Public Meeting of Council

Wed 13 May 2026, 12:30 - 17:00

General Dental Council Offices, 37 Wimpole Street, London, W1G.

Members are reminded to declare any interests against the agenda items.

Agenda

12:30 - 12:30
0 min

1. Welcome and apologies

Information *Joanna Clift*

For Information

- GOsC Charter.pdf (2 pages)
- Public Agenda - May 2026 - FINAL.pdf (2 pages)

12:30 - 12:30
0 min

2. Questions from observers

Information *Joanna Clift*

12:30 - 12:30
0 min

3. Minutes of the 130th public meeting of Council

Decision *Joanna Clift*

For approval

- Public Item 3 - Unconfirmed Public Minutes of Council - February 2026 - FINAL.pdf (11 pages)

12:30 - 12:40
10 min

4. Matters Arising/Action Log

Information *Joanna Clift*

For noting

- Public Item 4 - Matters Arising and Action Log - FINAL.pdf (3 pages)

12:40 - 12:50
10 min

5. Chair's Report

Information *Joanna Clift*

For noting

- Public Item 5 - Chair's Report May 2026 - FINAL.pdf (1 pages)

12:50 - 13:10
20 min

6. Chief Executive and Registrar Report

Decision *Matthew Redford*

For decision

- Public Item 6 - Chief Executive and Registrar Report - FINAL.pdf (18 pages)

13:10 - 13:25
15 min

7. Assurance Reporting

Information *Matthew Redford*

For noting

- Public Item 7 - Assurance reporting - FINAL.pdf (1 pages)

7.1. Business Plan monitoring report to 31 March 2026

Information *Matthew Redford*

For noting

Public Item 7 - Annex A - Business Plan Monitoring - to 31 March 2026 - FINAL.pdf (30 pages)

7.2. Financial report to 31 March 2026

Information *Darren Pullinger*

For noting

Public Item 7 - Annex B - Finance Report, March 2026 - FINAL.pdf (14 pages)

7.3. Six-month Registration Report: 1 October 2025 to 31 March 2026

Information *Ben Chambers*

For noting

Public Item 7 - Annex C - Registration report - FINAL.pdf (7 pages)

13:25 - 13:45
20 min

8. Fitness to Practise report and dataset

Information *Sheleen McCormack*

For noting

Public Item 8 - FTP quarterly report (Q4 2025-26) - FINAL.pdf (8 pages)

8.1. Fitness to Practise dataset

Information *David Bryan*

For noting

Public Item 8 - Annex A - FTP dataset - FINAL.pdf (9 pages)

8.2. Revised Fitness to Practise dashboard

Information *David Bryan*

For noting

Public Item 8 - Annex B - FtP dashboard - FINAL.pdf (4 pages)

13:45 - 14:00
15 min

9. Investment Portfolio: change of management company

Decision *Darren Pullinger*

For approval

Public Item 9 - Change of Investment Manager - FINAL.pdf (3 pages)
Public Item 9 - Annex A - GOsC Risk Approach - FINAL.pdf (1 pages)

14:00 - 14:15
15 min

Break

14:15 - 14:30
15 min

10. CPD Guidance

Decision *Fiona Browne*

For approval

Public Item 10 - CPD Guidance - FINAL.pdf (11 pages)
Public Item 10 - Annex A - Concise CPD guidance and template - FINAL.pdf (9 pages)
Public Item 10 - Annex B - Standard CPD guidance and template - FINAL.pdf (12 pages)
Public Item 10 - Annex C - Detailed CPD guidance and template - FINAL.pdf (28 pages)

14:30 - 14:40
10 min

11. BCNO Group Recognised Qualification

Decision *Steven Bettles*

For approval

- Public Item 11 - BCNO Group Recognised Qualification - FINAL.pdf (13 pages)
- Public item 11 - Annex B - BCNO Final Report Nov 2025 - FINAL.pdf (77 pages)

14:40 - 15:00
20 min

12. Board Effectiveness review

Decision *Matthew Redford*

For approval

- Public Item 12 - Board Effectiveness Review update - FINAL.pdf (5 pages)

12.1. Scheme of Delegation

Decision *Lorna Coe*

For approval

- Public Item 12 - Annex A - Scheme of Delegation - FINAL.pdf (12 pages)

12.2. Strategic Priorities and Operational Measures

Decision *Matthew Redford*

For approval

- Public Item 12 - Annex B - Draft Strategic Priorities and Operational Measures - FINAL.pdf (4 pages)

12.3. Clarifying the role of observers at meetings

Information *Lorna Coe*

For noting

- Public Item 12 - Annex C - Observer's guidelines - FINAL.pdf (2 pages)

15:00 - 15:20
20 min

13. Strategic oversight of the GOsC's current and future use of AI

Decision *Matthew Redford*

For decision

- Public Item 13 - Strategic oversight of the GOsC's current and future use of AI - FINAL.pdf (9 pages)
- Public Item 13 - Annex A - Acceptable Use of Artificial Intelligence (AI) Policy for Members of the Governance Structure - FINAL.pdf (6 pages)

15:20 - 15:40
20 min

14. DHSC Consultation: Draft GMC Order

Information *Matthew Redford*

For noting

- Public Item 14 - DHSC consultation - Draft GMC Order - FINAL.pdf (8 pages)

15:40 - 15:50
10 min

15. Update from Committee Chairs

Information *Joanna Clift*

For noting

15:50 - 16:00
10 min

16. Any other business

Discussion *Joanna Clift*

16.1. Reflections on meeting aligned with GOsC Charter

16:00 - 16:00
0 min

17. Questions from observers

Information *Joanna Clift*

16:00 - 16:00
0 min

18. Date of next meeting Wednesday 15 July 2026

16:00 - 17:00
60 min

19. Private session for Council reflection

Discussion *Joanna Clift*

GOsC Charter: Principles for Effective Collaboration

Purpose of the Charter:

The Charter is to establish a shared ownership around the principles of effective collaboration.

Purpose of GOsC:

The overarching objective of the GOsC is the protection of the public. This involves the pursuit of the following objectives:

a. protecting, promoting and maintaining the health, safety and well-being of the public;
b. promoting and maintaining public confidence in the profession of osteopathy; and
c. promoting and maintaining proper professional standards and conduct for members of that profession.

Summary Statement:
We are purpose-driven and committed to clarity, inclusion, and continuous improvement. Through intentional dialogue and shared accountability, we create space to ensure a strong focus on our strategic objectives.

Principles of effective collaboration:

1. Focus and Clarity

Meetings are centred on purpose, with clear decisions and agreed outcomes.

2. Inclusive Participation

Every voice matters. We foster an environment where all Council members and the executive are heard, respected, and empowered to contribute meaningfully.

3. Active and Empathetic Listening

We listen to develop a shared understanding - creating space for thoughtful dialogue and deeper connection.

General Osteopathic Council

4. Continuous Improvement

We operate in an ego-free zone, recognising that everyone is working to improve the organisation - together we achieve more.

5. Constructive Challenge as Opportunity

We embrace constructive challenge as a catalyst for innovation, growth, and opportunity.

6. **Collective Ownership**

We acknowledge that differing viewpoints will arise; however, once a direction is agreed upon, we commit collectively and take joint responsibility for delivering the desired outcome.

Culture and environment:

For the principles of effective collaboration to thrive, we need a psychologically safe culture and environment which encompasses the following four stages:

Inclusion safety	Feeling accepted and valued
Learner safety	Freedom to ask questions and make mistakes
Contributor safety	Confidence to offer ideas and take initiative
Challenger safety	Ability to question the status quo constructively

Taken from the Fresh Air Leadership's framework.

General Osteopathic Council

The 131st meeting of the General Osteopathic Council to be held in public on Wednesday 13 May 2026 commencing at 12:30 and concluding at 16:00, with a private session for Council members only to follow.

	Item description	Purpose	Executive lead	Timing
	Declaration of conflict of interest: Members are reminded to make a declaration of a conflict of interest that they may have in relation to items on the agenda.			
1.	Welcome and apologies		-	12:30 - 12:40
2.	Questions from observers		-	
3.	Minutes of the 130th public meeting of Council	For approval	-	
4.	Matters arising/Action Log	For noting	Chief Executive and Registrar	
5.	Chair's Report	For noting	Chair of Council	12:40 - 12:50
6.	Chief Executive and Registrar Report	For decision	Chief Executive and Registrar	12:50 - 13:10
7.	Assurance reporting: A. Business Plan monitoring report to 31 March 2026 B. Financial report to 31 March 2026 C. Six-month Registration Report: 1 October 2025 to 31 March 2026	For noting	Chief Executive and Registrar, Head of Resources and Assurance	13:10 - 13:25
8.	Fitness to Practise report and dataset A. FtP dataset	For noting	Director of Fitness to Practise	13:25 - 13:45

	Item description	Purpose	Executive lead	Timing
	B. Revised FtP dashboard			
9.	Investment Portfolio: change of management company	For decision	Head of Resources and Assurance	13:45 - 14:00
Comfort break				**15 minutes**
10.	CPD Guidance	For decision	Director of Education, Standards and Development	14:15 - 14:30
11.	BCNO Group Recognised Qualification	For decision	Head of Education	14:30 - 14:40
12.	Board effectiveness review: A. Scheme of Delegation B. Strategic priorities and Operational Measures C. Clarifying the role of observers at meetings	For decision	Chief Executive and Registrar, Governance Manager	14:40 - 15:00
13.	AI	For decision	Chief Executive and Registrar, Governance Manager	15:00 - 15:20
14.	DHSC Consultation: Draft GMC Order	For noting	Chief Executive and Registrar	15:20 - 15:40
15.	Update from Committee Chairs	For noting	-	15:40 - 15:50
16.	Any other business • Reflections on meeting aligned with the GOsC Charter			15:50 - 16:00
17.	Questions from observers			
Date of next meeting: **Wednesday 15 July 2026**				
Council private time – from 16:00				

General Osteopathic Council

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Meeting of Council

Minutes of the 130th Meeting of Council held in public on Thursday 12 February 2026 at Osteopathy House, 176 Tower Bridge Road, London SE1 3LU and via video conference.

Unconfirmed

Chair:	Jo Clift
Present:	Dr Daniel Bailey Harry Barton (Chair, Audit Committee) (online) Sandie Ennis Professor Patricia McClure (Chair, Policy and Education Committee) Professor Debra Towse (Chair, People Committee) (online) David Propert Katie Oswell
Non-Voting Members Present:	Arwel Roberts (Council Associate) Amanda Cheesley (Patient Partner) (joined 1258) Reena Ainscough (Patient Partner)
In attendance:	Fiona Browne, Director of Education, Standards and Development Matthew Redford, Chief Executive and Registrar Lorna Coe, Governance Manager Sheleen McCormack, Director of Fitness to Practise (Online) (left at 1413) Darren Pullinger, Head of Resources and Assurance (online) David Bryan, Head of Fitness to Practise (Item 8) (online) (Joined 1306-1330.) Nerissa Allen, Executive Assistant (online) Steven Bettles, Head of Policy and Education (online)
Observers:	Dr Jerry Draper-Rodi, NCOR (online) Dr Alison Robinson Canham, Institute of Osteopathy (online)

Collette Byrne, Scrutiny Officer, Professional Standards Authority (online)
Sarah Fox, PSA (online)
Stephanie Jenkins, Osteopath

Declaration of conflict of interest:

The Chair reminded members to declare any conflicts of interest relating to items on the agenda. No conflicts were declared.

Item 1: Welcome and apologies

1. The Chair welcomed attendees, including newly appointed Scottish Registrant Member of Council, Katie Oswell, and Stephanie Jenkins, who will join as a Council Associate from 1 April 2026. The Chair noted for the record:

    a. Gill Edelman, Lay Council Member, stepped down in December 2025; recruitment of a lay member is underway.

    b. Gabrielle Anderson, Council Associate, stepped down early.

    c. Professor Patricia McClure has been formally reappointed as Lay Member of Council by the Privy Council.

2. Apologies were received from Caroline Guy and Liz Niman, Head of Comms and Engagement.

Item 2: Questions from observers

3. There were no questions from observers.

Item 3: Minutes of the 129th public meeting of Council

4. The minutes were agreed as an accurate record.

Item 4: Matters arising

5. Council noted the matters arising report:

    a. External auditors' reappointment was completed.

b. Minor amendments to the Research Framework were identified by PEC; an updated version would be circulated via AdminControl.

Item 5: Chair's Report

6. Council noted the Chair's report.

Item 6: Chief Executive and Registrar Report

7. The Chief Executive summarised activity regarding sector engagement, including attendance at the Institute of Osteopathy convention, webinars regarding the headquarter building sale, regional meetings, and the January Development Day (attended by 75 stakeholders). Engagement continues with DHSC; a joint statement regarding protection of title was issued with the Advertising Standards Association (ASA); and GOsC responses have been provided to relevant national reviews.

Council noted the report.

Council approved the following appointments and reappointments:

a. Reappointment of Rob Jones, Independent Lay Member of Audit Committee for a further 4-year term from 01 April 2026.

b. Reappointment of Sue Ware, Lay Member Professional Conduct Committee for a further 4-year term from 01 April 2026.

c. Appointment of Sarah Oliver, Osteopath Member of Investigation Committee for a 4-year term from 1 April 2026.

d. Appointment of Rebecca Messenger, Osteopath Member of Investigating Committee for a 4-year term from 1 April 2026.

Council noted:

a. The Privy Council appointment of Katie Oswell as Registrant Member for Scotland (1 February 2026 – 31 March 2029).

b. The decision taken electronically on AdminControl appointing Stephanie Jenkins as Council Associate (1 April 2026 – 31 March 2028).

Item 7: Assurance reporting

8. Annex A: Business Plan Monitoring was introduced by the Chief Executive and discussed by Council. Key points highlighted by Council included:

a. Request to use clear target dates rather than a timeline – report to be amended accordingly.

b. The public website implementation project was marked green despite a revised timeline because the completion date extended beyond the business plan period but remained on track in this reporting period.

c. Clarification was provided on what ethical queries related to. These are where an osteopath seeks advice from GOsC on how the osteopathic standards apply in a particular context in their practice.

9. The Head of Resources and Assurance introduced Annex B, The Finance Report. The key points were:

a. Expenditure for first 9 months was £81k over budget mainly due to increased Fitness to Practise (FtP) costs (more cases and more of a complex nature needing longer hearings), CRM and website projects).

b. Council requested year on year FTP caseload numbers in future reports to allow comparison.

c. There was a planned investment portfolio drawdown for cashflow management. These were designated funds.

d. Council requested separate reporting of transformation project spend against the respective budgets agreed by Council so they could keep a track of that and have an indication of milestones for larger payments to help ensure reserves keep within preferred target levels. This will be provided in future reports.

Decision:

Council noted the assurance reports set out at the annexes.

Item 8: Fitness to Practise report and dataset

10. The Director of Fitness to Practise and Head of Fitness to Practise introduced the item. The key points and discussion followed:

a. Third-party cases (police/criminal investigations) significantly affect KPIs.

b. At Investigating Committee (IC) stage the median figure overall is 42 weeks against the KPI of 26, however, it is on target when excluding third-party delays.

c. Professional Conduct Committee (PCC) median timeframe: 124 weeks, reduces to 72 weeks without third-party cases which account for about half of total PCC cases.

d. There was one High Court appeal against a PCC decision to impose an interim suspension order. That case has concluded with a sealed order of consent between GOsC and the osteopath that is being approved by the Court to set that decision aside. Council was assured that, whilst no details could be shared as it related to an ongoing case, the matter had been dealt with and the High Court had approved the position offered through the consent order.

e. AI use within FTP remains cautious and risk-based.

f. Internal audit – this showed no concerns regarding the most serious cases being identified and prioritised. The outcome of the internal audit will be reported to Audit then Council thereafter.

g. Council suggested a cost effectiveness KPI for the FtP process. The Executive noted that as a creature of statute with prescriptive and outdated legislation, GOsC is confined and so cost effectiveness can be a blunt tool to measure this area.

   Some areas where there is some have control have already been changed such as bringing investigation in-house, agreeing fixed fees with external providers but efficiencies in the process would require changes in statute.

   An example of this was provided: Interim Suspension Orders (ISO) - under GOsC legislation, the Investigating Committee can only issue an ISO for two months which is insufficient time for the hearing to take place. Then the Professional Conduct Committee need to meet and decide to impose a further ISO over the same case until the matter or hearing concludes which is an inefficient use of resources as it requires two interim order hearings before the Investigating Committee and the Professional Conduct Committee.

h. Council requested greater granularity on boundary-related concerns. The Executive noted that confidentiality, investigative complexity and case evolution limited the segmentation of data to provide detailed analysis of the content of

boundary concerns at that point and that the actual determinations provided the best insight.

Head of Fitness to Practise left at 1330.

Item 9: Independent Legal Assessors

11. The Director of Fitness to Practise explained the rationale for this paper which was to provide a wider pool of legal assessors to assist with the high volume of hearings (51 days in Q1).

Decision:

Council approved using Independent Legal Assessors Ltd in 2026–27 as a pilot year with consideration of a formal contract/retainer approach thereafter if it is decided to continue.

The Chief Executive left the room 1412-1414

The Director of Fitness to Practise left at 1413

Item 10: Financial and Asset Framework, 2026–30

12. The Financial and Asset Framework was presented in public for the first time, following earlier consideration of draft versions in private sessions during 2025. The purpose of the framework is to ensure the financial sustainability of the GOsC through to 2030, the end of the current strategic planning period.

13. The framework outlined the current challenge of expenditure outstripping income and the actions the Executive intends to take to address this. While a deficit is forecast for 2026/2027, projections show a return to surplus in 2027/2028 and 2028/2029.

14. In discussion, the following points were raised:

    a. Members expressed some concern about reliance, albeit conservative, on investment income, and questioned whether this level of reliance was appropriate. The Executive highlighted other measures being considered, including a potential increase in registration fees and reductions in staffing costs.

    b. Council requested clearer explanation of the distinction between usable and accounting reserves within future reporting.

c. Inflation modelling assumptions were discussed and the Executive confirmed that the model assumed expenditure and inflation would act in a linear way but that may not be the case for every item of expenditure. The Executive confirmed that flexibility would be retained and assumptions kept under review. However, to be prudent, it was accepted that the approach taken by the Executive was sound.

d. Council noted comments on staffing cost assumptions and stressed the importance of clarity for any potential future changes to staff structure given the impact uncertainty would have on staff welfare.

e. Members recognised the need for additional scenarios illustrating the impact of key variables such as a drop in registration fees.

f. Council thanked the Head of Resources and Assurance for the extensive preparation that had supported a constructive discussion.

g. Council reaffirmed its intention that expenditure should be met from income as a principle and this is the premise that the Executive are operating within. It noted that the Reserves Policy would be considered at a future Council meeting.

Decision:

Council approved the Financial and Asset Framework for publication.

There was a short break from 1331 to 1345

Item 11: Business Plan and Budget 2026–2

15. Annex A – Business Plan. The Chief Executive explained the Business Plan represented the third year of the current strategy, grouping activities under the three strategic priorities of strengthening trust, championing inclusivity and embracing innovation.

16. In discussion Council:

a. Requested that the Executive replace "timeline" with "target date" in future versions of the plan.

b. Enquired as to rag rating – the Executive advised that this was done in the business plan monitoring report that goes to every Council meeting.

17. Annex B Budget 2026-27. It was drawn to Council's attention that if the headquarter building were to be sold earlier and prior to March 2027 then the Executive would need to revert to Council with a revised budget.

18. In discussion Council:

    a. Noted deficit for 2026–27; return to surplus planned for later years.

    b. Queried the uplift in staffing costs – the Executive explained this was a provision for an uplift in salaries and pensions and which would be considered by the People Committee in March 2026.

    c. Council discussed whether the risk of relying on future efficiency measures, investment income and other potential significant changes would be sufficient and noted the need for contingency planning.

    d. The Chief Executive reminded Council of the expenditure decisions that would be taken in 2026/2027, as outlined in the Financial and Asset Framework, that would bring the budget back to a surplus position in 2027/2028 and 2028/2029.

Decision:

Council approved Annex A Business Plan

Council approved Annex B Budget.

Council noted Annex C Equality Impact Assessment

Item 12: Investment Portfolio – change of management company

19. The proposal was to move from Brewin Dolphin to Cambridge Investments due to lower fees but with comparable performance. GOsC would not be locked in and funds could be reallocated at any point.

20. Council questioned the risk appetite of a fund presented in the paper. The Executive needed to revert to the investment manager who was not present in the meeting and it was agreed to bring the clarification back to Council in May 2026.

Decision:

Council supported moving provider but the decision on fund selection (Balanced vs Active) was deferred pending clarification Executive to obtain further detail on the Cambridge fund and bring a paper back to May meeting.

Item 13: NCOR Concerns and Complaints Report

21. The Executive thanked Dr Jerry Draper-Rodi, NCOR, for the report.

22. The NCOR research showed that those osteopaths who have been in practice longer are at a higher risk of receiving a complaint. The reasons for this are not fully understood yet – the current data does not allow a greater understanding of that issue.

23. Key findings of the report:

    a. Complaints remained relatively low (103 osteopaths which is less than 2% of registrants).

    b. Higher risk among practitioners over 60 years and with more than 10 years in practice.

    c. Clinical care issues remained the highest cause for complaints with patient interactions issues and specifically communication concerns second.

    d. Sexual impropriety complaints have halved compared to previous reporting period, 2023.

    e. Insurers report 2025 as a stable year for complaints, but with rising costs (legal fees and damages).

    f. Monitoring concerns in pediatrics, AI usage, and multidisciplinary practice trends.

24. In discussion Council noted:

    a. The need for greater granularity in future reports – Executive to continue refinement of data collection templates.

b. The desire for more timely data, however, the Executive explained that the insurers cannot provide data any earlier than summer and so this is unlikely to be achieved.

Decision:

Council approved the publication of the NCOR Concerns and Complaints Report

Item 14: Board effectiveness review update

25. The Scheme of Delegation restructuring was underway and on reflection, rather than a working group, external input from the inter-regulatory governance group would be used as quality assurance.

26. No further progress had been made on the Strategic priorities and operational measures due to competing priorities but would be reported to Council in May 2026.

27. The GOsC Charter was presented for approval with the addition of collective ownership following the inspiring January development day.

28. Council discussed the meaning of psychological safety and the need for a shared understanding of that. This was to be explored further -possibly at September development day.

Decision:

Council approved the Charter as a living document.

Council approved next steps regarding Scheme of Delegation and Strategic Measures.

Actions:

Item 15: GOsC Social Media Policy

29. Council felt that it would be useful for them to be issued with a ten-point plan regarding social media practices as part of their induction/ongoing training however the Executive did not feel the policy was distillable into ten points.

30. Following Council discussion, the Executive agreed to explore developing training to support Council to exercise judgement on how to respond to misinformation on social media, clarify boundaries (registrant v Council Member) and awareness of the out-of-hours escalation process (contact Chief Executive).

Decision:

Council approved the Social Media Policy.

Item 16: Public minutes of the Policy and Education Committee, October 2025

31. Council noted the minutes of the Policy and Education Committee.

Item 17: Any other business

32. A query was raised on previously commissioned professional photographs - these are to be used in new website design.

Item 18: Questions from observers

33. None.

Date of next meeting: Wednesday 13 May 2026

Meeting closed at 1455.

Council reflection session was held privately following the meeting.

General Osteopathic Council

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Council
13 May 2026
Matters arising/Action Log

Classification	Public
Action	For noting
Purpose of the paper	To update Council on matters arising from the previous meeting.
Strategic Priority implications	Delivering on agreed actions will ensure trust is maintained.
Standards of Good Regulation implications	There are no direct links to the PSA Standards of Good Regulation.
Communications implications	None arising.
Financial, resourcing and risk implications	None arising.
Patient perspectives	None arising.
Diversity implications	None arising.
Welsh language implications	None arising.
Annex(es)	None
Author	Matthew Redford
Background reading	12 February 2026 Public minutes of Council.

Recommendation(s)	To note the content of the report.

Background

1. This paper addresses any matters arising from the 130th public minutes of Council not covered elsewhere on the agenda. The matters arising and actions are set out below.

2. Key: **Green = completed**

Amber = not yet due

Red = outstanding

No.	Action	Owner	Due Date	Status
1.	Circulate updated Research Framework with PEC amendments	Director of Education, Standards and Development	Before next Council meeting.	Outstanding – will follow up on Admincontrol after meeting
2.	Business plan 2026-27 to be amended to use terminology 'target date' rather than 'timeline'	CE / Head of Resources and Assurance	For next monitoring report in business cycle	Not yet due
3.	Separate reporting for transformation projects to track spend against respective budget	Head of Resources and Assurance	June Audit /May Council reports re website costs	√
4.	Review term "anonymous informant" in dashboard	Head of Fitness to Practise	Next Council meeting	√
5.	Revise Reserves Policy to distinguish usable vs non-usable reserves	Head of Resources and Assurance	Audit Committee June / Council July 2026	Not yet due
6.	Make it more explicit in notes for budget that any deficit would have to be funded from reserves/investment portfolio	Head of Resources and Assurance	Next budget report - November 2026	Not yet due
7.	Provide further details of Cambridge Investment	Head of Resources and Assurance	May 2026	√

No.	Action	Owner	Due Date	Status
	fund options - risk profile and rationale			
8.	Add psychological safety session to Council development programme	CE / Governance Manager	September Strategy Day 2026	Not yet due
9.	Consider training for Council on social media judgement and misinformation handling	Director of Education, Standards and Development / HR Manager	By next development session – September Strategy Day 2026	Not yet due

Recommendation: To note the content of the report.

Chair's Report to Council May 2026

Recruitment

We are interviewing for the new lay Council member role in early May – verbal update to be provided at Council.

We have appointed Dinah Cobbinah as an external member of the Audit and Risk Committee. Dinah has been appointed to support us with digital transformation.

We are starting the recruitment of a second external member of People Committee, to support the HR work and to ensure resilience in terms of committee attendance.

Appraisals

Council appraisals are taking place this month. We will be working with People Committee about how to make this a smoother and more modern process next year.

The CEO appraisal will take place in the next few weeks. We are using 360-degree feedback this year, with a view to rolling this out further within the organisation.

Stakeholders & external groups

Osteopathy Europe

I attended the Osteopathy Europe meeting in Austria in March. There was a useful session on the use of AI within the profession.

Professional Standards Authority

The Chairs of all the Health regulators are meeting on 14th May. We meet three times a year to discuss areas of mutual interest. The meeting in May will focus on AI.

Institute of Regulation

I am Chair of the Institute of Regulation Chairs' Forum. We met initially in February and will meet again in July. We considered the government's approach to regulation, and discussed areas of mutual interest.

I attended the Institute of Regulation Annual Conference in March.

I was interviewed for the Institute of Regulation podcast regarding the role of the Chair of a regulator.

General Osteopathic Council

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Council
13 May 2026
Chief Executive and Registrar Report

Classification	Public
Action	For decision
Purpose of the paper	A review of activities and performance since the last Council meeting not reported elsewhere on the agenda.
Strategic Priority implications	Activities within this report will align with all three of the GOsC strategic priorities around trust, inclusivity and innovation.
Standards of Good Regulation implications	The report has a specific section related to our interactions with the Professional Standards Authority and the Standards of Good Regulation.
Communications implications	Engagement activities with osteopaths, patients and partner organisations are referenced in the report.
Financial, resourcing and risk implications	Specific matters related to finance and/or risk not covered under previously agreed business plans or budgets will be identified in the report.
Patient perspectives	Where relevant, these will be identified within the paper.
Diversity implications	The report will include any updates on our work related to equity, diversity, inclusion and belonging not covered elsewhere on the Council agenda.
Welsh language implications	Where relevant, these will be identified within the paper.
Annex(es)	A. Briefing note on PSA Standards of Good Regulation B. PSA Standards of Good Regulation: new Standards – effective from July 2026 C. New website design images
Author	Matthew Redford

Background reading	PSA Standards of Good Regulation (current Standards)

Recommendation(s)	1. To note the content of the report. 2. To note the appointment, made via AdminControl, of: a. Dinah Cobbinah, Independent Lay Member of Audit Committee for a 4-year term from 1 April 2026.

Key messages

- We have held a successful Patient Forum Development Day.
- We have responded to the DEFRA consultation on proposed changes to the Veterinary Surgeons Act 1966.
- We have been engaging with the profession and sector bodies related to areas including but not limited to:
  - PSA Performance Review process
  - international activity
  - recording a podcast with Gilly Woodhouse, Osteobiz.
- The website development project continues to run smoothly and we have provided at Annex C some website design images for Council's awareness.
- Our independent Internal Auditors (TIAA) have completed their first year and audited four areas of our work. The audits have provided substantial and reasonable assurance across the work of: registration, fitness to practise, financial and budgetary control and risk management.

Introduction

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

Patients

2. We held a Patient Forum Development Day in March 2026 which has received feedback that is overwhelmingly positive. The day had speakers including, Simon Denegri OBE who presented on building confidence, influencing decisions and making your voice heard; Kathryn Parkin who presented on exploring professional boundaries in practice and Katie Griffiths, who presented on trust in osteopathy and considering trust and the Osteopathic Practice Standards.

Value of regulation

3. We continue to take every opportunity to raise awareness about the value of regulation, be that through our social media activity (corporate and individual accounts), through meeting with and presenting to osteopaths, or through engaging with alternative media sources.

4. I recently recorded a podcast with Gilly Woodhouse, Osteobiz, which Gilly has publicised to her network. The conversation, which lasted over an hour, addressed misconceptions about our work/role, and covered a range of areas from fitness to practise through to how we work with osteopaths to deliver high-quality care. The podcast can be heard here: In conversation with Matthew Redford at GOsC

5. In March 2026, we undertook filming with Blackrook Media who will produce 14 videos that GOsC can use through our new website and through social media to help raise awareness as to the value of regulation.

6. Involved in the filming: Glynis Fox, Chair of the National Council for Osteopathic Research (NCOR) and immediate past president of the Institute of Osteopathy; Yinka Fabusuyi, osteopath member of the Professional Conduct Committee; Dr Jerry Draper Rodi, Director of NCOR and educator at Health Sciences University (HSU); Arwel Roberts, Council Associate and South Wales Osteopaths regional lead; and Matthew Redford, GOsC Chief Executive and Registrar.

7. We will share with Council these resources when available.

8. In March and April 2026 Steven Bettles, Head of Policy and Education, attended HSU and presented to their final year students (part-time and full time) about issues of professionalism and preparations to join the Register. Fiona Browne, Director of Education, Standards and Development will be presenting to the University of Derby final year students on 9 May to discuss continuing professional development and registration and to respond to questions about standards and quality assurance.

Educators

9. We held our first educator workshop on 22 April 2026 in collaboration with the Collaborating Centre for Values Based Practice in Oxford. The purpose of the event was to build knowledge and skills in shared decision making and put patient values at the heart of what we do; facilitate peer learning and good practice in teaching, learning and assessing shared decision making as an integral part of osteopathic education; support peer learning and good practice across the osteopathic education sector and in practice and to foster collaborative cross-sector relationships.

10. The event was chaired by Amanda Cheesely, our GOsC Patient Partner. Speakers included Sarah Tilsed, Head of Patient Partnership, Patients Association, Professor Ashok Handa, Director of the Collaborating Centre for Values Based Practice and Professor of Vascular Surgery and Consultant, Dr Simon Jacklin, Director of Education, Keele University and Lecturer in Pharmacy, Professor Steven Vogel, Health Sciences University and Dr Paul Wright, NESCOT. Attendees include patients educators from osteopathic educational institutions, other regulators, osteopaths and researchers.

Institute of Osteopathy (iO)

11. We attended the opening two iO roadshows 2026 in Maidstone and Swansea. Attendance at these meetings give us the opportunity to build relationships with osteopaths and to listen to find out more about what matters to osteopaths.

12. In order to ensure there is a continued positive relationship between the GOsC and iO, the two senior leadership teams met for a bilateral meeting in April. Areas for discussion included: the DHSC GMC Order; the iO roadshows; the Educator workshop in Oxford and updates around our fitness to practise process.

Department for Environment, Food and Rural Affairs (DEFRA)

13. Since the previous meeting we have responded to a DEFRA consultation on proposed reform of the Veterinary Surgeons Act 1966. Our response was broadly positive to the proposed reforms recognising that it is timely to bring Allied Veterinary Professionals (AVPs) into regulation. We set out our agreement with the principle that the regulation of AVPs provides assurance of safety and quality for animals, and which will see the introduction of protected titles and standards for AVPs.

14. We will await the response from DEFRA and will consider what the implications might be for animal osteopathy and those on our Register who may, in the future, become dual registrants with GOsC and the future regulator.

Workforce Race Equity in Health and Social Care: Shared Principles

15. A number of healthcare regulators, including the GOsC, have endorsed the Workforce Race Equity in Health and Social Care: Shared Principles which will be published in May 2026 to coincide with the NHS Race and Health Observatory Conference: Improving Race Equality in your Organisation - Evidence Based Resources for Leaders - Race and Health Observatory.

16. When published we will put the shared principles on our website and the Senior Management Team will be reflecting with the staff team on how we embed the principles across the work that undertake.

International matters

17. Our work in the international space is important. Raising awareness of our standards supports workforce quality and growth and enables us to continue to raise standards and to break down potential barriers that prevent mobility between jurisdictions.

Osteopathy Europe

18. The Spring conference of Osteopathy Europe was held in Austria in early March 2026 with a number of focussed discussions on AI, a workshop on negotiating/communication, an update on revision of the CEN Standard and reports from the OE Committees.

19. I have worked in collaboration with Alison Robinson Canham, Chief Executive of the Institute of Osteopathy (iO) and Dr Jerry Draper Rodi (NCOR), to jointly contact the British Standards Institute (BSI) concerning the CEN Standard for Osteopathy and revision to the Standard from the UK perspective. We have written to the BSI and are seeking a collaborative meeting with them.

20. The conference saw Hanna Tómasdóttir (Denmark) conclude her term as President of Osteopathy Europe with Tomas Collin (Norway) elected as the new President. In her final written President's Report, Hanna made specific reference to the contribution of Tim Walker, former GOsC Chief Executive and Registrar for his support and, in more recent years, to the contributions/insights I have made in the international arena.

21. The board also saw Lluis Horta (Spain) finish his term of office with Julie Ellwood (Ireland) and Giacomo Consorti (Italy) elected to the Board. We recognise the significant work of both Hanna and Lluis and welcome Julie and Giacomo to the Board.

22. I connected with the representative from Switzerland who was attending their first meeting. Following this we have established a meeting to discuss the pathways for UK qualified osteopaths who wish to move to Switzerland as we have heard of barriers existing to entry. We will explore whether these barriers

do exist and how we may be able to support individuals who wish to move to Switzerland in the future.

23. I have been invited by the Nordic Osteopathic Alliance to attend and participate in their annual conference in Gothenburg in September. While there is no immediate direct regulatory benefit to GOsC I have agreed to attend the event, and will take annual leave and self-fund the trip, in order to continue to demonstrate our engagement with our European osteopathic community.

Australia and New Zealand

24. A regular trilateral meeting was held with colleagues from the Australian Health Practitioner Regulation Agency, Osteopathy Board, and the Osteopathic Council for New Zealand (OCNZ) in April 2026. The meeting involved sharing insights about developments within our jurisdictions as well as planning for the Osteopathic International Alliance Conference being held in November 2026.

Osteopathic International Alliance (OIA)

25. I reported to the February 2026 Council meeting that planning for the OIA 2026 Conference in Paris is already underway and that GOsC have made presentation submissions that focus on the patient voice and experience, alongside a separate joint-submission with the regulators of Australia and New Zealand. We have not yet heard if these submissions have been accepted.

26. The OIA have launched online member meetings with the first two to be held in May and June 2026 respectively. I have signed up to both meetings to understand more about the format, purpose and future plans of these sessions.

Canada

27. Following the OIA 2025 Conference in Toronto, I have maintained contacts with representatives from Toronto, New Brunswick and Nova Scotia. This has included for Toronto and New Brunswick providing GOsC resources (available online) concerning our education and registration standards, meeting with New Brunswick colleagues online to share insights, and for Nova Scotia commenting on a document they are preparing as they seek regulation in their province.

28. I was approached by Osteopathy British Columbia (OBC) to be their keynote speaker at their AGM. The online event, to be held on Sunday 24 May, will focus on the patient voice and specifically the shared decision-making resources GOsC have developed. This was a key part of the address I delivered at OIA 2025 and have been asked to replicate this for the OBC.

Research

29. The Professional Standards Authority published Barriers and Enablers to making a complaint in November 2025. We have recently been reviewing this as we update our website and our communication channels. Key actions that have been taken to date include:

- We have helped with setting expectations and better explaining the fitness to practise process by making it clearer the types of concerns we investigate, what will happen when we receive a concern, and we provide an indication of the timeframes for each stage of the process to help make it clear that the investigation of a concern can be a long process.

- On our Raise a concern web page we explain that patients might want to raise certain concerns with their osteopath directly, or with another osteopath in the same practice. We also explain what kinds of concerns we can and what matters are not usually capable of amounting to an FtP concern.

- We have tried to make it clear on our website which concerns should be raised with us and explain when it would be best to talk first to the osteopath in question or with another osteopath in the practice. We also suggest that if they need further advice, they should contact our Regulation Department by phone or email as we explain that we are here to help with any concern or complaint someone may have about an osteopath.

- We published an indicative timeline for the first time as part of the Fitness to Practise Annual Report 2023-24 and we have added improved explanations and indicative timelines to our web pages where we explain the concerns process.

- Considering neurodiversity and accessibility, we provide a variety of channels and methods for patients, the public and osteopaths to get in touch with us, including phone, email, WhatsApp, online forms, and video calls. Osteopaths (and students) are also invited to join our weekly online drop-ins where staff are always available to speak to them. We don't explicitly encourage people to use WhatsApp or the drop-ins to raise a concern but we have already had the drop-in used to initiate a conversation about a concern.

- We offer to discuss alternative routes for sending us concerns and ask people to call us to discuss this. We also promote the free and confidential access to the independent support service we fund which can offer emotional support.

- In line with the finding about the importance of raising awareness of our independent role as a regulator: We have done a good deal of work to help explain our role as our own research identified that there was a good deal of misunderstanding within the profession previously. For example we are clearer on our website and on our social media channels about what we do and what we don't do. We have also created a series of mythbusters to help clarify our role. We promote the mythbusters in our enewsletter to osteopaths and on our social media channels. We also recorded a podcast about FtP clarifying the process and our role, and we promote our podcast regularly across all of our channels.

30. The Kings Fund have been working closely with the Care Quality Commission on Evidence on what works in health and social care in an ongoing project with a team led by Professor Kieran Walsh. Key learning points were recently reported including:

    - Make sure the purpose of regulation, and its impacts, are central to the design of the regulatory model.
    - Clearly communicate the thinking behind the regulatory model including how regulatory interventions like registration and inspection are intended to affect organisations, patients and users.
    - There is a lot of existing evidence CQC can draw on to inform the design of the future regulatory model, and it is important that any learning is thoughtfully adapted to its context.
    - Invest in regulatory staff and support them to develop and maintain sector-specific, regulatory and relational expertise. For a regulator and its workforce, how you do it matters as much as what you do.
    - Make sure testing and evaluation is central to the rollout of the regulatory model. A culture of learning is vital to support ongoing development of the model and provide evidence on its impact.

National Council for Osteopathic Research Projects update:

31. In May 2024, Council agreed our role in workforce development. This included 'funding of research to explore issues related to recruitment and retention, in the context of our statutory objectives and recognising that the word 'promote' was removed from our legislation in 2006. Council also agreed to fund three projects which are outlined in the May 2024 private Council paper which collectively aimed to explore issues around recruitment and retention.

32. Due to issues in recruitment for project 1 (leavers from the register qualitative interviews) this has had to be stopped prior to data saturation but existing interviews will be written up and reported to Council. The impact of this is also that the original project 2 cannot go ahead as a piece of research as originally planned.

33. However, the research questions can be answered in a different way using interviews from osteopaths already on the register rather than leavers who do not want to engage further in this research. Therefore, the executive have agreed to use the original funding for project 2 for a different second project which will enable the original research questions to be answered in a different way by NCOR and GOsC. This means that there will be a cost saving on the Project 1 and also on Project 2, but also that it the designated funds will still be used for their original purpose. The third project related to enablers and barriers

to choosing osteopathy as a career and support for students will be completed and reported to Council in due course.

Nockolds Inter-regulatory complaints forum:

34. We participate in an inter-regulatory forum, hosted and facilitated by Nockolds Solicitors, which looks at learning from corporate complaints received by healthcare regulators – this aligns directly with Standard 4 of the Standards of Good Regulation.

