead – responsible for ensuring assurance of the quality of professional decisions and leading the relationship with the QA visitors
- Project Director – accountable for the delivery of the contract and key point of contact with GOsC
- Project/Operations Manager – responsible for the management of day to day contract overseeing delivery of the QA visits
- Project Officer – responsible for support to the delivery of the contract and support at the visit

During the visit process, MM are responsible for:

- Maintaining up to date guidance on the review process
- Recruiting and training QA visitors
- Identifying suitable visitors to undertake a review
- Providing timeframes for the review to providers and visitors
- Supporting visitors and providers throughout the review
- Providing the platform to facilitate the review
- Observing visits where appropriate
- Collating and confirming the draft report post visit and liaising with the visitor team if amendments are required
- Submitting the draft report to GOsC and the provider **five weeks** after the review
- Reviewing provider comments on the draft report in collaboration with the visiting team
- Finalising the visit report following receipt of the provider comments

Reviewing the action plan in collaboration with GosC where necessary

1.5 Students

Students will participate and feedback on the QA process to help visitors triangulate their findings.

1.6 Patients

Patients will participate and feedback on the QA process to help visitors triangulate their findings

2 Quality Assurance Purpose

QA of osteopathic education allows us to ensure that students who register with GOsC are able to demonstrate compliance with the OPS.

Only qualifications recognised by GOsC and approved by the Privy Council (RQs) entitle graduates to apply for registration with GOsC and practise lawfully as an osteopath.

Section 14 of the Osteopaths Act 1993 provides that GOsC may 'recognise qualifications', subject to the approval of the Privy Council, when it is 'satisfied that a qualification granted by an institution in the United Kingdom is evidence of having reached the required standard of proficiency'. The required standard of proficiency is set out in the OPS (2019) available here.

In order to ensure that RQs are only awarded to students meeting the OPS, GOsC must ensure that courses of osteopathic education meet its requirements for standards and quality, as well as governance and management of the course provider. Those that do, are recognised and awarded RQ status. This allows graduates from those courses to register with GOsC and practise osteopathy legally in the UK. The RQ is subject to approval from the Privy Council. The full GOsC QA policy can be found in Annexe E.

Decisions concerning the initial recognition, maintenance, renewal and withdrawal of RQ status are made by GOsC following reviews of osteopathic courses and course providers, and the consideration of a recommendation from the PEC on behalf of the Privy Council.

All forms of GOsC review share the same purpose, which is to enable GOsC to satisfy itself that RQs are only awarded to graduates meeting the OPS and to assure itself that providers are capable of evaluating and enhancing their programmes of study and where appropriate, to make decisions on approval (or on occasion withdrawal of an RQ) subject to the approval of the Privy Council.

The maintenance of the RQ status currently follows a cyclical process. Where required, PEC may apply an expiry date to the RQ. This decision will be made based on anticipated level of risk that the RQ presents.

GOsC will usually recognise qualifications for a fixed period of time in the following circumstances:

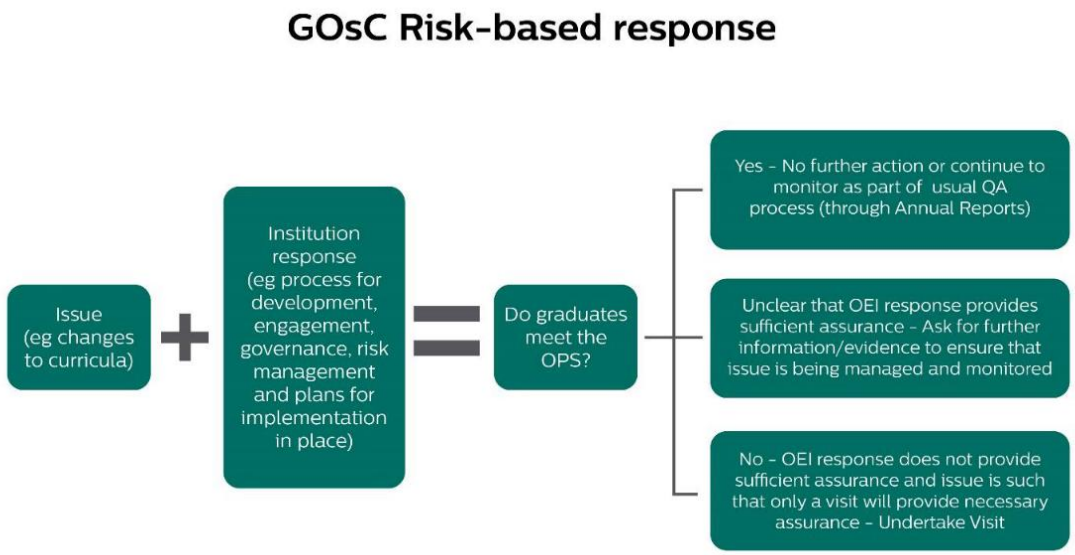
- A new provider or qualification
- An existing provider with a risk profile requiring considerable ongoing monitoring.

For existing providers, GosC will usually recognise qualifications without an expiry date in the following circumstances:

- an existing provider without conditions or
- an existing provider with fulfilled conditions and without any other monitoring requirements or
- an existing provider who is meeting all QA requirements (providing required information on time) or an existing provider with outstanding conditions, an agreed action plan and which is complying proactively with the action plan and
- an existing provider engaging with GOsC.

This will be subject to satisfactory review of the providers annual report.

QA follows a risk-based approach, as outlined in the diagram below:



MM deliver these QA activities on behalf of GOsC.

2.1 Recognised qualifications

Decisions around granting or renewing RQs are made following reviews and visits to providers. Evidence is provided by the provider which is reviewed by a team of QA visitors. The visitor team then attend the provider to triangulate that evidence and observe both teaching and learning. This is then followed by a recommendation to PEC and Council to approve the outcome of the review, subject to approval from the Privy Council.

There are three variations to the purpose of visits:

- Initial recognition review (IRR) – for new qualifications seeking RQ status
- Renewal of Recognised Qualification (RRQ)
- Monitoring review (MR)

To see the outcomes of these reviews, please refer to the outcomes section.

The following standards and guidance should be reviewed alongside the handbook:

- OPS (2019) - https://standards.osteopathy.org.uk/
- Guidance for Osteopathic Pre-registration Education (2015) (GOPRE) – the outcomes expected of graduates in order to meet the OPS - https://www.osteopathy.org.uk/news-and-resources/documentlibrary/training/guidance-for-osteopathic-pre-registration-education/

  This supports the OPS and provides a reference point for students, education institutions and patients. It describes the professional aspects of osteopathic pre-registration education

and the outcomes that graduates are expected to demonstrate before graduation to demonstrate that their practise will meet the OPS.

- The Quality Code and standards for education and training, published by the Quality Assurance Agency (QAA), 2018, are available here.
- GOsC Student fitness to practise guidance (2017) - https://www.osteopathy.org.uk/news-and-resources/document-library/training/guidance-professional-behaviours-and-ftp-students/
- GOsC Guidance about the management of health and disability (2017) - https://www.osteopathy.org.uk/training-and-registering/becoming-anosteopath/management-of-health-and-disability/

2.2 Themes of review

GOsC review addresses the following eight areas:

- Governance and management
- course aims and outcomes (including students' fitness to practise)
- curricula
- assessment
- achievement
- teaching and learning
- student progression
- learning resources

QA reviews are conducted by a team of suitably qualified lay and osteopathic visitors. The visitors are recruited, deployed, trained and appraised by MM.

2.3 Training and Guidance to providers and visitors

Providers are supported by QA materials such as this handbook to detail the QA process. MM also provide a help desk for any specific queries. GOsC work with providers to provide guidance and support for all QA matters.

Visitors are trained and supported by MM. Visitors are required to undertake annual training that MM will schedule. Where possible this training will be closely aligned to the annual visit schedule. Annual training will be mandatory for all visitors who wish to be selected to undertake visits. This training is aligned to any visits that are due to ensure visitors are provided with the most up to date training and opportunities to refresh their knowledge as close to any activity as possible.

Alongside the mandatory training, visitors who are selected to attend visits will be required to attend a visit briefing. This will provide opportunity to ensure visitors are up to date with both current process and policy, and also provide opportunity for a detailed briefing specifically for the institution they are reviewing.

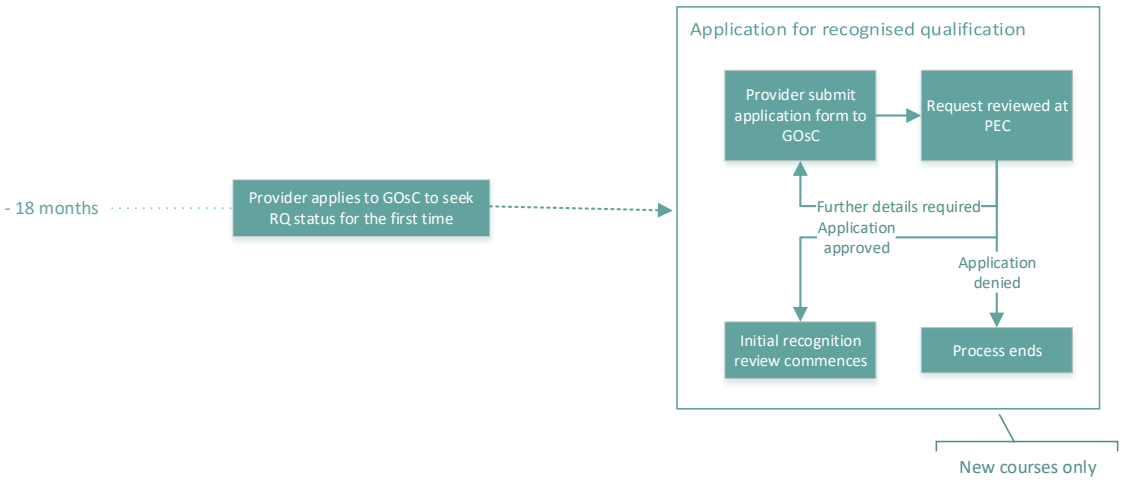
Visitors will also work within a community of practice so that development and support can be driven by a peer approach.