35. Nockolds have produced an Output Report which summaries the work of the forum and we will be publishing this report on our website. We will advise Council members when the report is available.

Independent Internal Audits

36. TIAA were appointed as independent Internal Audits in 2025. They have completed their first year and have audited four areas of activity, reporting their findings to Audit Committee. The areas of focus were: registration, fitness to practise, financial and budgetary control and risk management.

37. TIAA have four levels of assurance being:

Assurance level	**Narrative**
Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

38. TIAA reported to Audit Committee the following:

Audit area	**Assurance level**
Registration	Substantial assurance
Fitness to Practise	Reasonable assurance
Financial and budgetary control	Reasonable assurance
Risk Management	Reasonable assurance

39. Each audit identified recommendations for action and these are being taken forward by the Executive leads, with Audit Committee monitoring the implementation of these actions.

Professional Standards Authority (PSA)

40. Since the previous meeting of Council we have continued to engage with the PSA consultation on our performance for the 2025-26 reporting year. As a reminder for members, the PSA operate a three-year cycle where one year is a periodic, detailed review, with two years being monitoring reviews. The 2025-26 reporting year, which runs from April-March, is a monitoring year. We expect the report on our performance to be published in the summer.

41. The PSA have set out changes to the Standards of Good Regulation which will come into effect in July 2026; however, due to the timing of their implementation we will be assessed against the new Standards for the first time in the reporting year 2027-28. These standards matter because they act as a driver to help us deliver our functions efficiently and effectively and to support high quality care.

42. As a briefing note for members, attached at Annex A, is an indicative timeline of the PSA performance review process and where the GOsC business as usual activity interfaces with the Standards of Good Regulation. The Chief Executive and Registrar will speak to Annex A at the meeting.

43. Further information about the new Standards for Good Regulation is provided in Annex B.

Website development project

44. The website development project continues to progress well with an implementation date for launch of the new website scheduled for July 2026.

45. The aim of the new website is to be warmer and more approachable and to ensure that the information it contains is easier to find. The project aims support our strategic priorities:

    - **Strengthening trust**: The website is a key touchpoint for osteopaths, patients, students, and the general public. It should be a trusted source of information that is reliable, easy to navigate, transparent, and user-focused.

    - **Championing inclusivity**: A modern website must meet the needs of all users, including those with disabilities, diverse language needs, and varying levels of digital literacy.

    - **Embrace innovation**: By incorporating modern web technologies and design principles, the website reflects GOsC's commitment to innovation. Features such as interactive content, video explainers, and enhanced search functionality demonstrate a forward-thinking approach to digital engagement.

46. An initial home page design is attached at the Annex to give Council an indication of what the new website will look like.

47. User testing has been central to the process and we will test the new website with real users before it goes live. This will include:

    - asking osteopaths to try key **o** zone tasks, such as updating their details
    - asking patients to try common tasks, such as checking the Register, raising a concern and contacting GOsC
    - using online testing to check whether people can find the right information
    - testing the site structure to make sure it makes sense
    - reviewing the results and making any important improvements before launch

Appointments and Reappointment activity

Appointments

48. The Audit Committee selection panel successfully recruited an additional lay member and satisfactory due diligence has been completed. Council agreement was sought electronically via AdminControl and the decision is written into the record in this paper.

    a. the appointment of Dinah Cobbinah, lay member of the Audit Committee for a 4-year term from 1 April 2026.

External engagement – bringing insight into our business

49. Other meetings, which have not been referenced elsewhere in the report, include:

    - Chief Executives of the Regulatory Bodies forum
    - Institute of Regulation Annual Conference
    - Inter-regulatory forums including education, communications and engagement, research, EDI, governance and performance, Alliance UK Regulation in Europe and artificial intelligence and meetings with regulators on a variety of topics
    - Institute of Osteopathy Education and Practice Committee Meeting
    - Institute of Osteopathy Equity, Diversity, Inclusion and Belonging Reference Group
    - Meeting with the Chief Allied Health Professions Officer England
    - Meeting of the Regulator and Education Liaison Group (RELM)
    - Meeting with the Office for Students
    - Meetings with individual existing osteopathic educational providers
    - Meetings with prospective osteopathic educational providers
    - Health Sciences University: launch of Chancellors Fund

- Regular supervision meetings with Dr Emma Harris, Professor Louise Wallace and Professor Gemma Blackwell-Ryan for our PhD student Kathryn Parkin
- National Council for Osteopathic Research Trustee Board
- Institute of Osteopathy (iO) meetings
- External QAA training for our staff and visitors on Quality Assurance
- Meeting of the Osteopathic Alliance
- Meeting with the Council of Osteopathic Educational Institutions
- Martin Chaney, IT Consultant (website development)
- Nick Jones, Chief Executive and Registrar, General Chiropractic Council
- Lizzie Lockett, Royal College of Veterinary Surgeons
- Katie Griffiths, GOsC acting as host organisation for completion of her MBA
- Ongoing engagement with osteopaths including contributions to consultations and focus groups and CPD sessions with regional groups including the East Midlands Group
- Ongoing engagement with patients including contributions to consultations
- Ongoing meetings with students in different osteopathic educational institutions
- All staff meetings and workshops.

Executive view

50. We are continuing as a staff team to engage proactively with the profession across a range of topics. We welcome the opportunity to further engage with the profession and sector organisations and would encourage individuals and organisations to reach out to the team if opportunities present.

Recommendations

1. To note the content of the report.

2. To note the appointment, made via AdminControl, of:

    b. Dinah Cobbinah, Independent Lay Member of Audit Committee for a 4-year term from 1 April 2026.

Council briefing on PSA Standards

Timeline:

Step/sequence	Event / description	Timeframe
1	Start of the 202X – 2X reporting year, which is a monitoring year or a periodic review year *	April 202X (Month 1)
2	Dialogue meetings between GOsC and PSA	All year
3	PSA submit questions for response, mainly on Standard 3, EDI, but with some relating to other Standards *(monitoring year)*	January 202X (Month 10)
4	As above but with potential for more detailed auditing of functions, most likely Fitness to Practise *(Periodic Review year)*	January 202X (Month 10)
5	Responses provided to PSA which inform PSA initial assessment of performance against the Standards	January – February 202X
6	Expected receipt of the PSA's initial assessment against the Standards of Good Regulation	By end February 202X (Month 11)
7	PSA Final panel determination received for the 202X – 2X year	March - April 202X (Month 12)

* The PSA operate a 3-year cycle where one year is a periodic, detailed review with the other 2 years being monitoring reviews.

NB: the 2025-26 cycle is a monitoring year with 2026-27 cycle being a periodic review. The periodic review cycle is always a more labour intensive review by default of it being detailed in nature. We can expect areas of focus to be those considered higher risk, such as registration and fitness to practise.

Link between GOsC BAU activity and PSA Standards:

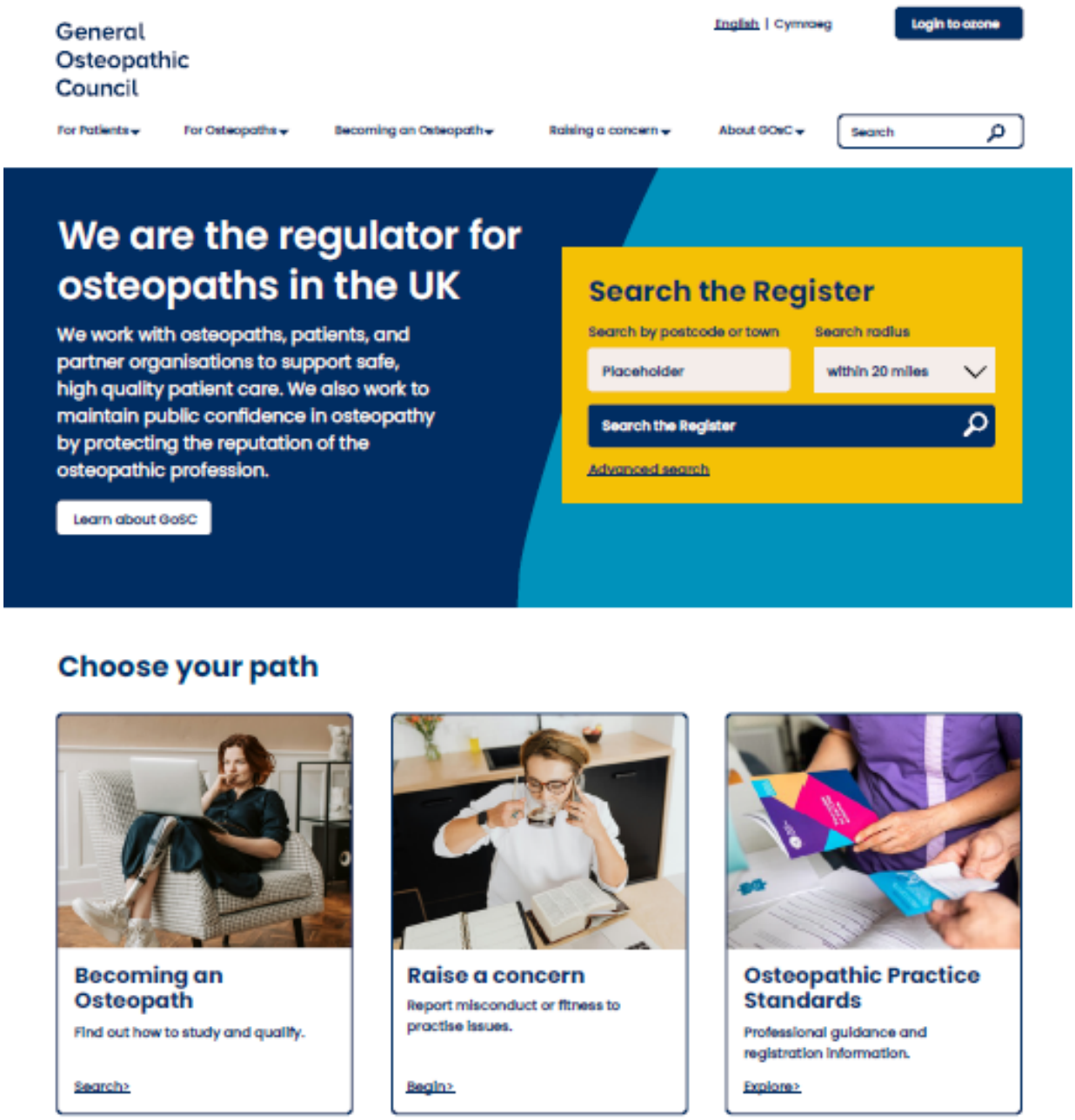
GOsC BAU activities (not exhaustive list)	Standards of Good Regulation (narrative abridged)
• Website maintained, information refreshed, accurate and timely; communication channels open and accessible (e.g. WhatsApp, Drop-in's, regional talks) • Policies/guidance available publicly including through Council/Committee papers • EDIB Annual Report and associated work • Council/Committee effectiveness reviews • Consultations published in-year	**General Standards (1 to 5)** • Accurate, accessible information available • Clear about purpose and application of policies/guidance/learning • EDI • Assesses own performance and addresses concerns • Consults on work
• OPS and associated guidance in place, reviewed and refreshed regularly • Ethical queries received from osteopaths responded to	**Guidance and Standards (6 to 7)** • Maintains up to date Standards and provides guidance to help delivery of Standards
• OPS and associated guidance in place, reviewed and refreshed regularly • In-house QA activity • Engagement with Education sector, RELM, Educator workshops	**Education and Training (8 to 9)** • Maintains up to date Standards • Has a proportionate approach to assessing Education providers
• All registration entry and renewal processes including: CPD; student talks; support • s32 cease and desist letters, prosecutions, work with ASA • Collection of EDI data through renewal • Registration stats/demographics to Council	**Registration (10 to 13)** • Maintains an accurate Register; operates fair registration processes; protects the title; has proportionate requirements to ensure registrants fit to practise

GOsC BAU activities (not exhaustive list)	Standards of Good Regulation (narrative abridged)
• Clarity on website and in associated materials about raising concerns • All FTP processes from start of complaint process to end • All associated guidance for parties involved in FTP process including panels • Independent Support Service availability and promotion • FTP dataset and quarterly report to Council especially timeliness of cases and performance • Independent audits	**Fitness to Practise (14 to 18)** • Ensure anyone can raise a concern • Process for handling complaints fair, proportionate, timely; decision makers can reach fair outcomes; decisions fair and consistent • Prioritise cases of high risk to patients • Support all parties in the complaints process

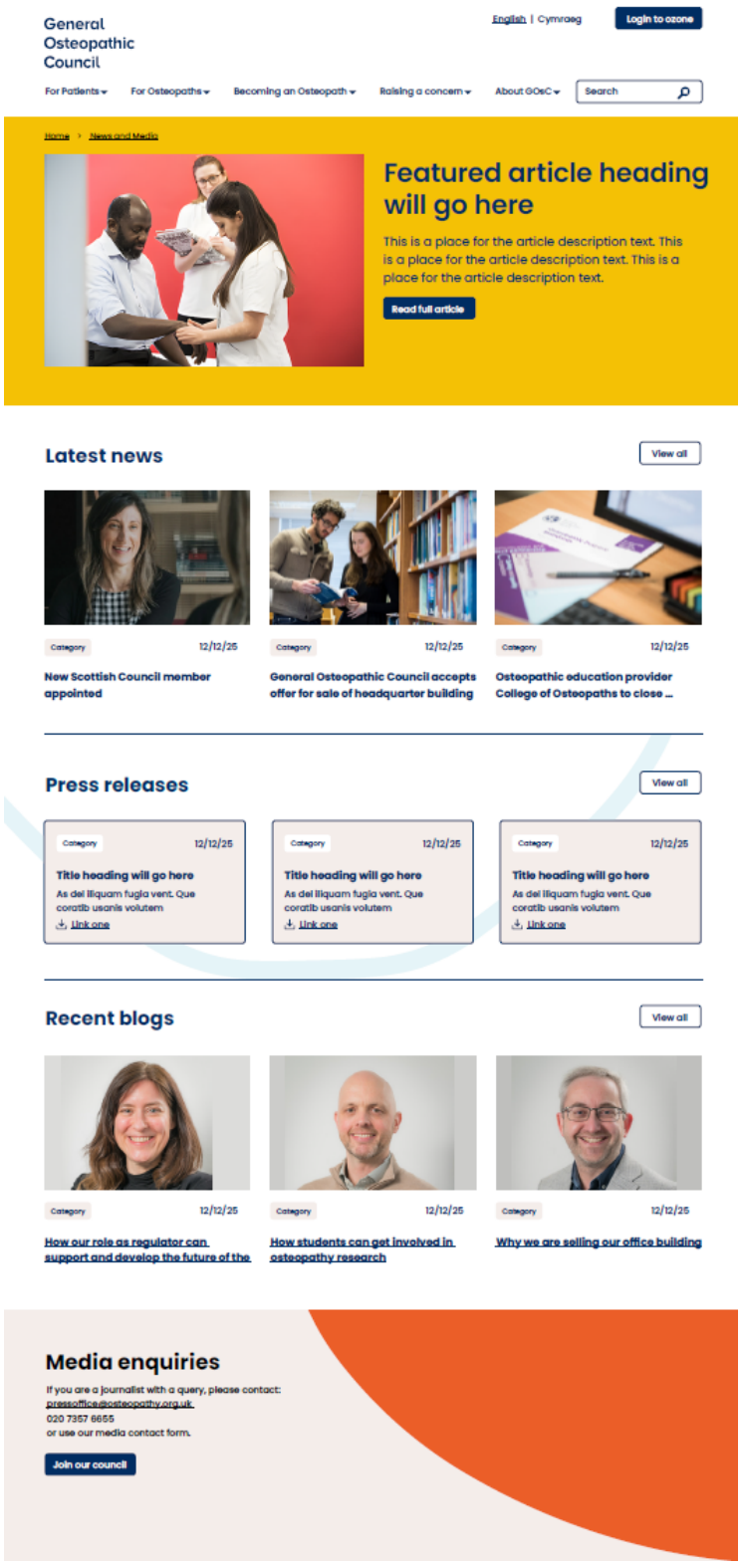
New website design images

The following images are provided to give Council members an indication of how the new GOsC website will look ahead of it going live in July 2026.

Home Page:



Webpage layouts:



General Osteopathic Council

English | Cymraeg

Login to ozone

For Patients ▾ For Osteopaths ▾ Becoming an Osteopath ▾ Raising a concern ▾ About GOsC ▾ Search

Home > Visiting an osteopath > What to expect

What to expect

What happens when you visit an osteopath, what a treatment is likely to cost and how to find a local osteopath.

This information is also available in Welsh: Beth i'w ddisgwyl gan osteopathiaid

In this section

- → Find an osteopath
- → What to expect
- → About osteopathy
- → NHS and private treatment
- → Referrals to osteopaths
- → Get involved in our work

Before your first appointment

Check that the osteopath is registered with the General Osteopathic Council (GOsC), the regulatory body for osteopathy. You can do this by checking the Register on this website or calling us on 020 7357 6655.

Osteopathic practices should be able to provide information about the osteopath, the clinic, what the treatment involves, payment methods and anything you need to know in advance of your first visit.

General Osteopathic Council
I'M REGISTERED
Registration no. 0000
www.osteopathy.org.uk

Osteopaths might highlight their registered status by using a GOsC Registration Mark or posters in their practice or on their patient information.

Listening and examining

Diagnosis and treatment

How much does it cost?

Ongoing care

Is referral from a doctor necessary?

What happens if something goes wrong?

Read more:
About osteopathy

General Osteopathic Council

Council
13 May 2026
Assurance reporting

Classification	Public
Action	For noting
Purpose of the paper	To provide Council with a set of assurance reports about the performance of the GOsC.
Strategic Priority implications	Activities within this report will align with the GOsC strategic priorities.
Standards of Good Regulation implications	The assurance reports will touch on many of the PSA Standards of Good Regulation.
Communications implications	None
Financial, resourcing and risk implications	These are set out in the annexes to this report.
Patient perspectives	Where relevant, these will be identified within the paper.
Diversity implications	The report provides demographic data about the Register.
Welsh language implications	We need to report annually on the number of Welsh registrants and Welsh language speakers on our Register.
Annex	A. Business Plan monitoring report - 31 March 2026 B. Financial Report - 31 March 2026 C. Registration Report - 1 October 2025 to 31 March 2026
Author	Matthew Redford
Background reading	None

Recommendations	To note the assurance reports set out at the annexes.

GENERAL OSTEOPATHIC COUNCIL

Business Plan

April 2025 - March 2026

Monitoring Report as at 31 March 2026

GOsC BUSINESS PLAN 2025-26

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

- Strengthening trust
- Championing inclusivity
- Embracing innovation

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

Legend

Status

 On track

 Delayed

 Cancelled/postponed

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
Seek changes to enhance public protection under Section 32 of the Osteopaths Act - Protection of Title.	Undertake consultation and analyse responses.	March - June 2025	Chief Executive, Fitness to Practise, Professional Standards, Communications		Consultation launched on 17 June with wide ranging communication activity to encourage awareness and participation. Consultation closed 16 October with 372 responses received.	
	Agree Council position.	July 2025			Considered by Council in November 2025	
	Seek amendment to Section 32 with Department of Health and Social Care.	From July 2025			Communication with DHSC underway	
Implementation of Strategic Patient Partnership Programme at Council level.	Patient partner recruited and induction and ongoing support in place.	September 2025	Professional Standards		Our two patient partners started in role in September 2025. First 3 and 6 month evaluation data collected.	

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Ongoing development of the Patient Involvement Forum to enhance quality of patient input to our policy development.	July 2025			Patient involvement forum development day took place during March with external speakers on influencing, boundaries, trust and the OPS review. Feedback was very positive and will inform the first meeting of the OPS review group. Ongoing briefings and debriefings have taken place with the patient forum members as they are feeding into our work throughout the year. Patients from our patient involvement forum also attended our Sector wide Development Day on 20 January 2026.	
	Ongoing evaluation.	Post October 2025				
Develop and publish guidance and other online resources specifically for participants in GOsC remote hearings.	Undertake a comprehensive review of remote guidance for witnesses and registrants for preparing for, and appearing in, GOsC remote hearings inviting contributions from	From June 2025	Regulation, Communications		Communications and Regulation team met in July to discuss approach. As part of the wider FtP work, remote guidance has been highlighted as a priority. The plan is a two phased approach, with the first phase focusing on updating the guidance and website pages (alongside updating content for the new website project). As part of a second phase of activity we are exploring further ideas for different kinds of media to compare options by cost and impact and also based on user insight/feedback. A review of the remote hearing guidance documents and web	

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	stakeholders including Victim Support and the Witness to Harm project at Open University.				pages with a view to suggesting changes is being undertaken by comms.	
	Undertake consultation on guidance.	August - October 2025				Summer 2026
	Publish guidance.	November 2025				FY2026-27
Take long-term financial and asset decisions which support delivery of statutory responsibilities and GOsC strategic aims.	Consideration of future registration fee modelling undertaken with any relevant consultations launched, responses analysed and results published.	From July 2025	Chief Executive, Resources, Communications		Papers under consideration by Council.	

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
To support students and osteopaths to practise to high standards in accordance with the Osteopathic Practice Standards.	Publish NCOR Concerns Report collaborating with NCOR, iO and insurers.	February 2026	Professional Standards, Communications		On Council agenda, February 2026.	
	Development of joint statement with insurers around professional responsibilities.	July 2025			Further consideration of feedback from sector parties required to find ground on which there can be collective agreement. There was a GOsC/NCOR/insurers meeting in February 2026 but unfortunately, there wasn't time to discuss this item and further discussion will be undertaken on email.	February 2026
	Ongoing development of resources and engagement to support implementation of standards.	All year			We are continuing to respond to osteopaths queries on how to apply the standards to issues that arise during their practice. We monitor and collate these to gauge common themes, and reflect on whether more widespread guidance is necessary, or other ways of supporting the implementation of standards. Workbooks to support CPD in boundaries and EDIB are currently being tested with groups of osteopaths for feedback.	

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Ongoing quality assurance activity as quality assurance of osteopathic education brought in-house.	All year to March 2026			Visits to HSU and BCNO have taken place in this business year, plus analysis of annual reports, consideration of concerns and ongoing sharing of good practice in areas such as Artificial intelligence and shared decision making.	
	Begin review of the Osteopathic Practice Standards by launching call for feedback.	From June 2025			The call for feedback was launched in December 2025 with a news story issued in January 2026. The call for feedback closed in March 2026. PEC established an OPS working group which will hold its first meeting in April 2026 and will be chaired by Patricia McClure.	
	Provide ongoing analysis of standards and ethical queries and responses to inform OPS call for feedback.	October 2025			An analysis was provided to PEC in June 2025. We are continuing to record all queries we receive from stakeholders and this continues to inform our communications and insight.	
	Complete report on Osteopathic Practice Standards call for	March 2026			The call for feedback launch was delayed to user test our feedback form and to make sure that we had broad stakeholder engagement and feedback on it before launch. This analysis	Summer 2026

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	feedback and launch Review of the OPS.				report of the initial feedback will be delayed to Summer 2026 following consideration of the initial draft by the OPS Working Group in April.	
Implementation of actions arising from independently facilitated review of GOsC Tone of Voice.	Independent review completed with action plan.	April 2025	Communications, Registration, Fitness to Practise		Ongoing sharing of resources to maintain momentum. Very positive online workshop held on 16 October with new members of staff, those unable to attend the in person session and members of the Communications team.	
	Implementation of agreed actions.	From May 2025				
Raise awareness of our role and increase engagement with stakeholders and implement DJS actions.	Implement student engagement plan.	From April 2025	Communications, Professional Standards		Successful first meeting of the student forum was held on 20 October. 8 students from a number of providers attended. Just over half were mature students. Topics covered included the importance of networks, loss of tutor supervision, how to find a supportive principle, mentorship, compassion fatigue, and the effect of negative social media forums on new students. Second and third meetings of student forum were successfully held – 3 students attended in December to discuss how we communicate with students, and 5 students attended in February to discuss feedback on the OPS. We have held a subsequent forum in April on our approach to	

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
					QA. We have 18 students on our forum mailing list as of 31 March 2026. Student visit programme for 2025/26: Student engagement already undertaken includes sessions with cohorts from College of Osteopaths, Derby, London School of Osteopathy, HSU, Swansea and NESCOT. Promotion of student ebulletin continues on social media, and via student ebulletin and posters to education providers.11 sign-ups from first and second year students have been received so far. Carried out section 32 consultation which focuses on our role as the regulator Recorded podcast with Gilly Woodhouse of OsteopathyWorks. Additionally myths and Independent Support Service details have been provided to share in her Facebook group. We are working with Independent Support Service to develop a new poster/social media image for promotion of the service.	

Strengthening trust: We will work to enhance/improve our relationships with those we work with so together we can help protect patients and the public						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
					WhatsApp continues to be positively received by users We have run a user feedback survey and we evaluate the stats as part of our regular digital evaluation.	
	Explore appetite for holding an educator conference.	October 2025	Professional Standards		We are working with the Collaborative Centre for Values Based Practice in Oxford and other disciplines to hold a workshop to support teaching, learning and assessment of shared decision making in undergraduate clinical education on 22 April 2026. Two OEIs have expressed interest in jointly hosting educator conferences to date and initial discussions are taking place with regards to dates during 2026. Agenda items are planned to include GOsC standards, outcomes and quality assurance, sharing good practice in teaching and learning with AI and inclusive practice: equity, diversity, inclusion and belonging.	
	Undertake ongoing face to face regional engagement with osteopaths.	All year	All staff		We met with the Waltham Forest Osteopathy Group in June 2025 to discuss boundaries and equality, diversity, inclusion and belonging. We attended the Scotland Osteopathic Society in September and visited the NI regional group on 4 October. We undertook online session on the CPD scheme for new graduates organised by the Kent & East Sussex group, and with the Cheshire	

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Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
					group in January 2026. We visited the Molinari Institute in December 2025 to talk to postgraduate students on the women's health programme. We also undertook face to face separate 2 hour sessions on inclusive practice: equity, diversity, inclusion and belonging (together with Alistair Booth) and boundaries (together with our PhD student, Kathryn Parkin) at the Institute of Osteopathy Convention in November 2026. We undertook a session with more than 20 osteopaths in the East Midlands Regional Group on shared decision making, boundaries and inclusive practice in March 2026.	
	Update fitness to practise sections of the website to include digital assets to explain the process clearly and accessibly.	July 2025	Communications, Regulation		Fitness to practise and 'Raise a concern' sections on the website have been updated to include visuals on the concerns process/timelines, myth busters, and hearing set ups. The content has been reviewed following the publications of the FtP annual report and updated to reflect the report. A podcast episode on FtP was published in April and audiograms highlighting the FtP process and the Independent Support Service were shared	

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Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
					on social media. These continue to be shared on social media and the ISS is promoted monthly on social, and appears in the ebulletin regularly. Work is ongoing to enhance the FtP content, including a jargon buster, remote hearing visuals and further promotion of the Independent Support Service, on social media, as well as in the ebulletin.	
	Update social media strategy and monitor use and impact of new communication channels and approaches including updated social media, WhatsApp and Drop in Sessions and evaluate.	March 2026	Communications		The monthly digital report has been established, evaluating social media (and other digital channels). The report highlights social media audiences and key learnings. The comms team will reflect on the evaluation every 12 weeks and use it to enhance social media content. The GOsC discontinued its use of X (formerly known as Twitter). This followed agreement by SMT based on a short paper provided by the Communications Team. The social media strategy outlined in next year's business plan will explore the use of other more appropriate channels. WhatsApp launched in late January 2025 and has seen consistent engagement with approximate 50-60 messages each month. Response times are consistently improving with	

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Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
					most enquiries receiving a response within 5-30 minutes. WhatsApp continues to be promoted on social media (monthly) and in the ebulletin.	

Championing inclusivity: It is important to us that people who interact with us, or who work for us, can be their true selves and that we understand and break down any barriers which prevent them from doing so						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
Collect, analyse, publish equality, diversity and inclusion data changes made, or mitigations put in place, where we have identified there is an undue impact on those with protected characteristics.	Publish information, throughout the year, including but not limited to: - Registration renewal - Governance and appointments - Fitness to practise - registrants and complainants - Policy development and consultations.	From April 2025	Chief Executive supported by Professional Standards, Regulation, Communications, Registration, Resources and Human Resources		We launched an EDI monitoring survey in the summer which has seen a response rate close to 20% of the profession, which has significantly enhanced the data we hold. Now the CRM has been implemented we are collecting EDI monitoring data at the point of annual registration renewal.	

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Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Equality Impact assessments for all policies and processes which allow GOsC to demonstrate changes made or mitigations put in place.	From April 2025			Our approach to Equality Impact Assessments is considered by the Senior Management Team and at their team meetings.	
Promote our Equality Duty responsibilities and the actions we intend to take to further our commitment to Championing Inclusivity. Coe Lorna 05/05/2026 16:36:44	Demonstrate progress against the new Equity, Diversity, Inclusion and Belonging Framework to include: • Updated social media, and image strategy • EDIB progress updated on website • Key messaging for the CRM roll out to encourage	All year with a specific Council annual report, July 2025	Chief Executive, Communications		Promotion of the student ebulletin and forum created and shared in Welsh too. Quarterly student ebulletin sent out in to students living and/or studying in Wales (October, February, March). Consultation on Section 32 published in June including an assessment of the impact on opportunities to speak Welsh. New images showing a wider diversity of people have been sourced and are being used across the ebulletin and social media. Regular social media posts acknowledging religious and diversity days/campaigns from February 2026 with the aim that by the end of 2026 we will have acknowledged campaigns	

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Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	completion of EDI data • Compliance with the Welsh Language Standards • Ongoing monitoring and reporting of equality impact assessments including for policy development and consultations • Ongoing support and resources for implementation of EDIB CPD subject to consultation.				across all major religions and protected characteristics. Welsh online registration form and EDI monitoring form implemented as part of new online registration process following new CRM implementation in January 2026.	
Implementation of recommendations arising from	Independent review completed.	From May 2025	Human Resources, Chief Executive		Independent report completed and considered by People Committee.	

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independent review into non-executive recruitment activity.						
	Action plan arising from independent review developed.	June 2025			Agreement from People Committee in October 2025 about approach for future non-executive recruitment campaigns in 2026+ for IC/PCC and Council appointments.	October 2025
	Implementation of agreed actions.	From July 2025			The 2026 IC/PCC appointment campaigns will follow our existing approach with a focus on streamlining questions and making the process as efficient as possible.	From October 2025
Support workforce recruitment and retention to maintain and increase a sustainable, diverse profession and to support osteopaths to practice in	Publication of NCOR Research projects on recruitment and retention.	July 2025	Professional Standards, Communications		The 2023 report was published in April 2025. The 2024 report is being considered on the February 2026 agenda.	
	Implementation of NCOR research recommendations.	September 2025 onwards			We consulted on boundaries and inclusive practice: equity, diversity, inclusion and belonging becoming a mandatory part of CPD and we also developed and are testing workbook resources to support CPD in this area alongside our detailed work on boundaries as part of Kathryn Parkin's PhD.	

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Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
accordance with high standards.					We updated our infection control guidance and we disseminated the NCOR findings to OEIs via our Regulator and Educational Liaison meetings and in our ebulletin for osteopaths.	
	Transition into practice: Hold workshop with Osteopathic Development Group organisations to explore and inform sector wide actions including development of GOsC guidance.	June 2025			There was a slight delay in arranging the workshop which was independently facilitated. First very positive workshop was held in person on 14 October. Some suggested outcomes, for example the career development framework are being taken forward with the Institute of Osteopathy.	October 2025
	Consideration of workshop findings and agreement to next steps.	October 2025			A meeting took place with Adrienne Skelton on 11 December to discuss the findings and next steps for the workshop. A meeting is taking place with the Institute of Osteopathy on 12 February 2026 to discuss next steps on the practitioner / new graduate charter and a new graduate survey. A proposal to take forward a series of working groups with different principals and graduates is part of the Business Plan for 26-27.	

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Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Ongoing discussions with European Regulators to clarify requirements for the recognition of professional qualifications and agree next steps.	All year			We met with Philippe Sterlingot, President, Syndicat Francais des Osteopathes (a professional body representing osteopaths in France) in September. We discussed recognition issues for UK trained osteopaths in France and he has agreed to support us in representations to the French government. We were due to meet again in November, but agreed to postpone given current political pressures in France. We plan to meet again with Philippe during Spring 2026. We also met with Giacomo Consorti in October from the Italian Register of Osteopaths who provided an update on the Italian government's progress in introducing osteopathic regulation in Italy. This helps us to understand the process for UK trained osteopaths wishing to practise in Italy once regulation is introduced. We also attended meetings with Osteopathy Europe, which has enabled us to raise our profile with European colleagues and forge	

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Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
					relationships to aid work on qualification recognition.	
Implement and evaluate health and disability guidance.	Publish health and disability guidance for students.	July 2025	Professional Standards, Communications		Both the student and the educator versions published in English and Welsh on 5 September. Easy Read versions are in development.	August 2025
	Take steps to integrate health and disability guidance into engagement plans.	August 2025			We mention the guidance when presenting to students to draw attention to it (and to the professionalism/FtoP guidance). We have asked educators to share this guidance with students and are including it in any student comms. Longer term we will be sharing this during every student visit as part of our wider approach to EDI.	
	Collect data on awareness and use of guidance.	Ongoing to March 2026			Anecdotal evidence suggests awareness of our supplementary guidance remains low. We are working on raising awareness of our supplementary guidance as part of our educator workshops during 2026/27 in addition to the student awareness workshops as outlined above. Our work to obtain the email addresses of students and educators and explore the best ways of communicating	

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					in addition to face to face and online workshops and emails will help us to improve and enhance dissemination, access and awareness. Consequently, collection of data currently has been delayed.	
	Publish evaluation report in implementation.	March 2026			Delayed.	
Strengthen Equity, diversity, inclusion and belonging with the GOsC CPD scheme.	Complete consultation and analysis of results on updated CPD scheme strengthening communication and consent requirements through a focus on mandatory EDI and boundaries activities.	June 2025	Professional Standards		We consulted on adding a mandatory requirement to incorporate CPD in boundaries and EDIB to the current mandatory communication and consent element of the scheme. The consultation outcomes were reported to our Policy and Education Committee in June 2025. The Committee paused a decision on mandatory CPD pending further development of accessible guidance and resources. We did a blog to encourage CPD in these areas pending further development of resources. Further resources have now been developed and are currently being tested with osteopaths alongside more layered and accessible guidance and PDR forms. In March 2026, PEC recommended updated guidance to Council for agreement which will make CPD in inclusive practice:	

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Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
					equity, diversity, inclusion and belonging mandatory.	

Embracing innovation: We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
Through tendering, identify a supplier and develop a new public website which provides scope for more modern, innovative and engaging channels and content.	Invitation to Tender process concludes with identification of supplier.	June - July 2025	Communications, Chief Executive		We received 20 submissions in response to our ITT. We shortlisted 4 suppliers and presentations took place in July. The panel were unanimous in their decision to appoint DXW.	
	Development of new public website.	From July 2025			Contract has been awarded and project initiated. After a slight delay in creating/finalising the complex contracts, kick off meetings were held from 16 October and we are now in the discovery phase of the project.	Contract awarded and project initiated with supplier: September 2025
	Implementation of new public website.	March 2026			The initial Discovery phase has been completed. This involved user research and technical investigation to refine user and technical requirements. Development is now in progress, with successful integration to the new CRM already established. Visual design, content migration, user research, testing and configuration will continue through spring and early summer 2026. Our GOsC content working group is in place and is working on the review, migration and redevelopment of website content.	Website implementation planned July 2026.

Embracing innovation: We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
					User research including with students, patients and osteopaths, continues to inform delivery, with further testing planned during development to validate key user journeys and how easy it is to find content before go-live. Following some delay during mobilisation and delivery setup due to unexpected long term supplier sickness, new public website is now scheduled for July 2026.	
Review the impact of changes in the delivery of healthcare including artificial intelligence on osteopathic education and osteopathic care and the use of artificial intelligence in health care for patients and to consider	Analysis of feedback on use of AI and agreement to statement about expectations and use of AI in education and practice (if possible in collaboration with health professional regulators).	June 2025	Professional Standards, Chief Executive, IT, Human Resources		We launched our interim guidance on the use of AI in osteopathic practice in May 2025. We are in the process of developing further supporting materials to aid understanding and promotion of the guidance. We held further meetings at an inter-regulatory level and produced a draft joint statement on AI and healthcare professional education. This was presented at PEC in October and we published this with other interested regulators in February 2026. We are continuing to work with osteopathic educators to develop a shared position with regards to AI use and osteopathic education. This is also part of the new Council for Osteopathic	

Embracing innovation: We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
impact on osteopathic standards and regulation.					Educational Institutions' Strategy and we will collaborate on this.	
	Commission research to support ongoing understanding about use of artificial intelligence ongoing in osteopathic practice.	July 2025			Our Business Plan for 2026/27 states that we will 'Put in place mechanisms for assessing use of AI in osteopathic practice and emerging risks.' We have been spending time this year making clear how our standards apply to the use of artificial intelligence in education and practice and working closely with other health regulators on this. Our next step will be to assess use.	June 2026.
	Agreement to process of updating and next steps.	July 2025			Feedback from stakeholders has not required the guidance to be updated to date. We are working on resources to support understanding and implementation.	March 2026

Embracing innovation: We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Procure appropriate models of AI for GOsC and ensure updates and training for all staff to ensure a skilled workforce fit for the future.	June 2025			We have developed appropriate governance measures to manage risk of use of AI within the organisation, whilst also ensuring benefits can be realised. An Acceptable Usage Policy is being rolled out to staff alongside a structured use of Microsoft Copilot.	February 2026
Seek continuous improvement arising from independent reviews of board effectiveness and internal audit activities.	Results of board effectiveness review presented to Council.	July 2025	Chief Executive, Governance, Resources		Paper presented to Council 15 July with the headline themes set out by Praesta (reviewers). Facilitated session held at September Strategy Day to prioritise recommendations.	
	Implementation of actions identified through board effectiveness review.	From August 2025			Action plan arising from BER report developed in a facilitated session at Council Strategy Day in September. Output to be presented to Council in November and subsequent meetings.	November 2025
	Internal Audit plan agreed by Audit Committee.	June 2025			Three-year plan for 2025-2028 developed with TIAA and presented to Audit Committee in June. Revised by Audit Committee in October 2025.	

Embracing innovation: We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
	Internal Audits programme commences.	From July 2025			Audits of registration (reported to Audit Committee, October 2025), fitness to practise, financial and budgetary control and risk management completed (reported to Audit Committee in March 2026).	
Refine and implement Theory of Change to measure progress and implementation of the Strategy.	Hold theory of change workshops with staff.	June 2025	Professional Standards			
	First draft of Theory of Change to Council for consideration.	July / September 2025			On Council private agenda, July 2025	
	Ongoing development and agreement to final evaluation strategy and refine data collection.	October 2025			Theory of Change work stopped as was not to Council's preference. November Council considering direction of illustrative framework for measurements to underpin strategy.	From November 2025

Embracing innovation: We will continually seek and take opportunities to improve what we do and how we do it, so we continue to improve as an organisation						
Activity	**Measurable actions**	**Timeline**	**Lead**	**Status**	**Narrative**	**Revised timing if relevant**
Implement more streamlined approach to data mapping, collection, insight and analysis and actions.	Collate comprehensive data map across organisation and update privacy policy and collection notices.	From May 2025	Professional Standards and Research, Data and Insight		Data collection mapping is complete across organisation. Draft privacy policy for staff and organisation are developed and are being refined. Data sharing agreements are updated and discussed with colleagues. Further work is being undertaken on our registration form consent notice to take account of changes in privacy notice, particularly around research consent.	
	Align data sets and develop systematic analysis and reporting.	November 2025			This work is ongoing. We are working to update the connection between student and registrant data and to consider how we make this data publishable. Work has been undertaken with regulation in relation to witness EDI forms which are now in place. The new CRM will provide more options for systematic collation and analysis of data and in particular linking student enrolment, progression, graduation and registration data more accurately.	

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

In 2025-26 we expect to:

Metric	Status	Narrative, if relevant
Process c5,500 registration forms (UK and International applicants and annual renewal of registration forms) and c5,000 reminder notices.		5,691 renewal of registration forms processed to end March 2026. 4,366 fee reminders (28-day). 645 (14-day fee and renewal form).
Support c220 first-time applicants to join the UK Register (including applications from internationally qualified applicants and from UK qualified graduates).		230 new applications fully processed at end March 2026. 1 international application fully processed at end March 2026.
Receive c200 queries from patients, members of the public, registrants and other healthcare professionals, leading to c75 fitness to practise cases being opened, of which c30 will be referred for investigation leading to c12 being referred for a final determination hearing.		As of 31/03/2026: 243 queries/concerns received 100 opened as an FTP case, of which 46 currently referred for Investigation 18 substantive hearings heard, three rule 19 considerations and two cases disposed of by Rule 8 process (consensual disposal)
Undertake quality assurance processes with 7 osteopathic educational providers including analysis of 7 annual reports and undertaking visits to four osteopathic educational providers.		Ongoing. Seven annual reports analyses will be considered by the Policy and Education Committee in March 2026. Two planned visits were undertaken this year.
Holding 3 good practice events and continue to engage on a 1:1 basis with all osteopathic educational providers during the year.		We have continued to meet with COEI as a group and with education providers on a 1:1 basis. We continue to offer engagement with all new students (in person or online) to introduce them to regulation and professionalism, and to any other student year group as requested by the provider/s.
Respond to c2,000 enquiries into our osteopathic information support service for osteopaths, patients and the public; c60 policy and ethical queries related to our standards; c4,600 registration queries and c650 student queries.		2,100 queries received at 31 March 2026. 72 policy and ethical queries related to the application of the OPS at 31 December 2025. 5,595 registration queries received at 31 March 2026. 638 student queries received at 31 March 2026.
Send out 12 monthly ebulletins to registrants achieving an open rate of c60%.		April - 58% May - 59%

Metric	Status	Narrative, if relevant
		June – 60% July – 56% August – 60% September – 59% October – 26% November – 32% December – 27% January – 47% February – 61% March – 62%
Send out 4 quarterly English language student ebulletins to 450 students (penultimate and final year) achieving an open rate of c40%.		February: 64% May: 55% October: 20% February 2026: 73%
Send out 4 quarterly Welsh student ebulletins to 70 students living in Wales (penultimate and final year) achieving an open rate of c30%.		February: 55% May: 53% October: 12% February 2026: 65%
Receive and fulfil 150 requests for personalised Registration Marks		142 requests received at 31 March 2026
Attend and participate in upwards of 25 osteopathic sector meetings, webinars and regional events engaging with osteopaths, students, patients and osteopathic organisations and other stakeholders reaching approximately 250 students and 500 osteopaths.		2 events attended by 31 March 26 with 80 osteopaths, students and other interested parties attending. Held 1 comms and consent webinar with 23 attendees plus 3 small focus groups around the CPD guidance with approximately 12 osteopaths.
Ensure the patient voice informs the work of the GOsC through at least 100 interactions (formal and informal) with members of the patient involvement forum.		4 patient engagement events held as at end March 2026. 105 individual touch-points with patients including where patients provide follow-up ideas to our work as at March 2026.
Host 2 recruitment webinars attracting interested applicants for our governance roles.		Scottish Recruitment webinar in October - 3 osteopath attendees IC recruitment webinar in October - 4 osteopath attendees, a further 8 registered. All were sent follow-up emails.

Metric	Status	Narrative, if relevant
Continue to regularly request and hope to receive feedback after our webinars and events that attendees have shifted their perceptions in a positive way e.g. are less fearful and have a deeper understanding about the topic		Positive feedback received after first Student Forum in October. Feedback collected from: East midlands CPD group presentation, sector development day
Ensure Council and Committee scrutiny and oversight of our work through servicing 15 meetings.		Council and Committee meetings have been held throughout the business year.
Provide training, development and strategy opportunities for c.50 members of the GOsC governance (decision making) structure, as well as those who advise on our statutory decision making including 12 education visitors and 8 registration assessors.		Induction meetings for new members happened from April. Council development/strategy day held in September. Education visitor training held. Sector wide development day held, January 2026
Provide training and development opportunities for our staff team.		Ongoing throughout the year.

Annex B to 7

Financial Report 2025-26 (12 months to March 2026)

PLEASE NOTE THAT THESE FIGURES ARE DRAFT WHILST THE YEAR END AUDIT IS IN PROGRESS

Key messages from the report:

- Total income is around £3.33m and is £134k over budget for the year.
- Operational expenditure is around £3.41m and is £220k over budget for the year. Spending from designated reserves was £185k in the year.
- Cash at bank is currently around £258k lower than at year end; we have had a large cash spend on infrastructure projects, such as the website, along with the increase in Regulation expenditure. Other operational spending is much as we had anticipated.
- The result for the year shows a deficit of just over £80k. The last quarter showed expenditure of £910k. This compares to anticipated expenditure of £771k, based on the forecast in the December 2025 Finance Report.

Background information

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

2. The budget for FY2025-26 was approved by Council in February 2025, and the budget for the 2026-27 financial year was approved by Council in February 2026.

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

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

5. The financial quarters are as follows:

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

6. This financial report covers the 12-month period ending 31 March 2026, which marks a full financial year. Please note that these figures are unaudited and subject to change as we move through the year-end audit process.

7. The structure of this report is:

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

Summary of financial position

8. At the end of the 12-month period to 31 March 2026, the income and expenditure account shows a deficit position (before designated spending from reserves) of £80k. Spending from reserves budgets in the 12-month period was £185k.

Income

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

10. At 31 March 2026, total income totalled around £3.33m, which is approximately £134k over budget for the same period. Registration fees accounted for 96% of the total income received. Investment gains, registration assessments, bank interest, and other income accounted for around 4% of income in the same period.

Expenditure

11. After the 12-month period, we have recorded actual expenditure of around £3.41m. This is approximately £220k over budget for the same period. We are anticipating costs to remain high in the 2026-27 year due to the Fitness to Practise caseload. Council will recall we significantly increased the budget for this area of our work.

12. Actual expenditure in the fourth quarter was £910k, £139k higher than we anticipated in the December 2025 Finance Report where we forecasted the full-year expenditure to be £3.27m (actual full-year expenditure is £3.41m)

13. The fourth quarter expenditure was largely due to fitness to Practise costs of £172k, compared to forecasted spend of £100k. This overspend has uncovered

weaknesses in the way we forecast future expenditure, which we will rectify going forward in the new financial year. The current method takes the year-to-date expenditure, and adds on any unused budget for the remainder of the year. To reduce the effect of the increase in Fitness to Practise expenditure, we have utilised the General legal reserve for some of the legal fees going through the department.

14. We will revise the way we forecast to ensure we have fewer surprises at the end of the year. One of the recommendations from the internal audit on budgetary control and financial planning was that we prepare the financials on a monthly basis instead of quarterly, which we will start doing; this was reported to Audit Committee in March 2026, with internal auditors TIAA in attendance. In addition to this, the Senior Management Team will apply additional scrutiny and more rigorous reviews when performing their checks on the financials as the year progresses.

15. Another area of overspend when compared to the forecast is Employment costs. Due in part to additional staff resource in the Regulation team, and the year-end adjustment for unused annual leave, the overspend compared to the forecast is around £58k.

16. Taking into account spending on designated reserves, the overall budget for the year was a deficit of £241k; we have come in slightly over that at £265k.

Income and Expenditure Account (top-level summary)

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

	Year to Date 1 April 2025 – 31 March 2026			
	Actual	**Budget**	**Variance**	
			£	**%**
Income				
Registration fees	3,198,646	3,113,225	85,421	3
Registration assessments	3,450	20,000	(16,550)	(83)
Other income	130,249	65,050	65,199	100
Total	**3,332,345**	**3,198,275**	**134,070**	**4**
Expenditure				
Employment costs	1,948,820	1,933,025	(15,795)	(1)
Education and professional standards	112,761	119,539	6,778	6
Communications, research and development	92,645	91,186	(1,459)	(2)
Registration administration	4,223	20,000	15,777	79
IT and infrastructure	141,395	125,110	(16,285)	(13)
Fitness to practise	584,802	400,000	(184,802)	(46)
Governance	254,939	260,450	5,511	2
Central resources and financing	272,970	243,217	(29,753)	(12)
Total	**3,412,555**	**3,192,527**	**(220,028)**	**(7)**
(Deficit)/surplus before designated spending	**(80,210)**	**5,748**	**(85,958)**	
Designated spending	185,241	246,500	61,259	
Deficit after designated spending	**(265,451)**	**(240,752)**	**(24,699)**	

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

18. Detailed departmental expenditure accounts can be found further in the document.

Balance Sheet

19. The Balance Sheet at 31 March 2026 shows total reserves of £2.34m (including designated funds). Cash held in hand and at bank totals £20k with a further £846k in the managed investment portfolio. The balance sheet below reflects the March 2026 valuation of the investment portfolio.

20. The Balance Sheet as at 31 March 2026 is set out below:

	31 March 2026			31 March 2025	
	£	£		£	£
Non-current assets					
Assets (fixed/intangible)		2,160,719			1,717,043
Investment (portfolio)		845,835			1,317,560
Current assets					
Debtors	109,509			193,311	
Cash in bank and in hand	19,918			277,969	
	129,427			**471,280**	
Liabilities					
Creditors:					
within one year	(800,359)			(904,809)	
	(800,359)			**(904,809)**	
Net current liabilities		**(670,932)**			**(433,529)**
Total assets less total liabilities		**2,335,622**			**2,601,074**
Reserves					
General reserve		2,174,332			2,065,385
Designated funds		161,290			535,689
Total Reserves		**2,335,622**			**2,601,074**

Balance Sheet explanatory notes

Debtors

21. Debtors have decreased to £110k from the year end position of £193k. This is predominantly due to movements in the prepayment balance. We would expect to see a fluctuation throughout the year as expenses are processed through the system.

Creditors

22. Creditors have decreased to £800k from the year end position of £905k. this is predominantly due to the movement in the deferred income balance (£260k), offset by an increase in the invoices payable balance (£102k).

Designated reserves update

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

Reserve	Reserve at March 2025	New allocation in year	Spend in year	Transfer (to)/from General reserve	Reserve at March 2026
IT investment	152,093	-	-	(152,093)	-
Registrant perceptions	3,772	-	-	(3,772)	-
General legal reserve	123,031	-	123,031	-	-
NCOR infrastructure costs	123,500	-	28,700	-	94,800
Website development	136,005	300,000	-	(436,005)	-
Innovation fund	-	100,000	33,510	-	66,490
IO Convention 2023	(2,712)	-	-	2,712	-
Total	**535,689**	**400,000**	**185,241**	**(589,158)**	**161,290**

NB: We have capitalised the spend on both the new CRM system and the new website development; these will be amortised over their useful life once they have been implemented. The balances have been released back into general reserves. The CRM project has already started amortising towards the end of the 2025-26 year.

24. Total spend so far on live transformation projects is £241k, compared to the approved budget of £436k.

Cash flow and investments

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

26. The cash at bank balance has decreased to £20k from the year end position of £278k. The cash position has trended down largely due to spending on major investment projects and an increase in Fitness to Practise activity. To manage the cash position until the main registration renewals, we have drawdown on the investment portfolio.

Investment portfolio

27. At 31 March 2026, the investment portfolio stood at £846k. The portfolio saw good investment returns in the year of around £145k before charges.

Charity Commission reporting

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

29. We did not need to make a report to the Charity Commission during financial year 2025-26. The annual report submission to the Charity Commission was completed in November 2025.

Departmental Expenditure Accounts

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

Employment costs

	Year to Date 1 April 2025 – 31 March 2026			
	Actual	**Budget**	**Variance**	
			£	**%**
Expenditure				
Salaries & Pensions	1,859,719	1,846,000	(13,719)	(1)
Staff development & training	25,331	38,425	13,094	34
Recruitment	25,147	15,000	(10,147)	(68)
Other pension costs	7,356	-	(7,356)	(100)
Temporary staff	4,411	3,500	(911)	(26)
Annual P11d tax cost	1,414	1,600	186	12
Staff benefits:				
Insurance premiums	16,519	17,000	481	3
Other staff costs & benefits	8,923	11,500	2,577	22
Total	**1,948,820**	**1,933,025**	**(15,795)**	**(1)**

31. The fourth quarter position shows a total expenditure of £1.95m, against a year-to-date budget allocation of £1.93m. The overspend is predominately due to salaries, pension, recruitment, and pension fund costs. There was an offset in staff development costs.

32. The overspend in salary and pension costs reflects additional staffing requirements in the Regulation team due to the increased workload; recruitment costs are also partly linked to this.

33. Other pension costs relate to the set up and management of the two pension funds GOsC operates.

Education and professional standards

	Year to Date 1 April 2025 – 31 March 2026			
	Actual	**Budget**	**Variance**	
			£	**%**
Expenditure				
Quality assurance	90,327	89,105	(1,222)	(1)
Research projects	16,279	26,225	9,946	38
Osteopathic Practice Standards	6,155	2,209	(3,946)	(179)
Publications & subscriptions	-	2,000	2,000	100
Total	**112,761**	**119,539**	**6,778**	**6**

34. The fourth quarter position shows a total expenditure of £113k, against a year-to-date budget allocation of £120k. There is a small overspend on QA work; however, bringing the QA process in-house has significantly reduced costs in that area (down 61% compared to the same period last year). The overspend is due to an extension of the Mott McDonald contract through to October for their attendance at PEC in October, and completion of the HSU visit.

35. The Research projects category includes costs in relation to a PhD student doing research work, with budget in place for Boundaries (£6k), OPS (£12k), and other Research Projects (£2k). The budget for Publications & subscriptions will not be utilised following a review of costs, and can be used to offset any overall overspends in the department.

36. Also to note is that from April 2026, the data and research elements of this department will be shown separately, as per the approved budget for 2026-27.

Communications, research, and development

	Year to Date 1 April 2025 – 31 March 2026			
	Actual	**Budget**	**Variance**	
			£	**%**
Expenditure				
Digital	28,361	25,795	(2,566)	(10)
Publications	13,104	5,818	(7,286)	(125)
Welsh Language Scheme	7,405	8,406	1,001	12
Engagement and events	7,149	11,167	4,018	36
Research				
IJOM	36,626	40,000	3,374	8
Total	**92,645**	**91,186**	**(1,459)**	**(2)**

37. The fourth quarter position shows a total expenditure of £93k, against a year-to-date budget allocation of £91k. The overspend is predominantly due to Digital, with some underbudgeted spend on WhatsApp and Google, and an unbudgeted

Student Ebulletin; these have been allowed for more appropriately in the approved 2026-27 budget.

38. The overspend in Publications relates to two invoices from Mighty Agency which were sent late by the suppler; the work was in the previous financial year but missed the year end cut off. There was also an unbudgeted Disability & Health publication. However this is largely offset by underspends in Engagement & events, and a reduced cost for IJOM research journals following a review of the titles we supply to registrants; this followed an examination of the most used titles supported by a small engagement exercise with the profession where we asked for their preferences.

39. Also to note is that from April 2026, the data and research elements of this department will be shown separately, as per the approved budget for 2026-27.

Registration administration

	Year to Date 1 April 2025 – 31 March 2026			
	Actual	**Budget**	**Variance**	
			£	**%**
Income				
Registration assessment income	3,450	20,000	(16,550)	(83)
Total	**3,450**	**20,000**	**(16,550)**	**(83)**
Expenditure				
Registration assessments	4,223	20,000	15,777	79
Total	**4,223**	**20,000**	**15,777**	**79**
Net expenditure	**773**	**-**	**(773)**	**(100)**

40. The fourth quarter position shows a total net expenditure of just under £1k. The cost of registration assessments is largely offset by the fee-paying applicants applying for the assessments, and we expect the income and expenditure to be largely equal and opposite once assessments are completed.

IT infrastructure

	Year to Date 1 April 2025 – 31 March 2026			
	Actual	**Budget**	**Variance**	
			£	**%**
Expenditure				
CRM and infrastructure	85,830	76,510	(9,320)	(12)
IT Security	26,034	22,450	(3,584)	(16)
Software - Licensing	14,801	18,150	3,349	18
IT Consultancy cover	8,850	5,000	(3,850)	(77)
Other IT costs	5,880	3,000	(2,880)	(96)
Total	**141,395**	**125,110**	**(16,285)**	**(13)**

41. The fourth quarter position shows a total expenditure of £141k, against a year-to-date budget allocation of £125k. The overspend is predominantly due to spending on CRM and Infrastructure, annual leave IT cover, and IT Security costs.

42. CRM spend is overbudget due to the new CRM having taken longer than planned to implement and therefore paying for two systems at the same time; we had to renew the existing CRM system in November for a full year to November 2026.

43. We changed supplier in the year for cover for when the IT Manager is away; this ongoing cost is a lot lower and the following year will reflect this. IT Security costs in general are increasing which is reflected above. We currently have six systems in place to bolster our cyber security.

Fitness to practise

	Year to Date 1 April 2025 – 31 March 2026			
	Actual	**Budget**	**Variance**	
			£	**%**
Expenditure				
Statutory committee costs:				
• Professional Conduct Committee	383,537	299,100	(84,437)	(28)
• Investigating Committee	144,890	64,000	(80,890)	(126)
FtP panel member holiday pay & pension	54,671	20,000	(34,671)	(173)
Section 32 cases	1,704	4,400	2,696	61
Other FtP projects	-	12,500	12,500	100
Total	**584,802**	**400,000**	**(184,802)**	**(46)**

44. The fourth quarter position shows a total expenditure of £585k, against a year-to-date budget allocation of £400k. There is an overspend of £185k in costs across the various committees in the year so far due to the large increase in cases this year. The increased caseload, and also the complexity, shows no signs

of slowing down, and the approved budget for 2026-27 reflects this increased activity.

45. We would like members to note the panel member holiday pay and pension costs: £27k of the amount paid so far relates to the two years to 31 March 2025. We have £20k budgeted per year for this, and for the twelve months of the year to date, we have paid just under £24k on holiday pay and pensions (next year's budget has been increased slightly to £23k). At the 2024 year end, the provision for FtP panel member holiday pay and pension was removed after taking advice from the external auditors; had this been left in, we would not have had that additional expense in the current year, which in fact relates to previous years.

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

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

48. As of 29 April 2026, the following hearings and meetings for the next six months are scheduled:

May 2026	**June 2026**
1x 5-day PCC hearing 1x 3-day PCC hearing 1x 3-day PCC hearing 1x 3-day PCC hearing 1 x 4-day PCC hearing 1x 1-day PCC review hearing 1x 1-day PCC Rule 8 meeting 1x 1-day IC meeting	1x 1-day PCC ISO hearing 1x 3-day PCC hearing 1x 1-day IC meeting
July 2026	**August 2026**
1x 1-day IC meeting 1x half day PCC panel chair training	1x 1-day IC meeting 1x 4-day PCC hearing (remaining days from February)
September 2026	**October 2026**
1x 1-day IC meeting	1x 1-day IC meeting

Governance

	Year to Date 1 April 2025 – 31 March 2026			
	Actual	**Budget**	**Variance**	
			£	**%**
Expenditure				
Honorariums & responsibility allowances	105,354	110,000	4,646	4
Council and committee costs, incl. reappointments	67,442	60,010	(7,432)	(12)
Board effectiveness	43,200	36,000	(7,200)	(20)
Internal Audit	19,440	14,400	(5,040)	(35)
PSA levy	15,621	16,240	619	4
Tax liability (Council expenses)	2,742	10,000	7,258	73
Equality & Diversity	1,140	2,000	860	43
Skills audit	-	11,800	11,800	100
Total	**254,939**	**260,450**	**5,511**	**2**

49. The fourth quarter position shows a total expenditure of £255k, against a year-to-date budget allocation of £260k. The majority of underspends are due to the new project for a skills audit of Governance members and tax payable on Council member expenses. No spend has gone through in the year to date for the skills audit; this project has been put on hold. The tax payable on Council member expenses was also lower than expected.

50. There are some overspends in Council and Committee costs, mainly due to appointments (the recruitment process for the Scottish member of Council was run multiple times; this was ultimately successful). Board Effectiveness costs were also overspent due to an additional facilitated session requested by Council. The overspend on Internal Audit was due to some of the work taking longer than TIAA had anticipated (they charge on a day rate).

51. Honorarium and responsibility allowances of £105k represent 41% of the total expenditure for the 12-month period.

Central resources and financing

	Year to Date 1 April 2025 – 31 March 2026			
	Actual	**Budget**	**Variance**	
			£	**%**
Expenditure				
Premises	78,040	80,220	2,180	3
Depreciation & amortisation	66,050	53,900	(12,150)	(23)
Office administration	51,472	37,170	(14,302)	(38)
Financing	38,234	34,000	(4,234)	(12)
Financial audit fee	25,140	26,208	1,068	4
Publications and subscriptions	7,149	5,019	(2,130)	(42)
International conferences	6,885	6,700	(185)	(3)
Total	**272,970**	**243,217**	**(29,753)**	**(12)**

52. The fourth quarter position shows a total expenditure of £273k, against a year-to-date budget allocation of £243k. The majority of the overspend relates to unbudgeted expenses in relation to marketing the headquarter building (shown under Office administration above), depreciation & amortisation, and bank charges.

53. The overspend on depreciation relates to a programme of upgrading and replacing staff laptops, in addition to upgrading the office backup power system; the costs for these are spread over three years.

54. The two principal areas of expenditure within the Central resources department (not including depreciation or financing) are the cost of premises including rates and service contracts (£78k), and office administration including insurance, postage, and photocopying (£40k). These two areas represent 44% of the total expenditure after the 12-month period.

General Osteopathic Council

Annex C to 7

Council
13 May 2026
Registration report

Classification	Public
Action	For noting
Purpose of the paper	To note the registration statistics for the six-months to 31 March 2026.
Strategic Priority implications	Activities within this report will align with the GOsC strategic priorities around trust and inclusivity.
Standards of Good Regulation implications	This paper relates to Standards 10 and 11 of the PSA Standards of Good Regulation.
Communications implications	None
Financial, resourcing and risk implications	The primary source of income for the GOsC is from registration fees, and therefore any movement in the Register has an impact on our annual income and future budget forecasts.
Patient perspectives	Where relevant, these will be identified within the paper.
Diversity implications	The report provides demographic data about the Register.
Welsh language implications	We need to report annually on the number of Welsh registrants and Welsh language speakers on our Register.
Annex	Registration data
Author	Ben Chambers
Background reading	None

Recommendation	To note the content of the registration report.

Key messages

- At the end of March 2026 there were 5,653 osteopaths on the Register.
- The number of non-practising registrants stands at 184 at the end of March 2026.
- Three return to practise assessments were completed in the reporting period. Five registration assessments, connected to internationally qualified applicants were completed.

Background

1. The registration report to Council provides detailed information about the statistics and activities which have been undertaken within the Registration team and covers the six months from 1 October 2025 to 31 March 2026.

Executive view

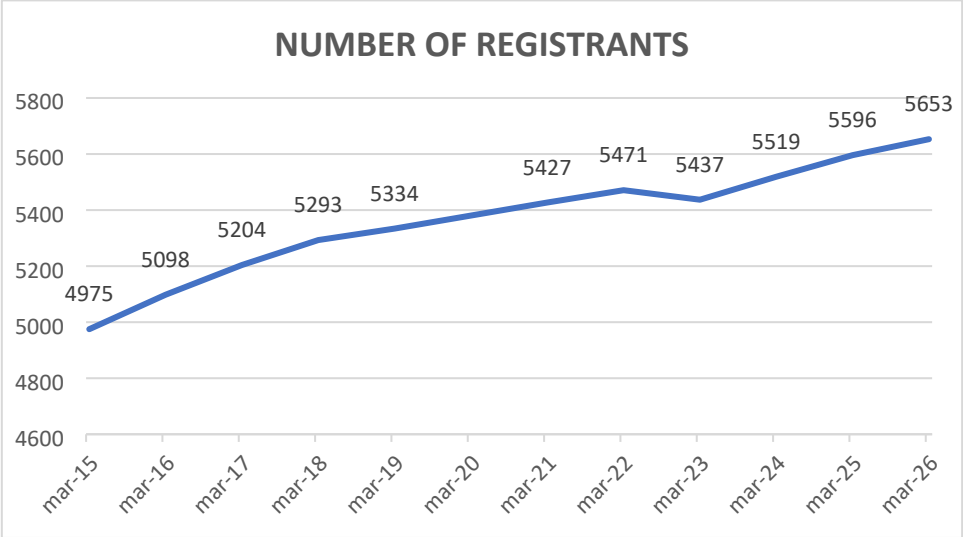
2. After analysing the registration data, I have no concerns to share with Council and the data is within normal ranges for what I would expect at this point in the year.

Recommendation: To note the content of the registration report.

Registration data

Number of registrants

1. At the end of March 2026, the Register contained 5,653 registered osteopaths. The graph below outlines the number of registrants, from March 2015 to present, to give Council members an overall picture on the average growth of the register.



Gender split of registrants

2. At the end of March 2026, split by gender, the Register comprised of 2,996 female registrants (52.69%) and 2,657 male registrants (47.31%).

3. Thirteen years ago (March 2012) the Register contained 4,584 osteopaths, with the female to male registrant ratio being 49:51. Over this period the Register has grown by just over 1,060 osteopaths and there are now a greater proportion of female registrants compared to male registrants.

Age split of registrants

4. The age breakdown of the Register at the end of March 2026 was:

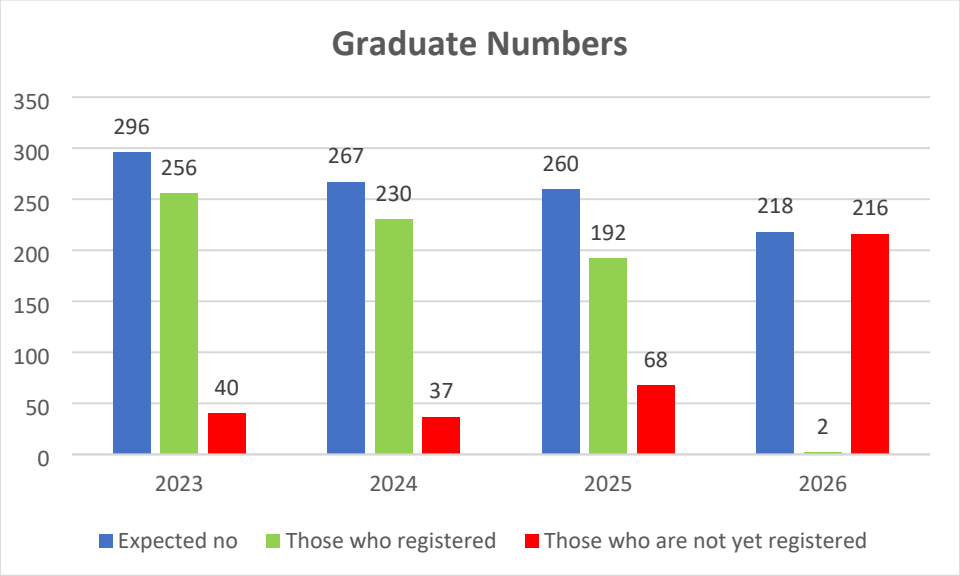
Age	Total registrants	Of which	
		Practising	Non-practising
Under or equal to 30	700	673	27
31-40	1,270	1,202	68
41-50	1,364	1,326	38
51-60	1,403	1,374	29
61-70	793	769	24
71-80	113	113	0
81+	9	9	0
Total	**5,653**		

5. **16.19%** of the register are aged 61+. This is something which we need to factor into the longer term financial planning for the GOsC, as a reasonable assumption is that a proportion of registrants in this group may leave the Register in the next 5-10 years.

Number of final year students

6. The information set out in the table and graph below outlines the number of students we are expecting to graduate and the number of UK graduates who subsequently registered with the GOsC:

Graduation year	Graduate numbers (est)	Of which	
		Registered	Unregistered
2023	296	256	40
2024	267	230	37
2025	260	192	68
2026	218	2	216



7. It should be noted that the majority of UK graduates qualify and subsequently register between the months of June to October each year so the main 2026 graduate cohort are still undertaking their studies.

Entrants to the Register (01 October 2025 to 31 March 2026)

Total number of entrants to the Register	58

of which

First time applications	51
Restorations to the Register (taking a break)	7
Restorations to the Register (following FtP case)	-

of which

Number of registrants living in the UK	55
Number of registrants living overseas	3

Removals from the Register (01 October 2025 to 31 March 2026)

Total number of removals (excluding resignations, retirements and death)	12

of which, those removed for

Non-compliance with CPD	-
Non-payment of fee	9
Unacceptable professional conduct	1
Under PII Rules	2
Fraudulent application to the Register	-

8. Since the reporting of statistics to Council began, 510 registrants have been removed from the Register. The data below sub-analyses the removal from the Register data into different categories including age and gender.

Removals from the Register (age)

9. Of those registrants removed from the Register, 73% (371 registrants) were below the age of 50.

10. The age range per reason for removal is set out in the table below.

Age range	Number of registrants	Removed for fee non-payment	Removed for CPD non-compliance	Removed under FtP proceedings	Removed under PII Rules or fraudulent application
20-29	90	66	19	1	4
30-39	142	73	49	3	17
40-49	139	69	39	10	21
50-59	84	27	29	7	21
60-69	38	9	6	6	17
70+	17	6	4	2	5
Total	**510**	**250**	**146**	**29**	**85**

Removals from the Register (gender)

11. The total number of registrants removed from the Register since reporting of statistics to Council began in October 2011, indicates 55:45 split between male to female registrants removed from the Register.

Gender	Number of registrants	Removed for fee non-payment	Removed for CPD non-compliance	Removed under FtP proceedings	Removed under PII Rules or fraudulent application
Male	283	136	77	27	43
Female	227	115	69	2	41
Total	**510**	**251**	**146**	**29**	**84**

Reasons for resignations (01 October 2025 – 31 March 2026)

Total number of resignations	42

of which, the reasons cited were

		Average length of registration with GOsC
Moving overseas	16	7 years

Career change	12	13 years
Other *	14	11 years

**Other includes the following reasons; Ill health/deceased, No longer practising, Cannot afford fee, Taking a sabbatical, Family/personal reasons, Does not like GOsC/agree with policy and No reason provided. Due to persons being potentially identifiable if reporting less than 10, these have been consolidated.*

12. The number of resignations is slightly lower compared with the same period in the previous year (84 in March 2025) which reflects the nature of registration renewals that happen monthly rather than at a single point in time.

Non-practising registrants (as of 31 March 2026)

Total number of registrants who are listed as non-practising	184

13. Based on the statistics reported to Council since October 2011, at any one-time GOsC has on average 154 registrants who are out of clinical contact with patients. The main reason for registrants to be listed as 'non-practising' is because of maternity leave.

Return to practice activity (01 October 2025 – 31 March 2026)

14. We offer a return to practice process to all applicants who have been away from UK practice for two years or more to support their transition back to practice. This process involves a self-assessment activity, which may then be followed by a meeting with two trained Return to Practice Reviewers.

Total number of applicants who went through the Return to Practice self-assessment process	3

International Registration Assessment activity (01 October 2025 – 31 March 2026)

15. A total of five registration assessments were completed in the reporting period.

Number of Non-UK Review of Qualifications	3
Number of Further Evidence of Practice forms	1
Number of Assessments of Clinical Performance	1

Council
13 May 2026
Fitness to Practise report

Classification	Public
Action	For noting
Purpose of the paper	Quarterly update to Council on the work of the Regulation department and the GOsC's Fitness to Practise committees.
Strategic Priority implications	Delivery of our statutory fitness to practise activity in a timely and fair manner will help with the strategic priority of Strengthening Trust. We have outdated, prescriptive legislation so to be efficient and cost-effective and fair we also Embrace Innovation.
Standards of Good Regulation implications	There are five Standards of Good Regulation which relate specifically to Fitness to Practise. The paper and annexes speak to these five Standards - see background reading.
Communications implications	We engage with registrants, complainants and third parties throughout the whole fitness to practise process. All parties involved in an investigation have access to the Independent Support Service.
Financial, resourcing and risk implications	Financial aspects of Fitness to Practise activity are considered in Annex B of the Chief Executive and Registrar Report.
Patient perspectives	Our fitness to practise processes are central to patient protection and the public interest. We support complainants who raise concerns at every stage of the fitness to practise process.
Diversity implications	Ongoing monitoring of equality and diversity trends will form part of the Regulation department's future quality assurance framework.
Welsh language implications	There are no implications for the Welsh Language arising from this paper.
Annex(es)	A. Fitness to Practise Data Set B. Fitness to Practise Dashboard

Author	Sheleen McCormack, David Bryan
Background reading	PSA Standards of Good Regulation The GOsC Concerns Process Fitness to Practise Annual Report 2024-25 Protecting the osteopathic title, Section 32

Recommendation(s)	To note the report.

Key messages

- We are continuing to manage a high number of open cases.
- In this reporting period, we have received the highest number of screener decisions (33) for eight years.
- Currently 38% of the overall caseload relates to concerns regarding a breach of boundaries. This represents a slight decrease in the number since the last quarter (39%).
- The Investigating Committee met on two occasions and considered 7 cases in total.
- During the reporting period six substantive hearings were held by the PCC, in which three concluded and three were part heard.
- There was a high volume of hearing days that took place during Q4, with a total of 34 hearing days.
- We have held various training days throughout the reporting period including the Investigating Committee (IC) annual training day, new chair training and induction training for new IC members.
- The key findings and recommendations from the FtP audit conducted in October 2025 are detailed within this report. A headline point falling out of the audit is that GOsC identifies and prioritises all cases which suggest a serious risk to the safety of patients/service users and general public.

Fitness to practise caseload and case trends

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

2. Of the 19 concerns received: 5 related to a breach of boundaries, 3 related to poor communication, 1 related to conduct not linked to treatment, 1 related to a registrant's conviction, 1 related to the Registrant's poor health, 6 related to inadequate treatment, 1 related to a lack of insurance and 1 misuse of social media.

3. Of the 19 formal concerns opened: 1 related to a misuse of social media, 2 related to a breach of boundaries, 2 related to conduct not linked to treatment, 1 related to the Registrants health, 1 related to a lack of insurance and 12 related to inadequate treatment.

4. Currently 38% of the overall caseload relates to alleged breach of boundaries, a 1% decrease from the last quarter. The majority of these cases relate to allegations of sexual touching / sexually motivated conduct.

5. As at 31 March 2026, the Regulation Department's fitness to practise caseload was 98 cases (82 formal complaints and 16 concerns) which represents an increase by 1 case reported last quarter (97). This represents the highest number of open cases since 2017-18.

6. In comparison, the Regulation department's fitness to practise caseload as of 31 March 2025, was 78 cases (59 formal complaints and 19 concerns). An explanation on the impact throughout the end to end FtP processes is illustrated below:

    - There has been a sustained increase in the number of new concerns received over each quarter during the last year, resulting in the highest number of concerns received in a year since 2019-20.

    - Over recent quarters screeners have referred more concerns to the Investigating Committee. In this reporting period screeners have referred 19 concerns to the IC which represents the highest referral rate for the last eight years. This means that there are a higher number of cases at the IC stage.

    - The number of third party cases, over the last few years, has impacted the number of live cases as these cases remain open for longer due to ongoing police investigation and/or court procedures.

7. We continue to encounter delays in the progress of some cases related to third-party investigations. During the reporting period 23% of our total caseload is a third party investigation.

8. We continue to experience ongoing difficulties in terms of engaging and re-engaging complainants. This has negatively impacted on progress some cases expeditiously. This is particularly challenging in light of the high number of serious concerns we have are continuing to receive. We are managing several complex cases involving vulnerable witnesses and have been managing fluctuations in their engagement with the FtP process.

9. During the reporting period, there were no applications to the Investigating Committee (IC) for the imposition of an Interim Suspension Order (ISO). There were two applications for an ISO made to the PCC, in which suspension orders were imposed in both cases.

10. During the reporting period six substantive hearings were considered by the PCC over 34 hearing days. Three cases were concluded and three went part heard.

Fitness to practise case progression

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

Case stage	Key Performance Indicator	Performance Target	Median figures achieved this quarter	Median figures excluding 3rd party cases
Screening	Median time from receipt of concern to the screener's decision	9 weeks	11 weeks	11 weeks
Investigating Committee	Median time from receipt of concern to final IC decision	26 weeks	51 weeks	49 weeks
Professional Conduct Committee	Median time from receipt of concern to final PCC decision	52 weeks	56 weeks	62 weeks
Health Committee	Median time from receipt of concern to final HC decision	52 weeks	N/A	N/A

12. In this reporting period the Screener KPI was not met. This is the first time we have failed to meet this KPI since 2020. The work of the regulation team this quarter has been particularly challenging, in that we have been managing a high volume of cases considered by Screeners (33 cases), and targeting our resources on high risk concerns and the back to back hearings that scheduled over this

period. We have successfully recruited additional short term resources focussed at the screener stage to ensure process cases are actively progressed. We are therefore confident that in the forthcoming quarters we will meet the screeners KPI.

13. The IC KPI was not met during this reporting period. This was for several reasons including: a lack of engagement from complainants (in one case the complainant was seriously ill); rescheduling a case for IC consideration at the request of the Registrant and one case having previously been adjourned by the IC.

14. As previously reported to Council, cases that are otherwise ready for consideration by the IC cannot be considered for the next IC meeting (or two) due to the fact that the IC cannot consider more than around 2/3 cases per meeting and advance agendas are already full.

15. We have, where possible, listed additional meeting days to counter this increase but this has been hindered by the upward trend in other IC activity such as interim order hearings and costs. Given these issues, we have been considering alternative ways of improving IC efficiency by enabling more cases to be considered at meetings whilst not compromising the quality of decision making and the written reasons.

16. We have decided to implement a pilot which we hope will streamline how written reasons are finalised using SharePoint. We wrote to all panellists and legal assessors on 15 April 2026, explaining that the pilot using SharePoint will commence at the IC meeting scheduled in May 2026. We will review feedback and make technical changes where required throughout the pilot and will report to Council in July 2026 on progress. We have not formally set an end date on the pilot as we want to assess how it progresses in practice.

17. The median output of the PCC cases was 56 weeks, and the KPI of 52 weeks was not met during this quarter.

Third party investigations - data comparison

18. We are unable to progress cases that are being investigated by the police and/or are before the courts. We have provided a table below where 'third party' investigations have been excluded from the median figures provided.

	Median age including 3rd party cases	Median age excluding 3rd party cases	Total number of 3rd party cases at each stage
Pre-screener stage	10 weeks	9 weeks	1 (6%)
IC stage	32 weeks	28 weeks	8 (19%)
PCC stage	84 weeks	6 weeks	12 (44%)
Total	**38 weeks**	**32 weeks**	**21 (24%)**

PCC and IC Training

19. A further Chair training session for PCC lay panellists took place on 20 March 2026. This event, like the previous one, focussed on best practice and skills required to chair a hearing, including softer skills relating to witness management. There remain two more lay members to train in this regard. Once they have been then all PCC lay members will be readily available to chair PCC hearings. This would assist with the timely scheduling of PCC hearings.

20. On 12 March 2026 we held training for two new Osteopathic members of the Investigating Committee. The training detailed the Fitness to Practise process, what happens at IC meetings and IC suspension order hearings, training delivered by an External Barrister on the IC's function and 'Case to Answer', as well as mandatory training relating to Equality, Diversity and Inclusion.

21. The IC Annual training day took place at Osteopathy House on 16 February 2026. The agenda included a session on Causation and FtP, an update on the threshold criteria and, similar to the PCC training day, a session on AI and its impact on FtP as well as an interactive session on case law updates.

Fitness to Practise Audit

22. As reported to Council at its last meeting in February 2026, TIAA, who were appointed by GOsC as internal auditors in April 2025, conducted an internal audit of the FtP function in October 2025. The auditors tested a sample of open and closed cases.

23. The scope of the review covered two of the PSA Standards of Good Regulation[1] and specifically the following Key Performance Indicators (KPIs)

KPI: That parties must be notified of the Screener's decision within five days.
KPI: That all parties are notified of the IC's decision and reasons within two working days of the decision being made.
KPI: That all parties to a complaint are kept updated on the progress of their cases at least monthly.
KPI: That there is evidence of an initial and continuing risk assessment on a case upon receiving new evidence or information throughout the life cycle of the case.

24. A sample of open and closed cases in the past 12 months were reviewed for quality and timeliness of communications sent. Feedback was provided to the

- [1] Standard 17: The regulator identifies and prioritises all cases which suggest a serious risk to the safety of patients or service users and seeks interim orders where appropriate and

  Standard 18: All parties to a complaint are kept updated on the progress of their cases and supported to participate effectively in the process.

Regulation team in December 2025 following the completion of the audit. The report was considered by the Audit Committee at its meeting in March 2026.