3 Key terms

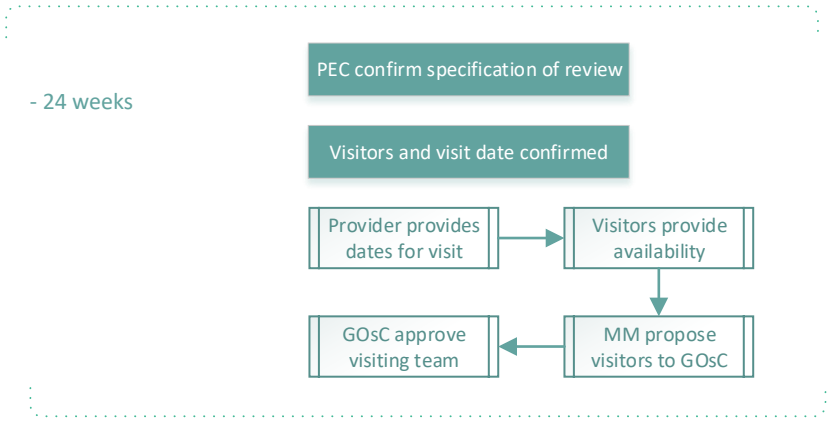
Action plan	The plan that outlines how conditions will be met, produced by the provider.
Condition	A condition is applied to a RQ where there are specific actions that need to be taken to provide assurance. Fulfilment of the condition is required to ensure that graduates awarded a RQ continue to meet the OPS.
GOsC	General Osteopathic Council
Initial recognition	When a provider seeks RQ status for a programme qualification for the first time.
Mapping tool	The self-evaluation document to be completed by the provider before the visit, this document is then reviewed by the visiting team and used to inform the structure, progress and outcomes of the visit.
Mott MacDonald	The QA provider on behalf of GOsC.
OPS	Osteopathic Practice Standards
PEC	Policy and Education Committee
Provider	Osteopathic Education Institution (OEI) delivering programme.
QA visit	A visit to a provider to inform initial recognition of a qualification, renewal of recognition or a visit to confirm whether an education provider continues to provide an education provision that allows students to meet the OPS.
RQ	Recognised qualification
Specification	The focus for the review approved by the PEC.
Visiting team	The team of QA visitors that will be involved in the review.

4 The review process – flow diagram

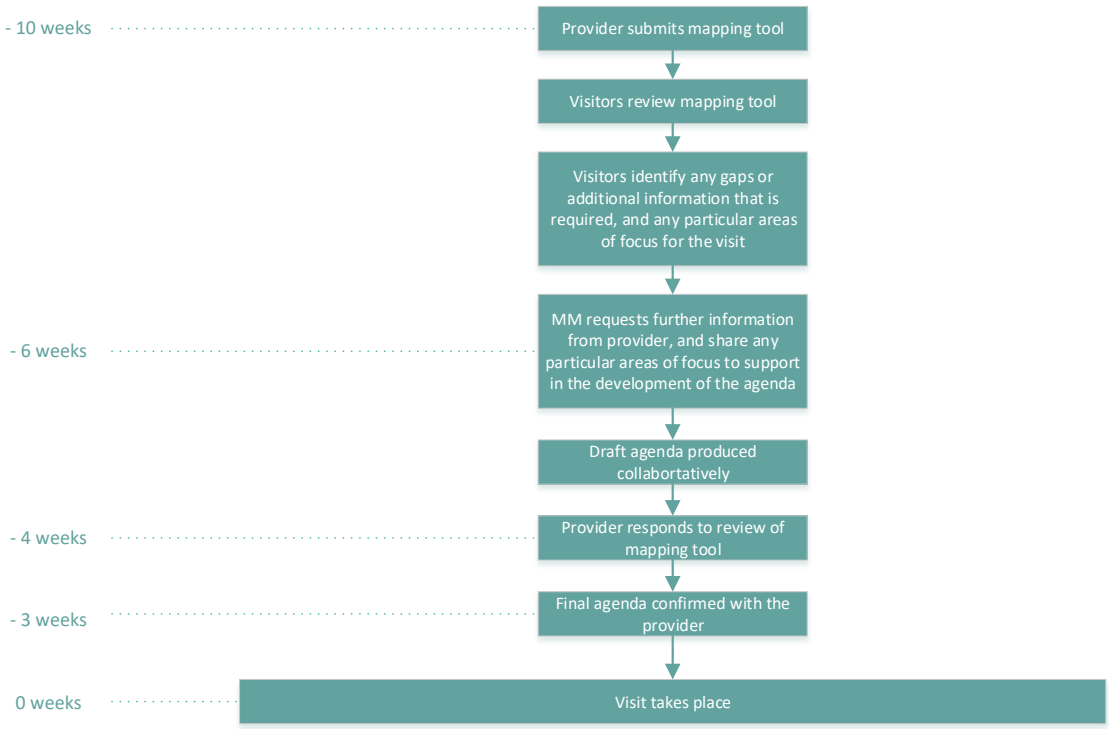
4.1 Application for initial recognition review



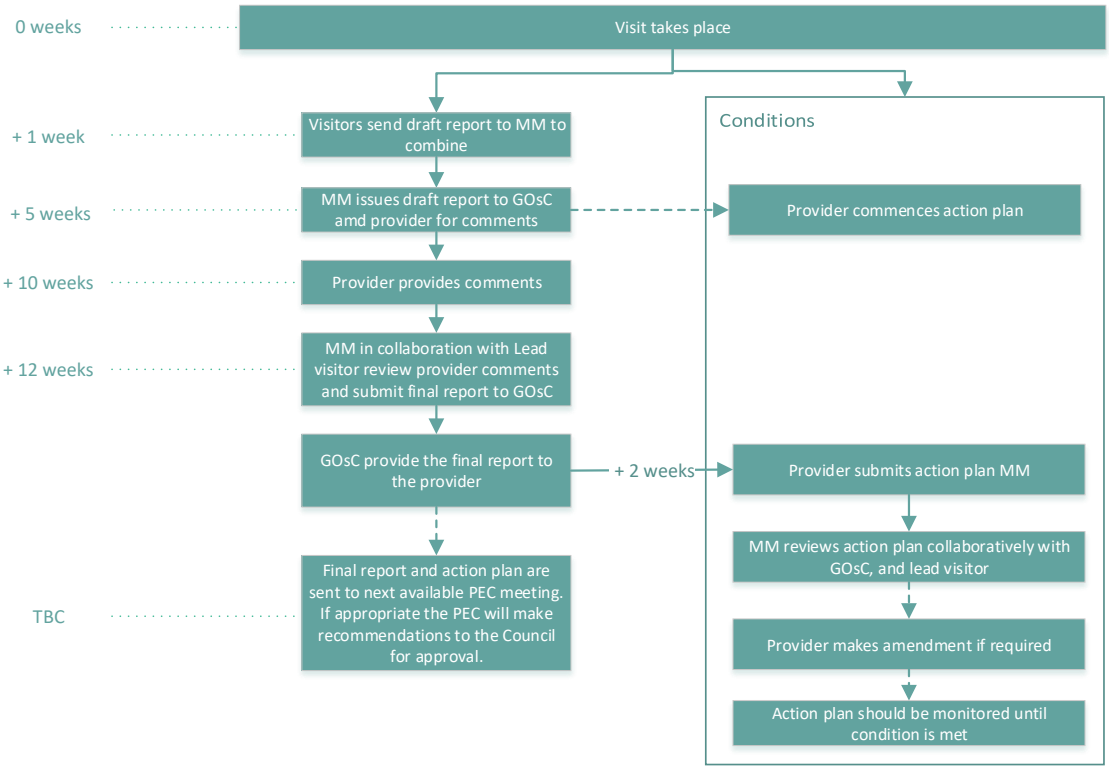
4.2 Confirmation and visit planning



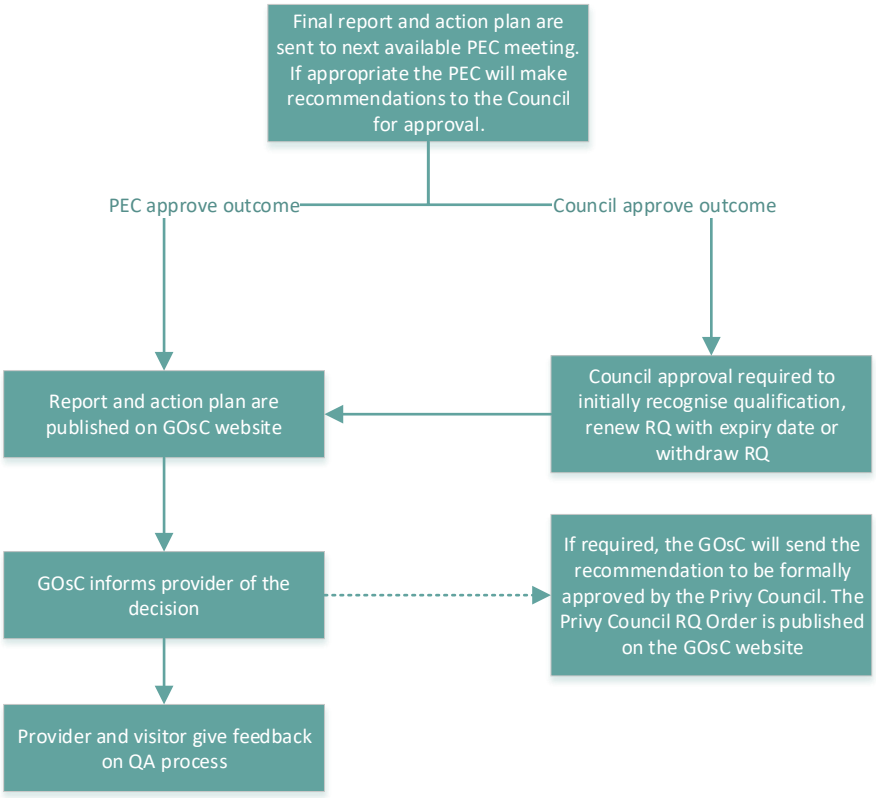
4.3 Pre-visit



4.4 Post-visit



4.5 Outcome


Final report and action plan are sent to next available PEC meeting. If appropriate the PEC will make recommendations to the Council for approval.
PEC approve outcome
Council approve outcome
Report and action plan are published on GOsC website
Council approval required to initially recognise qualification, renew RQ with expiry date or withdraw RQ
GOsC informs provider of the decision
If required, the GOsC will send the recommendation to be formally approved by the Privy Council. The Privy Council RQ Order is published on the GOsC website
Provider and visitor give feedback on QA process

5 The review process

This section details the QA visit process undertaken for both IRRs and RRQs. The initial section covers the process for the recognition application, and the following sections cover both IRRs and RRQs, as the process for both visits is the same.

There may be an exceptional circumstance when the process outlined in the handbook cannot be followed. Should the visitor or the provider wish to alter a specific part of the process, formal written agreement in advance of the review process commencing is required from GOsC. This ensures a fair and consistent approach to the QA process.

The purpose of the review is to ensure that only students who are able to meet the OPS are awarded a RQ. The review should be undertaken in line with GOsC Code of Conduct in their Governance Handbook.

The RRQ visits should take place at least nine months before the expiry date of the current RQ. Where a RQ does not have an expiry date, a visit will take place between years four and six of the visit cycle, in view of the course framework.

If the provider wishes to establish RQ status for a new osteopathic course or introduce new qualifications, they are required to complete and submit an application form to GOsC. This visit will then take the form of an IRR.

Where a request for RQ for a new course coincides with the renewal of an existing RQ, the review may be combined. This will be agreed by GOsC.

5.1 Application for Recognised Qualification

Confirming intention to run a recognised qualification

A provider seeking RQ for a programme for the first time should apply to GOsC at least 18 months prior to the intended start date of the course, by completing the application form. It cannot be guaranteed that the Council will make a decision within the 18-month period, as such the application should be submitted at the provider's earliest convenience.

The application will be considered, the provider may be asked to submit further details to support the application. A RQ review specification will be prepared for consideration at the PEC.

The form can be accessed here and contains further details about the process.

Following the application, the IRR visit follows the same process as the RRQ visits, this can be seen in the following sections.

5.2 Confirming the specification of the visits

GOsC will develop a specification for the visit, this will be based on the outcomes of the previous visit, information from the providers annual report and any other information during the previous RQ period which may impact on standards. The PEC will confirm the specification of the visit. This will typically be at least 24 weeks prior to the visit taking place.

The specification will identify areas for focus for the QA visitors during the pre-visit work and at the visit, and also inform the providers of the areas for focus.

The purpose of the visit itself is to provide the opportunity to triangulate the evidence uploaded in the pre-visit work and observe teaching and learning. This will allow for the opportunity to follow up any concerns at the visit.

5.3 Agreeing the date of the visit and confirmation of visitors

At 24 weeks prior to when the visit is due to take place, MM will contact the provider to request up to three preferred dates for the visit. MM will provide the range of which these dates can fall, to ensure there is sufficient time for the review process to take place before the expiry of the RQ or the requested start date for the new RQ status, if applicable. As this point, the provider should identify who will be the main point of contact for the review process.

Following receival of the three preferred visit dates, MM will identify a team of suitable visitors for the visit.

The PEC is responsible for the appointment of visitors under section12 of the Osteopaths Act 1993. MM will recommend to GOsC the visiting team, following confirmation of availability and review of conflict of interest.

Following approval of the visitors by PEC, MM will write to the provider to confirm their visiting team. The provider will be asked for final confirmation that there is no conflict of interest with the visitors.

Conflict of interest is referred to in section 12 of the Osteopaths Act 1993 whereby:

(3) No person appointed as a visitor may exercise his functions under this section in relation to—

> *(a) any place at which he regularly gives instruction in any subject; or*
>
> *(b) any institution with which he has a significant connection.*

(4) A person shall not be prevented from being appointed as a visitor merely because he is a member of—

> *(a) the General Council; or*
>
> *(b) any of its committees*.

In addition, visitors must follow the Conflicts of Interest Policy outlined in the Governance Handbook at Annex 3. Please refer to the policy in full. Relevant extracts include:

> *'A conflict of interest is any situation in which the personal interests of an individual (or the responsibilities or allegiances owed by them to another body), may or may appear to influence their personal judgment, actions or decision making.*
>
> *In UK law the legal test for bias, derived from case law is: whether the fair-minded observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased' (Porter v Magill [2002] 2 AC 357). Therefore, it follows that a perception of wrongdoing, impaired judgement or undue influence can be equally as detrimental as any of them actually occurring.*
>
> *Conflicts may be financial as well as non-financial, and may be direct or indirect. So for example, conflicts can arise from an indirect financial interest (e.g. payment to a spouse) or a non-financial interest (e.g. preserving the individual's reputation).*

Conflicts of loyalty may arise in respect of an organisation of which the individual is a member or with which they have an affiliation, or from personal or professional relationships with others, e.g. where the role or interest of a family member, friend or acquaintance may influence an individual's judgement or actions, or could be perceived to do so. Depending upon the individual circumstances, these factors can all give rise to potential or actual conflicts of interest.

A conflict of interest may also be anticipatory, where the actions of an individual may be perceived to put them in a more favourable future position in relation to another party.

Members and all those who act on behalf of the GOsC are expected to act impartially and objectively in carrying out the GOsC's business.

In considering what might constitute a potential conflict, those covered by this policy should bear in mind the seven principles of public office: selflessness; integrity; objectivity; accountability; openness; honesty; and leadership.'

5.3.1 Briefing packs

5.3.1.1 Visitors

Following the appointment of the visitors, and confirmation of the visit date, the visitors will receive:

- Contract of appointment which will need to be signed and returned to MM
- A briefing on the visit, with the visiting team
- The specification for the visit, agreed by the PEC; this will outline the areas for focus at the visit
- Supporting information, including:
  - Relevant Committee papers and reference documents
  - An electronic copy of this handbook to reference throughout the review
  - A schedule of the QA process, outlining key dates specific to the visit (standard QA process and timeline can be seen in Section 4)
- Details of other visitors involved in the QA process, and the key contact from the provider
- Details of how to access online systems that facilitate the review process.

Following the receival of the briefing pack, the MM project officer will coordinate an introduction email for the visiting team and provider. Email correspondence between the provider and visiting team must have the GOsC-Mott@mottmac.com email address copied in.

For details on the role of the visitor during the review process, see the roles and responsibilities section.

5.3.1.2 Providers

Following the appointment of the visitors, and confirmation of the visit date, the providers will receive:

- Confirmation of the visiting team

- The specification for the visit, agreed by the PEC; this will outline the areas for focus at the visit
- Supporting information, including:
  - Relevant Committee papers and reference documents
  - An electronic copy of this handbook to reference throughout the review
  - A schedule of the QA process, outlining key dates specific to the visit (standard QA process and timeline can be seen in Section 4)
- Details of how to access online systems that facilitate the review process

For details on the role of the provider during the review process, see the roles and responsibilities section.

5.4 Pre-visit review

5.4.1 Completion of the mapping tool - provider

Prior to the visit taking place, the provider will be required to complete the mapping tool. The mapping tool provides the basis for the review and will be used as a reference throughout the visit.

The aim of the mapping tool is to self-evaluate against the review criteria, reflecting on strengths and areas for development, in an open and honest way, to ensure that all information and evidence relating to the review criteria is seen prior to the visit. Any missing information could result in a condition at the visit.

The review criteria will sit under the eight Themes of Review:

1. governance and management
2. course aims and outcomes (including student fitness to practise)
3. curricula
4. assessment
5. achievement
6. teaching and learning
7. student progression
8. learning resources

The review criteria allow providers to clearly identify how their qualification, through self-evaluation, maps to delivery of RQs meeting the OPS.

When providing evidence against the review criteria, this should be existing documentation rather than new material produced for the purpose of the review. The main focus around the evidence is to understand how this has been implemented and the effects/outcomes/processes that have been generated by the use of the documents.

Where gaps in documentation or areas for development are identified, the focus should be on the course of action/ the plan for resolution and how the risks are managed. This shows proper risk management and wider thinking about the impacts on students and their ability to meet the OPS.

When completing the mapping tool, the narrative against the review criteria should be concise. Further information on completing the mapping tool, can be seen in Annex A.

The provider will be given access to a secure SharePoint folder, where they will be able to access key information, and upload documentation and the mapping tool. The provider must submit their mapping template at least **ten weeks** prior to the visit taking place, to ensure there is sufficient time for the visitors to review and ask for any additional information. Please see section below for process, for providers, to responding to queries raised on the mapping tool.

5.4.2 Review of the mapping tool – visitor

All visitors undertaking the visit will be required to review the evidence prior to the visit. The MM project officer would disseminate the information to the other visitors. This will be accessible via a secure SharePoint folder.

The purpose of reviewing the mapping tool is to identify any gaps prior to the visit and help inform the agenda for the visit. The mapping tool will also support in tracking evidence viewed throughout the process that is used to inform the final report.

The visitors should meet virtually* to discuss their review of the mapping tool and any gaps that have been identified or additional information that is required, and any particular areas of focus for the visit. **Six weeks** prior to the visit taking place, these elements should be confirmed with the provider, the visiting team will collaboratively provide feedback detailing any additional queries to the MM project officer. The MM project officer will then send queries to the provider. If further documentation is requested, this will be clearly demonstrated on the mapping template.

The provider will then have **two weeks** to respond accordingly.

** MM will facilitate a MS Teams meeting*

Where there are significant issues prior to the review, the visit will be flagged to the Project Director or Technical Lead and the appropriate steps will be discussed and agreed with GOsC. This is to ensure that resources are not used on providers that are not ready to deliver RQs.

5.4.3 Data protection

When uploading information, providers should ensure that the contents of documents complies with the General Data Protection Regulations (GDPR). Providers should ensure that no personal information is included in any documents provided for the pre-visit evidence review, this may require some documents to be redacted. If it is necessary to upload personal data, providers must ensure that they have complied with the processing requirements of the GDPR (2018).

The GOsC Privacy Notice is at: www.osteopathy.org.uk/privacy.

It is recognised that the osteopathic industry is a small sector operating in a competitive market. If there is any commercially sensitive information that the provider does not wish to be openly discussed during the visits, this must be agreed prior to the visit taking place and accommodated via the agenda development process. All visitors are contracted in line with MM confidentiality and data protection requirements. If there is a particular concern, the provider is to raise this with MM prior to the visit to ensure that this can be addressed.

5.5 Setting the agenda

The agenda will confirm key representatives who will be required to attend the visit and detail what teaching, and learning will be observed.

The provider, along with support from the MM project officer will draft an agenda that will be shared with the visiting team. The visitors will discuss and agree this at their pre-visit briefing

and will consult with the provider if necessary. The final agenda should be confirmed with the provider **three weeks** prior to the visit taking place.

The provider will have had the opportunity to review who the visitors require to be available at the visit (such as students, clinical observations, service users etc), and the observation of the teaching and learning requested, when the visitors responded with their initial review of the mapping tool. The provider will then be able to respond and set plans in motion to ensure the visit can accommodate the requirements. Where teaching learning observations have been identified, it will be the providers responsibility to ensure that the teacher/lecturer is aware that the observation will take place.

An example agenda can be found in Annexe B.

5.6 The visit

The purpose of the visit itself is to provide the opportunity to verify and triangulate the mapping tool and evidence, through meeting key representatives, the observation of teaching and learning, and where appropriate view further visual documentation. There is also the opportunity to follow up any concerns at the visit. This triangulation process allows the visitors to form a consensus of whether the provider and the courses allow the students to meet the OPS. Visitors may ask for additional evidence/documentation to be provided on the day to support in their decision making.

The structure of the visit will be agreed in advance following PEC confirmation of the specification for the visit and agreement of the agenda between the provider and visitor.

The visit may be observed by a member of the MM team or GOsC. If this is the case, the provider will be notified in advance. The role of observer will be maintained unless there are issues arising that relate to public protection that may require the need to address these.

The visit will provide assurances that:

- facilities and resources are in place to support student's education to allow them to demonstrate the OPS
- appropriately qualified external examiners are in place to report on the quality of learning
- providers policies are aligned to the agreed themes of review
- curricula and assessments enable students to achieve the OPS
- the learning environment supports a diverse learning environment
- patients and service users are fully engaged in the process
- appropriate governance structures and resources are in place

The length of the visit should be sufficient to meet the outcomes of the RQ specification and will be discussed and agreed with the provider in each case.

At the start of the visit, an introductory meeting will be required. This allows for visitors and key provider staff to introduce themselves. The provider must make the visitor aware of who is leading the visit coordination and emergency point of contact.