25. The key findings together with the recommendations and our responses are set out below:

- There is suitable evidence of an initial and continuing risk assessment on a case upon receiving new evidence or information.
- Relevant parties are provided with regular updates on case progression and where Investigating Committee hearings have been held decisions are communicated to all relevant parties within two working days.
- GOsC identifies and prioritises all cases which suggest a serious risk to the safety of patients/service users and general public.
- There are policies and procedures in place pertaining to the Fitness to Practise function. In line with best practice these should be reviewed at least every three years.

Recommendation	**GOsC response**
Management should develop and implement a formal Escalation Procedure that clearly defines: • Criteria for escalation (e.g., prolonged lack of engagement beyond a specified timeframe). • Roles and responsibilities for initiating escalation. • Communication steps to ensure timely resolution and accountability.	We plan to draft written guidance capturing non exhaustive criteria to be applied to cases and the procedure to be followed by the end of April 2026.
To demonstrate best practice, the Organisation should review policies and procedures at least every three years. In the next review, this should include both, the Fitness to Practise - Complaints Procedures (Osteopaths under investigation) Guidance for Osteopaths (July 2017) and the Initial Closure Procedure (October 2020).	Guidance for screeners was reviewed and amendments made and published in February 2026 to strengthen our commitment and approach to our Public Sector Equality Duty. To ensure and enable all to raise a concern against an osteopath, we have stated in our Business Plan for 2026-27 that we plan to review, update and publish our guidance documents: How to

Recommendation	GOsC response
	complain about an osteopath and The Fitness to Practise -Complaints Procedures (Osteopaths under investigation). We have also conducted a review of the threshold criteria after the external audit findings in 2025. This was shaped in discussion with the legal auditor that conducted the review. The draft threshold criteria was also discussed and further feedback received at the Investigating Committee annual training day and meeting on 16 February 2026. We are currently considering next steps including a consultation.
Ensure that decisions are chased by Case Manager's routinely, and that the relevant parties are notified within the set five-day timeframe.	We discuss the progression of cases at each case audit, also including where we are waiting for a report/material from a screener, for example. Usually screeners are quite prompt with their decisions however we have, and will, continue to chase decision makers for their decisions in a timely fashion in order to reduce any unnecessary delays in the caseload.

Executive view

26. We are of the view that our fitness to practise process enables GOsC to deal with cases fairly, justly and expeditiously in the public interest. We are mindful that dealing with cases justly and at proportionate cost includes dealing with a case proportionately:

    i. to the importance of the case
    ii. to the complexity of the issues.

Recommendation: To note the report.

Annex A to 8

Fitness to practise dashboard 01 January 2026 to 31 March 2026 (Q4)

Case progression – at a glance

- We have received 19 new concerns during the reporting period, this represents a decrease by 10 cases from the previous quarter.
- The Investigating Committee (IC) met remotely on two occasions and considered 7 cases.
- During this reporting period the Professional Conduct Committee (PCC) considered six hearings, concluding three and another three hearings going part heard.

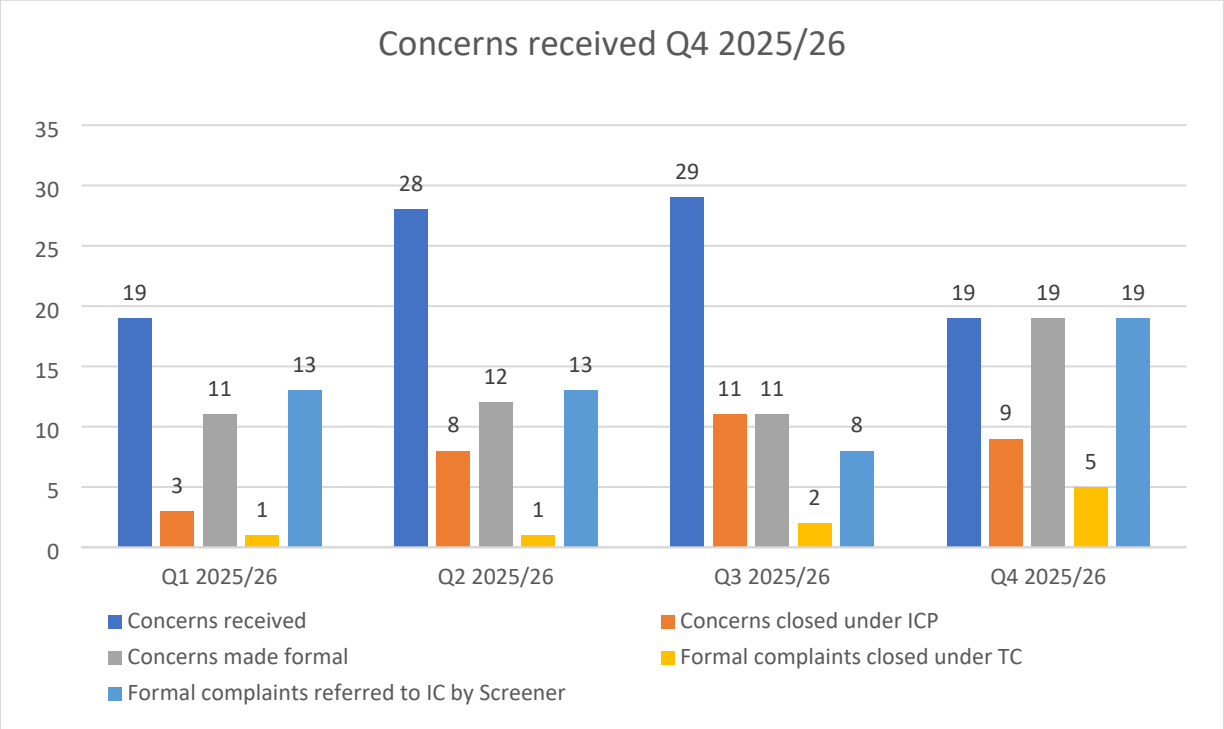
Referrals Received	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Formal complaints closed under TC	1	1	2	5
Formal complaints referred to IC by Screener	13	13	8	19
Formal complaint referred to IC by Screener but not yet considered (as at end of quarter)	29	34	32	43
Referred to PCC/HC by IC but not yet heard (as at end of quarter)	29	30	30	29
Referred to PCC/HC by IC and listed for hearing (as at end of quarter)	6	16	14	15
PCC/HC Cases part heard (as at end of quarter)	2	2	1	4
Formal complaints open (as at end of quarter)	62	67	68	80
Cases that need review hearings (as at end of quarter)	4	3	6	8

Age of Caseload from Date Received	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
52 weeks – 103 weeks	19	16	13	16
104 weeks – 155 weeks	14	9	11	10
156 weeks and above	6	7	10	8

New Referrals

- We have received 19 new concerns during the reporting period.
- Nine cases were closed under the Initial Closure Procedure (ICP).
- Five cases were closed under the threshold criteria.

- There were 33 cases considered by screeners, the highest number of screener decisions made in a quarter in the last eight years. 19 of these were referred to the IC, which represents a record high.



Referrals Received	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Concerns received	19	28	29	19
Concerns closed under ICP	3	8	11	9
Concerns made formal	11	12	11	19
Formal complaints closed under TC	1	1	2	5
Formal complaints referred to IC by Screener	13	13	8	19

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

Source of formal complaints	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Self-referral by the registrant	1	1	3	1
Registrar's allegation	1	0	0	0
Non-NHS employer	0	0	1	1
Patient or service user	14	9	20	16
NHS	0	0	0	0
Another registrant	1	0	1	0

Anonymous complainant	0	0	0	0
Another regulatory body	0	0	0	0
Any other complainant	2	2	4	1
Total	**19**	**12**	**29**	**19**

Key Performance Indicators

- The Screener KPI was not met, at eleven weeks.
- The Investigating Committee KPI was not met, at 51 weeks.
- The Professional Conduct Committee KPI was not met, at 56 weeks.

Performance at a glance

Case stage	Key Performance Indicator	Performance Target	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
Screening	**Median time from receipt of concern to the screener's decision**	**9 weeks**	6 weeks	9 weeks	8 weeks	11 weeks
Investigating Committee	**Median time from receipt of concern to final IC decision**	**26 weeks**	51 weeks	26 weeks	42 weeks	51 weeks
Professional Conduct Committee	**Median time from receipt of concern to final PCC decision**	**52 weeks**	91 weeks	72 weeks	124 weeks	56 weeks

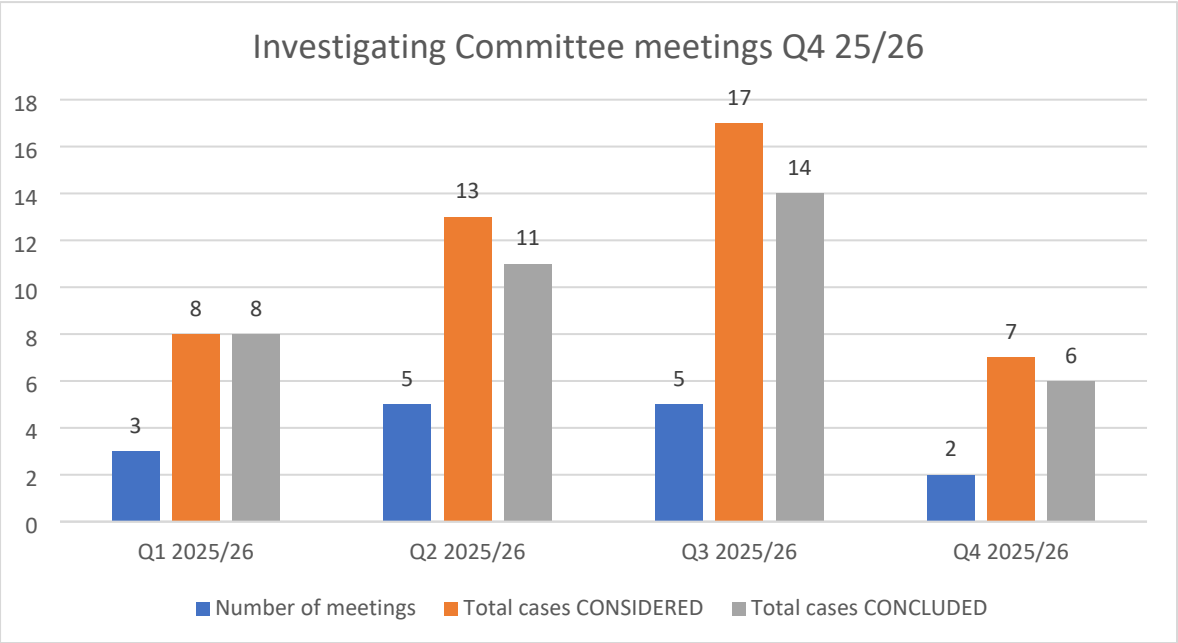
Performance in detail

Time from receipt of complaint to the screener's decision (9 weeks)	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Median	6 weeks	9 weeks	8 weeks	11 weeks
Longest case	22 weeks	33 weeks	28 weeks	30 weeks
Shortest case	0 weeks	1 week	1 week	3 weeks
Time from receipt of complaint to final IC decision (26 weeks)	**Q1 2025/26**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**
Median	51 weeks	26 weeks	42 weeks	51 weeks
Longest case	84 weeks	110 weeks	104 weeks	100 weeks
Shortest case	29 weeks	26 weeks	10 weeks	29 weeks
Time from final IC decision to final PCC decision or other final disposal of the case (26 weeks)	**Q1 2025/26**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**
Median	36 weeks	43 weeks	45 weeks	46 weeks
Longest case	80 weeks	24 weeks	175 weeks	98 weeks

Shortest case	18 weeks	153 weeks	29 weeks	22 weeks
Time from receipt of referral to final PCC decision or other final disposal of the case (52 weeks)	**Q1 2025/26**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**
Median	91 weeks	72 weeks	124 weeks	56 weeks
Longest case	141 weeks	174 weeks	203 weeks	76 weeks
Shortest case	43 weeks	72 weeks	58 weeks	45 weeks
Median time to interim order committee decision:	**Q1 2025/26**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**
From receipt of referral	5 weeks	23 weeks	9 weeks	N/A
From decision that there is information indicating the need for an interim order	3 weeks	5 weeks	4 weeks	N/A

Investigating Committee

- The IC met remotely on two occasions during the reporting period and considered 7 cases.
- The IC KPI was met not met during this quarter, at 51 weeks.
- The overall number of cases awaiting IC consideration (ie under investigation) has increased dramatically from 33 cases to 42 cases. This is due to the large number of screener decisions made and the higher number of concerns referred to the IC during the reporting period.
- 8 of the 42 cases (19%) at the IC stage are currently recorded as third party cases.
- The IC did not consider any Interim Suspension Order (ISO) applications during the reporting period.



Investigating Committee Decisions	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
No Case to Answer	4	3	4	3
No Case to Answer with advice	1	0	2	1
Referred to PCC	3	7	6	2
Referred to HC	0	0	0	0
Referred to PCC and HC	0	0	0	0
Adjourned	0	2	3	1
Stayed	0	0	0	0
Rule 19 agreed	0	1	2	0

Professional Conduct Committee

- During the reporting period six substantive hearings were considered by the PCC, of which three were concluded and three went part heard. Some of these hearings consistented of a number of individual cases (ie more than one 'case' considered by the PCC at one hearing).

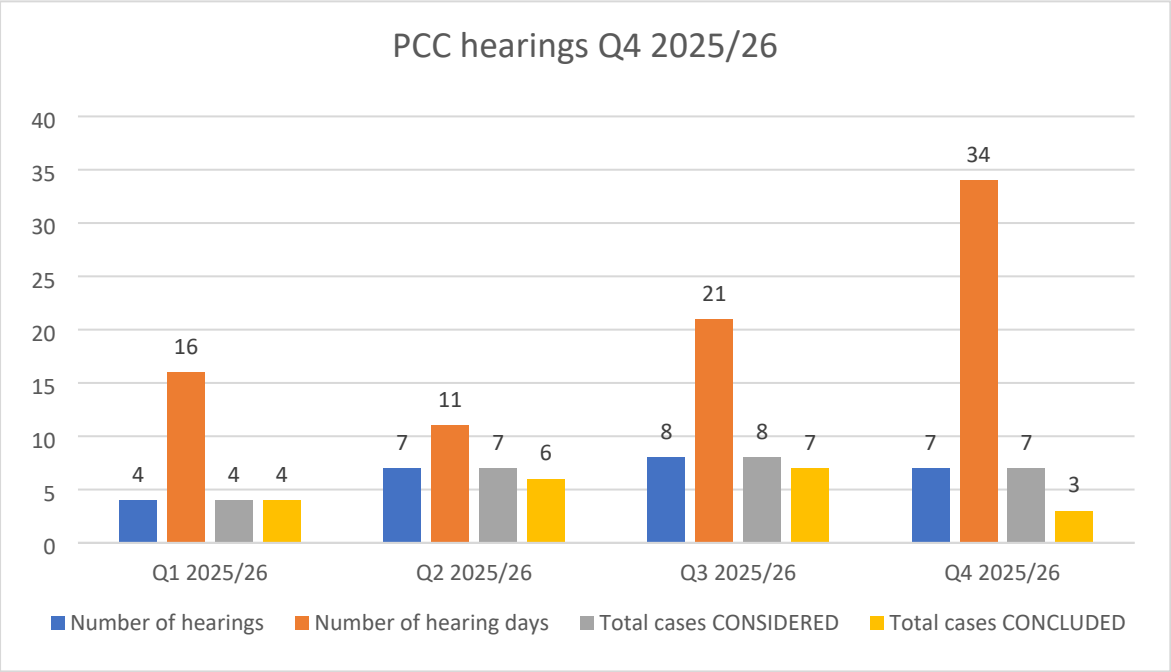
- The number of cases at the PCC stage (29) has decreased by one since the previous quarter.

- 41% of cases at the PCC stage are, or were, third party cases which is a decrease from 47% recorded at the previous quarter.

- The status of the 29 cases at the PCC stage are broken down as follows:

- Four cases have been served on the Registrant and we are awaiting the listings questionnaire before we can schedule the hearing.
- Four cases are part heard and have been re-scheduled.
- Seven cases have been scheduled for hearing
- Five cases we are in the process of scheduling the hearing dates
- Three cases are with the police for investigation and so are currently recorded as 'third party' cases
- Six cases we are preparing to serve on the registrant

Professional Conduct Committee Hearings	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Number of hearings	4	7	8	6
Number of hearing days	16	11	21	34
Total cases CONSIDERED	4	7	8	6
Total cases CONCLUDED	4	6	7	3



PCC Decisions	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Allegation not 'well founded'	1	2	1	1
Admonished	1	1	1	0
Conditions of Practice	1	0	1	0
Suspension	0	0	2	1
Removal	0	0	0	1
Rule 19	0	1	2	0
Adjourned	0	1	1	4
Conditions/Suspension to expire at end of order	0	0	0	0
Rule 8 Admonishment	0	2	0	0
Stayed	0	0	0	0
Referred to the HC	0	0	0	0
Referred to PCC hearing (rule 8)	0	0	0	0
Conviction has no material relevance	1	0	0	0

Health Committee

- The Health Committee (HC) considered one review hearing during the reporting period.

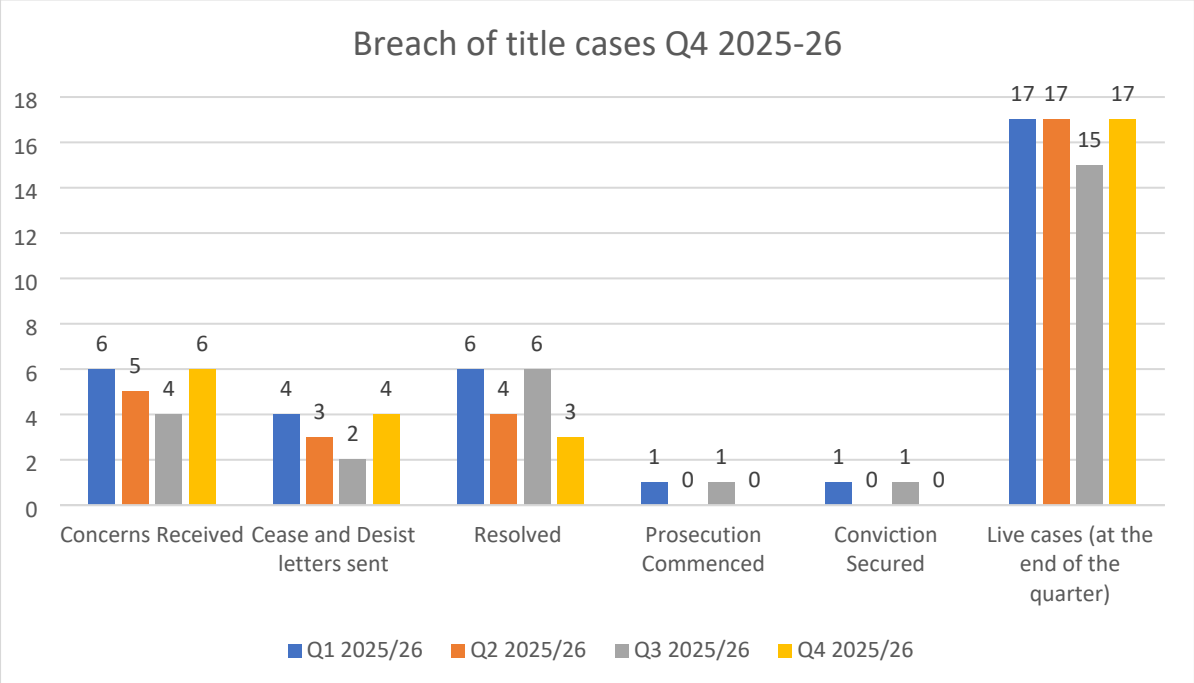
Interim Suspension Orders

IC Interim Suspension Order Decisions	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
Applications made	1	4	4	4
Interim Suspension Order imposed	0	1	3	3
Undertaking	0	0	1	1
Adjourned	0	0	0	0
Median time to IC decision from receipt of referral	5 weeks	23 weeks	9 weeks	9 weeks
Median time to IC decision from decision that there is information indicating the need for interim order	3 weeks	5 weeks	4 weeks	4 weeks

PCC/HC Interim Suspension Order Decisions	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
Applications made	0	1	3	2
Interim Suspension Order imposed	0	1	3	2
Undertaking	0	0	0	0

Protection of Title

- There are currently 17 active Section 32 investigations, An increase by 2 since the previous quarter.



Protection of Title	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Concerns Received	6	5	4	6
Cease and Desist letters sent	4	3	2	4
Resolved	6	4	6	3
Prosecution Commenced	1	0	1	0
Conviction Secured	1	0	1	0
Live cases (at the end of the quarter)	17	17	15	17

Appeals

- No appeals have been received during the reporting period.

Total number of registrant appeals in the quarter which are:	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Ongoing	0	0	0	0
Opened	0	0	1	0
Concluded	0	0	1	0
Outcomes of registrant appeals against final fitness to practise decisions:	**Q1 2025/26**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**

Upheld and outcome substituted	0	0	0	0
Upheld and case remitted to regulator for re-hearing	0	0	0	0
Settled by consent	0	0	1	0

Voluntary Removal

- No voluntary removal applications have been received n the reporting period.

Number of voluntary erasure/removal applications: Subsequent to the FTP case being considered by an IC.	**Q1 2025/26**	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**
Received	1	3	2	0
Granted	1	0	0	0

Fitness to Practise dashboard (Annex B to 8)

01 January 2026 – 31 March 2026 (Q4)

Statistics at a glance

Key:

Green represents that this statistic is on target, amber represents that the fact we are over KPI but there is both active progression of cases and cogent reason for being over KPI, with red representing that there was no active progression of cases or cogent reasons for being over KPI.

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Screener stage				
Formal concerns referred to IC by Screener	13	13	8	19
IC stage				
Concerns referred to the PCC	3	7	6	2
Awaiting IC consideration	29	34	32	
PCC stage				
Awaiting PCC consideration	29	30	30	43
Awaiting PCC consideration – listed for hearing	6	16	14	7
PCC/HC Cases part heard	2	2	1	5
Cases that need review hearings	4	3	6	8
General statistics				
Formal complaints open	62	67	68	80

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Receipt to screener decisions (9 weeks)	6 weeks	9 weeks	8 weeks	11 weeks
Receipt to IC decision (26 weeks)	51 weeks	26 weeks	42 weeks	51 weeks
Receipt to PCC de (52 weeks)	91 weeks	72 weeks	124 weeks	56 weeks

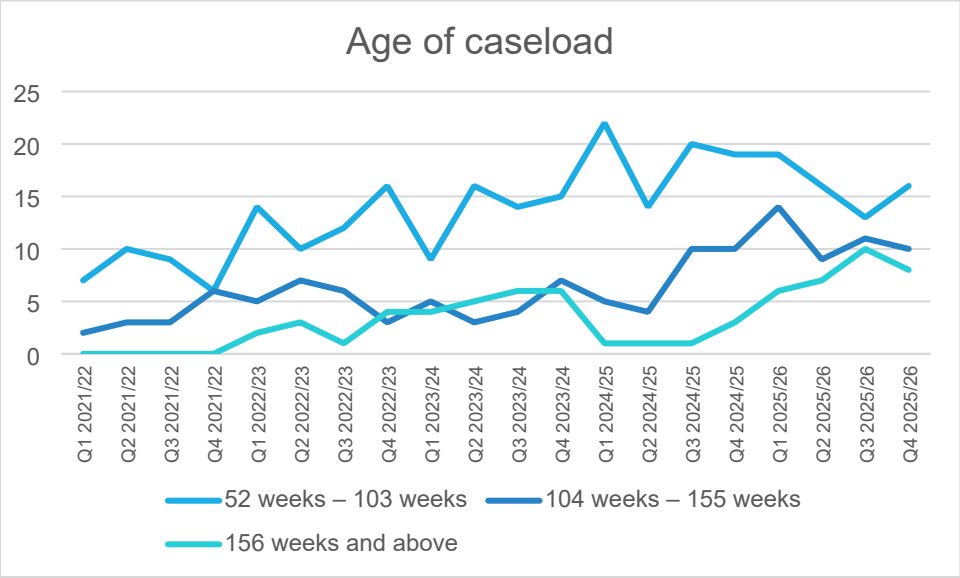
Third party statistics

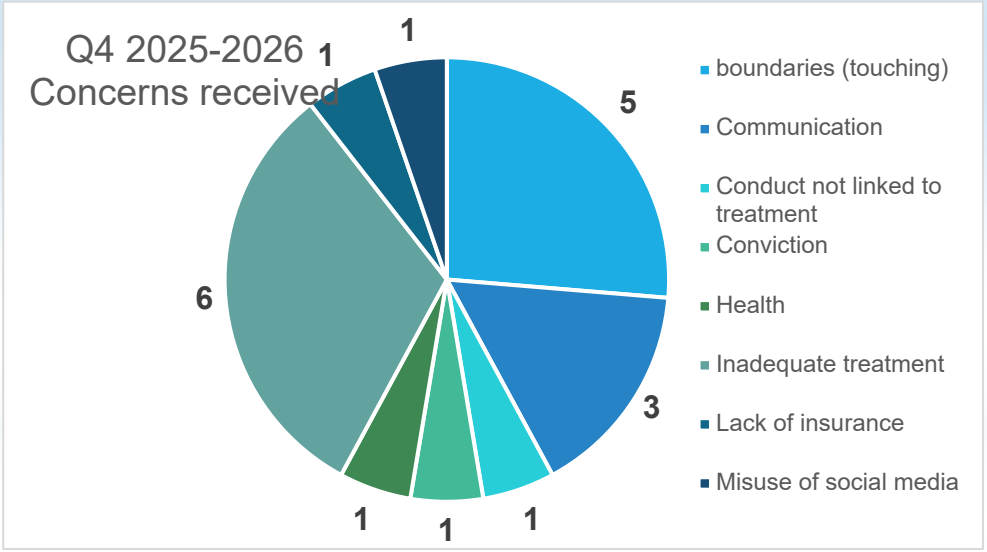
	Median age including 3rd party cases	Median age excluding 3rd party cases	Total number of 3rd party cases at each stage
Pre-screener stage	10 weeks	9 weeks	1 (6%)
IC stage	32 weeks	28 weeks	8 (19%)
PCC stage	84 weeks	66 weeks	12 (44%)
Total	**38 weeks**	**32 weeks**	**21 (24%)**

Fitness to Practise dashboard (Annex B to 8)

01 January 2026 – 31 March 2026 (Q4)

Age of Caseload



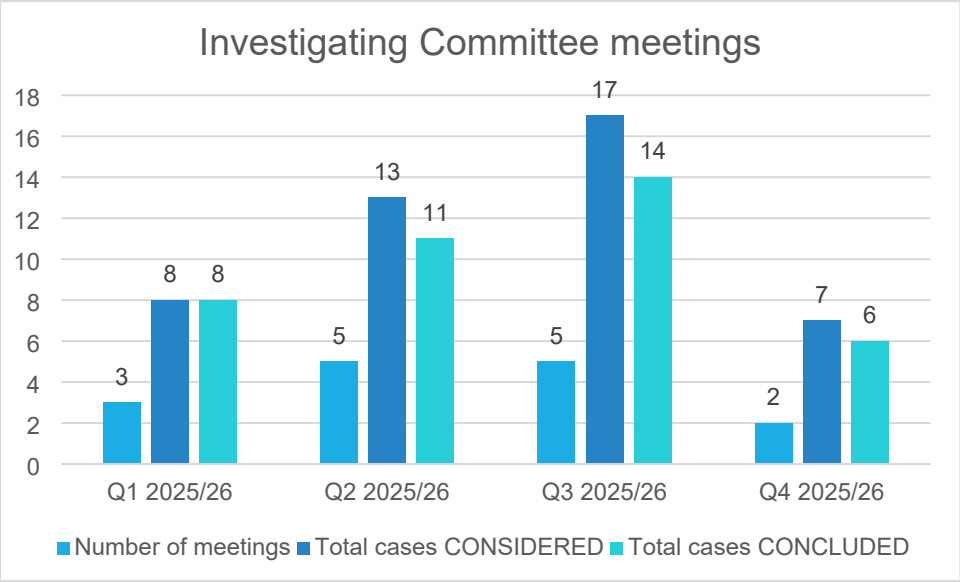


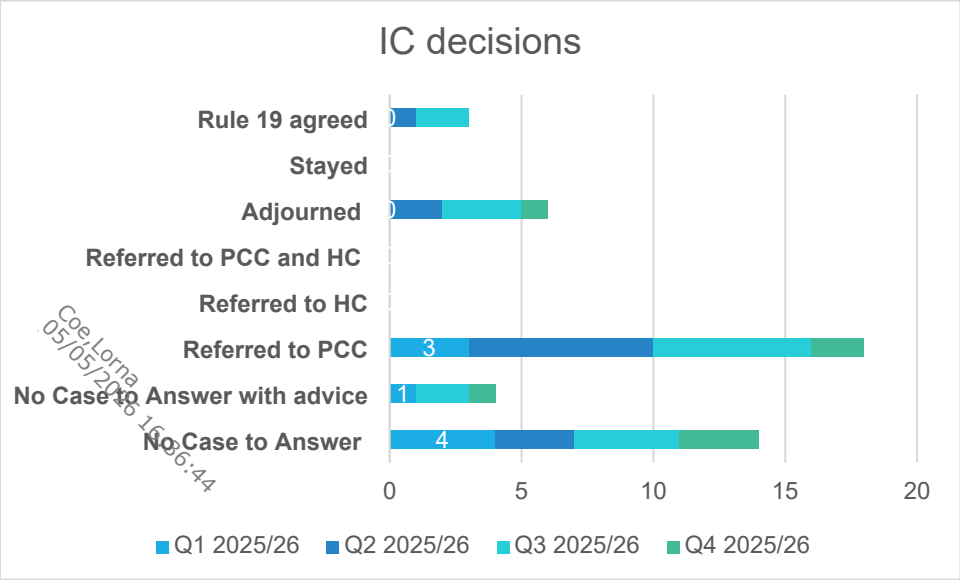
Screener stage

Referrals Received	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Concerns received	19	28	29	19
Concerns made formal	13	12	11	19
Screener decisions made	17	17	21	33

Source of formal complaints	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Self-referral by the registrant	1	1	3	1
Registrar's allegation	1	0	0	0
Non-NHS employer	0	0	1	1
Patient or service user	14	9	20	16
NHS	0	0	0	0
Another registrant	1	0	1	0
Anonymous complainant	0	0	0	0
Another regulatory body	0	0	0	0
Any other complainant	2	2	4	1

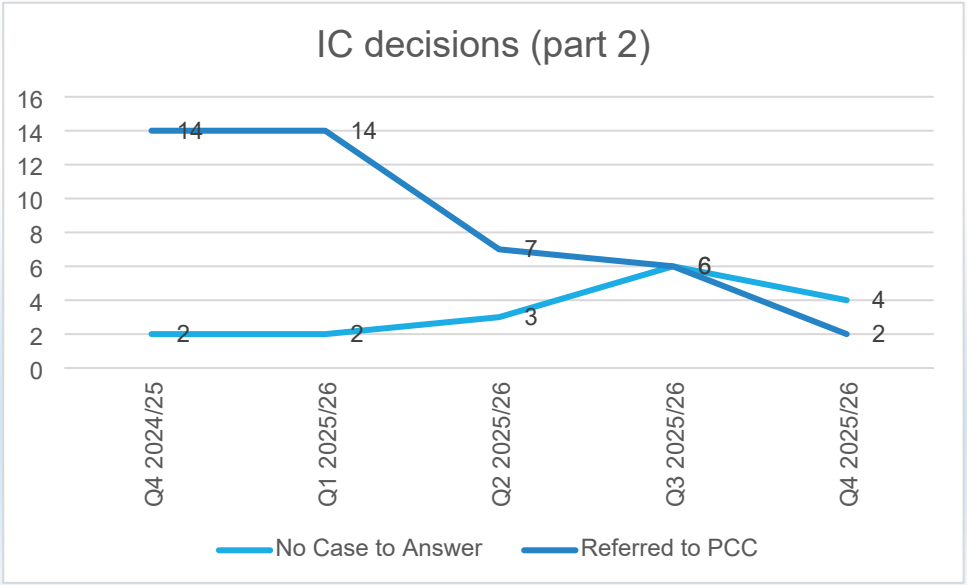
Investigating Committee stage



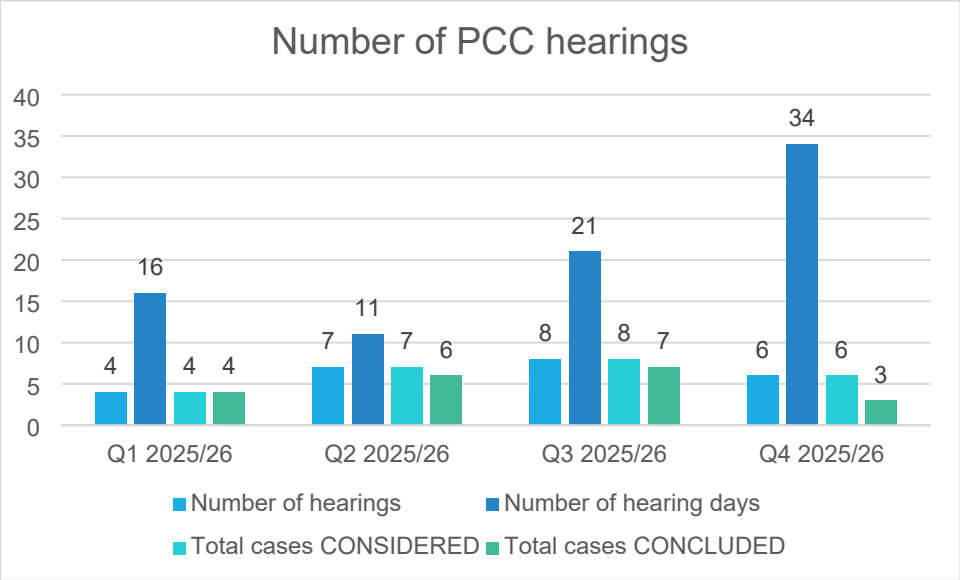


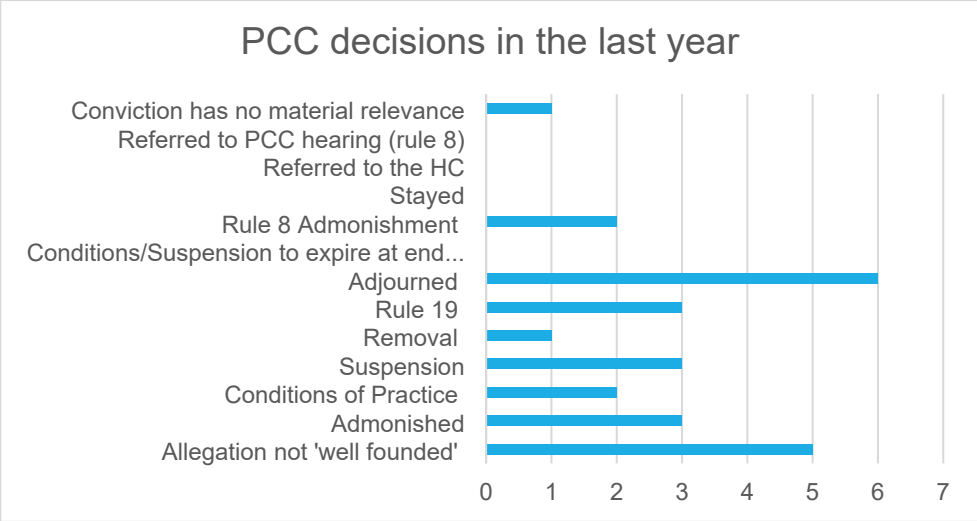
IC stage observations

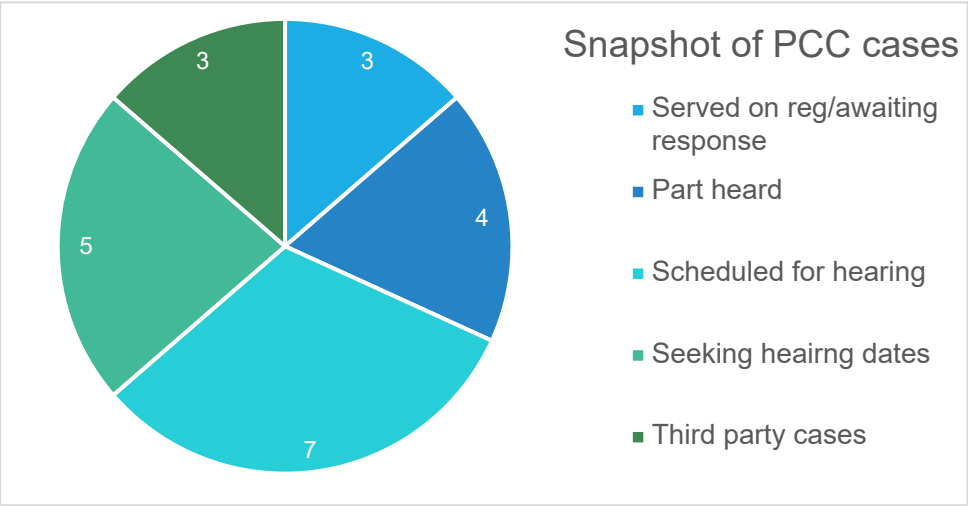
- There were 19 cases referred to the IC by the screeners, the highest number for the last eight years.
- Feedback from the IC suggests that cases are taking longer for the IC to consider at meetings. Such causes are the particulars being lengthy and that the remote environment can cause technical delays.



Professional Conduct Committee stage







PCC stage observations

- Six hearings were conducted by the PCC during the reporting period.
- We have scheduled 7 of the 29 cases at the PCC stage.
- Three PCC hearings went part heard during the reporting period due to complex issues and legal arguments arising very close to, and during, these hearings.

General Osteopathic Council

Council
13 May 2026
Change of Investment Manager

Classification	Public
Action	For decision
Purpose of the paper	The current Investment Managers, Brewin Dolphin, have been in place for nine years. We are recommending a change of Investment Manager to Cambridge Investments Limited based on investment returns and fee structure.
Strategic Priority implications	This work shows we are proactive in looking at the best options to maximise the return on investments and reduce costs so we can support delivery of our strategic priorities.
Standards of Good Regulation implications	There is no direct Standard of Good Regulation but being proactive in managing the organisation's assets shows that the Executive and the Committee are looking at ways to maximise income for the GOsC.
Communications implications	The change will be reported in the Annual Report and Accounts, and in the Audit Committee and Council papers following the change.
Financial, resourcing and risk implications	We anticipate higher investment returns and lower fees by changing to a different Investment Manager. The fee for arranging the change will be around £10k.
Patient perspectives	Better investment returns mean that we will have more resources to invest in our statutory duty of protecting the public.
Diversity implications	None arising from this paper
Welsh language implications	None arising from this paper

Annexes	Annex A - GOsC Risk Approach
Author	Darren Pullinger
Background reading	Members can revisit the Council paper from February 2026, paper 12, for the annexes previously shared.

Recommendation(s)	1. To agree that the Tracker Balanced fund is the preferred option of the two Cambridge Investment funds.

Key messages

- The current Investment Manager Brewin Dolphin have been in place for almost nine years.
- Council agreed in February 2026 to change the investment manager to Cambridge investments.
- Members asked for confirmation of the risk appetite of the suggested fund, which is provided in this paper.
- The Tracker Balanced fund aligns more with Council's choice of a more moderate and balanced approach when investing the funds.

Introduction

1. The current Investment Manager, Brewin Dolphin, has been in place since the end of the 2016-17 financial year. As part of a draft Financial and Asset Framework introduced to Council in November 2024, we undertook a review of the investment portfolio to assess whether there are changes needed.

2. This paper is a follow up to the paper presented to Council in February 2026. Members asked the Executive to confirm the reasons for selecting the Tracker Balanced fund over the Tracker Active fund which had better historic returns.

Discussion

3. At the February 2026 Council meeting, members were happy to change investment manager from Brewin Dolphin to Cambridge Investments, but queried the choice of fund. Whilst the Tracker Active fund demonstrated better historic returns, the Tracker Balanced aligned more closely with our moderate and balanced approach to investing the organisation's reserves.

4. The Tracker Active fund does have better historic returns, but has a higher weighting of equity in the fund, which brings with it a higher level of volatility and risk. GOsC takes a more moderate and balanced approach to investing, given that it isn't the predominant activity of the organisation.

5. Annex A outlines the risk appetite of the GOsC and how it links to the fund recommended; this document was prepared by our independent financial advisors Perspective.

Executive view

6. We are satisfied that the Tracker Balanced fund is the best option, both in terms of historic returns, but also fees and charges.

7. Whilst many investment funds are performing well in the current market, the charges on the Cambridge portfolio will give us significant savings each year, to help in the reduction of our overall cost base.

Recommendations:

1. To agree that the Tracker Balanced fund is the preferred option of the two Cambridge Investment funds.

Perspective
MANAGING WEALTH

The General Osteopathic Council (GOsC) – Risk Approach

The GOsC has always focused and documented its approach to risk when investing in the Equity Markets, as those of a balanced Investor. The Council on advice has taken the view that when investing for the longer term, of 10 years or more the portfolio should have an equity content that is both strategically placed and aligned with their sustainably focus. The investment portfolio should also hold enough equity content to enable the manager to position the holdings accordingly which will drive the longer-term returns. The portfolio should also allow the investment manager to hold a more cautious array of funds and indices, thus allowing the manager some degree of protection and preservation, in more volatile markets. A balanced approach to longer term investing should produce higher average returns, than simple deposit-based strategies. The strategy and risk approach should be reviewed on an annual basis to ensure it still meets with the Councils' needs and objectives.

We feel that the Cambridge Balanced Strategy allows for the above and meets the Councils longer term investment requirements. To substantiate that we detail below the confirmed strategy and objectives of the Cambridge Balanced Tracker Portfolio.

Cambridge Tracker Balanced Strategy

In order to generate potential returns consistent with the assigned level of risk, this portfolio invests across a selector of underlying asset classes. These primarily include stock market investments (equites), fixed interest investments (bonds) as well as cash. The portfolio is constructed using passively managed tracker funds.

Portfolio Objectives - Cambridge Tracker 60% Equity.

The main objective of this portfolio is to maximise potential returns for a given level of risk over the long term (5 – 10 years or more). We will do this by inversing in a variety of assets. One measure of portfolio risk is how much of the portfolio is invested in equites (company shares). Generally, 60% of this portfolio is invested in equites but this figure may change by a maximum of ±12.5% in the short term depending on variators in the stock markets, or in the longer term to keep the portfolio within its' risk limits.

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General Osteopathic Council

10

Council
13 May 2026
CPD Guidance

Classification	Public
Action	For decision
Purpose of the paper	To agree the final revised Continuing Professional Development (CPD) guidance (including mandatory CPD in the areas of boundaries and inclusive practice and template resources for Council approval, following extensive consultation, accessibility review and redrafting.
Strategic Priority implications	Trust: Working in partnership with osteopaths, patients, educators and other stakeholders to model the values and behaviours expected of all healthcare professionals and Inclusivity: Championing inclusivity The updated CPD guidance also supports our statutory function to promote high standards of osteopathic practice by ensuring CPD requirements are based on our data and insight from the osteopathic and wider health sector and that our resources are clear, accessible, proportionate and aligned with regulatory requirements.
Standards of Good Regulation implications	Strengthens transparency, clarity of expectations, fairness, and accessibility. Enhances registrant understanding of CPD requirements and supports consistent compliance. **Standard 7:** The regulator provides guidance to help registrants apply the standards and ensures this guidance is up to date, addresses emerging areas of risk, and prioritises patient and service user centred care and safety
Communications implications	A number of implementation tasks will be delivered during the professional-design and communications phase, including multimedia content, seasonal inclusive practice: equity, diversity, inclusion and belonging prompts, final accessibility checks, and black-and-white formatting for the detailed template.

Financial, resourcing and risk implications	Professional design and communications delivery are incorporated into resource allocation. Clearer CPD resources reduce the risk of misunderstanding, inconsistent compliance, and avoidable fitness-to-practise concerns.
Patient perspectives	More accessible CPD resources support registrants to engage meaningfully with learning, reflection and inclusive practice: equity, diversity, inclusivity and belonging considerations, contributing to improved patient experience and safer care.
Diversity implications	The revisions incorporate extensive neurodiversity and accessibility improvements, including simplified language, reduced cognitive load, consistent structure, and enhanced readability. The layered approach ensures equitable access to core information across all versions.
Welsh language implications	Final resources will be prepared for translation following professional design.
Annexes	A. Concise CPD guidance and template B. Standard CPD guidance and template C. Detailed CPD guidance and template
Author	Dr Stacey Clift, Paul Stern, Fiona Browne, Steven Bettles, Stacey Towle
Background reading	• CPD Guidance and Resources (PEC, March 2026, Item 3 • CPD Consultation Analysis Report (PEC, June 2025, Item 11) Rule 4(6) of The General Osteopathic Council (Continuing Professional Development) Rules Order of Council 2006 as amended by The (Continuing Professional Development) Amendment Rules Order of Council 2018 (made under sections 6, 17, 35 and 36 of the Osteopaths Act 1993) provides that the Council must issue CPD Guidance. This paper is dealing with this updated CPD Guidance.

Recommendation(s)	To agree the revised CPD guidance and templates for publication.

Key messages

- The CPD resources have been substantially improved for accessibility, clarity and neuroinclusivity.
- The layered approach has been strengthened so all versions contain the same core information.
- The EDI consultant's tone and accessibility principles have been preserved throughout.
- Some implementation tasks will be completed during the communications and design phase.

Background

1. Since the introduction of the revised CPD scheme in 2019, the GOsC has gathered annual feedback from osteopaths about their experience of meeting the scheme's requirements. Survey findings indicated that while the scheme was valued, several elements were perceived as difficult to navigate. Registrants reported that the Peer Discussion Review (PDR) template was complex and time-consuming, and that the CPD guidance was repetitive, difficult to navigate, and lacked clarity in key areas.

2. In early 2025, the GOsC launched a public consultation to explore potential improvements to the scheme. The consultation sought views on simplifying the PDR template and strengthening guidance in areas including professional boundaries and equality, diversity and inclusion (EDI), range of practice, the use of artificial intelligence, accessibility, and opportunities for community and peer engagement.

3. The consultation generated a wide range of views. Respondents welcomed the intention to improve clarity and usability but highlighted contrasting concerns: some felt the proposed changes might increase the overall workload of the scheme, while others were concerned that simplification could reduce the depth of reflection. Views on introducing EDI and professional boundaries as mandatory elements were similarly mixed. While many supported this direction, others emphasised the need for clear rationale, evidence, and practical resources to support meaningful engagement.

4. Feedback also identified the need for clearer definitions, stronger support for reflective practice, improved accessibility across formats, and greater flexibility to accommodate different learning styles and levels of experience.

5. Following the CPD consultation undertaken in early 2025, the GOsC has progressed a significant programme of work to strengthen the clarity, accessibility and relevance of the CPD scheme. This work has focused on addressing the issues raised through the consultation, including the need for clearer guidance, more flexible templates, stronger support for reflective practice, and improved resources relating to establishing and maintaining professional boundaries and equality, diversity, inclusion and belonging (EDIB).

Development of the CPD Resources

6. In response to the consultation findings, the GOsC developed a suite of six new resources designed to offer a more flexible, layered approach to meeting the CPD requirements. These include:

- Layered CPD Guidance (concise, standard and detailed versions)
- Peer Discussion Review (PDR) Template Options (concise, standard and detailed versions)
- Choosing the Right Guidance & Template decision-support tool
- PDR Assessment Matrix to support fair and consistent peer judgements
- Professional Boundaries Workbook
- EDI Resource Suite, including an EDI case-based discussion workbook, microaggressions case-based discussion template and microaggressions quiz

7. These resources were designed to accommodate different learning styles, levels of experience and preferences for depth of engagement, while maintaining consistent expectations across the scheme.

8. Participants responded very positively overall, welcoming the layered guidance for its flexibility, appreciating that the PDR Assessment Matrix supports fair and consistent peer judgements, and valuing the Professional Boundaries Workbook for its strong relevance and reflective scenarios. Many also highlighted the usefulness of the EDIB case materials—especially the microaggressions quiz—and agreed these resources offer meaningful support, particularly for newer practitioners.

Evolving External Context

9. Since the CPD consultation began, the wider regulatory landscape has continued to evolve, particularly in relation to equality, diversity, inclusion and belonging (EDIB). Recent developments, including the Mann Review on antisemitism and the emerging Workforce Race Equity Principles for health and care regulators, emphasise the need for professionals to understand how discrimination, including racism and discrimination based on religion or belief, affects patients and colleagues. These developments reinforce the importance of ensuring that registrants engage meaningfully with EDIB-related learning within the CPD scheme.

Discussion

10. The resources outlined in Point 6 have been further consulted on during February and March 2026 by:

- Policy and Education Committee discussions (12 March 2026)
- Targeted interviews with neurodiverse osteopaths[1]
- A short neurodiversity survey[2]
- Further feedback from practitioners[3]

[1] 3 osteopaths were interviewed
[2] 3 osteopaths completed the survey
[3] 2 osteopaths joined CPD themed drop-in session

- EDI consultant review of documents

11. The Policy and Education Committee (PEC) has recommended that mandatory CPD on Professional Boundaries and Inclusive Practice: equity, diversity, inclusion and belonging be introduced, and that the revised layered CPD guidance (concise, standard and detailed versions) be approved for publication following final design refinements.

12. As part of this work, an external EDI consultant was commissioned to review these resources through a neurodiversity and accessibility lens. The consultant redrafted all six documents:

    - Standardising terminology (Concise, Standard and Detailed Versions)
    - Simplifying language
    - Reducing sentence length
    - Removing italics and capitalised headings
    - Increasing the use of white space and full stops to support readability.
    - Removed the "layered" concept, which was identified as abstract and potentially confusing.

13. The consultant noted that the existing structure already contained strong accessibility features, including the ability to choose between versions to manage cognitive load, repeated reinforcement of key CPD requirements, and the use of bullet points, examples and role-specific adaptations. Their revisions therefore built on these strengths while further enhancing clarity, consistency and neuroinclusive design.

14. During the Professional Standards Team's review of the consultant's draft, it became clear that some sections had been removed entirely from certain versions in order to shorten and tighten up the documents. This meant that the Concise, Standard and Detailed versions no longer contained the same core information. As the purpose of the layered approach is to allow osteopaths to choose any version without missing essential requirements, it was important to ensure that all versions retained the same content, presented at different levels of detail. The team therefore reinstated key sections across all versions to maintain consistency, fairness and regulatory clarity. These additions were rewritten in the same tone and style established by the consultant, ensuring that the accessibility and neuroinclusive improvements were preserved throughout the full suite of documents.

15. The final resources therefore reflect a balanced approach that integrates:

    - Accessibility and neurodiversity considerations
    - Professional feedback

- Regulatory clarity
- EDIB principles of transparency and equity

Overview of changes

16. The revised resources now include:

    - A layered guidance structure each paired with an updated PDR template (Concise, Standard and Detailed – **Annexes A-C**)
    - Refined PDR Assessment Matrix
    - A refined decision-making tool for selecting guidance and PDR template
    - Updated EDIB and Professional Boundaries workbooks
    - Key terms explained resource[4]
    - Objective activity – external feedback resource[5]
    - Improved formatting, navigation, and accessibility features

17. The revisions preserve the consultant's supportive, profession-led tone while reinstating essential regulatory clarity around:

    - Verification and audit
    - Record-keeping
    - Annual declaration
    - Peer selection and confirmation
    - Learning with others

18. These elements were necessary to ensure the guidance remains accurate, transparent, and enforceable.

19. If you would like to view the suite of resources, they are available on request. Please email **Dr Stacey Clift** at sclift@osteopathy.org.uk

How Feedback Shaped the Revisions

20. The revised CPD materials have been shaped by extensive feedback from osteopaths, the EDI consultant, and participants in the neurodiversity interviews and survey. This feedback highlighted the need for clearer navigation, improved accessibility, and a more intuitive structure that supports different learning styles and cognitive needs. The changes made reflect a deliberate shift towards a more user-centred and inclusive design approach.

[4] This resource expands on a series of key terms to support both clinical and non-clinical osteopathic roles. The key terms explained include osteopathic practice, proportionate to practice, activities that benefit patients, impact on others and learning with others.

[5] This resource expands on the seven reflective questions for feedback in the detailed guidance and provides examples of external feedback in clinical and non-clinical roles and examples of external feedback sources in non-clinical roles.

21. A consistent theme across the feedback was that the materials felt text-heavy, visually dense, and at times overwhelming. Both the EDI consultant and neurodiverse osteopaths emphasised that this created unnecessary cognitive load and made it harder to engage with the content. In response, the documents have been restructured to improve spacing, chunk information[6] into manageable sections, and reduce density. Professional design will further enhance readability and visual clarity.

22. Navigation was another area where users reported difficulty. Osteopaths and the EDI consultant noted that the previous structure relied too heavily on cross-referencing and lacked a clear, linear flow. We have addressed this by simplifying the structure, reducing cross-referencing, and improving the logical sequencing of information. Professional design will build on this foundation to strengthen visual navigation and overall usability.

23. Accessibility was a significant focus of the feedback. Neurodiverse osteopaths highlighted the importance of screen-reader compatibility, consistent formatting, and alternative ways of engaging with the material. The EDI consultant also identified formatting inconsistencies that could create barriers for users with access needs. These issues have been addressed through standardised formatting, improved compatibility with assistive technologies, and clearer layout. Further improvements will be made during the design and communications phase.

24. Feedback also indicated that some osteopaths would benefit from alternative formats, including spoken-word or video explanations, and from black-and-white printable versions of all templates. These preferences were raised both in post-consultation feedback and in the neurodiversity interviews. While the documents have been prepared in a way that supports printing, the communications team will explore multimedia options and ensure that all templates, including the Detailed version,[7] are available in black-and-white.

25. Finally, osteopaths requested clearer pathways through the CPD process. In response, the materials have been reorganised into three distinct versions - concise, standard, and detailed - each with its own matching PDR template. This provides a more intuitive structure and supports practitioners in selecting the level of detail that best suits their needs (see **Annex A-C**).

26. Overall, the changes made reflect a strong commitment to accessibility, clarity, and user-centred design. The remaining improvements will be delivered through professional design and communications work to ensure that the final materials

[6] Information chunks refers to content delivered in manageable sections to support understanding
[7] The detailed version currently contains a coloured PDR template

are visually accessible, easy to navigate, and supportive of diverse learning preferences.

27. The table below summarises the key themes raised, the source and distinguishes between what has been completed for Council publication and what will be delivered during the professional-design and communications phase.

Table 1: You Said / We Did / We Will – Integrated Feedback Table

You Said…	Source	We Did (Completed for publication)	We Will (Post design/communications phase)	Impact
The decision-making tool for selecting guidance and template is too long and overwhelming	Post consultation feedback	Shortened simplified, and moved comparisons table to the start	--	Easier to navigate; reduced cognitive load
Formatting inconsistent (tics/bullets)	EDI consultant and neurodiversity interviews	Standardised formatting across all documents	--	Improved clarity and accessibility
You want clear pairing of concise, standard and detailed versions	Post consultation feedback	Reorganised pack into three clear pathways, each with its matching PDR template	--	Clearer structure; easier to choose the right version
PDR templates had inconsistent prompts	Post consultation feedback	Aligned prompts across all templates	--	Consistent user experience
Declaration wording was confusing	Post consultation feedback	Rewrote declaration so the osteopath confirms completion and the peer confirms participation	--	Clearer accountability and regulatory alignment
Outdated references caused confusion	Post consultation feedback	Updated references to the iO CPD diary and the GOsC PDF template	--	Accuracy restored
Documents are text heavy and overwhelming	Neurodiversity interviews and survey; EDI consultant	Information chunked content, added spacing, reduced density	Professional design will further enhance layout and readability	Lower cognitive load; more accessible for

You Said...	Source	We Did (Completed for publication)	We Will (Post design/communications phase)	Impact
				neurodiverse practitioners
Navigation is difficult	Post consultation feedback, neurodiversity survey, EDI consultant	Added bullets, linear structure, and reduced cross referencing	Professional design will further improve navigation and visual structure	Easier to follow and less cognitively demanding
Screen reader compatibility is essential	Neurodiversity interviews	--	Communications team to ensure final PDF/HTML meet accessibility standards	Improved accessibility and compliance
Formatting issues made templates hard to use	EDI consultant and post consultation feedback	Reformatted and tested for accessibility	Professional design will finalise layout and ensure consistency	Improved usability and digital accessibility
Videos/spoken word would help	Post consultation feedback and neurodiversity interviews	--	Communications team to develop multimedia content as part of implementation	Supports different learning styles
Need black-and-white printable versions	Post consultation feedback and neurodiversity interviews	All documents except the detailed PDR template are already black-and-white	Professional design will produce a black-and-white detailed template	Supports diverse preferences and practical needs
EDIB workbook needs more follow-on reading/training options	Post consultation feedback	Added some signposting	Consult NCOR to identify appropriate osteopathic research references for each case study	Supports deeper learning; ensures accuracy and credibility
Timed releases (e.g. Ramadan) contextualise EDIB	Neurodiversity interviews	Already have schedule for seasonal diary prompts	Communications team to deliver these through planned communications	More relevant and timely learning

Regulatory assurance

28. We have then audited the layered guidance templates (see **Annex A-C**) against the existing CPD guidance (2018) and PDR guidance template (2020) and we are confident that:

    - All three-layered guidance and templates fully reflect the requirements set out in the 2018 CPD Guidance, including:

        - maintaining and developing a range of professional practice
        - completion and reflection on objective CPD activity
        - completion of mandatory CPD that benefits patients – communication and consent
        - maintenance of an appropriate CPD record
        - completion of a Peer Discussion Review
        - verification and audit processes are clearly explained

    - No mandatory requirement described in the 2018 guidance is absent from any version of the layered templates.

29. Across the Concise, Standard and Detailed PDR templates:

    - the PDR is consistently framed as a professional, reflective discussion
    - the peer's function is limited to confirming engagement through discussion
    - responsibility for compliance decisions remains clearly with GOsC under the verification and assurance process.

30. These final resources therefore reflect:

    - The EDI consultant's accessible tone
    - The profession's feedback
    - The needs of neurodiverse practitioners
    - The regulatory clarity required for consistency and fairness

Recommendation: To agree the revised CPD guidance and templates for publication.

CPD -CONCISE VERSION

1. Concise Guidance
2. Concise Template

Version 1: Concise - Essentials Only

Your Core Requirement (3-Year Cycle)

As a registered osteopath, you must complete:

- 90 hours of CPD over three years
- At least 45 hours learning with others
- CPD across all four Osteopathic Practice Standards (OPS) themes
- At least one objective activity (external feedback)
- CPD in three mandatory topic areas
- A Peer Discussion Review (PDR) towards the end of the cycle
- Keep a record of CPD activities and reflection

CPD supports professional development across all aspects of your work as an osteopath and is a condition of registration.

What is CPD?

CPD is any learning that helps maintain, develop, or improve your work as an osteopath, across all the roles you undertake.

This may include:

- courses, seminars, webinars, reading, or research
- discussions with colleagues or practice meetings
- mentoring (as mentor or mentee)
- preparing for or taking part in a Peer Discussion Review

CPD is most effective when you reflect on what you learned and how it influenced your practice or professional judgement.

Osteopathic Practice Standards (OPS) Themes

Across each cycle, your CPD must cover all four OPS themes:

- A: Communication and patient partnership
- B: Knowledge, skills and performance
- C: Safety and quality in practice
- D: Professionalism

Your CPD should reflect the breadth of your professional work, including clinical practice and any teaching, research, management, leadership, or other non-clinical roles.

Objective Activity (External Feedback)

You must complete at least one activity where someone else gives you feedback and reflect on what this shows about your practice.

Examples include:

- patient feedback
- peer observation
- clinical audit
- case-based discussion
- Patient Reported Outcome Measures (PROMs)

Non-clinical roles: teaching observation, peer review of research, appraisal or 360-degree feedback

Not currently practising: case discussion or simulated learning with feedback

Mandatory Topics (Higher-Risk Areas)

You must complete CPD in all three areas:

- Communication and consent

- Professional boundaries
- Inclusive practice: Equity, diversity, inclusion and belonging (EDIB)

These areas are informed by patient concern data and support safe, inclusive care.

These activities might be combined, for example boundaries and communication.

Keeping Records

You must keep CPD records showing:

- what prompted the learning
- what you learned
- how your thinking or practice changed
- the impact on patient care or professional relationships

There is no set format. Records may be paper-based or electronic. Keeping records as you go is recommended.

Peer Discussion Review (PDR)

- A 1–1.5 hour structured discussion with a peer
- Choose your peer early (ideally Year 1).
- Choose someone you can talk openly with (osteopath or other registered health professional)

After the discussion, your peer confirms that you have met the CPD requirements by signing off your completed PDR template.

Annual Registration Renewal

Each year, you will be asked to declare your CPD activity, including:

- total CPD hours and learning with others hours
- OPS themes covered
- progress with objective activity

- completion of mandatory topics
- peer identified / PDR completed (where relevant)

This annual declaration helps confirm that you are on track across your three-year CPD cycle.

Keeping a record of what you declare each year is recommended.

Verification and Audit

The GOsC carries out random checks of CPD records.

If selected:

- you usually have 28 days to submit evidence
- evidence may include CPD records, reflections, objective activity evidence, and the PDR template

Verification is a supportive process focused on improvement, not punishment

Using AI Responsibly

Use AI only to organize or format your records, not to generate content.

Do not input any information that could identify patients.

Help and Support

Email: cpd@osteopathy.org.uk

Phone: +44 (0)20 7357 6655

Resources: cpd.osteopathy.org.uk

Standards: osteopathy.org.uk/standards

Templates available at cpd.osteopathy.org.uk/resources:

- Objective Activity Reflection Template
- Peer Discussion Review Template
- Keeping Records Workbook

- Planning Templates

If you can’t meet the requirements:

GOsC can extend or vary requirements for good reason.

GOsC can make “reasonable adjustments” to requirements.

Be aware that failure to comply without good reason risks registration removal.

Don't wait until last minute - we're here to help you succeed

Key Principles for Success

- Reflect on learning and impact, not just activity
- Plan CPD across the three-year cycle
- Complete mandatory topics early
- Identify your peer early
- Keep records of your CPD as you go

Concise PDR Template

Osteopath name:	
Osteopath reg. number:	
Peer name:	
Peer profession/reg. number:	
Date of review:	

CPD Standard 1: Range of Practice

Has the osteopath undertaken CPD across all four themes of the Osteopathic Practice Standards and relevant to their practice roles?

(Practice roles refer to the different professional functions and responsibilities undertaken as part of an osteopathic career, beyond direct patient treatment.)

Osteopath reflection: Provide examples of CPD across the four OPS themes (A-D) and practice roles:
Peer comments:
Standard met: ☐ **Yes** ☐ **No**

CPD Standard 2: Objective Activity

Has the osteopath demonstrated that an objective activity has contributed to practice and quality of care?

(Objective activities include case-based discussion, clinical audit, patient feedback, peer observation and PROMs)

Osteopath reflection: Describe objective activity, outcomes, and impact on practice:
Peer comments:

Standard met: ☐ **Yes** ☐ **No**

CPD Standard 3: CPD Benefiting Patients

Has the osteopath undertaken CPD in communication and consent, professional boundaries, and Inclusive practice: Equity, Diversity, Inclusion and Belonging (EDIB)?

Osteopath reflection: Describe CPD in the three mandatory areas and impact on patient care:
Peer comments:
Standard met: ☐ **Yes** ☐ **No**

CPD Standard 4: Record Keeping

Has the osteopath maintained a continuing record of CPD activities?

Peer comments:
Standard met: ☐ **Yes** ☐ **No**

Overall Discussion

Strengths:
Areas for development:

Declarations

Peer Declaration:

I confirm that I have participated in this Peer Discussion Review and that, in my opinion, the CPD standards have been met.

I confirm that the osteopath has demonstrated meaningful engagement with CPD activities relevant to their practice.

I confirm that all information provided on this form is correct to the best of my knowledge.

Peer signature:	**Date:**

Osteopath Declaration:

I confirm that I have completed this Peer Discussion, and that the information provided on this form is correct to the best of my knowledge.

I confirm that I will retain a copy of this form in my CPD record.

Osteopath signature:	**Date:**

CPD -STANDARD VERSION

1. Standard Guidance
2. Standard Template

Version 2: Standard Guidance - Explanation and Examples

What You Need to Know

As a registered osteopath, you must complete 90 hours of Continuing Professional Development (CPD) every three years.

At least 45 hours must involve learning with others.

You must declare your CPD annually at registration renewal to maintain your registration.

CPD supports professional development across all aspects of your work as an osteopath

What CPD Means

CPD is any learning that maintains, enhances, or develops your osteopathic practice.

This includes clinical work and non-clinical roles such as teaching, research, management, or adjunctive therapies.

Examples include:

- Courses and seminars.
- E-learning.
- Reading and research.
- Practice meetings.
- Discussions with colleagues.
- Mentoring relationships.
- Preparing for or participating in a Peer Discussion Review.

Critical point: CPD only counts when you reflect on what you learned and how it changed your thinking or practice.

Without reflection, CPD risks becoming attendance based. With reflection, it supports professional growth and improved practice.

Understanding Reflection (Keep It Manageable)

Reflection transforms activity into learning.

For every CPD activity, ask yourself:
- Why did I choose this activity?
- What did I learn or reconsider?
- How does this improve patient care, safety, or professional practice?

If helpful, also consider:
- What would I do differently next time?
- What further learning does this highlight?

Reflection does not need to be academic writing. Bullet points are acceptable.

Understanding Reflection (Keep It Manageable)

The key expectation is that reflection demonstrates impact or change, not just description.

The Requirements (Three-Year Cycle)

Range of Practice

Across the three-year cycle, your CPD must include all four themes of the Osteopathic Practice Standards (OPS) in your CPD:

Theme A - Communication and patient partnership.

Theme B - Knowledge, skills and performance.

Theme C - Safety and quality in practice.

Theme D - Professionalism.

Your CPD must reflect the breadth of your professional work (clinical work including adjunctive therapies used), teaching, research and / or any management or leadership) and be proportionate to how you divide your time.

Objective Activity (External Feedback)

You must complete at least one activity involving feedback from others, and you must reflect on it.

Examples include:

- Patient feedback.
- Peer observation.
- Clinical audit.
- Case-based discussion.
- Patient Reported Outcome Measures (PROMs).

For non-clinical roles, suitable alternatives include teaching observation, peer review of research, conference feedback, or appraisal feedback.

The key requirement is analysis and reflection on what the feedback tells you and how you will act on it.

If you are not currently practising, objective activities may include case discussion with colleagues or simulated activities with feedback to help keep skills and professional judgement current.

The requirement is not simply collecting feedback but analysing what it shows about your practice and how you will act on it.

Mandatory CPD (Benefiting Patients)

You must complete learning in the following areas:

- Communication and consent.
- Establishing and maintaining professional boundaries.
- Inclusive practice (Equity, diversity, inclusion and belonging (EDIB).)

These topics are identified from patient concern data and are considered higher-risk areas.

Many osteopaths choose to complete these earlier in their CPD cycle.

These activities might be combined, for example boundaries and communication.

Keep Records

You must keep records of your CPD activities and reflections.

Your records should demonstrate:

- what prompted the learning
- what was learned
- how your thinking or practice changed
- the impact on patient care or professional relationships

There is no required format. Records may be paper-based or electronic, including diaries, templates, or e-portfolio platforms.

Peer Discussion Review (PDR)

Towards the end of your cycle (usually Year 3), you must complete a structured 1-1.5-hour discussion with a peer.

Your peer can be another osteopath or a registered health professional.

You must complete the PDR template together, covering how you met each requirement, your strengths, development areas, and plans for the next cycle.

Identifying a peer early in your cycle can support ongoing discussion and reflection, rather than a single conversation at the end

The Peer Discussion Review template supports this discussion.

Following the review, your peer confirms that you have met the CPD requirements for the cycle.

Planning Across Three Years

You must complete all CPD requirements by the end of Year 3, but you have flexibility in how learning is organised across the cycle.

Many osteopaths find it helpful to:

- complete an objective activity and identify a peer early
- complete mandatory topics by Year 2
- use Year 3 for consolidation and the PDR

Learning With Others

Learning with others involves meaningful interaction with colleagues or other professionals, whether in person or online.

Examples include interactive courses or webinars, mentoring relationships, practice meetings, and case discussion.

Interaction is the key element, not the location.

Annual Registration Renewal

Each year you will be asked to declare:

- Total CPD hours completed.
- Learning with others hours.
- OPS themes covered that year.
- Objective activity status.
- Mandatory topics status.
- Peer identified (Years 1-2) / PDR completed (Year 3).

This annual declaration helps confirm that you are on track across your three-year CPD cycle

Verification and Audit

The GOsC randomly selects 5-10% of osteopaths over the course of a year for verification.

If selected, you will have 28 days to submit evidence.

The process is supportive and focused on improvement, not punishment.

Evidence may include CPD records, reflections, objective activity documentation and your completed PDR template.

Verification helps ensure the CPD scheme works effectively, supports consistent standards, and maintains public confidence in osteopathic practice because osteopaths keep up to date

Using AI Responsibly

Your CPD records and reflections must be your own work. Your reflections must represent your own thinking.

AI tools may help format or organise your thoughts, but reflections must genuinely represent your thinking.

Critical considerations:

Data protection: Never use general AI tools (ChatGPT, etc.) for patient-identifiable information. Only use AI tools that comply with data protection laws and have appropriate security measures.

Fact-checking: Always verify AI-generated clinical information against reliable sources before applying it to practice.

More information: osteopathy.org.uk/standards/guidance-for-osteopaths/artificial-intelligence

If You Can't Meet CPD Requirements

Contact the GOsC as soon as possible during your cycle if exceptional circumstances prevent completion.

The GOsC has statutory power to extend or vary the three-year requirement if there's good reason. Apply in writing with supporting evidence.

GOsC can make “reasonable adjustments” to requirements.

Be aware that failure to comply without good reason risks registration removal.

Don't wait until last minute - we're here to help you succeed.

Failure to comply without good reason puts your registration at risk of removal.

Don't wait until the last minute - we're here to help you succeed

Failure to comply without engagement or good reason may put your registration at risk

Help and Support

Email: cpd@osteopathy.org.uk

Phone: +44 (0)20 7357 6655

Resources: cpd.osteopathy.org.uk

Standards: osteopathy.org.uk/standards

Templates available at www.cpd.osteopathy.org.uk/resources:

- Objective Activity Reflection Template
- Peer Discussion Review Template
- Keeping Records Workbook
- Planning

Key Success Principles

Many osteopaths find it helpful to:

- reflect on learning and impact, not just activity
- plan CPD across the cycle
- complete mandatory topics early
- identify a peer early
- Keep evidence as you go – Don't try to reconstruct three years of learning at the end
- ensure CPD is proportionate to your professional work

Standard PDR template

Section 1: Review Details

Name of Osteopath:_____

Name of Peer:_____

Date of Review: _____

Location/Format:
☐ In person
☐ Online
☐ Phone

Section 2: About Your Practice

Briefly describe your current practice (context, patient types, hours per week, other roles):

Section 3: The Four OPS Standards

Standard 1: Range of Practice

Have you undertaken CPD across all four themes of the Osteopathic Practice Standards and relevant to your practice roles?

(Practice roles refer to the different professional functions and responsibilities undertaken as part of an osteopathic career, beyond direct patient treatment.)

Themes covered (tick all that apply):
☐ Theme A: Communication and patient partnership
☐ Theme B: Knowledge, skills and performance
☐ Theme C: Safety and quality in practice
☐ Theme D: Professionalism

Brief examples of CPD in each theme:

Theme A:

Theme B:

Theme C:

Theme D:

Peer confirms this standard is met:
☐ Yes
☐ No

Peer signature: _____ Date: _____

Standard 2: Objective Activity

Have you completed at least one objective activity and reflected on how it informed your practice?

Type of objective activity undertaken (tick at least one):
☐ Patient feedback
☐ Peer observation
☐ Clinical audit
☐ Case-based discussion
☐ Patient Reported Outcome Measures (PROMs)
☐ Other:

What did you learn and how has it changed your practice?

Peer confirms this standard is met:
☐ Yes
☐ No

Peer signature: _____ Date: _____

Standard 3: CPD Benefiting Patients

Have you undertaken CPD in communication and consent, boundaries, and Equality, Diversity, Inclusion and Belonging (EDIB)?

Mandatory areas covered (tick all that apply):
☐ Communication and consent
☐ Establishing and maintaining professional boundaries
☐ Inclusive practice: Equity, Diversity, Inclusion and Belonging (EDIB)

How has this CPD improved your patient interactions?

Peer confirms this standard is met:
☐ Yes
☐ No

Peer signature: _____ Date: _____

Standard 4: Keeping Records

Do you maintain documented CPD records including reflections?

Method of record keeping (tick all that apply):
☐ GOsC Keeping CPD Records workbook template
☐ iO Online CPD Diary
☐ Electronic record (Word, Google Doc, etc.)
☐ Paper record
☐ E-portfolio platform
☐ Other

Peer confirms documented evidence has been shown:
☐ Yes
☐ No

Peer signature: _____ Date: _____

Section 4: Reflection and Planning

Key Strengths Identified:

Areas for Development:

CPD Plans for Next Three-Year Cycle:

Section 5: Final Declarations

Declaration by Peer

I confirm that I have participated in this Peer Discussion Review and that, in my opinion, the CPD standards have been met.

I confirm that the osteopath has demonstrated meaningful engagement with CPD activities relevant to their practice.

I confirm that all information provided on this form is correct to the best of my knowledge.

Signed: _____ Date: _____

Print name: _____

Profession: _____

Registration number (if applicable): _____

Declaration by Osteopath

I confirm that I have completed this Peer Discussion Review and that the information provided is correct to the best of my knowledge.

I confirm that I will retain a copy of this form in my CPD record.

Signed: _____ Date: _____

Print name: _____

Profession: _____

Registration number: _____

CPD Hours Summary

Total CPD Hours Completed: _____ hours (minimum 90 required)

Hours of Learning with Others: _____ hours (minimum 45 required

DETAILED VERSION

1. Detailed Guidance
2. Detailed Template

Version 3: Detailed - Full Context and Comprehensive Detail

Introduction

This guidance supports osteopaths in meeting the General Osteopathic Council (GOsC) Continuing Professional Development (CPD) requirements.

The CPD scheme promotes engagement, professional discussion, peer support and high-quality patient care.

What is CPD?

Continuing Professional Development (CPD) is any learning activity that helps you maintain, develop, or improve your work as an osteopath.

This includes learning related to:

- clinical practice
- education, teaching, or supervision
- research or academic work
- management, leadership, or governance responsibilities
- adjunctive or extended-scope practice
- preparing for, participating in, or acting as a peer in a Peer Discussion Review

CPD also supports osteopaths returning to practice after time away.

CPD is not only about completing activities. It is most effective when you reflect on what you have learned and how this influences your current or future practice.

Legal Requirement

Every three years you must:

- Complete 90 hours of CPD
- Include at least 45 hours involving learning with others
- CPD across all four Osteopathic Practice Standards (OPS) themes and across your practice
- One objective activity involving external feedback
- Learning in three mandatory topic areas
- A Peer Discussion Review (PDR)
- Keep appropriate CPD records and reflections

Understanding Your CPD Cycle Dates

You can find your cycle start and end dates by logging into the ozone. Understanding your dates helps you plan learning activity, track progress, plan your PDR, and make accurate annual declarations.

Key Terms Explained

Osteopathic practice: All aspects of your professional work as a registered osteopath, not only hands-on patient treatment. This may include teaching, research, management, governance, education delivery, or any role where your osteopathic qualification informs professional judgement.

Proportionate to practice: Your CPD should reflect how you divide your professional time. There is no fixed formula; the key expectation is that you can explain how your learning aligns with your actual practice. For example, if you work 80% clinically and 20% teaching your CPD should cover both of these areas, and you should be able to explain how you are keeping up to date in both.

Activities that benefit patients: Learning activities that can contribute to the improvement patient care, safety, experience, or trust. Mandatory topic areas have been identified from patient concern data.

Impact on others: How your communication, behaviour, and professional decisions affect patients, and colleagues and developing awareness to ensure this impact is positive.

Learning with others: Meaningful interaction with colleagues or professionals. Examples include interactive courses, mentoring, peer discussion, case discussion, or practice meetings.

Reflection: The Core of CPD

Reflection transforms activity into learning and impact.

For each CPD activity, it is helpful to record:

- your learning needs before starting
- what you learned during the activity
- how this learning changed (or confirmed) your practice
- the impact on patient care and professional relationships.

Without reflection, CPD risks becoming attendance-based. With reflection, it supports growth and improvement

Building a supportive learning culture

CPD works best when osteopaths support one another's learning. Learning communities enable shared reflection, support wellbeing, and strengthen patient safety.

How you can contribute

You can contribute by:

- approaching CPD with curiosity
- being open about learning needs
- creating safe spaces for discussion
- sharing practice experiences honestly
- giving and receiving feedback respectfully
- taking a proactive approach by seeking learning opportunities and peer discussion

CPD Requirements in Detail

Range Of Practice

Across the three-year cycle, your CPD must include all four themes of the Osteopathic Practice Standards (OPS):

Theme A - Communication and patient partnership.

Theme B - Knowledge, skills and performance.

Theme C - Safety and quality in practice.

Theme D - Professionalism.

Your CPD must reflect the breadth of your professional work, which may include clinical practice, adjunctive therapies, education, research, or management and leadership and be proportionate to how you divide your time.

Objective Activity – External Feedback

You must complete at least one activity involving feedback from others, and you must reflect on it.

Examples include:

- Patient feedback.
- Peer observation.
- Clinical audit.
- Case-based discussion.
- Patient Reported Outcome Measures (PROMs).

These questions are designed to support meaningful, role-relevant objective activities for all osteopaths, including those working in clinical practice, education, research, governance, leadership, or other non-clinical roles. They provide a consistent framework for reflection and help ensure that feedback and learning remain connected to your professional identity as an osteopath.

Reflective questions:

- How does this role relate to my professional identity as an osteopath? Consider how osteopathic principles, values, or standards shape your approach to clinical care, teaching, research, leadership, or decision-making.
- What aspect of my performance in this role would benefit most from external feedback? This may include communication, clinical reasoning, hands-on technique, teaching effectiveness, research integrity, leadership, collaboration, or professional judgement.
- Who is best placed to provide meaningful and appropriate feedback? This may be another osteopath, a colleague from another profession, a student, a research collaborator, a manager, a peer reviewer, or a clinical supervisor.
- What does the feedback tell me about my strengths and areas for development as an osteopath working in this role?
- How does this feedback influence my understanding of safe, effective, or professional practice? This includes safety and professionalism in clinical care, education, research, governance, or leadership.
- What, if anything, will I change, develop, or continue as a result of this feedback?
- How does this learning support my ongoing development as an osteopath, now or in future roles?

The key requirement is analysis and reflection on what the feedback tells you and how you will act on it.

Mandatory Topics High Risk Areas – Benefiting Patients

You must complete learning in all three of the following areas:

- Communication and consent.
- Establishing and maintaining professional boundaries.
- Inclusive practice (Equity, diversity, inclusion and belonging (EDIB).

These topics are identified from patient concern data and are considered higher-risk areas.

These activities might be combined, for example boundaries and communication.

These three areas help to:

- Involve patients in decisions about their care
- Patients to feel safe
- Provide inclusive, respectful care to all

Peer Discussion Review (PDR)

Towards the end of your cycle, you must complete a structured discussion with a peer.

Choosing a peer

Your peer should be someone you feel able to have an open, honest professional discussion with. Identifying a peer early supports ongoing reflection.

This discussion typically lasts 1-1.5 hours.

You will review:

- How you met each CPD requirement.
- Your reflections and learning journey.
- Strengths identified.
- Areas for development.
- Plans for the next cycle.

Your peer confirms that you have met the CPD requirements for the cycle.

Using the Peer Discussion Review template

The template supports structured discussion and confirmation of requirements. It is

brief and does not replace your CPD records. You must retain the completed template.

Templates and guidance are available at: **cpd.osteopathy.org.uk/resources**

Recording Your CPD

You must maintain records that demonstrate:

- Completion of 90 hours over three years.
- At least 45 hours involving learning with others.
- Coverage of all four OPS themes.
- Completion of one objective activity.
- Completion of the three mandatory topics.
- Completion of the PDR (at the end of the cycle).

For each activity, your record should include:

- What prompted the learning.
- What you learned that was new or surprising.
- How your approach changed.

The impact on patient care or professional relationships.