The provider will be responsible for ensuring there is appropriate space available to conduct the review. This should consist of a private space for the visiting team to work and discuss, and another space to meet students and staff. In advance of the visit, the provider should arrange with key representatives when they will be required during the visit and prepare examples of students work. Student work will support in determining whether:

- the curriculum is delivered as outlined in the documentation
- the assessment results obtained by students allow them to meet the OPS
- the learning outcomes are reflected in the delivery of the teaching

All meetings with students, staff and patients will be confidential.

Teaching and learning observation

- Provider will have briefed teacher/lecturer and students who are to be observed on completion of the agenda
- Usually only one visitor will observe teaching and learning at a time to ensure this is not disruptive
- Visitors are not to make comments during the observation
- Observations are used to inform the review criteria
- Reports will detail overall observations, and not name specific lectures/classes when discussing how the teaching and learning criteria are met

Unsolicited information

Other stakeholders in the GOsC review (students, staff and patients) have the right to bring information forward about the provider and their courses. Information should be emailed to MM at GOsC-Mott@mottmac.com for review and, if appropriate, this will be escalated to GOsC. This information should not be provided directly to the visitor, as for transparency reasons, the visitors should comply with the specification agreed by the PEC.

If unsolicited information is given to the visitor at the visit, this should be sent to MM to action as stated above.

For concerns outside of the review period, these will be dealt with in accordance with the GOsC Managing of Concerns policy. This can be seen in Annexe C.

5.7 Conclusion of the visit

On the last day of the visit, the visiting team will meet in private to discuss their findings and agree a provisional outcome.

The visiting team will provide high level feedback at the conclusion of the visit. This discussion will not confirm outcomes of the visit as this is not possible until the report has been collated and any conditions confirmed. The feedback will allow for general themes of the visit to be discussed, and questions around the next stages of the process to be asked.

5.8 Post- visit

5.8.1 Draft report

Following the visit, the visiting team will have **one calendar week** to produce the report and send to MM to combine and review. Visitors will review the combined draft report and confirm it accurately reflects the findings of the visit.

Report format

The report will reflect the review criteria seen in the mapping tool.

The overall summary section provides an opportunity to reflect on the review as a whole, with areas for strengths and good practice, areas for development and recommendations, and proposed conditions.

For each review criteria, there will be the option to identify whether visitors feel they are ‘met’ or ‘not met’; where a review criteria is ‘not met’ conditions may be recommended. Additionally, under each review criteria in the report there will be the opportunity to identify strengths and good practice, areas for development and recommendations, and if applicable, the conditions. More information on each of these areas can be seen in the following sections.

The draft report will be shared with the provider 5 weeks post visit (see 5.10 below).

5.9 Outcomes of the visit

Once the visit is concluded, the visitors will confirm their findings to MM/GOsC and recommend the outcome of the visit including any conditions via the draft report.

5.9.1 Initial recognition reviews

Acknowledging that the receival of initial RQ status is not approved until the decision is made by the Council (for IRR only), and approved by the Privy Council, the following outcomes would be implemented:

- Recommended to recognise qualification status
- Recommended to recognise qualification status subject to conditions being met
- Not recommended to recognise qualification status

Once a decision has been made by Council, subject to approval from the Privy Council, the outcome will change to reflect this:

- Recognised qualification status approved
- Recognised qualification status approved with conditions
- Recognised qualification status denied

5.9.2 Renewal of recognised qualifications

For the renewal of a current RQ, or withdrawal of a RQ, the decision will be made by the Council, and approved by the Privy Council. Acknowledging that the decision is not final, the following outcomes would be implemented:

- Recommended to renew recognised qualification status
- Recommended to renew or no change (if RQ without expiry date recognised qualification status subject to conditions being met
- Recommended to withdraw recognised qualification status

Once a decision has been made, by the Council, subject to approval from the Privy Council, the outcome will change to reflect this:

- Recognised qualification status renewed
- Recognised qualification status renewed with conditions
- Recognised qualification status withdrawn

If approval with conditions is recommended, this means that visitors have identified significant problems in one or more of the eight areas of review/review criteria that have not been closed out at the visit. If the number of conditions are too high, then the recommendation to not approve will be made as this signifies too high a risk to student's ability to meet the OPS.

Further information on conditions is detailed in section 5.9.5.

5.9.3 Strengths and good practice

The visit report will detail any strengths and good practice that has been observed in both the documentary analysis and at the visit. The strengths under the themes of review should reflect where a provider is particularly strong in meeting the review criteria and contributes to the provider's delivery of education.

The identification of good practice is a fundamental part of the GOsC QA process. The publication of the review reports facilitates in the sharing of good practice across the osteopathic sector.

Good practice is a practice that has been proven to work well and produces good results and establishes a good model to follow.

5.9.4 Areas for development and Recommendations

Areas for development and their subsequent recommendations are where it has been identified that there is the opportunity for improvement, but a condition is not necessary. These areas should be monitored by the provider and the recommendations implemented, if appropriate.

These areas must be reported on as part of the providers annual report submission to GOsC.

Recommendations and areas for development should not be included in the action plan with conditions. For further information, see the action plan section.

5.9.5 Conditions

A condition is applied to a RQ where there are specific actions that need to be taken to provide assurance. Conditions can be identified following a visit and will be detailed in the visit report. They can also be identified via other monitoring such as from review of annual reports. Fulfilment of the condition is required to ensure that graduates awarded a RQ continue to meet the OPS.

Where applicable the outcome of the visit report will recommend any conditions to PEC. These may be accepted, amended or new conditions imposed on review of the report.

Conditions should reflect the principles of good regulation in being:

1. targeted at a specific issue

2. proportionate to the scale of the perceived problem

3. transparent in specifying what should be done and by when

4. conditions should also deal with the identification, management and ongoing monitoring of an issue

Where conditions are required following a visit, visitors are to consider the provider's governance and management processes, and the providers ability to recognise the problems

identified at the visit. Where this is deemed to be inadequate it will be difficult for visitors to reach a judgement of ‘approval with conditions’ and approval will be declined. Consideration is also to be made about whether the provider will be able to meet a condition within an appropriate time, to ensure that students can continue to meet the OPS.

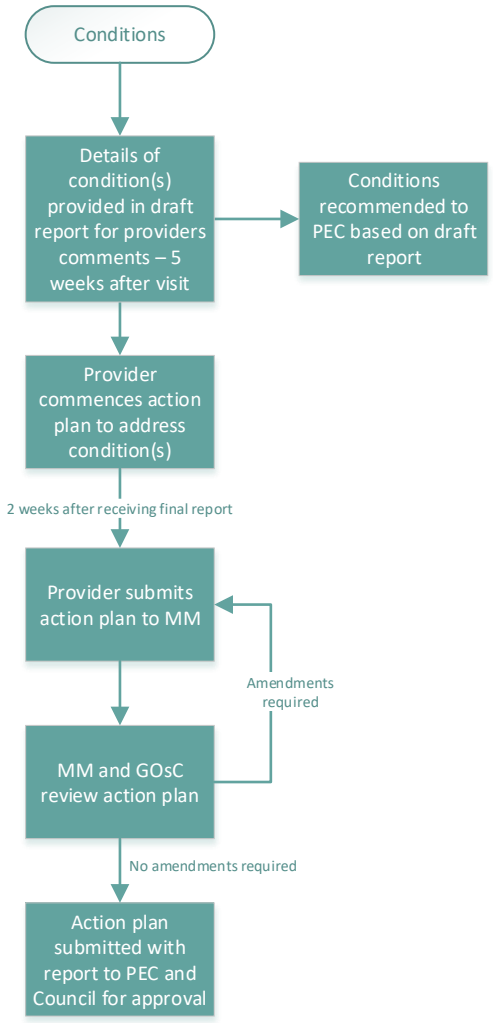
Conditions will be published alongside the recognition of the qualification and monitored, and progress updates provided in public action plan because these conditions directly impact on ensuring that graduates meet the OPS.

Where conditions are set, providers will be required to complete an action plan (see section 5.9.7). Where an action plan is developed following a QA visit, the visiting team will be asked to feedback on the plan to ensure the actions detailed will sufficiently address the concerns that resulted in the condition being set. This action plan will be monitored by PEC to ensure sufficient progress is being made. Providers are required to update the action plan as actions are completed or if there are further risks to being able to fulfil the condition.

5.9.6 Conditions and follow-up

The progression on fulfilling conditions is monitored through PEC meetings. PEC may decide to ask the provider for additional evidence to demonstrate that the conditions are being fulfilled, or impost additional conditions should there be concern that progress is not being made. Where sufficient progress is made, subsequent monitoring of conditions will take place via the provider annual reporting process.

5.9.6.1 Conditions



5.9.7 Action plan

If the outcome of the review is 'Recommended for approval subject to conditions being met', the provider will need to produce an action plan. The purpose of the action plan is to set out how the condition(s) will be fulfilled should be outcome focused.

For each condition, the action plan should include:

- the details of the condition and the required timeframe for resolution
- the actions the provider will take to fulfil the condition, and what evidence will be submitted
- how the changes will be implemented
- periodic monitoring of the conditions – when this will be, and updates against the progression

The action plan can be started as soon as the provider has received the draft report, detailing the proposed conditions, five weeks after the visit. See the section below for further details.

The provider should send the action plan to MM within **two weeks** of receiving **the final report**, this will be about 12 weeks after the visit, further information can be seen in the final report section. MM will then review the action plan collaboratively with GOsC and inform the provider if amendments are required. Visitors will also be asked to comment on the action plan to ensure that they are able to confirm whether they feel the actions described allow for the conditions to be fulfilled.

The template for the action plan can be seen in Annexe D.

5.10 Provider comments

Following the review of the draft report by MM, the report is submitted to the provider and a copy to GOsC to present initial findings, within **five weeks** of the visit. As per the Osteopaths Act, 1993, the providers have 'no less than **one month'** to return their comments (five weeks). All provider comments should be returned to MM within **five weeks** following receival of the draft report.

Upon receipt of the provider's comments, MM in collaboration with the visiting team will discuss whether to incorporate the comments and discuss with the provider if that is not the case.

The providers comments should be regarding factual inaccuracies and should be based on information at the time of the visit and should not reflect on any changes since the visit has taken place.

5.11 Final report

A final QA of the report will then take place by MM before submission of the final report to GOsC, **2 weeks** after receiving the providers comments, with the recommendation for that qualification to be considered at the next PEC meeting.

GOsC will then send the final report to the provider.

The timeframes for the final decision are dependent on when the PEC and Council meetings take place; upcoming dates for these meetings are published on the GOsC website: https://www.osteopathy.org.uk/about-us/the-organisation/meetings/.

5.12 Approval of review outcome

At the next available PEC meeting, the final report, along with the action plan, if applicable, will be reviewed.

The PEC will consider the report but has discretion as to whether or not they accept the visitors' findings. The PEC may accept the report as it is, or they might amend, add and remove conditions, or make a different judgement based on the visitors' findings.

When the PEC makes the recommendation to 'recognise', renew or withdraw recognition of RQ status to a course, this will be further considered by GosC Council, who will then make a recommendation to the Privy Council. Approval of the RQ is not given until the RQ Order has been agreed by the Privy Council.

Following approval of the review outcome by the privy Council, the report and action plan will be published on the GOsC website.

5.13 Feedback

Following the review, MM will invite the provider and visitors to give feedback on the review process. This will be via an MS online form; a link will be sent via email after the review process has been completed.

The feedback is used to facilitate a review of the review process and make improvements if appropriate.

6 Annual reporting and monitoring

6.1 Annual self-reporting

The annual report is a fundamental part of the QA process. The purpose of the report is to confirm the maintenance of the OPS. Each year GOsC will provide providers with an annual template for completion. This report is usually provided in August with a December deadline.

Reports are submitted to GOsC. Once the initial checks have been made, MM will analyse these reports. This analysis is presented to GOsC to consider. This is then considered at the following PEC meeting. As part of this process, providers may be required to provide additional evidence and assurance.

Providers are encouraged to provide evaluative comments where possible, demonstrating that they are able to evidence effective demonstration of the OPS/pre-registration education. Where risks are identified, providers are encouraged to demonstrate how they are effectively mitigating against those risks to ensure that the RQ is not compromised.

The usual areas of focus of the report are as follows:

- Follow up of conditions
- Summary of changes to provisions
- Areas of development
- Governance processes
- Evidence of implementation of the OPS – this should seek assurance that providers understand the Ops and embed them in their curriculum content
- Student data
- Feedback
- Appeals and complaints
- Fitness to practise
- External examiner reports
- Equality and Diversity
- Clinical hours

6.2 Monitoring visits

Following the risk-based approach described in section 2, there may be need for an additional monitoring and scrutiny to take place. Such triggers to this could be:

- Changes to curricula/course
- Feedback from the annual report
- Concerns over the progress of meeting conditions
- Concerns made from student feedback, or adverse reporting on the provider

Responses to any concerns will follow a systematic approach. Different layers of scrutiny will apply dependent on the level of risk presented. Providers may be required to provide additional evidence to be reviewed. If this evidence is not sufficient, or further triangulation is required, and there are seen to be lots of areas to follow up, a monitoring visit will take place. Where possible, this will also incorporate the elements of a RQ visit, to not duplicate the process.

If a visit is required, the specification will be agreed, and an agenda set as per section 5.2 above.

The appointment of visitors will follow the same process as described in 5.3 with confirmation of the visiting teams being made by GOsC.

Should there be a perceived significant risk to the student learning environment or the public safety, visits are to be scheduled outside of the timelines, and are subject to withdrawal of RQ.

A. Mapping tool guidance

The aim of the mapping tool is to self-evaluate against the review criteria, reflecting on strengths and areas for development, in an open and honest way, to ensure that all information and evidence relating the review criteria is seen prior to the visit. Any missing information could result in a condition at the visit.

The mapping tool and associated evidence should be uploaded to a secure SharePoint site. MM will provide each provider and visitor details on how to access this site when applicable.

There are five sections to the mapping tool:

1. Provider details: this section requires information on the provider and the course.
2. Overall aims of the course: in this section the provider should identify what the overall aims of the course are. This information will be used in the review to assess against and the report will identify if the course meets these broader aims.
3. Provider's key areas of focus: this section provides the provider the opportunity to reflect on what they think are the main concerns, and areas that should therefore be focused on, based on their latest annual report and previous conditions.
4. Review criteria: in the narrative section, under each review criteria, the provider should explain how each of the review criteria are met, identifying relevant evidence to support this information with the focus on how this evidence has been implemented into practice. The document mapping section should clearly identify what evidence provided supports the review criteria. Where only a specific section of a document is applicable, this should be made clear using section or page numbers.

   When uploading evidence, the nomenclature should reflect the review criteria numbering. For example, for review criteria 1.1, each piece of evidence that relates to this review criteria should start with 1.1 followed by a letter. E.g.

   – 1.1a Student feedback
   – 1.1b external examiners' report

   This will support in making it clear what the visiting team should be using when reviewing each review criteria.
5. Evidence seen at visit: this section is to detail further evidence seen at visit that was not originally submitted as part of the mapping tool by the provider. This ensures that all the evidence seen as part of the review is collated in one place. It is the responsibility of the visitors to update this section following the visit.

The section below provides guidance on the review criteria.

A.1 Guidance on the review criteria

1. Governance and management

Commercial and financial management

1.1 an understanding of current commercial and financial issue and how these are managed

- Appropriate policies, processes and structures are in place to manage issues – these should be proportionate to the size of the provider and subject to verifier's processes (if applicable)
- Appropriate routes for escalation
- Plans for ongoing monitoring and how issues can be mitigated (QA)

Evidence: policy and process documents, internal reports, external examiner reports

1.2 the ability to maintain financial stability

- A suitable business plan proportionate to the delivery of the provider
- Authenticated financial records that support the business plan
- Links to risk management in terms of student safeguarding
- Existing and previous cohort details, student progression, and graduate opportunities – how this information has been used

Evidence: business plan, appropriate financial records, quantitative student data

Risk management

1.3 the use of risk management processes to ensure programme delivery can continue if issues arise

- Adaptable risk management policies and processes that can be applied to various situations
- Fitness to Practice Standards are embedded in risk management processes
- Methods to monitor effectiveness of response implementation to risks identified
- Leadership lead implementation

Evidence: policy and process documents, risk register, impact assessments, student protection plans

Policies and processes

1.4 an understanding of culture and practices with the provider that assure a responsive and reflective management of the overall programme

- Appropriate feedback mechanisms in place
- How feedback is used to make improvements to overall programme and student experience
- Ongoing review of process

Evidence: student and staff feedback, internal reports, review meeting minutes, action plans

Management structure

1.5 the ability to demonstrate delivery of the OPS though an appropriate governance structure

- Effective methods in place within the governance structure to demonstrate that the provider is fulfilling its roles and responsibilities for delivery of the OPS

Evidence: Minutes of meetings, process for delegated responsibility can be evidenced where required, clearly defined roles and responsibilities, management teams are able to demonstrate understanding of GOsC requirements, risk management processes are able to demonstrate escalation of issues within governance structure

2. Course aims and outcomes

Rounded development

2.1 the ability to demonstrate a learning path with clear and incremental progression

- Focus on determining extent of well-designed course content and quality teaching resource that produce autonomous and reflective practitionership skills in students
- Learning outcomes relates to overall aims of course

Evidence: patient feedback from clinics, graduate employment data, performance data

- Aligned to OPS and GOPRE outcomes
- Student fitness to practice must be addressed and demonstrated
- Promote environment suitable to learning – evidence based, student professionalism and openness to challenge
- Demonstrable student competency in practice

Structured approach

2.2 the use of a transparent and clear course structure, that supports the course aims

- Communication of course structure to staff and students
- Strong monitoring and review mechanisms of course structure to ensure curriculum aims are delivered appropriately
- Accessible course structure

Evidence: module structures, guides, learning outcomes, student handbook

3. Curricula

Cohesive framework of content

3.1 the ability to identify a holistic programme of content that allows graduates to meet the OPS

- Staff and student engagement in development of curriculum
- Evidence of cross-referencing against the GOsC GOPRE outcomes
- Curriculum enable students to meet the fitness to practice standards
- The use of non-osteopathic modules to prepare students for post-graduation and professional development e.g. business management
- Appropriate balance of academic and practice-oriented content
- Delivery is suitably aligned to learning outcomes and embeds contextualised research and evidence-based learning
- Opportunities for students to engage with GOsC's CPD scheme

Evidence: curriculum, student feedback, module descriptors

- Inclusion of other healthcare professional in curriculum development

3.2 the use of non-academic/extra curricula opportunities

- Student education should not be limited to classroom settings and academic content
- Students are expected to understand their profession as within the wider community of healthcare professions and professionals
- Diverse clinical provision within NHS settings/wider healthcare exposure for students

Evidence: external reports, student feedback

3.3 the integration of educational offer

- Consistent QA of curriculum
- Process for development and review of curriculum, and the innovation around a changing curriculum
- Suitable structures for delivering an effective programme
- Strategy for adapting curricula, staffing and delivery methods in light of economical influences
- Strong change controls and feedback mechanisms to ensure adapted elements are well integrated into overall curricula, supporting overall quality being maintained
- Collaborative relationships between classroom teachers and clinic tutors to ensure continuity in content covered
- Support mechanisms for new and existing lecturers

Evidence: patient feedback, curriculum review reports

4. Teaching and learning

Teaching outcomes

4.1 the ability to identify how the curriculum is translated into teaching and learning

- Observation of teaching and learning
- Emphasis on culture of continuous improvement
- Strong monitoring measures and response mechanisms on quality of curriculum delivery

Evidence: performance metrics, action plans, student and staff feedback, patient feedback, lesson plans

• Range of formal and informal mechanisms for students and teaching personnel to feedback on modules and individual experiences, supported by reviewal and implementation processes to handle received feedback	
Quality of teaching	
4.2 the use of appropriate methods to monitor the quality and consistency of teaching	
• a holistic approach including all existing teachers, new teachers and teaching personnel outside of classroom settings • support for teachers in their development • consistent approach in seeking feedback on student work • strong induction processes and support mechanisms for new and existing teachers, with regular reviews of good practice and knowledge-sharing • clear objectives and plans for lessons • teaching methods suitable for needs of students	**Evidence: observation,** student feedback, handbooks, discussions with students, staff induction
4.3 the development of a culture of student curiosity and empowerment	
• emphasis on a student culture whereby students should feel empowered to be autonomous, critical and reflective learners • support environment for students to challenge things where appropriate	**Evidence:** student feedback, lesson plans, meeting with students
5. Assessment	
Assessment strategy	
5.1 the use of a fair and effective assessment strategy	
• Evidence of an evolving assessment strategy in line with current trends and climate • Strategy is suitably rigorous and effective in ensuring students meet expected learning outcomes	**Evidence:** process documents, feedback mechanisms, assessment strategy, review reports

- Strategy is suitably inclusive and accessible, supporting students with learning challenges
- Mechanisms to ensure processes within assessment strategy continue to be fair, transparent and robust
- Annual reviews and feedback mechanisms involving management bodies and all relevant stakeholders that acknowledge and absorb feedback from all stakeholders within the programme
- Evidence that each learning outcome is tested by multiple assessment methods
- Use of formative and summative assessments covering both theoretical and practical aspects

Assessment processes

5.2 the use of relevant assessment processes and routes of escalation

- Determine whether assessment criteria are modified in line with the school's learning expectations for the students - these expectations should be fundamentally linked to fitness to practice standards and OPS
- Identify that assessment criteria are applied with consistency and transparency
- Identify processes for student moderations and appeals, and identify its accessibility and responsiveness
- Involvement of external examiners and moderating bodies as much as is appropriate, for contributions to the marking and moderation processes
- Evidence of clear communications with the student body and reasonable timescales for students to undertake effective review and revisions
- Evidence of double marking involving two separate assessor bodies, effective means to screen for plagiarism and collusion