To record your CPD you could use:

- GOsC Keeping CPD records workbook template
- iO CPD Diary
- Your own reflective diary
- Paper records containing CPD evidence

- Electronic records (MS Word, Apple Pages, Google Doc, Dropbox, Google Drive
- E-portfolio platforms (Pebblepad, Folio Spaces, Padlet, Mahara)

Planning Your CPD Across Three Years

You must complete all requirements by the end of your three-year cycle and you have the freedom to choose how you do this. Here's an example of how you might structure this:

Example Year-by-Year Breakdown

You may choose to complete all mandatory activities in Year 1 and continue with other activities in Years 2 and 3, but you must ensure all requirements are met by the end of Year 3.

Year 1	Year 2	Year 3
30 hours CPD (15 hours learning with others)	**30 hours CPD** (15 hours learning with others)	**30 hours CPD** (15 hours learning with others)
Objective activity analysis and reflection, plus other activities. Identify your intended peer.	CPD in communication and consent, professional boundaries, and EDIB, plus other activities.	CPD across all OPS themes and all aspects of your practice, plus complete Peer Discussion Review.
Registration Renewal: Declare hours completed and elements completed. GOsC confirms you're on track.	**Registration Renewal:** Declare hours completed and elements completed. GOsC confirms you're on track.	**Registration Renewal:** Confirm that Peer Discussion Review has been completed (no need to submit unless this is requested by the registration team). Move to next cycle or receive warning if incomplete.

Reflection Focus: What are my learning priorities this year? How will I measure the impact of my CPD?	**Reflection Focus:** How has my practice evolved? What gaps still exist?	**Reflection Focus:** How has my three-year learning journey changed me as an osteopath? What are my priorities for the next cycle?

You may choose to complete all mandatory activities in Year 1 and continue with other activities in Years 2 and 3, but you must ensure all requirements are met by the end of Year 3.

Using AI Responsibly

Your CPD records and reflections must be your own work. AI tools may help format or organise thoughts, but reflections must genuinely represent your thinking.

Critical considerations:

Data protection: Never use general AI tools (ChatGPT, etc.) for patient-identifiable information. Only use AI tools that comply with data protection laws and have appropriate security measures.

Fact-checking: Always verify AI-generated clinical information against reliable sources before applying it to practice.

More information: osteopathy.org.uk/standards/guidance-for-osteopaths/artificial-intelligence

Annual Registration Renewal

Each year you will be asked to declare:

- Total CPD hours completed.
- Learning with others hours.
- CPS themes covered that year.

- Objective activity status.
- Mandatory topics status.

Peer identified (Years 1-2) / PDR completed (Year 3).

Illustrative example Annual Renewal Declaration

Here's what the CPD section of your annual renewal looks like:

"You are required, over 3 years, to undertake 90 hours CPD of which a minimum of 45 hours must be learning with others. Over 3 years you will need to ensure you have undertaken activities across the four themes of the Osteopathic Practice Standards, an objective activity, an activity focused on communication and consent, and a peer discussion review towards the end of the three-year cycle."

In the past renewal year, I have undertaken: [32] hours of CPD, of which [18] hours are in the category of learning with others.

I have undertaken activities which cover: ☑ Osteopathic Practice Standards Theme A ☑ Osteopathic Practice Standards Theme B ☑ Osteopathic Practice Standards Theme C ☑ Osteopathic Practice Standards Theme D ☑ Objective activity ☑ Communication and consent ☑ I have identified my peer ☐ I have completed and recorded my peer discussion review

If You Can't Meet CPD Requirements

Contact the GOsC as soon as possible during your cycle if exceptional circumstances prevent completion.

The GOsC has statutory power to extend or vary the three-year requirement if there's good reason. Apply in writing with supporting evidence.

Failure to comply without good reason puts your registration at risk of removal.

Don't wait until the last minute - we're here to help you succeed.

Verification and Audit

Who gets audited and when?

We randomly select 5 to 10% of osteopaths to look at evidence of their CPD. This means if you're completing your cycle, you have approximately a 1 in 15 chance of being selected for verification.

What happens if you're selected?

You'll receive an email asking you to submit evidence of your CPD activities within 28 days. The email will outline what is required. It may be one or more of the following:

- Your CPD records showing 90 hours completed (45 hours learning with others).
- Evidence of activities across all four OPS themes.
- Documentation of your objective activity and reflection.
- Evidence of mandatory CPD (communication/consent, boundaries, inclusive practice: Equity, Diversity, Inclusion and Belonging).
- Your completed Peer Discussion Review form.

What evidence do you need to provide?

- Course certificates or attendance confirmations.
- Notes from practice meetings or discussions.
- Your reflective notes eg your CPD diary or CPD log.
- Objective activity documentation (e.g., patient feedback summary, audit results).
- Any other records that demonstrate your learning and reflection

The review process:

We'll review your evidence within 4-6 weeks.

We may contact you for clarification or additional information.

You'll receive feedback on your CPD and confirmation of compliance.

If there are gaps, we'll work with you to address them.

Why we verify:

This process helps us:

- Ensure the CPD scheme is working effectively
- Identify where osteopaths need more support or resources
- Provide feedback to improve the scheme
- Maintain public confidence in osteopathic standards

Support during verification:

Remember, this is a supportive process. If you're selected:

- Contact us immediately if you have concerns about providing evidence.
- We're here to help you understand what's needed.
- The focus is on learning, support and improvement, not punishment.
- What if there are issues?

If your evidence shows gaps in your CPD:

- We'll discuss what additional learning is needed
- You'll have the opportunity to complete missing requirements
- We'll agree on a reasonable timeline for completion
- Only persistent non-compliance after support leads to regulatory action

Key Success Principles

1. Reflect deeply - Document not just what you did, but what you learned and how it changed your practice.
2. Plan ahead - Spread activities across your cycle; don't leave everything to Year 3.

3. Complete mandatory topics early - These are higher-risk areas identified from patient concerns.

4. Identify your peer in Year 1 - Enables ongoing discussions throughout your cycle.

5. Be proportionate - Your CPD should reflect how you spend your professional time.

6. Keep evidence as you go - Don't try to reconstruct three years of learning at the end.

7. Be honest - Your reflections must be your own work, genuinely representing your thinking.

Getting Support

Email: cpd@osteopathy.org.uk

Phone: +44 (0)20 7357 6655

Resources: cpd.osteopathy.org.uk

Standards: osteopathy.org.uk/standards

Templates available at cpd.osteopathy.org.uk/resources:

- Objective Activity Reflection Template
- Peer Discussion Review Template
- Keeping Records Workbook
- Planning Templates

Remember

CPD isn't just about meeting requirements or attending events. It's about:

- Thoughtful reflection on your practice
- Being part of a learning community that puts patients first

- Continuously improving the quality of osteopathic care

The three mandatory topics (communication/consent, boundaries, inclusive practice: equity, diversity, inclusion and belonging) have been identified as higher-risk areas from patient concern data. Completing these demonstrates your commitment to patient safety and high-quality care.

Your CPD cycle dates are individual to you - find them on the ozone. Start planning now, identify your peer early, and contact us if you need any support.

This guidance is effective from [date]. We strongly recommend that even if you're partway through your CPD cycle when this guidance comes into force, you complete each of the mandatory activities before your cycle ends, as these have been identified as higher-risk areas for concerns.

Detailed PDR Template

Name of osteopath

Name of peer(s)

This review is taking place in the following way:

Please put an (x) in the relevant box.

A	**Within a framework put in place by your local group**	
Please provide the name of the regional group:		

B	**Within a framework put in place by an osteopathic educational institution**	
Please provide the name of the institution:		

C	**Within a framework put in place by a clinical interest group or member of the osteopathic alliance**	
Please provide the name of the institution:		

D	**With an osteopath you work with**	

E	**With an osteopath known to you but who you do not work with directly**	

F	**With an osteopath not known to you**	

G	**With another health professional**	

H	**Other**	
If the 'Other' option has been selected please describe:		

Date(s) of review	
Location(s) of review	
Fee paid (if any)	

About the osteopath

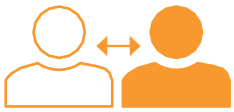
In this box please describe:

- How long you have been practicing.
- How often you practise.
- The number of patients you treat in a typical week.
- What type of patients you treat.
- The context in which you work (eg sole practitioner, multidisciplinary practice).
- Your approach to practice.
- Other roles you may have (eg regional lead, research, education).

Standard 1: Osteopathic Practice Standards

Osteopath to complete this section

Indicate in this section, how you've met this standard.



Peer

Peer to complete this section

Has the osteopath undertaken CPD activities in relation to each of the four themes of the Osteopathic Practice Standards and CPD appropriate to their osteopathic practice?

Please put an (x) in the relevant box

Yes		No	

If no, please explain where the gaps are and how these could be addressed.

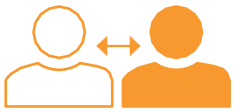
Comments

CPD Standard 2: Objective activity

Osteopath to complete this section

Indicate how you've met this standard.

For example, if this was through **patient feedback, peer observation, case-based discussion, Patient Reported Outcome Measures (PROMs)** or a **clinical audit**. (Try not to exceed 100 words)



Peer

Peer to complete this section

How has the osteopath used feedback from their objective activity and CPD to inform their practice?

(Try not to exceed 100 words)

Comments

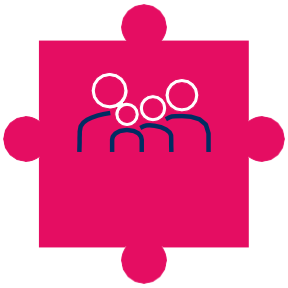
Has the osteopath undertaken at least one objective activity that produced evidence and provided a summary which includes the information outlined in the table below?

Please indicate in the box below which objective activity the osteopath has undertaken:

- Case-based discussion
- Peer observation
- Patient feedback
- Clinical audit
- Patient Reported Outcome Measures (PROMs)

Objective Activity	Yes	No	Comment
	(Please put an x in the relevant box)		(Indicate in the relevant box below if there are any gaps in these elements, and how they might be addresses)
Has the osteopath provided evidence on the aim of the objective activity?			
Has the osteopath provided a description of method used and discussion of why this was chosen?			
Outcome			
Conclusion			
Action Plan			

CPD Standard 3: Benefitting patients



The osteopath demonstrates that they have sought to ensure that their CPD benefits patients (CPD in communication and consent).

Peer to complete this section

Has the osteopath undertaken CPD activities in communication and consent, boundaries, and Inclusive practice: Equity, Diversity, Inclusion and Belonging (EDIB) Please put an (x) in the relevant box

Yes		No	

Comments

CPD Standard 4: Keeping a record

The osteopath maintains a continuing record of CPD.

Peer to complete this section

Does the CPD record demonstrate documented CPD for this CPD cycle, including notes of all activities discussed in this Peer Discussion Review? Please put an (x) in the relevant box

Yes ☐ **No** ☐

Comments

If you have selected no, please indicate gaps within the osteopath's CPD record. Please note the role of the peer is not to verify an osteopath's entire CPD cycle. It is to have an open and constructive dialogue between two practitioners about their learning.

Overview

This section allows the peer and the osteopath to summarise their overall views of the osteopath's CPD and practice.

Overall discussion and feedback

Coe Lorna
05/05/2026 16:36:44

Comments

Strengths

Areas for development

CPD Action Plan for the next three-year cycle

Osteopath

Osteopath to complete this section

Plans for CPD over the next three years - to meet areas for development identified during the most recent three-year cycle:

Comments:

Conclusion

Peer to complete this section

Have the CPD Standards been met?

CPD Standard 1: Osteopathic Practice Standards

Has the osteopath demonstrated a full range of osteopathic practice?

Please put an (x) in the relevant box.

Yes		**No**		**Date**	
Signed					
Print name					

CPD Standard 2: Objective activity

Has the osteopath demonstrated that an objectivity activity has contributed to practice and the quality of care?

Please put an (x) in the relevant box.

Yes		**No**		**Date**	
Signed					
Print name					

CPD Standard 3: Benefitting patients

Has the osteopath sought to ensure that their CPD benefits patients?

Please put an (x) in the relevant box.

Yes		**No**		**Date**	
Signed					
Print name					

CPD Standard 4: Keeping a record

Has the osteopath maintained a continuing record of CPD activities?

Please put an (x) in the relevant box

Yes		**No**		**Date**	
Signed					
Print name					

Declaration by Peer

To be signed by the peer only when the Peer Discussion Review has been successfully completed.

I confirm that I have participated in this Peer Discussion Review and that, in my opinion, the CPD standards have been met. I confirm that the osteopath has demonstrated meaningful engagement with CPD activities relevant to their practice. I confirm that all information provided on this form is correct to the best of my knowledge.

Date	
Signed	
Print name	
Profession	
Registration number	

Declaration by Osteopath

To be completed in all cases.

I confirm that I have participated in this Peer Discussion Review, and that the information provided on this form is correct to the best of my knowledge.

I confirm that I will retain a copy of this form in my CPD record.

Date	
Signed	
Print name	
Profession	
Registration number	

General Osteopathic Council

11

Council
13 May 2026
BCNO Group – Renewal of Recognition of Qualifications (RQ) (reserved)

Classification	Public
Action	Decision
Purpose of the paper	Consideration of the Recognised Qualification (RQ) review at the BCNO Group in relation to: • Masters in Osteopathy (MOst) • BSc (Hons) Osteopathy (modified attendance) • BSc (Hons) Osteopathic Medicine (a level 6 exit award for those unable to pass their dissertation within the MOst)
Strategic Priority implications	Strengthening trust - Working in partnership with the sector to understand the issues and responsibilities connected to the recognition of professional qualifications. Assuring the quality of 'recognised qualifications' is a core part of our statutory duties which helps to maintain the trust and confidence of all our stakeholders.
Standards of Good Regulation implications	Standard 8: The regulator maintains up to date standards for registrants which are kept under review and prioritise patient and service centred care and safety. Standard 9: The regulator has a proportionate and transparent mechanism for assuring itself that the educational providers and programmes it oversees are delivering students and trainees that meet the regulator's requirements for registration, and takes action where its assurance activities identify concerns either about training or wider patient safety concerns. Our quality assurance process as outlined in our Interim Handbook and the Osteopaths Act 1993 ensures that 'recognised qualifications' are only awarded to graduates meeting the Graduate Outcomes and the Osteopathic Practice Standards.
Communications implications	Reports are published on our website

Financial, resourcing and risk implications	This visit was managed in-house. The cost of the in house visit is budgeted at £13,000 and incorporated within existing agreed budgets.
Patient perspectives	Patient perspectives were sought as part of the review process.
Diversity implications	Equality and diversity issues are reflected with the Standards for Education and Training, and form part of RQ review processes.
Welsh language implications	None
Annex(es)	A. RQ Specification B. Visitors' Report
Author	Steven Bettles and Rekita Sparrow
Background reading	N/A

Recommendation	1. To agree to recognise the following programmes awarded by the BCNO Group subject to the conditions set out in paragraph 17, from 1 September 2026 to 30 September 2030 subject to the approval of the Privy Council: • Masters in Osteopathy (MOst) • BSc (Hons) Osteopathy (modified attendance) • BSc (Hons) Osteopathic Medicine

Key messages

- This paper presents the outcome of the Recognised Qualification Review Visit in relation to the BCNO RQ programmes which are currently in teach-out phase. The visit took place from 11-13 November 2025
- The outcome was recommendation of renewal of recognition subject to conditions as outlined, and the Visitors' report was considered by the Policy and Education Committee at its meeting on 12 March.
- The Committee agreed to recommend that Council recognise the programmes subject to the conditions specified, from 1 September 2026 to 30 September 2030, subject to the approval of the Privy Council.

Background

1. A draft RQ specification was approved by the Committee at its October 2024 meeting and the Committee agreed a team of three Education Visitors under s12 of the Osteopaths Act 1993 to undertake the review which was originally planned for February 2025.

2. Following the BCNO Group's decision to cease recruitment to its London campus, the Committee agreed in January 2025 (via email) to proceed with the review pf BCNO's new three year BSc programme in February 2025. The renewal visit of the existing BCNO programmes was postponed until November, by which time we had taken our Quality Assurance function in-house. The updated RQ specification as a result of this late change is attached as Annex A.

3. The visit took place in from 11-13 November 2025.

4. The courses under review are subject to teach-out, and are not being recruited to. The only BCNO RQ course to which recruitment is taking place is the three year BSc taught at the Maidstone campus, which underwent initial review in February 2025, and which was recognised by Council in July 2025.

5. The Visitors' Report was considered by the Policy and Education Committee at its meeting of 12 March 2026. The Committee agree to recommend that Council recognise the following programmes awarded by the BCNO Group subject to the conditions specified, from 1 September 2026 to 30 September 2030 subject to the approval of the Privy Council:

    - Masters in Osteopathy (MOst)
    - BSc (Hons) Osteopathy (modified attendance)
    - BSc (Hons) Osteopathic Medicine

Discussion

6. The final visitors' report is attached at Annex B. The recommendation of the Visitors is approval with four specific conditions. When we recognise an RQ, we also recognise in accordance with the general conditions which are also specified below.

Strengths and good practices

7. The visitors identified several specific areas of strength and good practices in the final report, including:

    - There was widespread recognition among students of the support provided by the management team and the effective resolution of issues. Students spoke highly of the new Head of College and the middle management team, noting increased visibility and more open communication, which had furtherstrengthened student confidence.

- The University includes more formatives and tutorials to review the expectations for practical examinations highlighting in a way that students can clearly understand and experience how they can achieve the higher grades.

- The BCNO Group has developed a strong, positive relationship with the University of Plymouth where feedback is valued and acted upon.

Recommendations

8. Recommendations may be made by visitors when they consider that 'there is an opportunity for improvement, but a condition is not necessary. These areas should be monitored by the provider and the recommendations implemented, if appropriate.'

9. The visitors in this case made a number of recommendations within the report.

10. These areas should be monitored by the provider and implemented if appropriate with updates reported in the next annual report process. A request will be made for BCNO to provide a progress update with regard to these specific areas as part of their 2025-26 Annual Report submission.

Conditions recommended by the Visitors

11. Four specific conditions have were recommended in the report by the Visitors. These are:

    - Given the impact of recent changes the BCNO Group must ensure the risk register is not just reviewed but also updated on a monthly basis. The governance section must be reviewed as a matter of urgency and brought fully up to date.

    - Considering the importance of more clarity on the future direction of the organisation for interested parties including staff and students, a decision should be made by the Board by February 2026 regarding the strategic plan, and following this, a clear summary document be produced and communicated which sets out how the chosen options will be achieved up to 2028. The strategy should be reflected in an action plan with effective timeframes, costings, review dates, KPIs and areas of responsibility, so that progress towards the targets will be measurable.

    - This academic year, the BCNO Group must ensure that all out of date policies are updated. and policy access centralised through a single repository, maintaining a simple central register

- The BCNO Group should ensure that KPIs are regularly reviewed, recorded and updated at least each semester in order to measure progress and effectiveness of the Teach out plan.

12. A draft action plan to outline how the conditions will be addressed and monitored was submitted by the institution on 24 February 2026, and at the time of the Committee meeting had been commented on by the visitors, and was being finalised by BCNO. There is an existing action plan against the conditions agreed by the Committee in relation to the RQ Report relating to the BSc (Hons) Osteopathic Medicine from February 2025, and this progress against this was reported to the Committee in March 2026. Once this latest action plan is finalised, the two will be combined so that there is one plan relating to BCNO, albeit to some extent in relation to different programmes.

13. Some of the issues being monitored in relation to the February 2025 conditions also relate to the conditions recommended by the visitors from the November 2025 visit. For example in relation to the strategic plan and decision making as to the future of the London campus - in relation to the condition which requires a decision to be made by February 2026, a statement was issued to staff and students in January 2026 which includes confirmation that following an extensive review process, the Board has reached conclusions which include:

    - The London campus is no longer able to deliver a sustainable economic contribution to the charity in the long term.

    - Subject to the successful completion of the current teach-out, the Kent campus will become the Group's sole centre for undergraduate delivery from September 2028.

    - The Kent campus will operate as a Group campus, supporting the long-term future and identity of both the ESO and BCOM brands, rather than representing a continuation of any single institution alone.

14. The action plans across all conditions will continue to be monitored by the staff team and further reported to the Committee in June 2026.

Approval

15. As the Osteopaths Act 1993 refers to qualifications, we have in this section simply referred to the named qualifications rather than the descriptions of the different courses.

16. The Visitors' Report recommends recognition of qualification status subject to conditions being met. This means that the visitors have determined that the course will deliver graduate who meet the Osteopathic Practice Standards.

17. The Committee agreed to recommend to Council that specific conditions be imposed and recognition be agreed with an expiry date, as follows (including the general conditions that apply to all recognised programmes with an expiry date):

CONDITIONS	
1	Given the impact of recent changes the BCNO Group must ensure the risk register is not just reviewed but also updated on a monthly basis. The governance section must be reviewed as a matter of urgency and brought fully up to date.
2	Considering the importance of more clarity on the future direction of the organisation for interested parties including staff and students, a decision should be made by the Board by February 2026 regarding the strategic plan, and following this, a clear summary document be produced and communicated which sets out how the chosen options will be achieved up to 2028. The strategy should be reflected in an action plan with effective timeframes, costings, review dates, KPIs and areas of responsibility, so that progress towards the targets will be measurable.
3	This academic year, the BCNO Group must ensure that all out of date policies are updated. and policy access centralised through a single repository, maintaining a simple central register
4	The BCNO Group should ensure that KPIs are regularly reviewed, recorded and updated at least each semester in order to measure progress and effectiveness of the Teach out plan.
6	BCNO Group must submit an Annual Report, within a three month period of the date the request was first made, to the Education Committee of the General Council.
7	BCNO Group must inform the Education Committee of the General Council as soon as practicable, of any change or proposed substantial change likely to influence the quality of the course leading to the qualification and its delivery, including but not limited to: i. substantial changes in finance ii. substantial changes in management iii. changes to the title of the qualification iv. changes to the level of the qualification v. changes to franchise agreements

	vi. changes to validation agreements vii. changes to the length of the course and the mode of its delivery viii. substantial changes in clinical provision ix. changes in teaching personnel x. changes in assessment xi. changes in student entry requirements xii. changes in student numbers (an increase or decline of 20 per cent or more in the number of students admitted to the course relative to the previous academic year should be reported) xiii. changes in patient numbers passing through the student clinic (an increase or decline of 20 per cent in the number of patients passing through the clinic relative to the previous academic year should be reported) xiv. changes in teaching accommodation xv. changes in IT, library, and other learning resource provision xvi. any event that might cause adverse reputational damage xvii. any event that may impact educational standards and patient safety
8	BCNO Group must comply with the General Council's requirements for the assessment of the osteopathic clinical performance of students and its requirements for monitoring the quality and ensuring the standards of this assessment. These are outlined in the *Graduate Outcomes for Osteopathic Pre-registration Education* and *Standards for Education and Training*, 2022, General Osteopathic Council. The participation of real patients in a real clinical setting must be included in this assessment. Any changes in these requirements will be communicated in writing to BCNO Group giving not less than 9 months notice.

Recognition period

18. The interim Quality Assurance handbook[1] sets out the current criteria regarding the period of RQ approvals stating:

[1] https://www.osteopathy.org.uk/news-and-resources/document-library/about-the-gosc/qa-handbook/

"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."

19. The BCNO Group programmes under consideration here are currently recognised with an expiry date of 31 August 2026.

20. Given the context of the teach out of these programmes and the conditions recommended by the visitors, the Committee recommended a fixed expiry date of 30 September 2030, to allow sufficient time for teach out. The majority of students will be completed by September 2028, but recognition beyond this point will allow for those who take a break from studies or need to resit.

Recommendation:

1. To agree to recognise the following programmes awarded by the BCNO Group subject to the conditions set out in paragraph 17, from 1 September 2026 to 30 September 2030 subject to the approval of the Privy Council:

- Masters in Osteopathy (MOst)
- BSc (Hons) Osteopathy (modified attendance)
- BSc (Hons) Osteopathic Medicine

General Osteopathic Council

Annex A to 11

Review Specification for BCNO Group - Renewal of Recognised Qualification Review (updated September 2025)

Background

1. The BCNO Group currently provides the following qualifications which are due to expire on 31 August 2026:

    - Masters in Osteopathy (MOst)
    - BSc (Hons) Osteopathy (modified attendance)
    - BSc (Hons) Osteopathic Medicine
    - Master of Osteopathy and BSc (Hons) Osteopathy, (validated by Buckinghamshire New University (BNU) awarded by the ESO)
    - Masters in Osteopathy (M.Ost) and Bachelors in Osteopathic Medicine (BOstMed), (validated by University of Plymouth (UoP) awarded by BCOM)

2. Recruitment to all of these courses has ceased, and a teach out phase has begun. For the BCNO London campus, this will lead to closure in 2028. For its Maidstone campus, delivery will focus solely on its three-year programme (subject to the outcome of the initial review process undertaken in February 2025). As the Maidstone campus was visited in February 2025, the intended focus of the renewal visit in late 2025 will be the London campus from a resource perspective, though issues in relation to delivery and teach out at both campuses will be addressed.

3. The programmes above validated by Buckinghamshire New University which were delivered by the European School of Osteopathy originally should see their final students graduate in 2025. Similarly, The MOst and BOst Med awarded by BCOM finish in 2025 and none of these require renewal.

Review Specification

4. The GOsC will appoint Education Visitors to review and to report on the following qualifications:

    - Masters in Osteopathy (MOst)
    - BSc (Hons) Osteopathy (modified attendance)
    - BSc (Hons) Osteopathic Medicine (a level 6 exit award for those unable to pass their dissertation within the MOst)

5. The aim of the GOsC Quality Assurance process is to:

    - Put patient safety and public protection at the heart of all activities
    - Ensure that graduates meet the standards outlined in the Osteopathic Practice Standards

- Make sure graduates meet the outcomes of the Guidance for Osteopathic Pre-registration Education.
- Identify good practice and innovation to improve the student and patient experience
- Identify concerns at an early stage and help to resolve them effectively without compromising patient safety or having a detrimental effect on student education
- Identify areas for development or any specific conditions to be imposed upon the course providers to ensure standards continue to be met
- Promote equality and diversity in osteopathic education.

6. The format of the review will be based on the GOsC Quality Assurance Handbook and the Graduate Outcomes and Standards for Education and Training (2023). In addition to the usual review format for a renewal of recognition review, the Committee would like to ensure that the following areas are explored:

    - Teach out arrangements of the existing RQ programmes and how students and staff are supported through this transitional period within an open and collaborative culture to ensure the continued delivery of Graduate Outcomes and Standards for Education and Training.
    - Arrangements to manage current and future fallow years as programmes are taught out, including impacts on staffing and patients.
    - Any foreseen impact of the teach-out on clinical provision and the continued recruitment of sufficient patients to meet the educational needs of students.
    - The impact of the planned departure of the current senior management team and the restructuring of this, including how any risks from this are identified, mitigated, managed and monitored.
    - How feedback from staff is gained to ensure that staff needs are addressed appropriately.
    - How shared decision making with patients is embedded within the teaching clinics and how staff are trained and supported in delivering this.

7. The following Standards for Education and Training are highlighted as particularly important to review in terms of the teach out phase of existing RQs and the planned closure of the London campus, but all will be significant and will be explored as part of the review:

    a. Programme design, delivery and assessment

        - All staff involved in the design and delivery of programmes are trained in all policies of the educational provider (including policies to ensure equality, diversity and inclusion and are supportive, accessible and able to fulfil their roles effectively)
        - Curricula and assessments are developed and evaluated by appropriately experienced and qualified educators and practitioners

- They involve the participation of students, patients, and where possible and appropriate, the wider public in the design and development of programmes, and ensure that feedback from these groups is regularly taken into account and acted upon.
- Assessment methods are reliable and valid and provide a fair measure of students' achievement and progression for the relevant part of the programme.
- Subject areas will be delivered by educators with relevant and appropriate knowledge and expertise

b. Programme governance, leadership and management

- They implement effective governance mechanisms that ensure compliance with all legal, regulatory and educational requirements…. This should include effective risk management and governance and ….governance over the design, delivery and award of qualifications.
- Systems will be in place to provide assurance with supporting evidence that students have fully demonstrated learning outcomes.

c. Learning culture

- Students are supported to develop as learners and professionals during their education
- External expertise is used within the quality review of osteopathic pre-registration programmes

d. Quality evaluation, review and assurance

- effective mechanisms are in place for the monitoring and review of the programme, to include information regarding student performance and progression (and information about protected characteristics), as part of a cycle of quality review.
- external expertise is used within the quality review of osteopathic pre-registration programmes

e. Resources

- they provide adequate, accessible and sufficient resources across all aspects of the programme, including clinical provision, to ensure that all learning outcomes are delivered effectively and efficiently.
- the staff-student ratio is sufficient to provide education and training that is safe, accessible and of the appropriate quality within the acquisition of practical osteopathic skills, and in the teaching clinic and other interactions with patients.

f. Students

- are provided with clear and accurate information regarding the curriculum, approaches to teaching, learning and assessment and the policies and processes relevant to their programme.

g. Clinical experience

- clinical experience is provided through a variety of mechanisms to ensure that students are able to meet the clinical outcomes set out in the Graduate Outcomes for Osteopathic Pre-Registration Education.
- there are effective means of ensuring that students gain sufficient access to the clinical experience required to develop and integrate their knowledge and skills, and meet the programme outcomes, in order to sufficiently be able to deliver the Osteopathic Practice Standards

h. Staff support and development

- there are sufficient numbers of experienced educators with the capacity to teach, assess and support the delivery of the Recognised Qualification. Those teaching practical osteopathic skills and theory, or acting as clinical or practice educators, must be registered with the General Osteopathic Council, or with another UK statutory health care regulator if appropriate to the provision of diverse education opportunities.

i. Patients

- patient safety within their teaching clinics, remote clinics, simulated clinics and other interactions is paramount, and that care of patients and the supervision of this, is of an appropriate standard and based on effective shared decision making.
- the staff student ratio is sufficient to provide safe and accessible education of an appropriate quality.

Provisional Timetable

8. The provisional timetable for the review will be as follows, but is subject to review in discussion with the BCNO Group, Mott and the Visiting Team:

RQ visit in TBC 2025

Month/Year	**Action/Decision**
April 2025	Committee agreement of initial review specification and statutory appointment of visitors
10 weeks before the visit c August 2025	Submission of mapping document

11-15 November	Review visit takes place
5 weeks following visit	Draft Report to BCNO for comments - statutory period.
February 2026	Comments returned and final report agreed.
March 2026	Recommendation from the Committee to Council whether to renew recognition of programmes
May 2026	Recognition of Qualification ongoing by the General Osteopathic Council
July 2026	Privy Council Approval

This timetable will be the subject of negotiation with BCNO Group, to ensure mutually convenient times that fit well with the quality assurance cycle.

GOsC Education Quality Assurance
Renewal of Recognised Qualification Report

This report provides a summary of findings of the providers QA visit. The report will form the basis for the approval of the recommended outcome to the GOsC's Policy and Education Committee.

The review process is set out in detail within the GOsC Quality Assurance Handbook

Provider:	BCNO Group
Date of visit:	11th -13th November 2025
Programme(s) reviewed:	Masters in Osteopathy (MOst) BSc (Hons) Osteopathy (modified attendance) BSc (Hons) Osteopathic Medicine (a level 6 exit award for those unable to pass their dissertation within the MOst)
Visitors:	Phil Stephenson, Stephen Hartshorn, Ana Molares Bargiela
Observers:	Steven Bettles, Rekita Sparrow

Outcome of the review

Recommendation to PEC:

☐ Recommended to renew recognised qualification status

☒ Recommended to renew recognised qualification status subject to conditions being met

☐ Recommended to withdraw recognised qualification status

Current recognition period: 1 September 2021 to 31 August 2026

General Osteopathic Council

Abbreviations

AGC	Academic Governance Committee
BCNO	British College of Naturopathy and Osteopathy - The BCNO Group comprises the merged European School of Osteopathy (ESO) and British College of Osteopathic Medicine (BCOM) though these brand names continue within the merged institution
BSc (Hons)	Bachelor of Science (with Honours)
CEO	Chief Executive Officer
CPD	Continuing Professional Development
EDI	Equality Diversity and Inclusion
EE	External Examiner
ESO	European School of Osteopathy
FEG	Faculty Engagement Group
FtP	Fitness to Practice
HOD	Heads of Department
HR	Human Resources
KPI	Key Performance Indicators
NHS	National Health Service
NSS	National Student Survey
PEG	Patient Engagement Group
PPH	Professional Practice Handbook
PT	Personal Tutor
Pts	Patients
QA	Quality Assurance

RA	Reasonable Adjustments
SEG	Student Engagement Group
SEWO	Student Engagement and Welfare Officer
SMT	Senior Management Team
UoP	University of Plymouth
VLE	Virtual Learning Environment
AGC	Academic Governance Committee
BCNO	British College of Naturopathy and Osteopathy
POLAR	Participation of Local Areas
IMD	Index of Multiple Deprivation

Overall aims of the course

The overall aims of the M.Ost and BSc programmes are aligned in to providing a stimulating appropriate teaching and learning environment to create a self-reflective effective osteopath who has the ability to work in contemporary healthcare. Graduates are expected to understand professional and inter-professional practice in modern healthcare practice. The graduate will understand their lifelong learning requirements and future career pathway, and aims are based on the requirements of GOsC and its relevant standards.

The aims as detailed in the programme specifications are below:

- Provide the student with knowledge, skills and clinical training reflective of advancing healthcare standards in osteopathy and health and its promotion;
- Develop the student's competence in applying clinical skills to osteopathic practice;
- Develop the reflective, critical, leadership and analytical skills of the student, allowing them to deal in a self-directed manner with complex issues, making sound judgements in the absence of complete data, and promoting excellence in professional practice;
- Develop reflective practice and communication skills to develop an effective partnership with patients, other healthcare professions in a changing healthcare environment
- Develop general problem-solving, key-transferable skills and research skills to allow the student to understand the evidence-based practice and become autonomous practitioners.
- Provide the students with the skills to respond positively to change (i.e. unfamiliar or unprecedented situations or problems);
- Enhance reflective skills, to provide effective, safe osteopaths
- Enhance interpersonal skills, enabling clear communication with all audience levels;
- Develop the skills for autonomous practice and team-working;
- Develop the skills to advance knowledge and understanding by independent life-long learning.

Overall Summary

The visit to the BCNO Group was undertaken over three days at the BCNO campus in London. The RQ visit was limited in its purpose to undertake only a review of the teach out of the M.Ost and BSc (Hons) osteopathy programmes. Teach out of the MOst is also taking place at the Maidstone campus which was the subject of a review visit in February 2025 in relation to the BCNO's new three year BSc programme.

Visitors met with a range of relevant groups from the London and Maidstone campuses to support their work in relation to the visit specification. These included SMT, teaching staff, clinic administration staff, support services, Trustees, students, recent graduates, UoP partner and patients. Meetings across the three days were held in an open and honest way to support the visitors with triangulation. The stakeholders which the visitors met with were generous with their time and candour, and were able to provide visitors with valuable information.

Strengths and good practice

There was widespread recognition among students of the support provided by the management team and the effective resolution of issues. Students spoke highly of the new Head of College and the middle management team, noting increased visibility and more open communication, which had further strengthened student confidence. (1.ix)

The University includes more formatives and tutorials to review the expectations for practical examinations highlighting in a way that students can clearly understand and experience how they can achieve the higher grades.

The BCNO Group has developed a strong, positive relationship with UoP where feedback is valued and acted upon.

Areas for development and recommendations

- For the final Clinical Competency Assessment, two assessors are present, and an independent moderator oversees the process to ensure fairness and subsequently produces a report. The External Examiner is invited to oversee the final Clinical Competency Assessment, but was unable to attend last year for the final Clinical Competency Examination, leaving a gap in the evaluation of the reliability and validity of that particular exam. It is recommended that The BCNO Group endeavour to ensure that an External Examiner is present at the Clinical Competency Examinations to provide to provide this additional assurance. (1.viii)

- Feedback from some students on the BSc programme indicated that they feel that BCNO sometimes struggles to recruit educators for weekend teaching, and that consequently, educators may be recruited at short notice and are not familiar with what they should be teaching. This impacts on consistency of teaching and student confidence. It is recommended that The BCNO Group take steps to manage staff recruitment and oversight adequately during weekends and ensure that educators are sufficiently supported to deliver material at the appropriate level. (1.ix)

- Although staff development is supported, there is still not a structured annual appraisal process to evaluate staff, provide feedback, and set development objectives. It was stated that there are plans to reinstate a system based on the previous 360 feedback appraisal process, and it is recommended that this be actioned as soon as practicable. (1.ix)

- The BCNO Group should consider ways of incentivising students to become student representatives and attend all relevant meetings to ensure their voice is more effectively heard and consider additional ways of significantly improving student response rates to surveys and module feedback. (6.iv)

- Although there are clear KPIs linked to the teach out plans, they are very ambitious and some may be difficult to accurately measure given student engagement levels. SMT should ensure that the KPIs in the teach out plan are regularly reviewed and recorded by SMT to help ensure any difficulties are addressed in a timely manner. (4.i)

- The BCNO Group should ensure that the FTP policy (linked to UoP) is uploaded once it has been reviewed to replace the current version. (2.ii)

- Although students said that they felt able to provide regular informal feedback and were happy with this, it is recommended that both formal and informal concerns and complaints are thoroughly logged so that SMT and AGC accurately review the concerns, see any patterns and respond to them on a more regular basis with the 'You Said We Did' approach. (1.vi) (1.x) (2.iii)

- The BCNO Group might consider exploring other channels for feedback, such as organising structured, and documented, student user groups that can feed into formal engagement processes or incentivising students for their active participation. (6.v)

- The BCNO Group should place the safeguarding information and other patient information throughout the clinic to increase visibility and therefore patient access to that information. (9.ii)

- It was evident from patient feedback that the BCNO teaching clinics are much valued by the local communities. To address patient concerns regarding the future of the London clinic, once a decision is reached, it is recommended that The BCNO Group create a detailed communication plan to announce formally to patients and the community about the teach out and future of the London campus clinic. (9.vi)

Conditions

1. Given the impact of recent changes the BCNO Group must ensure the risk register is not just reviewed but also updated on a monthly basis. The governance section must be reviewed as a matter of urgency and brought fully up to date. (2.i)

2. Considering the importance of more clarity on the future direction of the organisation for interested parties including staff and students, a decision should be made by the Board by February 2026 regarding the strategic plan, and following this, a clear summary document be produced and communicated which sets out how the chosen options will be achieved up to 2028. The strategy should be reflected in an action plan with effective timeframes, costings, review dates, KPIs and areas of responsibility, so that progress towards the targets will be measurable. (2.i) (4.iii)

3. This academic year, the BCNO Group must ensure that all out of date policies are updated. and policy access centralised through a single repository, maintaining a simple central register (4.iii)

4. The BCNO Group should ensure that KPIs are regularly reviewed, recorded and updated at least each semester in order to measure progress and effectiveness of the Teach out plan. (2.i)

Assessment of the Standards for Education and Training

1. Programme design, delivery and assessment

Education providers must ensure and be able to demonstrate that:

i. they implement and keep under review an open, fair, transparent and inclusive admissions process, with appropriate entry requirements including competence in written and spoken English.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO has a comprehensive admissions policy and clear processes and entry requirements for students, updated in 2023. Policies and specific information for the programmes for the London campus are available on the BCNO website.

The BCNO London campus is at this moment following a teach out process and therefore, there are no new cohort admissions to their courses M.Ost and BSc(Hons) osteopathy.

However, if students wish to apply to a currently run course, the BCNO has the relevant APL/RPL policies published in the BCNO website. For student's applications, there is a comprehensive recognition of learning mapping form, to review and process each student as required.

The admissions process offers online and face-to-face interviews to allow the institution to assess applicants and gives applicants the opportunity to ask questions and engage with the institution.

Additionally, the recent review and approval of the Equity, Diversity, and Inclusion policy through committee structures highlight the institution's commitment to fostering an inclusive and supportive environment for all students.

Based on the evidence submitted and meetings with SMT, we are assured that the BCNO continues to implement an open, fair, transparent and inclusive admissions process.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. there are equality and diversity policies in relation to applicants, and that these are effectively implemented and monitored.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The Equity, Diversity and Inclusion Policy, updated in July-25 is published in the policies page of the BCNO website to ensure equal opportunities and the avoidance of discrimination of prospective applicants.

From interviews with the staff and students during the visit, it is clear that all of them know where to find the EDI policies.

Students stated that they complete a very comprehensive life questionnaire upon joining the College to identify any specific needs they may have. A student that recently joined year 2 told us that he was very happy with student services as he was evaluated during the process of joining the College and subsequently allocated a tutor to support him.