Evidence: assessment criteria, moderation and appeals processes, student work, assessment data, evidence of external examiners

6. Achievement

Achievement

6.1 the ability to identify a clear structure of achievement

- Achievement pathways should be incremental and have a reasonable progression
- Achievement standards are linked to the OPS and GOPRE outcomes
- There should be a tiered structure of different levels of qualification outcome resulting from each pathway
- There should be support mechanisms for students who aren't reaching their expected grades
- The criteria used by the Progression Award Board should be a key focus of QA
- Achievement should be conceived widely as lifelong, beyond an exam-centric and degree focus
- The evidence of early identification and support mechanisms for students achieving lower than expected, evidence of support plans implementation
- The evidence of ongoing graduate support and integration of their experiences into informing course development

Evidence: achievement structure, student work, achievement data, external examiners' reports, clinical practice reports/feedback

6.2 the ability to demonstrate an inclusive approach to achievement

- Achievement should be inclusive and equitable in the sense that all students are able to attain achievements and qualifications/awards suitable to their individual levels
- Where achievement of full award is not possible this should be clearly communicated to students
- Communication should be in an ongoing capacity in line with the student's progression through their studies
  - identification of clear communication trails and methods to inform students of options available to them
- Student review process is fully objective
- Reasonable adjustments are not a hindrance to student achievement

Evidence: student feedback, achievement data

7. Student progression

Recruitment and admissions

7.1 the use of appropriate recruitment and admissions processes

- The evidence of ongoing QA of admissions standards
- The evidence and examination of admissions criteria rationale to ensure it is inclusive
- Annual figures and demonstrable rationale for the change in admissions criteria
- A clear integration of equality and diversity into processes
- Appropriate marketing to engage with prospective students

Evidence: policies and procedures for recruitment and admissions, marketing materials, quantitative data for admissions

Student journey

7.2 an understanding of the student journey and support available

- A clear governance structure that incorporates inclusivity and transparency
- Student expectations and abilities are aligned to the provider's education provision and ability to deliver this effectively
- Impartial governance body or mechanisms to help manage student progression and consider the reasons and appeals behind unsuccessful student progression when required
- An explicit teaching and learning strategy that underpins the student journey
- Robust and effective induction processes in place, also modified/adapted in line with current global challenges
- Equality and Diversity Statement outlining process for students with reasonable adjustment requirements and available support
- The evidence of identified risks to student journey incorporated within wider provider risk management strategy

Evidence: student handbook, student feedback, equality and diversity policy, reasonable adjustments policy, student examples

8. Learning resources

Resource strategy

8.1 the use of a diverse and appropriate offering of accessible resources

- A diverse offering should feature technology-based provisions that are well integrated into overall delivery of programme
- A growing incorporation of online training and online provision of studies proportionate to economic influences
- Financial and technical support opportunities where relevant to ensure all students are able to access the full range of resources
- Clear strategy for monitoring quality of teaching personnel as a resource and for developing their skills

Evidence: Library provision, physical and online resources, subscriptions, tools

Non-academic provisions

8.2 the ability to identify clinical practice and education opportunities

- Provision of clinical practice and education opportunities should be understood within context of each provider's individual capacities and situation
- The evidence of clinical provision may vary, but can include clinic tutor to student ratio, diversity of clinical practice opportunities, large enough clinic size in terms of number of patients and breadth of patient demographics
- The evidence of impartial pastoral mechanisms that are in regular use by students, with positive feedback of its effectiveness
- Provision and evidence of face to face and online support mechanisms

Evidence: clinic details, provision in curriculum, internal reviews, clinic reports,

B. Example visit agenda

Agenda for visit

Provider:	**Click or tap here to enter text.**
Date of visit:	**Click or tap here to enter text.**
Course reviewed:	**Click or tap here to enter text.**
Key provider contact:	**Click or tap here to enter text.**
Visitors:	**Click or tap here to enter text.**

First day of visit

Start	Introduction meeting between visiting team and key provider personnel Standard fire and safety protocols
Morning	Triangulation of evidence received pre-visit
Afternoon	Review of student work Meetings with staff and students *+ details of staff and students*
Close	Visiting team review of first day

Second day of visit

Morning	Observation of teaching and learning *+ details of observing*
Afternoon	Triangulation of findings High-level feedback, follow-up actions and conditions to provider

C. GOsC Management of Concerns Policy

C.1 Procedure for dealing with concerns about osteopathic education

C.1.1 Summary

1. This document sets out how the General Osteopathic Council deals with concerns reported to it about osteopathic education.

C.1.2 Introduction

2. This guidance is for providers, students, staff, patients, osteopaths and others who have a concern about education being delivered in an OEI awarding qualifications in the United Kingdom recognised by the General Osteopathic Council and approved by the Privy Council.

C.1.3 Purpose

3. The purpose of the General Osteopathic Council in relation to quality assurance of undergraduate and pre-registration education is to ensure that 'Recognised Qualifications' deliver graduates meeting the Osteopathic Practice Standards.
4. This policy outlines how we manage concerns about osteopathic education.

C.1.4 About the General Osteopathic Council

5. The General Osteopathic Council is established under the Osteopaths Act 1993. Our statutory powers in relation to education are set out in sections 11 to 16 of the Osteopaths Act 1993. We have powers to recognise pre-registration qualifications, subject to the approval of the Privy Council, if the qualification is evidence of meeting our Osteopathic Practice Standards (referred to as the standard of proficiency in our legislation). We only have powers to withdraw this recognition if there is evidence that the qualification no longer meets the Osteopathic Practice Standards.
6. Decisions concerning the granting, maintenance and renewal of RQ status are made by the General Osteopathic Council and approved by the Privy Council following reviews of osteopathic courses and course providers.

C.1.5 What we will consider

7. GOsC will consider information from students, staff, patients or carers, or any other interested party which relates to the delivery of the Osteopathic Practice Standards. We can consider information if it is evidence of serious systemic or procedural concerns or has a broader implication of failings of the management of academic quality or standards, which impact on the delivery of the Osteopathic Practice Standards.

C.1.6 What we will not consider

8. We do not resolve individual complaints against providers. We cannot provide redress or compensation to any individual submitting a complaint to us.
9. Examples of matters which we may not be able to investigate include:

- problems that the provider has already resolved
- isolated mistakes or incidents of bad practice
- individual examination results

- matters of academic judgement
- grievances against staff
- matters considered by a court or tribunal

We will not normally look at complaints where the main issues complained about took place more than three years before the complaint is received by us.

C.1.7 The Public Interest Disclosure Act 1998

10. Concerns about academic standards and quality are not regarded as qualifying disclosures under the Public Interest Disclosure Act 1998. Those submitting concerns to us are therefore unlikely to be offered legal protection under the Act. However, there may be other circumstances in which statutory protection may be afforded.
11. It is our policy that the names of people raising concerns should normally be disclosed to providers.
12. If a person raising concerns has concerns about their identity being disclosed, they should discuss those concerns with the Fiona Browne, Head of Professional Standards, General Osteopathic Council at standards@osteopathy.org.uk to explore alternative options that may be available.

C.1.8 Procedure for considering concerns

C.1.8.1 Stage 1: Screening

13. The screening process helps us to consider whether information provided constitutes a concern requiring investigation under this policy. Is this a concern that should be investigated?
14. Information submitted will be considered by the General Osteopathic Council Professional Standards Team.
15. If the concern relates to immediate, ongoing patient safety issues, a recommendation will be made to the Chief Executive to take immediate steps to protect patients. This may include:
    a. Informing the OEI and ensuring that immediate action is taken
    b. Informing the relevant Department of Health
    c. Informing the police or social services
    d. Actions taken will normally be reported both to the OEI and the complainant

16. If the concern does not relate to an immediate patient safety issue, the complaint will be considered further by the Professional Standards Team. The person raising concerns may be asked for further information.
17. The Professional Standards Team will consider the information provided and will seek further information if required.
18. When the team has the information required, the team will determine the following:
    a. Has the complaint been made to the provider? If not, the person raising concerns will be asked to raise the complaint with the provider to provide the opportunity for a local resolution. If the complaint has been through a local resolution process, the team will consider the information provided.
    b. Does the complaint relate to delivery of the Osteopathic Practice Standards or wider issues affecting delivery of the Osteopathic Practice Standards?

19. A recommendation is made to the Chief Executive about whether or not the complaint should be screened in. The Chief Executive will decide on the appropriate outcome. The advice of the statutory Education Committee may be sought if appropriate.
20. A screening decision should be made within four weeks of receipt of all the information required for deciding at stage 1.

C.1.9 Outcomes of stage 1:

Outcome Action Concern proceeds for further investigation. Person raising concerns is requested to provide consent to share the concern with the provider. Concern is shared with the provider for a response. Concern is not relevant to the delivery of the Osteopathic Practice Standards Person raising concerns is advised of decision. Person raising concerns is provided with advice about the GOsC complaints process. Person raising concerns is provided with advice about other avenues of redress. For example, the Quality Assurance Agency, the Office for the Independent Higher Education Adjudicator or legal advice. Further information about other routes is provided at the end of this document.

C.1.10 Stage 2: Investigation

21. The applicant is asked for consent to share the complaint with the provider. Anonymous complaints will not be taken forward.
22. The complaint is shared with the provider for a response. The response of the provider should include:

- The nature of the complaint,
- The way the provider investigated and managed the complaint, and how the outcome has been monitored,
- The impact on the delivery of the Osteopathic Practice Standards at the time of the complaint and now,
- Any wider learning for the provider or the sector as a whole.

23. The Professional Standards Team will liaise with the OEI until sufficient information is obtained to allow the case to proceed to stage 3: decision.

C.1.11 Outcomes of stage 2

Outcome Action Sufficient information is provided to enable a decision to be made at Stage 3. Person raising concerns is advised of decision that case is ready to proceed to decision. OEI is advised of decision that case is ready to proceed to decision.

C.1.12 Stage 3: Decision

24. The information and the response are considered by the Professional Standards Team and a recommendation made to the Chief Executive on outcome.

C.1.13 Outcomes of stage 3

Outcome Activity Concern is not relevant to the delivery of the Osteopathic Practice Standards Person raising concerns is advised of decision. Person raising concerns is provided with advice about the GOsC complaints process. Person raising concerns is provided with advice about other avenues of redress. For example, the Quality Assurance Agency, the Office for the Independent Higher Education Adjudicator or legal advice. Further information about other routes for pursuing concerns is provided at the Annex. Concern is relevant to the Osteopathic Practice Standards - in the past but this has now been resolved.

Person raising concerns is advised of decision. OEI is advised of the decision. Information is reported to the statutory Education Committee and issue is managed as part of the Committee's quality assurance process. Concern is relevant to the Osteopathic Practice Standards - ongoing. Person raising concerns is advised of decision. OEI is advised of the decision. Information is reported to the statutory Education Committee along with an action plan from the provider to resolve and monitor the issues, and the issues continue to be monitored as part of the Committee's quality assurance process.