One student reported that while their specific learning needs were not initially reflected in assessment design, the institution demonstrated responsiveness when concerns were raised. Following subsequent adjustments, the student achieved positive outcomes.

The same student initially experienced challenges within the clinical environment, citing inadequate support and limited patient exposure, which raised concerns about their academic progress. It was confirmed that the Head of Clinic had identified these issues and was actively implementing targeted interventions to address the student's requirements.

Overall, student representatives confirmed that the BCNO Group has consistently provided appropriate accommodations in response to disclosed disabilities.

In addition, it was confirmed that the admissions cycle is reviewed annually mid-cycle (January cut off) and end of cycle for student demographics such as age, history of parental higher education, POLAR and IMD areas, ethnicity, gender and qualifications.

Existing EDI policies and procedures, and meetings during the visit assured us that EDI policies will continue to be effectively implemented and monitored.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iii. they implement a fair and appropriate process for assessing applicants' prior learning and experience.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

A clear RPL policy from the University of Plymouth (UoP) is published on the BCNO website for students who apply with Acquired Prior Learning (APL) or Recognised Prior Learning (RPL) and wish to follow this pathway to join a BCNO programme. If a student chooses to apply via this route, they are required to complete a comprehensive form used to review and map the applicant's RPL to the current courses.

During the visit, one student reported that he had recently been admitted through the RPL route. He expressed satisfaction with a process that was straightforward and uncomplicated, and noted that he received a full assessment during which his learning difficulties were identified immediately. As a result, he was provided with study support and a tutor to assist him with his learning needs. RPL students are invited to enrolment day to meet the academic and support teams. Clinical students are invited to begin their journey with BCNO through the pre-clinic introduction course.

Student Services and other students confirmed during the visit that it is standard practice for applicants to be invited to visit the College and the clinic, and that a thorough assessment is applied to all BCNO applicants in order to provide enhanced support within their teaching and learning environment.

The SMT stated that BCNO acknowledges students' prior learning and encourages them to share this within the College. Workshops have been organised to allow students with prior learning or experience in related healthcare fields, such as physiotherapy, to share their knowledge with their peers and with faculty.

The existing RPL policies and procedures, along with the meetings held during the visit, provided assurance that RPL policies will continue to be effectively implemented on the London campus.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. all staff involved in the design and delivery of programmes are trained in all policies in the institution (including policies to ensure equality, diversity and inclusion), and are supportive, accessible, and able to fulfil their roles effectively.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

During the visit, the team was assured that staff undertake mandatory training during their induction on BCNO-specific policies and UoP policies. This training includes equality and diversity, safeguarding and PREVENT, as well as more job-specific training.

Staff mandatory training is updated annually, and if staff are unable to attend and complete their training, this is recorded and uploaded to the VLE. Changes to policies are communicated to staff via email and through the Quality Newsletter, which is distributed to all staff. As an improvement, the Quality team has introduced a mapping document and an audit trail of policies, but although are made available on the VLE and on the BCNO website, it is felt that there is room for improving the systematic reviewing process as well as storing the policies in a single central repository.

A member of staff commented during the visit that BCNO is supporting him in undertaking a teaching qualification, and that all staff are offered the same level of support to pursue teaching qualifications.

Staff observations are carried out regularly, and structured, constructive feedback is provided to enhance teaching skills. Senior members of staff support junior staff in the student clinic, and staff observations with corresponding feedback are also conducted regularly within the clinic.

Students spoke positively about the support received from the teaching staff, including opportunities for personal and private conversations. There is an open-door policy which allows for informal meetings and students commented during the visit that staff are in supportive and approachable.

Existing staff training and meetings during the visit assured us that staff involved in the design and delivery of programmes had been trained in all policies and that they were supported and able to fulfil their roles effectively.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. curricula and assessments are developed and evaluated by appropriately experienced and qualified educators and practitioners.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BOst and MOst programmes currently delivered at the BCNO are validated by the University of Plymouth (UoP). Some modules from the programme are being slightly restructured to create parity between the Kent and London campus programmes, ensuring that all courses were aligned with the University of Plymouth. The BCNO courses are developed by senior staff and then undergo a rigorous approval and validation process by UoP. During the meeting with course and programme leaders, it was noted that they are involved in the process of syllabus development and in communicating with, and involving, faculty through regular formal and informal meetings.

Regarding the teach-out, the team was assured that a high level of academic standards is being maintained. The middle management team works collaboratively to evaluate and monitor module developments and adapt the programme for the remaining teach-out students. Changes and adaptations are discussed with the three members of the SMT who take responsibility for all areas of the institution, prior to implementation and review. For new modules in Year 4, staff reported that there is little impact from the teach-out, as the modules are new; they commented that it is “fresh and exciting” to design and implement new courses.

The research department has been reorganised and new experienced members of staff have been added to the team. They are producing new publications and securing funding to continue their research activities. Recently, additional members have been added to the middle management team to ensure parity of course delivery between the Kent and London campuses. Their aim is to ensure high-quality module delivery and to further support students during the teach-out so that the student experience remains unchanged.

Assessments are reviewed internally by the faculty delivering the module and the heads of department; examples are submitted to the external examiner to ensure mapping against the learning outcomes and the OPS. Assessments are conducted by trained faculty and practitioners in assessment methods. Members of staff are not permitted to participate in assessments unless they have received the appropriate training and have shadowed senior assessor staff.

External examiners are appointed to each RQ programme. Their reports have been positive following their annual visit to the BCNO and their subsequent annual report, which includes a review of academic materials, student–staff interaction, and assessment outcomes.

We are therefore assured that the curricular content has been developed by appropriately experienced and qualified educators and practitioners, who are also trained to participate in student assessments, and that ongoing evaluation is undertaken by suitably qualified staff.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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vi. they involve the participation of students, patients and, where possible and appropriate, the wider public in the design and development of programmes, and ensure that feedback from these groups is regularly taken into account and acted upon.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO has a Student Experience Group and a Patient Experience Group that provide feedback on aspects of the courses and resources, including the clinic and relevant policies.

During the patient meeting, it was confirmed that at the London clinic campus, reception staff, tutors, and students are very approachable. Patients feel that they are genuinely listened to and believe that clinic staff take any comments or suggestions seriously. In addition, patients receive a text message encouraging them to submit post-treatment feedback.

Students have representation on various bodies, including the UoP Joint Board of Studies and the Board of Trustees, where programme review is discussed. However, student engagement in feedback, class representation, and meeting participation continues to be low, raising concerns about whether the current student response data accurately reflects the wider cohort.

During discussions with the SMT, it was acknowledged that student engagement levels are low, and efforts are being made to increase participation. For example, student engagement has improved this academic year due to the introduction of formal feedback processes, which the SMT considers a significant improvement compared with the previous year. As a result of recent feedback, new technique video resources have been introduced at students' request, supervised practice sessions have been increased with teaching assistants present, and changes have been made to the current Year 2 course structure to provide additional support.

Efforts are also being made to increase the number of student representatives and their attendance at committees by raising awareness of the purpose of these committees and the importance of student involvement.

Course and programme leaders reported that they seek steady student participation by collecting feedback regularly at the start of each year and in every module. However, fewer than 10% of students provide module feedback, making it difficult to determine whether the feedback represents the wider student group or only individual views. They agreed that recruiting sufficient student representatives is challenging, and they are working to motivate representatives to understand their role and how they can influence the development of osteopathy.

As a small institution, BCNO Group benefits from close proximity to students, allowing for well-established informal feedback channels. This feedback is then reported to the SMT or the relevant staff member. Recent graduates confirmed that the SMT maintains an open-door policy and that concerns can be raised informally at any time.

Staff and students stated that the encouragement of ongoing informal feedback and subsequent discussion is welcomed by the staff team, and that feedback throughout the year is acted upon. Examples include increasing face-to-face teaching hours after students expressed concern about excessive online delivery and providing clearer information regarding Year 2 examinations. While this culture of informal dialogue facilitates feedback in classroom settings, it is not formally recorded, making it difficult to quantify. Course and programme leaders noted that they have now implemented written feedback collection three times per year and four meetings annually to ensure that feedback is documented.

During the meeting with the UoP representative, it was confirmed that UoP continuously reviews student feedback and meets with the BCNO SMT as needed so that any concerns can be addressed immediately. Formal meetings between UoP and BCNO are held each term and annually, including the review of student feedback, to identify areas requiring improvement. UoP also monitors the OfS report closely, and any concerns raised are scrutinised by the periodic review panel.

Regarding the teach-out, programme modifications have been introduced to support students, including the recruitment of additional staff for student support, and BCNO is using student feedback to guide these changes. Course and programme leaders reported that they aim to maintain clear communication with students regarding the teach-out and are aware of student concerns. They noted that while there were more concerns last year, improved communication this year has resulted in fewer issues being raised. In response to ongoing concerns, staff have reassured students that services will continue as normal, which has helped reduce anxiety. Staff also emphasised their commitment to maintaining normal day-to-day operations and continuing regular communication.

Based on the existing formal and informal feedback procedures, the close monitoring of student feedback by UoP and BCNO, and the staff's dedication to listening to students' ideas and concerns, we are assured that the institution actively involves students, patients, and, where appropriate, the wider public in the design and development of programmes, and ensures that feedback from these groups is regularly considered and acted upon

Strengths and good practice

None reported.

Areas for development and recommendations

Although students said that they felt able to provide regular informal feedback and were happy with this, it is recommended that both formal and informal concerns and complaints are thoroughly logged so that SMT and AGC accurately review the concerns, see any patterns and respond to them on a more regular basis with the 'You Said We Did' approach.

Conditions

None reported.

vii. the programme designed and delivered reflects the skills, knowledge base, attitudes and values, set out in the Graduate Outcomes for Pre-registration Osteopathic Education (including all outcomes including effectiveness in teaching students about health inequalities and the non-biased treatment of diverse patients).

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

All BCNO courses are mapped to the Graduate Outcomes, the OPS, and relevant national and GOsC standards and guidelines. The programme design ensures that students' learning is aligned with the competencies, knowledge, skills, and attitudes required for their future professional role and will enable them to meet the demands of the profession upon graduation. To ensure that students and staff are aware of the Graduate Outcomes, posters have been created and various course documents include the mapping for OPS and Graduate Outcomes.

The BCNO student clinics are committed to equality, diversity, and inclusion and therefore admits patients of all ages and backgrounds, including those who cannot afford treatment. During the visit, the Director of Clinical Education explained that the BCOM clinic provides free or reduced-cost treatments to patients who are unable to pay the full fee. The BCNO Group also offers treatments to the homeless population, both on site and at homelessness support locations, and the clinic collaborates with charities such as Versus Arthritis. Clinic staff ensure that all students are exposed to all patient groups through an internal periodic review audit. In addition, students follow required rotations, ensuring their participation in all specialised clinics and exposure to a wide variety of patients. This system enables students to learn in practice about health inequalities and the unbiased treatment of a diverse patient population. These expectations are reinforced in the student code of conduct, EDI policy, and fitness to practise policies, all of which are available in the clinic, on the VLE, and on the BCNO website.

We can therefore be assured that BCNO delivers the knowledge base, attitudes, and values set out in the Graduate Outcomes.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

☒ **MET**

☐ **NOT MET**

viii. assessment methods are reliable and valid, and provide a fair measure of students' achievement and progression for the relevant part of the programme.

Findings and evidence to support this

Students on the programmes delivered at the London campus are evaluated through a range of assessment methods throughout the course, including presentations, written papers, coursework, and clinical competency examinations. Assessments are designed to ensure that the curriculum, learning outcomes, and assessment processes are fully aligned to support a robust and coherent approach.

The BCNO ensures that students have access to detailed information about assessment criteria, weightings, and expected learning outcomes for each module through the module and programme handbooks available on the VLE for staff and students. These include assessment schedules, marking rubrics, and assessment briefs, ensuring that students are aware of the criteria on which they will be assessed and are clear about module expectations.

The reliability and validity of assessment methods are supported by input from External Examiners. Twenty percent of all written assessments that achieve a pass, as well as all failed scripts, are double-marked anonymously and reviewed by the External Examiner. All dissertations are double-marked blind and anonymously to ensure that marks are credible, transparent, and fair. Following marking and feedback, there is a cross-departmental review of marks and of the assessment process, including the results achieved. A moderation form is completed and submitted to the External Examiner. During practical assessments, a moderator is present throughout. For the final Clinical Competency Assessment, two assessors are present, and an independent moderator oversees the process to ensure fairness and subsequently produces a report. The External Examiner is invited to oversee the final Clinical Competency Assessment.

During the visit, the SMT assured the panel that the assessment quality assurance process will not be affected during the teach-out period at the London campus, and that BCNO's existing methods for maintaining validity and reliability will continue to be applied. As group sizes decrease during the teach-out, additional examiners will be brought in from the Kent campus to prevent bias, particularly during the Clinical Competency Assessments. The same team of experienced examiners is currently observing in the London clinic to ensure consistency and quality assurance. We were also assured that an External Examiner will be invited to the Clinical Competency Assessments to quality-assure the process and provide feedback on assessments, assessors, and students. External Examiner reports support the range of assessment methods, their alignment with the OPS and Graduate

Outcomes, and their effectiveness in assessing student achievement and progression. However, due to prior commitments, the External Examiner was not present for the final Clinical Competency Examination, leaving a gap in the evaluation of the reliability and validity of that particular exam.

During the programme leaders' meeting, it was reported that to support student learning and help them understand what is required in summative assessments, additional assessment briefs, tutorials, and formative exams have been introduced, particularly to prepare students for their final Clinical Competency Assessments. Structured, specific training is provided to staff to become assessors, and at the end of each academic year, modules are reviewed in relation to student outcomes.

Students reported that they are satisfied with the additional support provided and that students with learning difficulties receive appropriate adjustments during exams. Previous concerns raised by Year 2 students regarding the clarity of their exams have been addressed. However, BSc students expressed that the London campus struggles at times to secure tutors, particularly on Saturdays, and that provisional tutors are not always clear about the knowledge students require for assessments, which affects their preparation for subsequent exams.

During the meeting with the UoP representative, it was stated that when UoP has suggested improvements to BCNO's assessment methods, BCNO has consistently been responsive, listening to and implementing the recommendations provided.

Strengths and good practice

The University includes more formatives and tutorials to review the expectations for practical examinations highlighting in a way that students can clearly understand and experience how they can achieve the higher grades.

Areas for development and recommendations

The External Examiner is invited to oversee the final Clinical Competency Assessment, but was unable to attend last year for the final Clinical Competency Examination, leaving a gap in the evaluation of the reliability and validity of that particular exam. It is recommended that The BCNO Group endeavour to ensure that an External Examiner is present at the Clinical Competency Examinations to provide to provide this additional assurance. (1.viii)

It is recommended that The BCNO Group take steps to manage staff recruitment and oversight adequately during weekends and ensure that educators are sufficiently supported to deliver material at the appropriate level. (1.ix)

Conditions

None reported.

1x subject areas are delivered by educators with relevant and appropriate knowledge and expertise (teaching osteopathic content or supervising in teaching clinics, remote clinics or other clinical interactions must be

☒ **MET**

registered with the GOsC or with another UK statutory health care regulator if appropriate to the provision of diverse education). ☐ **NOT MET**

Findings and evidence to support this

The BCNO recruitment policy sets out a comprehensive framework to ensure that selection of new teaching staff is based on the specified criteria for skills, experience and qualifications set out in the job description and the role profile.

All osteopathic teaching faculty members are registered with the GOsC. During the visit, it was evident that the faculty members who met with the team were experienced and enthusiastic about teaching osteopathy. There is a comprehensive induction for new members of staff, shadowing and peer observations to monitor the quality of the academic and clinical delivery.

Various feedback mechanisms, including a peer review process, student feedback and external examiner reports are used to maintain the quality of the teaching and the staff.

Newly appointed and more senior staff have been offered a subsidy to help to do the training for the PGCert in education. In our meeting newly academic staff stated that they were encouraged to participate in reflective practice to identify areas of personal development.

However, there is not a structured yearly appraisal to evaluate staff, provide feedback, or set goals and plans for member of staff development. In the meeting with the SMT we were told that they are looking to reinstate the 360 BCNO formal yearly appraisal process, however, due to the staff uncertainty it has been put on hold. They plan to launch a new appraisal system based on previous 360 feedback appraisals in 2026.

Newly appointed programme, course leaders and the head of clinical education are highly qualified experienced educators that work across both sites (Kent and London) to maintain parity of the programmes and support their academic and clinical staff. They also work in conjunction to create a continuous learning and help students to apply their academic learning into the practical setting and to minimise the effect of the teach-out as much as possible in the London campus.

Research methods are delivered by the academic research team. The team oversee research activities and publications developed in the institution allowing students and patients to collaborate. The expertise and knowledge of the research team aims to raise the research levels of the institution.

At the meeting with recent graduates it was remarked that they received an excellent teaching delivery, that tutors were always available and that they felt very supported as students. Also, the variety of knowledgeable tutors in the clinic helped them to understand that there is not only one way of practising osteopathy. Regarding the teach-out there was a consensus that due to the teach-out in the London campus, some experienced staff members had left and that had created some uncertainty within students although it didn't affect their learning experience.

During the visitors' meeting, current students reported inconsistency in the quality of teaching, noting variability in the standard of lectures. The Year 2 London cohort attributed this to staff departures associated with the teach-out process. Students also expressed the view that, although the provision delivered by staff is generally of lower quality compared with other teaching staff, the overall osteopathic grounding they receive remains strong.

For the bachelor programme, students feel that the institution is struggling to find tutors especially on Saturdays to teach them and that makes them unsettled. They also pointed out that sometimes teachers come in at short notice, and they don't know what to teach so the consistency is not there. In general, however, students agreed that due to teach-out they are benefiting with a more personalised approach to teaching, sometimes this is a nearly one to one teaching. They also agree that they have a very good group of academic staff, that they receive a good quality of teaching and that teachers are very passionate about teaching and osteopathy.

We are therefore assured that the programmes are delivered by educators with relevant and appropriate knowledge and expertise.

Strengths and good practice

There was widespread recognition among students of the support provided by the management team and the effective resolution of issues. Students spoke highly of the new Head of College and the middle management team, noting increased visibility and more open communication, which had further strengthened student confidence.

Areas for development and recommendations

Although staff development is supported, there is still not a structured annual appraisal process to evaluate staff, provide feedback, and set development objectives. It was stated that there are plans to reinstate a system based on the previous 360 feedback appraisal process, and it is recommended that this be actioned as soon as practicable

It is recommended that The BCNO Group take steps to manage staff recruitment and oversight adequately during weekends and ensure that educators are sufficiently supported to deliver material at the appropriate level.

Conditions

None reported.

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x. there is an effective process in place for receiving, responding to and learning from student complaints.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO complaints policy is published on the organisation's website, making it accessible to students as needed, and students are reminded of the policy each year during induction. The Head of Student Services is available to assist any student in making a formal or informal complaint. However, the current complaints policy set by the University of Plymouth (UoP) does not allow for an anonymous formal complaint at the initial stage, as students must first submit an informal complaint before they are permitted to lodge a formal one.

During the visit, it was evident that although students know where to find the complaints policy and are regularly invited to provide feedback, participation in meetings, class representation, and formal feedback processes remains low. There is an established open-door culture at the London campus for informally discussing concerns and complaints. This informal system has been long in place, and, in the absence of a dedicated Student Services office, students use the library as their main point of contact to raise questions, concerns, or complaints. If the issue cannot be resolved immediately, students are directed to the appropriate department.

However, under this system, concerns or complaints are often not formally recorded or reported to the Academic Council for action or monitoring, but are instead addressed informally. This creates a risk of complaints being lost or not handled by the appropriate department.

During the meetings, students stated that they feel the support from lecturers more than from the wider college. Complaints such as the one regarding one lecturer appear to have been resolved primarily at the lecturer level rather than through institutional channels. Students acknowledged that communication could improve, although they reported that fundamental concerns; such as requests for additional practice sessions receive a response. They also indicated that communication has improved since September, and that although they do not always receive formal feedback, the small cohort size enables them to learn quickly when changes are made to the course.

With regard to the teach-out, students reported experiencing difficulties due to not fully understanding why the teach-out is happening. They felt that BCNO had not communicated all changes clearly, leaving them unsure about developments and future plans. Students also felt anxious about staff departures and uncertain about what would happen next. However, they noted that communication has improved this year, that they receive more one-to-one tuition, and that they feel more listened to. They expressed particular satisfaction with the new Head of College, who they felt provided reassurance and clarity about the direction of the institution during the teach-out.

As a result, we are assured that there is an effective process in place for receiving, responding to, and learning from student complaints.

Strengths and good practice

None reported.

Areas for development and recommendations

Recommendations:

As mentioned in a previous standard, it is recommended that BCNO consider putting in place a system to record informal complaints. If complaints are not documented makes it more difficult to

evaluate or develop procedures to ensure that student concerns are effectively identified and directed to the relevant area within the organisation for resolution in a timely and effective manner.

Create a better structured way of communicating feedback including feedback from informal complaints.

Conditions

None reported.

xi. there is an effective process in place for students to make academic appeals.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

BCNO utilises the University of Plymouth (UoP) policies for managing academic appeals, which are published on both the UoP and BCNO websites.

In the 2023/24 academic year, there were two academic appeals. One involved a BNU - registered student who questioned the marking and feedback of their dissertation. The marking process was reviewed by a senior academic, who confirmed that the validating university's policies and procedures had been correctly followed. The dissertation was also reviewed by the External Examiner, who did not challenge the result. This appeal remained at the informal stage, and the student was satisfied with the outcome.

The other case involves a UoP-registered student and is currently ongoing.

During the visit, students confirmed that they are aware of where to find the academic and complaints policies and how to access them if required.

As a result, we are assured that an effective academic appeal process is in place for the programmes.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

2. Programme governance, leadership and management

i. they effectively implement effective governance mechanisms that ensure compliance with all legal, regulatory and educational requirements, including policies for safeguarding, with clear lines of responsibility and accountability. This should include effective risk management and governance, information governance and GDPR requirements and equality, diversity and inclusion governance and governance over the design, delivery and award of qualifications.

☐ **MET**

☒ **NOT MET**

Findings and evidence to support this

Over the last two years the BCNO Group has undertaken a review of their governance structure, remits and membership of the 16 committees and sub-committees. These include student, faculty and patient experience groups who are able to give their feedback to the Academic Board and SMT. A number of surveys were undertaken to test the effectiveness of the governance structures and mechanisms. A Governance and Management Structure Handbook 2025-2026 has now been produced with a review scheduled to be undertaken every three years.

Through this structure and led by the CEO and SMT, the BCNO Group has made some significant changes to its direction of travel and future planning. Following the decision to teach out programmes in London, the BCNO Group has produced a teach out plan and a student protection plan which give key performance indicators to evaluate the success of its provision. It will be important to keep these documents under regular review to ensure that all future changes are accurately reflected. The KPI are very ambitious and this is recognised by SMT. In order to measure progress and effectiveness of the teach out plan it will be important for the KPIs to be regularly reviewed, recorded and updated each semester.

There are a number of opportunities for staff and students to be represented through the current governance structure but attendance at some meetings is often low. Attendance at the Academic Stakeholders Working Groups (SEG, FEG and PEG) in the last year has varied from 21%-64%. Although attendance at other committee meetings is higher we were concerned that the stakeholders' views (through these working groups) may not be sufficiently robust. Additionally there are currently nine vacancies for student representatives which may further weaken the more formal channels of communication. Students tell us that they find the timings of meetings make them difficult to attend as it may mean they miss lectures or have to take time off work. They also felt the pressure of work is such that the additional responsibility of this role is unsustainable. We spoke to recent graduates a number of whom had been student representatives and they recognised the value and importance of the role. The BCNO Group have advertised the vacancies and promoted the role but further consideration may be needed to incentivise students, staff and patients to attend the stakeholder working groups so that their voice is more effectively heard.

The students told us they prefer to use informal channels of communication and if they have a concern or complaint they would speak to a member of staff directly. Whilst students were generally happy with this approach and the responses they were getting there may be a danger that the more formal channels of communication are neglected and patterns of concern or complaint do not necessarily reach middle or senior management. Student response rates to surveys and feedback forms are also very low, averaging about a 20% response rate.

At the RQ visits on 11–13th January 2022 and 18-20th February 2025 it was recommended that a strategic plan was developed giving showing clear timeframes, costings, and areas of responsibility. Although the BCNO Group has recently produced a five year strategic plan 2025-2030 giving a future

vision, costings and areas of responsibility are not given and time frames are general rather than specific. It provides broad outline and direction for the future but does not detail how it will achieve this, when and by whom.

Through extensive marketing information, financial predictions and networking the SMT have been able to develop a number of options for the continued direction of the BCNO Group relating to teach out, use of buildings and future business possibilities. These will be presented at the November 2025 Board Meeting where decisions will be made on the future direction of the organisation up to and beyond November 2028. Given the uncertainty surrounding the future of the London campus and the impact upon student, staff and patients it will be imperative that once these decisions have been made, at the November 2025 Board Meeting, these must be effectively communicated to all stakeholders. Many of the staff and students we spoke to felt quite strongly that communication from the Board had been ineffective over the recent periods of change. They felt that communication with managers and SMT had been more effective. Bearing in mind the importance of more clarity on the future direction of the organisation it will be imperative that a clear summary document should be produced and linked to a detailed action plan which sets out how the chosen options will be achieved up to 2028 with effective timeframes, costings, review dates, KPIs and areas of responsibility.

The risk register is managed by the SMT and reviewed on a termly basis (last time October 2025). The risk register identifies risks associated with governance, operations, finance, external factors, and students. Although each risk is scored for likelihood and impact, in the “current score: review date” column dated entries varied from July 2020 to October 2025. Given the rapid pace of change within the BCNO Group and the impact of recent decisions it would be more useful for each risk on the register to be reviewed and dated each time. Although there are clear mechanisms in place for controlling risk and most areas are quite up to date 14 areas of the governance section have not been recently reviewed a with one as far back as July 2020.

The BCNO Group have adopted the UoP Safeguarding Policy which is available to staff and students through the website and VLE. Safeguarding is reported to a dedicated team who maintain a central repository. Processes and outcomes are reviewed annually through safeguarding audits. Safeguarding information and reminders are communicated via newsletters to staff and students on the VLE and on posters displayed in various locations, including clinics.

Although we are assured that BCNO has a clear governance and management structure to ensure compliance with legal, regulatory and educational requirements, we feel it is imperative that a clear summary document be produced and linked to a detailed action plan is needed to clearly show developments over the next 3 years.

Strengths and good practice

None reported.

Areas for development and recommendations

Conditions

Given the impact of recent changes the BCNO Group must ensure the risk register is not just reviewed but also updated on a monthly basis. The governance section must be reviewed as a matter of urgency and brought fully up to date.

Considering the importance of more clarity on the future direction of the organisation for interested parties including staff and students, a decision should be made by the Board by February 2026 regarding the strategic plan, and following this, a clear summary document be produced and communicated which sets out how the chosen options will be achieved up to 2028. The strategy should be reflected in an action plan with effective timeframes, costings, review dates, KPIs and areas of responsibility, so that progress towards the targets will be measurable

The BCNO Group should ensure that KPIs are regularly reviewed, recorded and updated at least each semester in order to measure progress and effectiveness of the Teach out plan.

To support student understanding, a student-centred poster was developed and displayed on campus. This presented the information in an accessible FAQ format, focusing specifically on what the changes meant for students.

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ii. have in place and implement fair, effective and transparent fitness to practice procedures to address concerns about student conduct which might compromise public or patient safety, or call into question their ability to deliver the Osteopathic Practice Standards.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

FtP policies and procedures follow those set by the university and the GOsC with local adjustments made for the context and profession specific requirements. These are published to staff and students and are accessible through the VLE and website. The current FtP policy linked to UoP may need updating as it was last reviewed in 2023.

The BCNO Group ensures that its students are not only familiar with its FtP procedures but also the wider range of the GOsC guidance including student guidance on professional behaviours and FtP for osteopathic students. The PPH was reviewed and updated in July 2025 and provides a wide range of relevant information for staff and students whilst in clinic or practical classes with regard to conduct which may compromise public or patient safety. Students and staff tell us they are know how to access policies and are confident that they would follow the relevant procedures.

The FtP policies, guidance, and procedures are in place. These are accessible and understood by staff and students so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

To ensure that the FTP policy (linked to UoP) is uploaded once it has been reviewed to replace current copy.

Conditions

None reported.

iii. there are accessible and effective channels in place to enable concerns and complaints to be raised and acted upon.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group conducts an annual review of its complaint management procedures. The students' complaints policy is adopted from the UoP and has a review date for 2026. The AGC reviews complaints from students, staff, and patients at each meeting as a standing agenda item, which helps identify any recurring themes. Written feedback, particularly through the module outcomes statistic report is helpful but student engagement with this is low varying between cohorts from 7% to 57% (average 27%).

Students told us they are aware of the formal channels to raise concerns and offer feedback, but most feel they do not always have sufficient time to respond to surveys or feedback forms. They told us that they felt concerns are resolved more effectively by informally emailing or talking to a member of staff. Their experience of raising concerns was mixed. Some students had complained about poor teaching and felt the response to this was slow and impacted their learning. Others told us they were listened to by staff and things changed for the better. Students told us that their student representatives find the additional demands on their time difficult to manage which may explain the current nine vacancies.

Students and staff informed us there are effective channels in place to enable concerns and complaints to be raised but some have reservations over how effectively they are acted upon and resolved.

Patients told us they were very happy with the opportunities they have to raise concerns, complain, or make compliments either electronically, in person or over the phone. They felt channels of communication were effective and accessible.

Many students told us they prefer to chat with or email a member of staff if they have a concern or complaint rather than going along a more formal route. Although it is evident that some complaints and concerns are logged there is a danger that if concerns, complaints, and feedback are not thoroughly logged any review of complaints will be incomplete. If all informal concerns and complaint were comprehensively logged it would be possible to accurately measure and review the concerns, see any patterns and respond to the stakeholders on a more regular basis using the 'You Said We Did' approach, which has already begun. This would be of particular use to the AGC when they review complaints in their meetings.

Overall, we found there were procedures and opportunities in place to enable concerns and complaints to be raised and acted upon. Our meetings with staff, students, and patients confirm this so we are confident that this standard is met.

Strengths and good practice

Students are confident to email and talk to staff if they have any concerns or complaints

Areas for development and recommendations

It is recommended that both formal and informal concerns and complaints are thoroughly logged so that SMT and AGC accurately review the concerns, see any patterns and respond to them on a more regular basis with the 'You Said We Did' approach.

Conditions

None reported.

iv. the culture is one where it is safe for students, staff and patients to speak up about unacceptable and inappropriate behaviour, including bullying, (recognising that this may be more difficult for people who are being bullied or harassed or for people who have suffered a disadvantage due to a particular protected characteristic and that different avenues may need to be provided for different people to enable them to feel safe). External avenues of support and advice and for raising concerns should be signposted. For example, the General Osteopathic Council, Protect: a speaking up charity operating across the UK, the National Guardian in England, or resources for speaking up in Wales, resources for speaking up in Scotland, resources in Northern Ireland.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Staff and students are informed about the BCNO Group's anti-bullying and harassment policy, sexual misconduct policies and procedures during induction. Through the VLE section there are also additional learning resources, and helpful guidance materials. There are also a range of recently reviewed policies including the student code of conduct and dignity at work which emphasises the behaviour expected of the BCNO Group staff and students.

Staff, students, and patients told us they would feel confident to speak up if they witnessed unacceptable or inappropriate behaviour, can access the relevant policies and are aware of the procedures to follow.

In addition to support available internally through PTs, the SEWO and student counsellors, students and staff have access to a number of external agencies who can provide additional support. This is signposted on the student welfare leaflet and VLE and includes access to the Health Assured Programme and links to Samaritans, Shout and Stay Alive.

We found there were policies and procedures in place as well as key staff available to listen to and signpost staff, students or patients if further support is needed. Our meetings with staff, students and patients confirm this so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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v. the culture is such that staff and students who make mistakes or who do not know how to approach a particular situation appropriately are welcomed, encouraged and supported to speak up and to seek advice.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Students tell us they feel comfortable about speaking up and seeking appropriate advice. Most have PTs but also find staff very approachable so they generally find somebody they are comfortable to approach. This initial contact may also lead to the student being appropriately signposted to receive additional help either by another staff member or an external support agency. The SEWO is well respected by the students as they find her very approachable, responsive and a useful catalyst for support. A full range of available support can be found on student newsletters, a student welfare leaflet and poster on display and on the VLE.

Staff told us they do feel confident to speak up and seek advice and support if needed. Training and additional CPD opportunities to acquire additional skills were available to all staff and SMT had been found to be receptive and responsive.

Although students are asked to provide feedback on their clinical tutors to ensure support for students and to flag any potential issues with tutors, student engagement with this is variable. Tutors who have poor feedback meet with the Head of Clinical Education to receive support and undergo peer observation of their clinical teaching. Clinic tutors have termly meetings chaired by the Head of Clinical Education to discuss updates and student progression. We did speak to teaching staff who had been involved in peer observation of teaching by HoD.

We found there were channels and procedures for students and staff to follow with key staff available to listen and signpost further support if needed. Our meetings with staff and students confirm this so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

vi. systems are in place to provide assurance, with supporting evidence, that students have fully demonstrated learning outcomes.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

As part of the annual programme monitoring, assessments and outcomes are reviewed to ensure students are meeting the approved learning outcomes. This is evidenced in module outcome reports, student characteristics and outcomes reports and the EE reports.

Students tell us that the quality of feedback they receive varies greatly but can be very helpful. They told us the marking criteria and rubrics are useful but they feel there is still considerable variation in the quality of feedback offered and marks given by staff. The academic teams mark and provide feedback using the marking rubric to help students identify areas for improvement. A rubric and marking criteria for each assessment is available for students, along with the marking criteria. There is also a guide for staff to assist in marking and an internal moderation for each assessment.

Our meeting with UoP confirmed a positive relationship with The BCNO Group and confidence in the approach and work of BCOM. EE reports confirm that modules contain a wide range of components which provide a sound knowledge base and align with the requirements of the OPS. EEs also provide feedback to the SMT regarding the credibility of assessment and whether it meets the requirements of the regulatory body. This feedback is largely positive but does indicate the need for more feedforward comments and indicates some variance in the quality and standards of marking.

The latest EE report confirms that modules contain a wide range components which provide a sound knowledge base and align with the requirements of the OPS. There is a wide range of assessment

tools in use which enable students to demonstrate skills in differing contexts which results in a well-rounded view of each student's abilities.

We found there were systems in place to provide assurance that students have demonstrated their learning outcomes and evidence from EEs supports this, so we are confident that this standard is met.

Strengths and good practice

The BCNO Group has developed a strong, positive relationship with UoP where feedback is valued and acted upon.

Areas for development and recommendations

None reported.

Conditions

None reported.

3. Learning Culture

i. there is a caring and compassionate culture within the institution that places emphasis on the safety and wellbeing of students, patients, educators and staff, and embodies the Osteopathic Practice Standards.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group has been through a challenging period of considerable change with difficult decisions needing to be made. This has had a major impact on all stakeholders. Whilst a number of the decisions made have not be universally popular, staff and students have acted professionally to support the effective teach out of the programmes. Despite the anger, uncertainty and frustration expressed, SMT have endeavoured to maintain a caring learning culture, recognising the importance of the safety and wellbeing of all stakeholders. There is a clear management structure which is backed up by a range of policies to emphasise a focus on the well-being of students, patients and staff as well as reflecting the OPS.

Although not all staff agree on some of the decisions made they tell us they are well supported in their role and have access to additional training to develop their skills or expertise if required. There is a range of support services available to staff and students linked to their well-being and these are clearly signposted in the VLE and on welfare posters.

Patients tell us they feel completely safe and praise the commitment and professionalism of both staff and students in all aspects of their treatment and aftercare.

The BCNO Group use SharePoint as a central repository for safeguarding which, they feel, has enhanced their ability to manage information more efficiently. Safeguarding reminders are visible and accessible, with posters displayed in clinics, staff and student areas and regular updates sent through newsletters and stored on the VLE.

We found that relevant information and policies are in place relating to the safety of staff, students, and patients. Our meetings with staff, students and patients confirmed that a caring and compassionate culture is evident, so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. they cultivate and maintain a culture of openness, candour, inclusion and mutual respect between staff, students and patients.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group promotes a culture of openness and candour by providing staff, students, and patients with opportunities to voice their feedback and concerns through a number of committees and experience groups. The staff and students we spoke to were aware of these opportunities but preferred to deal with things more informally by approaching or emailing a member of staff. Given the recent changes made across the BCNO Group there is an understandable current of anger and concern at some decisions made and the continuing uncertainty around the future, but staff and students seem to be approaching teach-out of the programmes with professionalism and determination. Patients and members of the PEG tell us they feel included and respected.

A source of frustration for staff and students is the continuing uncertainty on the future of BCNO London delivery, and the perceived poor communication from the Board. Although future decisions will be difficult and not universally popular it was felt that all stakeholders need to know clearly what is going to happen over the next three years. This needs to happen shortly after the November 2025 Board meeting.

The mechanisms for gathering more formal feedback from staff, students and patients are in place. Student related issues are held during SEG meetings and discussions about patient-related issues take place during PEG meetings. The FEG feed through to the programme leads who report back to the faculty. Student and staff representatives also form a key part of Board and governance meetings as well as being represented on the Board of Trustees. We noted that engagement with these important groups was extremely variable with attendance over the last year varying from 21-64%.

SMT recognise that student engagement is low and are keen to improve this. Student perception is that their workload and time issues hinder greater engagement and participation. The BCNO Group do create a range of opportunities for additional feedback including online surveys and module feedback but students still seem to prefer a more informal approach.

The BCNO Group has relevant guidelines for staff and student behaviour and expectations and tracks its complaints and disciplinary proceedings for both students and staff annually.

We found relevant policies and processes are in place to encourage and monitor a positive respectful culture between staff, students, and patients. Our meetings with staff, students and staff confirm a culture of openness, candour and respect is evident so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iii. the learning culture is fair, impartial, inclusive and transparent, and is based upon the principles of equality and diversity (including universal awareness of inclusion, reasonable adjustments and anticipating the needs of diverse individuals). It must meet the requirements of all relevant legislation and must be supportive and welcoming.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Nearly all the students and all the recent graduates we spoke to felt they were well supported and know how to access any additional help when needed. Through a range of policies including EDI, RA, FtP and FtS policies, the BCNO Group seek to ensure students and staff are treated fairly.

Students requiring RA are seen by the SEWO. Students confirm that this process is timely and supportive. Relevant faculty and staff are notified where appropriate and with consent of the student.

Students who struggle to engage with the course are highlighted through poor attendance and feedback from faculty. Informal meetings are arranged with the Programme Lead, HoD and SEWO to support the students. The SEWO oversees students' support and any trends affecting the attendance. There has been an ongoing drive to ensure the PT system works well but the availability and willingness of staff to undertake this role has caused some difficulties. However most students said they had a personal tutor but their response to how useful they were was mixed with students preferring to approach a member of staff who they felt would be able to help them.

Student characteristics and outcomes are monitored, including learning differences, long-term health conditions, age, gender, disability, and ethnicity to ensure that the learning culture remains fair, impartial, and inclusive.

A range of policies are in place to meet all legislative requirements. Staff and students tell us that they feel supported, so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. processes are in place to identify and respond to issues that may affect the safety, accessibility or quality of the learning environment, and to reflect on and learn from things that go wrong. ☒ MET ☐ NOT MET

Findings and evidence to support this

The CEO manages the team that oversees resources, facilities, access and health and safety. He takes a lead role in health and safety matters as Chair of the health and safety committee. This committee meets quarterly and considers all aspects of safety including buildings, students, patients, and staff.

Key areas such as academic appeals, student complaints, and FtP are reported to the AGC. Patient complaints are also directed to the AGC, while whistleblowing incidents are escalated to the Board. This structured approach aims to ensure oversight and adherence to governance standards.

Students are encouraged to voice their concerns formally through SEG and informally through various channels, including meetings with faculty teams, personal tutors, or student representatives. If staff note a particular issue, they can raise it directly with the facilities team or their line managers. Health and safety is a standing item on all committee agendas.

We found there are policies and procedures in place to reflect on aspects of safety, accessibility and the quality of the learning environment. Discussions with staff, students, and patients confirm their awareness of this so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. students are supported to develop as learners and as professionals during their education. ☒ MET

☐ **NOT MET**

Findings and evidence to support this

Students tell us they do feel supported both as learners and professionals throughout their course and if additional help is needed, for example, additional learning needs they have found staff very receptive. The SEWO plays a key role in signposting and providing support and students find her a very useful resource.