C.2 Alternative routes for redress

C.2.1 Quality Assurance Agency

The Quality Assurance Agency has a concerns process which relates to quality and standards rather than individual complaints.

Further information about this can be found at: www.qaa.ac.uk/reviewing-highereducation/how-to-make-a-complaint/complaints-about-qaa-and-appeals-against-decisions

C.2.2 The Office of the Independent Adjudicator (OIA)

The OIA is an independent body set up to review student complaints in England and Wales. Further information about the OIA and the complaints they can manage are available at: www.oiahe.org.uk/making-a-complaint-to-the-oia/can-the-oia-look-at-my-complaintcomplaints-wizard.aspx

C.2.3 Legal advice

In the event that the above options do not provide the redress required persons raising concerns can contact a solicitor. The Solicitors Regulatory Authority regulates solicitors in England and Wales. Information about finding a solicitor is available at: www.sra.org.uk/consumers/using-solicitor/find-solicitor.page

C.2.4 GOsC Corporate Complaints Procedure

Complaints about decisions made under this policy can be made through our Corporate Complaints Procedure which is available at: www.osteopathy.org.uk/news-andresources/document-library/our-work/making-a-complaint-about-the-gosc

D. Action plan template

GOsC Education Quality Assurance

Action plan template

Provider:	Click or tap here to enter text.
Date of visit:	Click or tap here to enter text.
Course reviewed:	Click or tap here to enter text.
Contributors to action plan:	Click or tap here to enter text.

This action plan template is to be completed following the outcome of a visit, where conditions have been identified.

For further details see section 5.9.5 of the handbook.

Ref.	Details of condition (from report)	Timeframe	Provider actions and implementation	How this will be monitored	Action closed

E. The GOsC Quality Assurance Policy

E.1 Purpose

1. This policy sets out the ways in which standards for entry to the Register of osteopaths are maintained through the General Osteopathic Council's (GOsC) quality assurance (QA) processes for UK recognised qualifications (RQs). These processes ensure that UK osteopathic RQs are only awarded to graduates who meet the Osteopathic Practice Standards (OPS). (Please note that different processes are in place to ensure that internationally qualified graduates meet the OPS. These processes are outlined on the GOsC website).

E.2 The legal framework

2. The General Osteopathic Council (GOsC) has a statutory duty to 'develop and regulate the profession of osteopathy' (see section 1(2) of the *Osteopaths Act 1993*).
3. 'The over-arching objective of the General Council in exercising its functions is the protection of the public.' (See section 1(3A) of the *Osteopaths Act 1993*).
4. 'The pursuit by the General Council of its over-arching objective involves the pursuit of the following objectives:
   a. to protect, promote and maintain the health, safety and well-being of the public
   b. to promote and maintain public confidence in the profession of osteopathy and
   c. to promote and maintain proper professional standards and conduct for members of that profession.' (See section 1(3B) of the *Osteopaths Act 1993*).
5. The GOsC undertakes a range of functions in order to exercise its statutory duties as outlined above by:
   - Keeping the Registers of all those permitted to practise osteopathy in the UK. Setting, maintaining and developing standards of practice and conduct.
   - Assuring the quality of undergraduate and pre-registration education (Quality Assurance)
   - Assuring that all registrants keep up to date and undertake continuing professional development.
   - We help patients with any concerns or complaints about registrants and have the power to remove from the Register any registrants who are unfit to practise.
6. The GOsC has a wide range of legal powers related to the quality assurance of undergraduate and pre-registration education and, where appropriate, these are outlined in further detail below.

E.3 Background

7. UK graduates are entitled to apply for registration with the GOsC to practise in the UK as osteopaths if they have a 'recognised qualification'.
8. The GOsC has a statutory duty to set and monitor the standards for pre-registration osteopathic education and a duty of 'promoting high standards of education and training in osteopathy.' It has statutory powers to visit providers (see sections 12 and 14 to 16 of the *Osteopaths Act 1993*) and also has wide powers to require information from osteopathic educational providers in order to ensure standards. (See section 18 of the *Osteopaths Act 1993*).

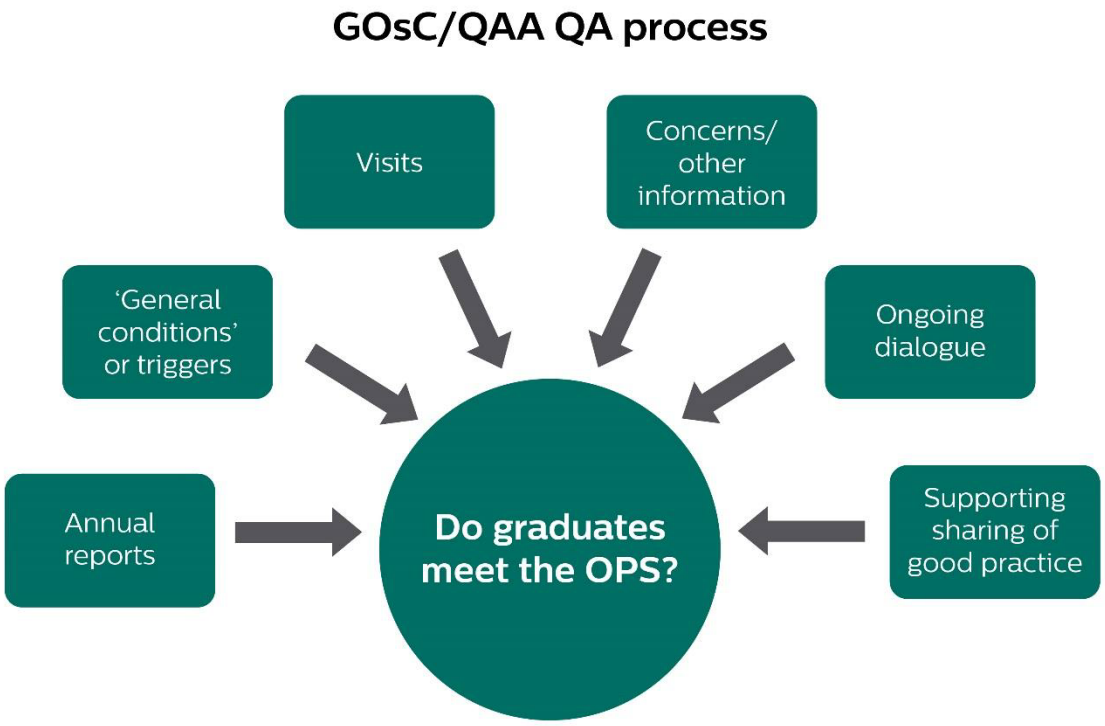
E.3.1 Aims and purpose of the GOsC quality assurance process

9. In order to meet both our overarching and specific statutory duties as outlined above, the GOsC quality assurance processes aim to:

- Put patient safety and public protection at the heart of all activities

- Ensure that graduates meet the standards outlined in the Osteopathic Practice Standards by meeting the reference points outlined in the Guidance for Osteopathic Pre-registration Education (2015) and the Subject Benchmark Statement: Osteopathy (2015) and the Student Fitness to Practise Guidance (2016)
  - Support self-sustaining quality management and governance in ensuring quality
  - Identify and sustain good practice and innovation to improve the student and patient experience
  - Identify concerns at an early stage and help to resolve them effectively without compromising patient safety or having a detrimental effect on student education
  - Facilitate effective, constructive feedback
  - Identify areas for development or any specific conditions to be imposed upon the course providers to ensure standards continue to be met
  - Promote equality and diversity in osteopathic education.

10. The General Osteopathic Council operates a range of policies and processes to ensure that only graduates meeting the Osteopathic Practice Standards are awarded an RQ and to meet the wider supporting aims of the quality assurance process. These policies and processes interlink and collectively enable the GOsC to understand how the provider is identifying, managing and monitoring issues impacting on quality. The information obtained enables the GOsC to respond proportionately to ensure that standards are met.
11. The quality assurance policies and processes are outlined in Figures 1 and 2 below. Figure 1 shows that information about issues potentially impacting on standards is obtained through a range of policies and processes. Some may be reported through the OEI's own quality management processes, some may be reported from other sources.



graduates meeting the Osteopathic Practice Standards are awarded an RQ.

12. The GOsC response to information received from a variety of sources will vary taking into account the original source of information, the response of the provider to this and the potential impact on the delivery of standards.

13. Figure 2 shows that taking into account the original issue, and the response of the OEI, helps the Committee to assess the degree of risk arising to the delivery of standards, and to make a decision about the proportionate action to take to ensure that standards are being met. For example, if the risks arising from the implementation of new curricula are outlined and a detailed plan including risks and mitigating actions is submitted by the provider, there is no need for the Committee to undertake any additional action. On the other hand, if the GOsC had received concerns from students, staff or others about the implementation of the new curricula, the GOsC may seek further information to assure itself that standards are being met. (Please note that these examples are merely illustrative. The Committee response will depend on the particular circumstances of the issue and the response in the context of all the information relating to a particular OEI.)

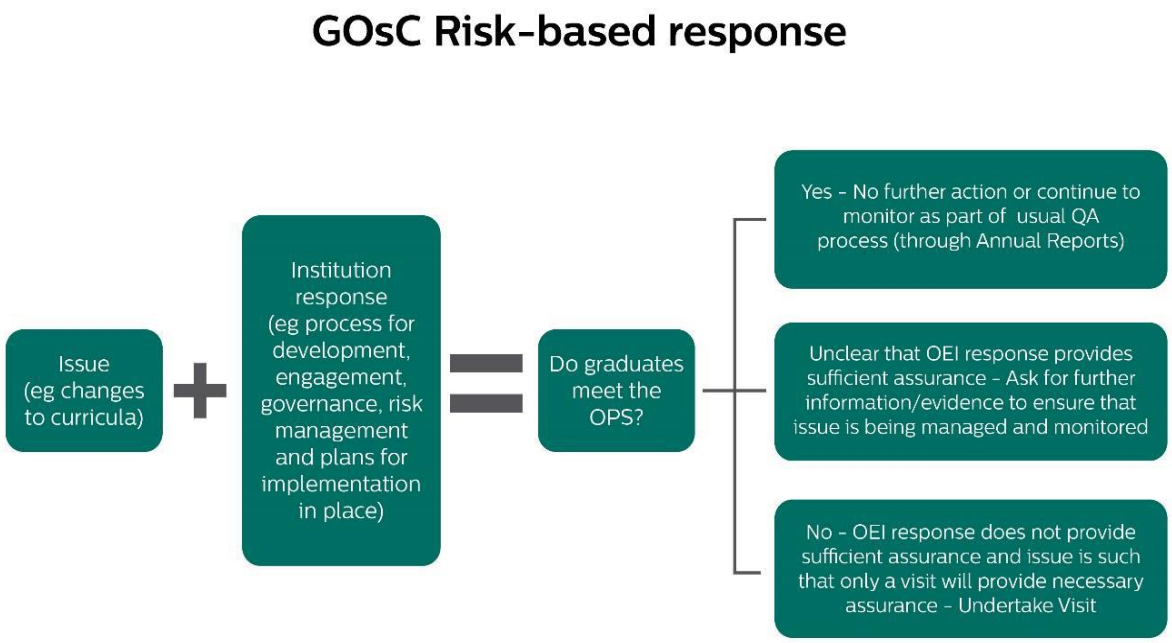


Figure 2 - GOsC risk-based response to the identification, management and monitoring of issues to ensure that only graduates meeting the Osteopathic Practice Standards are awarded an RQ.

14. The next sections of the paper provide further detail about the quality assurance policies and processes used to identify issues that may impact on the delivery of standards.

E.3.2 Annual Report Analysis

15. The purpose of Annual Reports is to confirm the maintenance of the Osteopathic Practice Standards, patient safety and public protection in pre-registration education and/or to identify and report on the management and monitoring of issues for action. Osteopathic educational institutions (OEIs) are requested to take a self-evaluative approach to reporting in order to demonstrate their management of risk and enhancement of practice.

16. The primary reference point for the content and evaluation of RQ Annual Reports is the Osteopathic Practice Standards, along with the Quality Code. The Guidance for Pre-registration Osteopathic Education (2015) and the Subject Benchmark Statement: Osteopathy (2015) are also used to inform the evaluation of effective management and delivery - in themselves essential to ensuring the Osteopathic Practice Standards are met. Section 18 of

the Osteopaths Act 1993 requires OEIs to provide the Committee with 'any such information as the Committee may reasonably require in connection with the exercise of its functions under this Act'.

17. The Annual Report template is available at: www.osteopathy.org.uk/news-and-resources/document-library/about-the-gosc/pac-june-2017-item-7-quality-assurance-annual- reports-template/?preview=true

18. The RQ Annual Reports provide both self-reported and third-party data and information from the OEI (including data about student and patient numbers, the analysis of feedback from patients, staff and students, external examiners, and the provider's own annual monitoring report and action plan) about the previous academic year. Reports include an update on specific and general conditions from the provider (for example changes in management and governance, student numbers, patient numbers). Information is also requested about the management of complaints and appeals

19. RQ annual reporting is not undertaken in isolation, but is part of the wider picture of quality assurance and enhancement. Wherever possible, the RQ Annual Report process seeks to use relevant evidence from OEIs' existing arrangements rather than ask for bespoke information.

20. The information provided is analysed by the QAA and the GOsC. If this analysis raises any questions and/or suggests any concerns about the course and/or the provider, it may be followed up directly in a range of ways, as outlined in figure 2. The information provided may also help the GOsC to identify and address issues of general concern or interest to the osteopathic education sector.

21. Information is also requested about good practice and this is shared with other OEIs with the aim of enhancing the provision of osteopathic education. It also informs joint- working between OEIs and the GOsC including good practice seminars. Examples provided are usually attributed to institutions.

22. Annual Report templates are sent out to OEIs in October of each year and are due for submission in December of each year. The reports deal with the academic period completed prior to the submission of the report. Reports are analysed in January and February and considered by the Education Committee in March.

E.3.3 Visits

23. The visit process is outlined in Section 12 of the *Osteopaths Act 1993*, which provides that the Committee appoints Visitors to report to the Committee as follows:

'(a) on the nature and quality of the instruction given, or to be given, and the facilities provided or to be provided, at that place or by that institution; and
(b) on such other matters (if any) as he was required to report on by the Committee.'

24. The *Osteopaths Act 1993* specifies that visitors must provide a report and there are statutory requirements for a copy of the report to be sent to the OEIs and for OEIs to have a period of time to comment on the report before it is finalised. Sections 14 and 15 of the *Osteopaths Act 1993* set out the process for making a decision to award a 'Recognised Qualification' by the GOsC Council which is then approved by the Privy Council. The 'recognised qualification' may be (but is not required to be) subject to conditions recommended by the Education Committee and can be time limited or otherwise.

25. Visits usually take place every five years. However, it is open to the GOsC to undertake visits more frequently for new courses or where there are concerns about standards being delivered such that a visit is required.

26. The purpose of the Visit is to ensure that RQs are only awarded to graduates meeting the Osteopathic Practice Standards. It is also about ensuring the wider aims of the quality assurance process outlined above at paragraph 9. The visit process is undertaken by expert, trained Visitors (both osteopathic and lay). The visit is managed by QAA on behalf of the GOsC to GOsC agreed standards and is carried out through triangulation of live information and evidence by speaking with staff and students, considering information from patients and the assessment of documented information to inform findings.

27. The operational aspects of the visit process are outlined in the GOsC/QAA Handbooks for providers and visitors (2012) available at: www.qaa.ac.uk/reviewing-higher-education/types-of-review/general-osteopathic-council-review.
28. All visits commence with the agreement of a specification by the GOsC Education Committee, which sets out any particular areas of interest that the Committee would like to follow up in relation to delivery of the Osteopathic Practice Standards or associated matters. The specification allows the Committee to target the Visit to particular areas of risk that have arisen since the last visit took place. It provides the Committee with an opportunity to ensure that issues continue to be identified, managed and standards maintained.
29. The review explores eight areas through a self-evaluation and supporting evidence prepared by the provider and the QA visit undertaken by trained visitors as follows:
    - governance and management
    - course aims and outcomes (mapped to the Osteopathic Practice Standards and including students' fitness to practise)
      curricula
    - assessment
    - achievement
    - teaching and learning
    - student progression
    - learning resources.
30. After the visit a report is produced including the visitor's judgement, with one of the following outcomes:
    - Approval without specific conditions
    - Approval with specific conditions
    - Approval denied.
31. The report is published on the GOsC website and updates about the fulfilment of conditions are also published on the GOsC website.
32. The visit method is also used for the following:
    - new RQ visits
    - monitoring visits - which are undertaken when there are particular concerns that require the triangulation of information that can only be undertaken on a visit.
33. The process followed is as for a five-yearly visit, but the RQ specification will be adapted to fit the particular circumstances of the visit.
34. The outcome of the visit is a report which informs the Committee's recommendations to Council about whether to award, renew or withdraw an RQ.

E.3.4 General conditions and triggers

35. A set of general conditions are currently attached to RQs which are published on the GOsC website at: www.osteopathy.org.uk/news-and-resources/document- library/publications/conditions-of-practice-order-guidance/. In due course, it is expected that OEIs will continue to report against these matters as part of their published reporting process if expiry dates for RQs (and therefore RQ conditions) are removed. Significant changes may impact on delivery of the Osteopathic Practice Standards. Therefore, OEIs are expected to
    monitor and report on these changes, and assess the risk to delivery of the Osteopathic Practice Standards and report on mitigating actions being undertaken. (Further guidance is provided in the RQ Change Notification Form which is available at www.osteopathy.org.uk/training-and-registration/information-for-education-providers.)
36. Examples of change may include, but are not limited to:
    - substantial changes in finance

- substantial changes in management
- changes to the title of the qualification
- changes to the level of the qualification
- changes to franchise agreements
- changes to validation agreements
- changes to the length of the course and the mode of its delivery
- substantial changes in clinical provision
- changes in teaching personnel
- changes in assessment
- changes in student entry requirements
- changes in student numbers (an increase or decline of 20 per cent or more in the number of students admitted to the course relative to the previous academic year should be reported).

37. The GOsC Committee considers the reported change, the way in which the information came to the attention of GOsC, the OEI response, the current context of the OEI, and any impact on the Osteopathic Practice Standards, in order to make a decision about how to respond, as outlined in Figure 2.

E.3.5 Concerns or other information

38. The *Procedure for dealing with concerns about osteopathic education* (the concerns procedure) enables the GOsC to consider information from students, staff, patients or carers or any other interested party which relate to the delivery of the Osteopathic Practice Standards which may arise either during a visit or at any other time.
39. The concerns procedure is a method for any person (patient, student, staff or other) to provide GOsC with information which may be relevant to our statutory duty to ensure that only those graduates who meet the Osteopathic Practice Standards are awarded an RQ.
40. The GOsC can consider information if it is evidence of serious systematic or procedural concerns or has a broader implication of failings of the management of academic quality or standards, which impact on the delivery of the Osteopathic Practice Standards. It is not, however, a mechanism for resolution of individual concerns between an individual and an OEI.
41. The purpose of the concerns procedure is to ensure patient safety and the delivery of the Osteopathic Practice Standards. The procedure outlines how processes are considered and managed, and how decisions are made and brought to the attention of the Committee.
42. Further information about our concerns procedure is available in the *Procedure for dealing with concerns about osteopathic education* available at Appendix 2.
43. If the concern is relevant to the Osteopathic Practice Standards, it is reported to the statutory Education Committee and the issue is managed as part of the Committee's quality assurance process. An appropriate response in accordance with Figure 2 is agreed.

E.3.6 Supporting sharing of good practice

44. An important aspect of quality assurance is promoting a culture of continual enhancement. The GOsC is committed to promoting and sharing discussion in this area in partnership with the OEIs, for example:
    - sharing examples of good practice within or external to the osteopathic sector annual reports explicitly ask for examples of good practice and share these.
    - thematic reviews identify and share good practice (for example a thematic review on boundaries).

- regular seminars exploring particular matters involving expert speakers have taken place on subjects such as boundaries, sharing examples of good practice within or outside the osteopathic sector, or working together on projects such as boundaries and professionalism which are relevant to the education sector and to practice. Examples are shared through annual reports and annual seminars on good practice.
- however, we are also keen to support the sustaining of good practice and we are consulting further on how we might do this.

E.3.7 Ongoing dialogue

45. Through a series of reviews from 2012 onwards, the GOsC has worked with OEIs to improve partnership and dialogue, self-assessment and self-reflection, and a right-touch approach. This is because matters of transparency and collaboration are essential components of quality assurance.
46. It is important for the GOsC QA approach to maintain ongoing relationships through regular discussion, including 1-to-1 and in-sector meetings focusing on supporting institutional quality management through:
    - identifying, managing and monitoring of issues - recognising implementation takes place over time
    - identifying, sustaining and maintaining good practice
    - being proportionate, helpful, respectful
    - but also avoiding regulatory capture - ensuring independence.
47. Good relationships with OEIs involve issues being shared early, and helpful discussions to support effective management and monitoring of issues. It means that the quality assurance process is focused on the high-quality education delivering desired outcomes and is not adversarial or assessment driven.
48. It is usually the case that ongoing and transparent dialogue between an OEI and the GOsC will not require any additional intervention, but each case will depend on the particular context for an appropriate and proportionate response.

E.4 Conclusion

49. This policy has set out the variety of mechanisms used by the GOsC to ensure that RQs deliver the Osteopathic Practice Standards and also deliver the aims of the quality assurance process. A separate GOsC/QAA Handbook contains more detail about how each of these processes is undertaken.