Although nearly all students had a personal tutor, their engagement with the students and adherence to the PT Handbook was quite variable. The SEWO and SMT are currently discussing ways of improving this and providing a broader base of PT to support the full range of students.

When we asked recent graduates and Year 4 students how well prepared they felt for their professional roles they were very positive about the range of experiences and the quality of their preparation and education. Some students complained about the variability of teaching quality but once concerns were raised, either through module feedback or direct to HoD, action had been taken by SMT.

All students praised the range of support available through library services across all year groups, including at dissertation stage, for support with developing academic writing and responsible use of AI.

A wide range of study skills are offered through presentations and workshops, for example, literature searching, plagiarism, referencing and paraphrasing. The VLE also offers resources, including information on referencing. The study skills handbook has been reviewed, updated and distributed to all year groups.

Through a range of policies and support students are encouraged to develop as learners and professionals. Discussions with students and patients confirmed they develop their skills, knowledge and confidence throughout the course, so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

vi. they promote a culture of lifelong learning in practice for students and staff, encouraging learning from each other, and ensuring that there is a right to challenge safely, and without recourse.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

There is a culture of questioning and challenge where students are encouraged to reflect on their own learning and learn from each other through problem-based approaches, reflective portfolios, lectures and tutorials. The BCNO Group's aim is for students to become reflective independent lifelong learners and for that to continue throughout their career as osteopaths.

Students are encouraged to become reflective learners through their use of the clinic portfolios, reflective logs, plus a range of additional resources such as anatomy workbooks. In the clinical settings, pre and post session debriefs and tutorials encourage students to question and discuss cases and diagnoses.

Students felt confident to express their opinions and challenge their learning without recourse and could give examples of when they had done this. For example when a lecturer's teaching fell well below expectations they had challenged this and the matter was resolved.

Staff tell advised that they feel well supported professionally, are encouraged to undertake CPD and develop their own skill sets.

Discussions with students confirmed that they do enjoy learning from and with each other and feel well supported by staff to develop as lifelong learners and so we are confident this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

4. Quality evaluation, review and assurance

i. effective mechanisms are in place for the monitoring and review of the programme, to include information regarding student performance and progression (and information about protected characteristics), as part of a cycle of quality review.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group has developed a strong relationship with the UoP with well-defined procedures for approving, monitoring, and reviewing academic programmes. These reviews are discussed at committee level and then through a joint board of studies meeting. Each year BCNO review module and assessment elements comparing them to the previous year's data in the student characteristics and outcomes report.

UoP have also been in discussion with the BCNO Group regarding the teach out and student protection plans. When we spoke to the UK Partnerships Manager of UoP he confirmed that he had good links with the SMT and is confident that their teach out and student protection plans are robust.

Our discussions with SMT, the programme team and the UoP confirm that there are mechanisms in place for the teach out of the programmes, so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

Although there are clear KPIs linked to the teach out plans, they are very ambitious and some may be difficult to accurately measure given student engagement levels. SMT should ensure that the KPIs in the teach out plan are regularly reviewed and recorded by SMT to help ensure any difficulties are addressed in a timely manner.

Conditions

ii. external expertise is used within the quality review of osteopathic pre-registration programmes.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The EEs have a key role in quality assurance and the annual monitoring of courses. The validation of these programmes follows the clearly defined UoP processes, which include experts from the profession to ensure thorough course reviews. The UoP confirmed that, in their experience the BCNO Group are always receptive to suggestions and change and are keen to improve and enhance the student learning experience.

Historically EE reports have been used to drive change in courses for example: increasing teaching observations, reviewing the use of rubrics for written feedback, and providing more informal feedback opportunities and feedforward comments. We reviewed one EE report, and whilst it was fit for purpose, we found that it was very basic and provided only simple detail.

In relation to standard 1.viii it was referenced that The External Examiner is invited to oversee the final Clinical Competency Assessment, but was unable to attend last year for the final Clinical Competency Examination, leaving a gap in the evaluation of the reliability and validity of that particular exam.

Discussions held with SMT and the UoP assure us that external expertise has been used with regard to original programme and will continue to be utilised during teach out plans, so we are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

It is recommended that The BCNO Group endeavour to ensure that an External Examiner is present at the Clinical Competency Examinations to provide to provide this additional assurance.

Conditions

None reported.

iii. there is an effective management structure, and that relevant and appropriate policies and procedures are in place and are reviewed regularly to ensure they are kept up to date.

☐ **MET**

☒ **NOT MET**

Findings and evidence to support this

There is a clear management structure from experience groups and committees through to Board level operating at both strategic and operational levels. Attendance at a variety of meetings particularly the three engagement groups seem to include a high number of apologies so there is a danger that true representation, for instance from the student and staff body, may mean that the stakeholder voice is diluted.

Although there is a clear management structure there is currently no written strategic development plan which means that the various committees up to Board level may find it difficult to assess progress towards goals or milestones leading to issues with accountability and financial planning. With the recent changes and feelings of uncertainty that prevail key decisions must be made at the next Board meeting in November. The outcomes and future direction of the BCNO Group and its buildings can then be communicated to all stakeholders.

Staff and students told us they know how to access all policies. Policies are organised for the course the student is undertaking, for example linking to UoP adopted policies where appropriate.

The process of reviewing and updating all BCNO policies is underway but due to staff sickness this process has not been fully completed or launched. A number of policies were reviewed in June and July 2025. It would be useful to ensure all out of date policies are updated. Furthermore, efforts should be made to centralise policy access through a single repository, currently they can be accessed through the website, VLE or through Teams. Similarly, a simple register should be kept to show the name of policy, last reviewed date and next review date.

There is a clear management structure and a wide range of policies available to all. Our discussions with SMT, the Board, staff, students and patients inform us that although the management structure works, there were some concerns regarding the regularity and content of communications received, particularly from the Board.

In order for an accurate vision of where the BCNO Group is heading a clear strategic plan with timings, responsibilities, and costings is needed. It is understood that at the next Board Meeting in November key decisions will be made in order to allay the anxiety of all stakeholders and it is imperative that the outcomes of this meeting are clearly communicated.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

This academic year, the BCNO Group must ensure that all out of date policies are updated. and policy access centralised through a single repository, maintaining a simple central register.

iv. they demonstrate an ability to embrace and implement innovation in osteopathic practice and education, where appropriate.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Innovation is encouraged, shared and developed by the BCNO Group. Opportunities have been explored linked to local charities including CWC (a homeless charity), Age UK and some interdisciplinary opportunities linking with physiotherapy students (through London Met) and the London Marathon. Within the clinic setting there are opportunities to treat a range of patients including those with sporting and performing arts related injuries.

Good practice and innovation is identified in lesson observations and research activities shared within the department. There are good links with the Kent site with shared experiences and opportunities particularly in the specialist clinic settings.

Documentation and discussions with staff and students assure us that opportunities for innovation are sought by the BCNO Group and appreciated by the students. We are confident that this standard is met.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

5. Resources

i. they provide adequate, accessible and sufficient resources across all aspects of the programme, including clinical provision, to ensure that all learning outcomes are delivered effectively and efficiently.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group operates across two sites: at Netherhall Gardens, London, and Tonbridge Road in Kent. At the Kent site, the BCNO Group has recently renovated a newly acquired building to include twelve treatment rooms, a large clinic reception area, rooms designated for students and tutors, and additional storage space. Treatment rooms are spread across two floors: four treatment rooms on the ground floor, two of which have wheelchair access, and a further eight on the first floor.

The London campus has fifteen treatment rooms arranged over two floors. Eleven of the treatment rooms are on the ground floor and the building offers good access for wheelchair users. Several rooms have been designated for priority use for elderly patients, given their proximity to the reception area, and one room has been designated for paediatric use. An additional room has been equipped with specialised apparatus to facilitate health screenings and fitness assessments. There are plans to open two additional treatment rooms on the second floor, to accommodate the needs of final year students participating in the teach out programme. Both sites have good provision for disabled parking.

Both locations feature dedicated teaching spaces designed to support both practical and academic instruction. There are hydraulic couches available for practical sessions and the teaching areas are furnished with screens that can display content from the Virtual Learning Environment (VLE) as well as other media sources.

A recent Office for Students report noted that the BCNO possessed suitable physical and digital infrastructure, supported by current VLE resources that effectively facilitate student learning. The report noted several initial challenges faced during the implementation of the updated VLE; however, observations made during the visit confirmed that considerable efforts have been made to effectively address these issues.

Students were able to access relevant learning materials ahead of lectures, and a comprehensive catalogue of policies and procedures was also available through the VLE. The BCNO Group continued to develop educational resources for the VLE and had established a video repository of techniques that is likewise accessible via the platform.

Library facilities at both locations provide good access to textbooks, journals, interactive media, support services and interactive equipment such as anatomical models. They also offer student support with literature searches and academic support to enhance student study skills. Students also have access to resources and facilities at the UoP and academic interlibrary loan services.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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ii. the staff-student ratio is sufficient to provide education and training that is safe, accessible and of the appropriate quality within the acquisition of practical osteopathic skills, and in the teaching clinic and other interactions with patients.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Historically, the BCNO Group has maintained an educator-to-student ratio of 10:1 for practical instruction and between 1:4 to 1:8 in clinical settings. However, Course Leaders reported that the educator ratios for both classroom and clinic increased during Teach Out meaning there were more educators per student, a finding corroborated by our observations of academic sessions (including online) and clinic visits.

Feedback from student representatives indicated that they felt well supported by staff during lectures and clinical sessions. In meetings with the Senior Management Team (SMT), we were assured that they would maintain their commitment to sustaining staff levels during the Teach Out process.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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iii. in relation to clinical outcomes, educational providers should ensure that the resources available take account, proactively, of the diverse needs of

☒ **MET**

students. For example, the provision of plinths that can be operated electronically, the use of electronic notes as standard, rather than paper notes which are more difficult for students with visual impairments, availability of text to speech software, adaptations to clothing and shoe requirements to take account of the needs of students, published opportunities to adapt the timings of clinical sessions to take account of students' needs.

☐ **NOT MET**

Findings and evidence to support this

The BCNO Group maintains a Reasonable Adjustments (RA) policy which ensures that students who disclose a disability either at the point of offer, or when later becoming aware of a disability are supported by the Student Welfare Officer in identifying suitable solutions. Discussions with student representatives indicated that the BCNO Group has historically demonstrated an effective response to disclosed disabilities by offering suitable accommodations.

Hydraulic couches are predominantly utilised in clinical and teaching settings; however, electrically operated couches can be made available to students, should they specifically require them. Support services staff indicated that provisions for visually impaired students, such as permitting tablet use for notetaking, can be arranged. Students are provided with support to enhance their study skills, such as memory training, managing various learning styles, and assistance for those with dyslexia. Nevertheless, there are presently no plans to transition from manual records to Electronic Patient Records (EPR).

Disabled access is available for clinic facilities at both the London and Maidstone campuses, and classrooms have not given rise to any reported accessibility issues for students on the Teach Out Programme. The administration has confirmed that they are able to accommodate requests for preferred seating arrangements during classes and specific room assignments within the clinic where reasonable.

Support service staff report that the Student Welfare Officer has initiated a programme of neurodiversity training to enhance support for both students and staff. There is also an initiative to provide mental health first aid training for staff. Students receive safeguarding training in year 3 (with a patient focus) and year 4 (with a focus on transition to practice).

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. there is sufficient provision in the institution to account for the diverse needs of students, for example, there should be arrangements for mothers to express and store breastmilk and space to pray in private areas and places for students to meet privately.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

During the visit, the team noted that students had access to dedicated quiet study areas, private meeting rooms, and communal social spaces. It was evident that these facilities enabled students to effectively utilise available resources for forming study groups, practising techniques, and engaging in academic discussions.

The BCNO Group report that designated quiet and contemplative areas for prayer are available upon request. Additionally, support is provided to new mothers returning to their studies, as confirmed in discussions with recent graduates, including one individual who returned to academia after childbirth.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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v. that buildings are accessible for patients, students and osteopaths.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Both campuses offered accessible entry to ground-level spaces for wheelchair users and individuals with disabilities. In addition, each location included clearly marked parking spaces reserved for people with disabilities. Several of the treatment rooms situated on the ground floor feature dedicated wheelchair-accessible facilities, ensuring convenient access for patients, students, and staff members.

Access to classrooms, library facilities, and study areas was not identified as an issue, and robust procedures for managing reasonable adjustments are in place and available for implementation if necessary. The BCNO Group performs comprehensive risk assessments in compliance with insurance requirements to maintain a safe environment for patients, students, and staff. Oversight of these processes is provided by the health and safety committee, which convenes quarterly.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

6. Students

i. are provided with clear and accurate information regarding the curriculum, approaches to teaching, learning and assessment and the policies and processes relevant to their programme.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The courses reviewed during the visit were in Teach Out status and were closed to new enrolments. All current students have full access to detailed course resources via the VLE, including course details, policy documents, procedural guides, and key organisational information. During the visit, the availability of this material was confirmed both by examining VLE content and by interviewing student representatives.

The Virtual Learning Environment (VLE) provides students with access to the Programme Specification for each course. These documents clearly articulate the programme's aims and objectives, offering an overview of module content, comprehensive mapping to learning outcomes, and details on alignment to the osteopathic practice standards.

Module handbooks offer students detailed information regarding their courses, and the BCNO Group is committed to uploading lesson-specific materials, including slide packs, to the VLE at least 48 hours prior to scheduled lectures. Providing these resources ensures students have a transparent overview of their educational pathway throughout their studies at the BCNO Group.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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ii. have access to effective support for their academic and welfare needs to support their development as autonomous reflective and caring Allied Health Professionals.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The support services team provide both academic guidance and pastoral care to students, ensuring their overall well-being. At the start of their studies, students are given comprehensive information about these services and are each assigned a personal tutor, who serves as their primary contact for any academic or personal concerns. The Student Engagement and Welfare Officer oversee the personal tutor system, which is described in the personal tutor handbook.

The personal tutor handbook states that tutors are required to meet with first-year students a minimum of five times throughout the academic year, and with students in their second, third, and fourth years at least once per semester. Additionally, all meetings must be documented, and any agreed actions should be submitted to the Student Engagement and Welfare Officer at the conclusion of each term. However, at the time of the visit, the Personal Tutor system was being reviewed in light of historical difficulties in recruiting staff into the role.

Discussions with student representatives revealed an awareness of the Personal Tutoring process and confirmation that Personal Tutors had been allocated. However, most respondents indicated that they did not meet with their tutors in a structured or regular way. As such, the student engagement with the personal tutoring system was on a relatively ad hoc basis and was not as originally intended. Nevertheless, students reported receiving adequate support when they did have cause to seek additional assistance.

Students have access to a 24-hour helpline that provides legal support, and they have access to counselling support when needed. Attendance policies are designed to spot students who might be "at risk" so early help can be offered. The BCNO Group provided targeted assistance, including support with accommodation expenses, to students seeking to transfer between the London and Kent campuses. Four students had recently utilised this opportunity and successfully transitioned their studies to the Kent campus.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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iii. have their diverse needs respected and taken into account across all aspects of the programme. (Consider the GOsC Guidance about the Management of Health and Disability).

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Students are encouraged to share information about disabilities during the application process or whenever they become aware of a disability throughout the period of their studies. During the first week of studies, the Student Engagement and Welfare Officer meets with students to discuss issues around disability, inclusion, and both mental and physical wellbeing. This ensures that students are aware of how to disclose needs, access support, and maintain overall well-being.

Upon notification of a disability, or any other concern, the Student Engagement and Welfare Officer assesses the individual requirements and, where feasible, coordinates suitable accommodations. Students are encouraged to communicate their needs at any stage of their academic journey, and ongoing reviews are conducted to ensure adjustments reflect any changes in health or learning circumstances.

The Student Inclusion, Welfare and Attendance Committee meets three times a year and has oversight for the welfare and inclusion of the student body. In doing so, it acts to ensure that all related policies and procedures are up to date and fit for purpose.

During our discussions with the support services team, it was observed that neurodiversity training for staff had been expanded and that mental health first aid training was being introduced. Meetings with student representatives demonstrated that the BCNO Group responds efficiently to requests for reasonable adjustments. They were also aware of how they could access policies relating to equity, diversity and inclusion, reasonable adjustments and student welfare.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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iv. receive regular and constructive feedback to support their progression through the programme, and to facilitate and encourage reflective practice.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

A recent report by the Office for Students highlighted instances of inconsistent practices regarding assessment design, marking procedures, and the quality of handwritten feedback. However, the report acknowledged that the BCNO Group had identified this issue, through student feedback, and had proactively implemented plans for the effective management of the problem.

Discussions with student representatives revealed that the BCNO Group has taken various steps to enhance the feedback process. However, whilst these initiatives have resulted in some progress, their application continues to lack consistency.

We are satisfied that students are provided with regular and constructive feedback, however, it is advisable for the BCNO Group to continue to monitor and adapt their initiatives, so the feedback process remains effective and impactful.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group should consider ways of incentivising students to become student representatives and attend all meetings to ensure their voice is more effectively heard and consider additional ways of significantly improving student response rates to surveys and module feedback.

Conditions

None reported.

v. have the opportunity to provide regular feedback on all aspects of their programme, and to respond effectively to this feedback.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

There are several formal channels available to allow for students to provide feedback. However, the BCNO Group recognises that it remains challenging to connect with students and understands the need to evaluate how student representatives can engage in an effective way.

Students expressed mixed feelings about formal communication channels, preferring instead to collaborate as a group and share feedback with the organisation via informal networks. Although respondents considered this approach to be effective, it creates potential inconsistencies in how the BCNO Group implements solutions across different cohorts.

Reasons given for not engaging with formal processes included lack of time, the energy consumed by their studies and the desire to “move on” following the completion of a module or academic year. However, students who were actively involved in the formal process recognised the value of their engagement.

Students reported a clear understanding of the procedures available for raising concerns. They expressed confidence in their capacity to report safeguarding issues or OPS breaches without fear of prejudice and trusted that such matters would be managed appropriately.

Strengths and good practice

None reported.

Areas for development and recommendations

The BCNO Group might consider exploring other channels for feedback, such as organising structured, and documented, student user groups that can feed into formal engagement processes or incentivising students for their active participation.

Conditions

None reported.

vi. are supported and encouraged in having an active voice within the education provider.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

It was evident that the BCNO Group has made a concerted effort to engage with the student voice through membership in various committees. However, this engagement had seen limited success and the organisation had struggled to recruit Student Representatives onto these committees.

In meetings with both students and alumni, similar reasons were given for lack of engagement. These included lack of time, the energy consumed by their studies and time conflict between scheduled meetings and work or study commitments.

There continued to be a discernible tendency to address concerns collectively and engage with the organisation through informal channels. Although the majority of interviewed students regarded this informal method as relatively effective, it was noted that such an approach lacks the rigour inherent in formal processes and may result in the undocumented and inconsistent resolution of issues across different cohorts.

Strengths and good practice

None reported.

Areas for development and recommendations

Given that current processes for engaging with the student voice have not functioned as intended, the BCNO Group might explore alternative methods of engagement. For example, organising structured, and documented, student user groups that can feed into formal engagement processes, incentivising students for their active participation or short, structured meetings at the end of classes.

Conditions

None reported.

7. Clinical experience

i. clinical experience is provided through a variety of mechanisms to ensure that students are able to meet the clinical outcomes set out in the Graduate Outcomes for Osteopathic Pre-registration Education.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Students of all BCNO London campus programmes are expected to attend to clinic over all four years of the course and in line with Graduate Outcomes, they are expected to attend 1000 hours of clinical training and move through their clinical placements gaining more autonomy as they progress.

Due to the structure of the modified attendance BSc course, some students find that they need to make up clinical hours during holiday clinics before they can progress to the following year. This flexibility is built into the course design, with clear guidance provided to students about the make-up hours and a mapped schedule that outlines how they can fulfil this requirement.

The Clinic Reception Team effectively record and monitor student hours regularly in order to ensure that students achieve a minimum of 1000 clinic hours prior to completion of the course.

In the meeting with the clinic manager it was evident that they regularly monitor student attendance by a well-structured recording system to identify potential problems with student clinic hours and offer the necessary support to bring the numbers back in line. We could see on the spread sheets that all 4th year students graduated last year exceeding the 1000 hours clinical experience required.

The Clinic Reception Team are also responsible for the allocation of new patients. They are provided with new patient priority lists which help ensure that new patients are allocated appropriately in order to enable students to meet their required new patient numbers.

The osteopathic student clinic in the BCNO London campus is a well established clinic considered by patients as part of the community. During the visit we were told that number of patients are monitored to ensure enough patient numbers for students to practice. The marketing team told us during the meeting that they release adequate promotions and marketing to get NPs numbers up when needed including during clinical competency exam season.

Staff stated that there have been some concerns from student and staff about the uncertainty about the clinic and patients' numbers. The 2nd years are the group that feel more anxious about the uncertainty of the clinic providing enough patients for them to graduate. However, we were assured by the SMT that strategies like marketing trying to make the right amount of variety of patients are in place to make sure students cover their 1000 hours in the clinic and patients are provided for them to graduate and meet the required learning outcomes.

Overall, we are assured that students will have clinical experience that is provided through a variety of mechanisms to ensure that students are able to meet the graduate outcomes

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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ii. there are effective means of ensuring that students gain sufficient access to the clinical experience required to develop and integrate their knowledge and skills, and meet the programme outcomes, in order to sufficiently be able to deliver the Osteopathic Practice Standards.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

BCNO utilises its patient booking system to ensure students gain sufficient access to patients and to an appropriate clinical experience.

During the marketing meeting we were informed that where there is a shortfall in a specific patient group, the clinic administration team will work with the marketing team to advertise for new patients.

The BCNO clinic offers students the opportunity to attend specialist clinics or to participate in placements outside the teaching clinic all of which are supervised by senior clinical tutors to ensure quality and OPS compliance.

The long established London clinic is, as patients stated, a popular clinic part of the community and includes specific clinics specialities like headaches, sports, and pregnancy clinics ensuring that students are exposed to a diverse patient demographic. Beyond the in-house clinical experience, BCNO operates an outreach homeless clinic where students attend supervised by a senior clinician.

The clinic collaborates with the London marathon and charities like Versus arthritis and Carers UK and the looking after yourself programme. These further additions widens even more the variety of patients seen by students.

The reception team has a structure system in place to monitor student hours, patient numbers and diversity of patients that each student sees. The patient auditing can be seen by students and decides the allocation of patients to students to increase variety.

During the marketing meeting it was confirmed that patient data is used to inform the marketing plans. The College utilises patient data to enable a strategic marketing plan of targeted advertising to ensure

a sufficient depth and breadth of patients and enough patient numbers, including the during clinical exam season.

During the visit it was demonstrated that the BCOM clinical experience offers a variety of patient exposure to students and a broad range of clinical experiences that allowed them to translate their clinical knowledge into practice.

A meeting with recent graduates confirmed that they were satisfied with their experiences of training at the BCNO London clinic, and that there are enough patients and a good range and variety of patients. They also stated that they felt well supported by clinicians in the clinic, clinicians had different styles but all were supported and helpful. Recent graduates felt that their training had adequately equipped them for professional practice.

During student group meetings, 2nd year students stated that they have observed a good variety of patients so far. And the 4th years are happy with the very good management from reception to make sure students have enough new patients numbers.

Overall, we are assured that the BCNO London clinic provides students with the number of patients and that they see a broad range of patients and patients' presentations.

Strengths and good practice

A highly committed and passionate Director of Clinical Education at the BCNO London ,who has introduced initiatives and projects designed to provide students with a rich, varied, and fulfilling clinical experience.

Effective use of patient data to inform a more targeted student–patient ratio, ensuring that students are exposed to a broad and appropriate range of patient presentations.

Areas for development and recommendations

None reported.

Conditions

None reported.

8. Staff support and development

i. educators are appropriately and fairly recruited, inducted, trained (including in relation to equality, diversity and inclusion and the inclusive culture and expectations of the institution and to make non-biased assessments), managed in their roles, and provided with opportunities for development.	☒ **MET** ☐ **NOT MET**

Findings and evidence to support this

The BCNO Group uses a structured recruitment process guided by its Recruitment Policy, which promotes fairness, transparency, and EDI. The process begins with the development of a Job Description and Role Profile based on an identified need, followed by the evaluation of applicants according to these criteria, and the invitation of shortlisted candidates for interview.

Interviews are conducted by a minimum of two members of staff, with at least one representative from the Human Resources team. Interviews are structured and scored to ensure that all questions are administered consistently and fairly across all candidates. The policy appears to be robust and staff who had been subject to the process reported that the experience appeared to be fair and transparent.

There is a formal induction process to support new starters into their roles. This requires them to gain a comprehensive understanding of key policies and to undertake basic training in areas such as health and safety, GDPR, fire safety, and manual handling. Prerequisite induction training courses can be delivered, and monitored, via the organisation's HR software platform.

At our meeting with the SMT, we learned that they do not currently have a structured performance management review process in place. However, they plan to reinstate this process after the Board meets to approve a detailed strategic plan thus enabling the organisation to establish a people programme that is more closely aligned with its strategic objectives.

However, it has been observed that no formal performance management process has existed since the onset of the pandemic. Subsequent consultations with Course Leaders revealed that some have adopted informal review processes which, while supportive of staff, may result in inconsistencies in staff development.

Strengths and good practice

None reported.

Areas for development and recommendations

Reintroducing the performance management process would enable the organisation to actively involve employees in implementing its strategy, while ensuring that workforce skills are aligned with the strategic and learning objectives of the organisation.

Conditions

None reported.

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ii. educators are able to ask for and receive the support and resources required to effectively meet their responsibilities and develop in their role as an educator.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

During our discussions with faculty members, staff reported feeling well-supported in their positions and confirmed that they could obtain the help and resources needed to carry out their duties. Although there is currently no formalised process for meetings between staff and their line managers, certain departments arrange regular informal meetings to ensure employees have the necessary resources to perform their roles effectively. Both staff and managers indicated that, given the size of the BCNO Group and the strong collaborative relationships, they feel comfortable seeking assistance as needed.

The resources available in both classroom and clinical settings were adequate to support staff in delivering high-quality instruction. These included interactive models, online learning tools, integrated technologies suitable for classroom implementation, access to the Virtual Learning Environment (VLE) and the use of interactive learning tools such as slido.com.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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iii. educators comply with and meet all relevant standards and requirements, and act as appropriate professional role models.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

BCNO Group policy requires everyone involved in clinical or technical teaching roles to be registered with the GOsC or another healthcare professional body. When the visiting team reviewed a sample of the faculty list and compared it with the GOsC database, they found that all individuals were properly registered.

All staff interviewed during the visit demonstrated a clear understanding of the procedures for reporting OPS breaches and safeguarding concerns. They also indicated that they felt comfortable bringing these issues to senior management without fear of prejudice or discrimination.

Documentary evidence was presented regarding the peer review process, which aims to deliver objective feedback and incorporates recommendations on teaching methodologies and professionalism. During our consultations with faculty, it became clear that most staff members interviewed had participated in or been subject to this process.

Students have several opportunities during the academic cycle to provide feedback on their learning experience. However, despite efforts to improve engagement with the student body, participation in the feedback process remains low.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

iv. there are sufficient numbers of experienced educators with the capacity to teach, assess and support the delivery of the recognised qualification. Those teaching practical osteopathic skills and theory, or acting as clinical or practice educators, must be registered with the General Osteopathic Council, or with another UK statutory health care regulator if appropriate to the provision of diverse education opportunities.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

In our meetings with the SMT, we received assurances that staff numbers would remain consistent throughout the teach-out process. This was further supported by discussions with students, who reported increased access to teaching staff, which was also reflected in our teaching and clinic observations.

Newly appointed teaching staff receive guidance from experienced colleagues and undertake teaching assistant responsibilities until they have acquired the necessary experience to lead their own classes. Teaching staff are encouraged to pursue formal qualifications in education and some teaching staff reported that they had been provided with financial incentives to encourage their participation in these programs.

All personnel involved in the teaching of practical osteopathic skills and theory, or serving as clinical or practice educators, are required to be registered with the General Osteopathic Council or another UK statutory healthcare regulator.

Despite the ongoing uncertainty surrounding the future of the London campus, and the significant change agenda experienced within the BCNO Group as a whole, staff retention has remained comparatively stable. It was evident that these challenges had impacted on staff morale and need to be sympathetically managed to prevent attrition rates from hindering course delivery. Nevertheless, at the time of the visit, there were an adequate number of suitably qualified staff available to deliver the programmes undergoing the Teach Out process.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. educators either have a teaching qualification, or are working towards this, or have relevant and recent teaching experience.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

Staff are eligible to apply for funding to pursue external courses; however, the available funding is limited and intended to support overall staff development rather than being dedicated specifically to teaching qualifications. Some of the staff members who spoke with the visiting team reported receiving support to undertake teaching, or other, qualifications. More generally, staff members demonstrated a broad spectrum of relevant qualifications and experience.

Given the uncertainty expressed by some staff members, and recognising that this may intensify as the Teach Out process progresses toward completion, the BCNO Group may wish to consider implementing a training bursary as a strategic incentive. Such an initiative could support staff retention throughout the remaining three years of the Teach Out programme whilst benefiting both the organisation and employee through additional skills acquisition.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

9. Patients

i. patient safety within their teaching clinics, remote clinics, simulated clinics and other interactions is paramount, and that care of patients and the supervision of this, is of an appropriate standard and based on effective shared decision making.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The Institution assures us that patient safety and high standards of care remain paramount to the BCNO.

All prospective students are required to undergo an enhanced pre-registration DBS check.

Both campuses have established teaching clinics where students undertake their clinical placements. These clinics are supervised by trained osteopaths registered with the GOsC, who oversee student–patient interactions and ensure patient safety throughout.

Discussions with staff, students, and patients confirmed that the BCNO maintains a strong commitment to patient care and that informed consent and shared decision-making are applied appropriately in clinical practice. These principles are reinforced throughout the curriculum and are formally assessed during the final clinical competency evaluation.

The students' clinic handbook provides detailed guidance on expectations and requirements for clinic attendance, including student responsibilities, safeguarding, consent procedures, first aid, and infection control.

We were assured by the Head of Clinical Education (London) who manages the site and the supervision of students and patients, that their aim it is to create safe experience for patients in the clinic. There are on-display in the clinic student room information about patient safety, code of conduct and fitness to practice available to students in the clinic discussion room. Though this was evident, increased visibility of safeguarding information would be useful.

BCNO maintains a high tutor-to-student ratio in both onsite clinics and clinical placements, and this was confirmed by staff and students. Students are supervised by qualified osteopaths who take responsibility for the patients' encounter.

At the London clinic, there is an intercom in the clinic rooms that allows students to call their tutors anytime they need. Clinic tutors are all registered osteopaths and undergo support, training and peer observation both at induction and throughout their time at BCNO.

During the visit to the clinic it was evidenced that the clinic reception team manage the clinic, patients schedules and appointment and looks after the patients prior their consultation efficiently.
The clinic uses an exercise prescription website, rehab my patient, which includes safety netting information, so patient is aware of possible sign or symptoms of potential serious illness and what to do in the case of needing help.

During the patients meeting there was a consensus that both campus clinics were very good at asking for patients' concerns. Students are extremely thorough during their questioning and treatment is agreed in consultation at all times with the patients. It was evident that an ethos of shared decision making is implemented, and patients are empowered to make informed decisions and exercise choice regarding their own treatment.

This provides assurance to us that patients will be kept safe and that students will be supervised to an appropriate standard.

Good innovation aligned with other allied health care practice: The clinic uses an exercise prescription website, (Rehab my Patient), which includes safety netting information, so patients are made aware of possible sign or symptoms of potential serious illness and what to do in the case of needing help.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

ii. Effective safeguarding policies are developed and implemented to ensure that action is taken when necessary to keep patients from harm, and that staff and students are aware of these and supported in taking action when necessary.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO has the relevant safeguarding policies in place to ensure the safety of all patients attending clinics in both campuses.

Staff and students receive appropriate training in safeguarding, child protection, health and safety and other areas that are designed to keep patients safe and enable them to take appropriate action when necessary.

Staff receive a mandatory yearly training in all the BCNO policies including safeguarding. Students received a safeguarding training when they join the clinic. During the meeting with student services, they stated that they are including more safeguarding training sessions for year 3 and year 4. We were told that as a new initiative, students receive their safeguarding training alongside clinic tutors from both clinics, these sessions are aimed at helping students to understand safeguarding, including clinical tutors' personal experiences of actual safeguarding cases. There is an extra safeguarding training for year four students on yellow flags prevention.

During the visit and discussions with staff and students, it was clear that staff and students knew where to find the safeguarding policies and were well informed on how to report a safeguarding issue.

The BCNO states that patients, students, and staff are well-informed about these policies through strategically placed safeguarding posters in clinics and common areas. However, during our visit to the clinic, the safeguarding and other posters and patient information were in a board next to the main entrance with little visibility.

We are assured that the College has effective safeguarding policies in place.

Strengths and good practice

None reported.

Areas for development and recommendations

Recommendation: Place the safeguarding information and other patient information throughout the clinic to increase visibility and therefore patient access to that information.

Conditions

None reported.

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iii. the staff student ratio is sufficient to provide safe and accessible education of an appropriate quality.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

During the SMT meeting we were informed that the guidelines for staff-student ratios are being adhered to, and in the London campus clinic is 1-4. There have been changes in the London clinic to put in place more support to students.

During the students meeting some concerns were raised regarding the teaching carried out by new clinical staff and their availability during clinical consultations. However, this was only noted in one incident that had occurred within the London clinic. In general, students are happy that they have more personal support and that they have more access to tutorials and resources in clinic due to reduced groups of students.

As a result, we are assured that there are sufficient staff-student ratios in place providing safe and accessible education.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

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iv. they manage concerns about a student's fitness to practice, or the fitness to practice of a member of staff in accordance with procedures referring appropriately to GOsC.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

The BCNO has the relevant fitness to practise policies in place and these are available in the BCNO and UoP websites for anyone to access. For the current programmes at the BCNO London campus, the policy in place is the UoP Fitness to Practise policy which had been reviewed in August 2025.

During the visit, and through discussions with both staff and students, we were reassured that all groups receive policy training to ensure they understand the processes and procedures to follow should any issues arise. Programme and course leaders, along with academic staff, demonstrated a clear understanding of their responsibilities in reporting fitness-to-practise concerns to the GOsC.

During the meeting with students, the second-year cohort stated that they feel very supported and encouraged to speak up, and that they find the Fitness to Practise and Safeguarding pathways very clear. Overall, students reported that they feel able to approach the Head of Clinic or another member of staff whenever support is needed.

There were no student Fitness to Practise concerns in 2024–25. Expected student and staff behaviours are outlined in the Professional Practice Handbook, which is updated annually and used across both campuses.

Therefore, we are assured the BCNO manages concerns and there are suitable procedures in place for managing fitness to practice concerns for staff and students.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

v. appropriate fitness to practise policies and fitness to study policies are developed, implemented and monitored to manage situations where the behaviour or health of students poses a risk to the safety of patients or colleagues.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

For University of Plymouth students, the Fitness to Practise Policy falls under the university's policies. Students are expected to comply with a professional code of conduct as well as the UoP Student Code of Conduct and Disciplinary procedure.

In addition to the GOsC website, the BCNO provides students with appropriate teaching, support, information and guidance about the standards of behaviour expected of students training as Osteopaths . The policies are available in the VLE portal and printed and available in the student room in the clinic. Additionally, it was noted that policies are available in the library at the London campus, and monitoring of these is conducted during departmental meetings.

During the staff meeting we were informed that they have a professional practice handbook, and that they are aware of the FtP and FtS policies. Policies are available via VLE and Teams and staff confirmed that if documentation is changed it is communicated via email and they get notifications when there is an update.

BCNO adheres to the University of Plymouth's Support for Study policy ensuring consistent support across institutions whilst maintaining support for students and patient safety. Fitness to Practise, safeguarding concerns, and Prevent issues are regularly reported to the Board of Trustees via the Academic Governance Committee.

Therefore, we are assured that appropriate fitness to practice policies and fitness to study policies are implemented and monitored.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

vi. the needs of patients outweigh all aspects of teaching and research. ☒ **MET** ☐ **NOT MET**

Findings and evidence to support this

During the visit we were assured that BCNO has in place the relevant policies and procedures to ensure patient safety. Communication and patient consent are embedded in the course and this is reflected in the clinical case notes.

Students at BCNO are not required to undertake primary data-gathering research projects; however, they receive comprehensive instruction on the principles of ethical clinical research and the primacy of patient safety. The research module emphasises the importance of safeguarding participants from harm and outlines the procedures for obtaining appropriate ethical approval when conducting research.

The BCNO Professional Practice Handbook has been revised and emphasises the focus on patient welfare above all other considerations.

During the patient meeting, we were assured that informed consent is obtained repeatedly, both in writing and orally during student–patient consultations. Patients reported that the continuous consent process and the explanations provided before and during treatment make the consultation experience clear and transparent. They also stated that students consistently explain what they are going to do and take thorough notes, including recording relevant symptoms. One patient gave an example of having experienced an episode of nausea/ dizziness after a treatment.

They noted that at the following session, the approach was adapted to prevent any further episodes of nausea or dizziness and that every student she saw would then follow the same protocol.
Regarding the teach out, the SMT team told us that patients are aware of the teach out through patient experience groups and the Media. However, there had not been a formal announcement or involvement of the BCNO with patients of the clinic regarding the teach out plans.

During the staff meeting, members of the academic staff expressed concern about the number of patients who would be left without access to the clinic, some of whom have been attending for

decades. Staff informed us that several letters had been sent to the Board from patients expressing serious concerns about the potential closure of the London campus clinic.

Students also expressed concern that patient attendance might decline toward the end of the teach-out period once patients become aware that the clinic will be closing, potentially affecting students' ability to see sufficient patients to meet their graduation requirements.

Although there were patient concerns about the closure of the clinic, the BCNO has demonstrated that patient care has been a priority, and we are assured that the needs of patients outweigh all aspects of teaching and research.

Strengths and good practice

None reported.

Areas for development and recommendations

Recommendation:
Create a detailed plan to announce formally to patients and the community about the teach out and the possibility of closure of the London campus clinic.

Conditions

None reported.

vii. patients are able to access and discuss advice, guidance, psychological support, self-management, exercise, rehabilitation and lifestyle guidance in osteopathic care which takes into account their particular needs and preferences.

☒ **MET**

☐ **NOT MET**

Findings and evidence to support this

During the visit to the London campus clinic, we were assured that students at both sites are trained to support patients with lifestyle advice, exercise, rehabilitation, and self-management. The Director of Clinical Education explained that students use the 'Rehab My Patient' application to prescribe exercises to patients. The clinic's system ensures that patients are prescribed only one exercise at a time, with clear explanation and review at each visit. A maximum of three exercises may be prescribed in total, alongside appropriate lifestyle advice.

In addition, the VLE serves as a valuable repository of information for both students and tutors. By providing access to NHS advice sheets, the VLE ensures that students have up-to-date, evidence-based information readily available. This resource supports student learning, professional development, and their ability to provide informed support to patients.

Patients stated that they feel cared for and that they found it easy to discuss things with the students and tutors. They reported that they feel heard and treated as individuals, received appropriate advice about their care and that they feel they could approach staff and students with difficult issues if the need arises.

Furthermore, patients stated that they are shown exercises post-treatment in the clinic like lifting weights and extra exercises to do. They also receive relaxing exercises and advice after treatment.

Therefore, we are assured that appropriate advice, guidance, psychological support, self-management, exercise, rehabilitation and lifestyle guidance is offered in the clinic to patients.

Strengths and good practice

None reported.

Areas for development and recommendations

None reported.

Conditions

None reported.

A. Evidence

A.1 Evidence seen as part of the review

The appended list below details the full documented evidence provided by the BCNO and reviewed by the visit team.

RQ25 - XXX	Evidence List
001	BCNO Programme Specification BSc (Hons) Osteopathy
002	BCNO Programme Specification M.Ost
003	BCNO Programme Specification BSc (Hons) Osteopathic Medicine - Draft
004	BCNO Applicant Report
005	Offer Holder Event Invite
006	Equity, Diversity & Inclusion Policy
007	Recognition of Prior Learning Policy
008	Recognition of Prior Learning Mapping Form
009	Recognition of Prior Learning Meeting Email Summary
010	Academic Policy Update for Staff – Autumn Term
011	BCNO Staff Newsletter #6
012	Staff Newsletter MS Teams Alert
013a	Policy Audit
013b	UoP Policy Pages
013c	BNU Policy Pages
014	Policy Audit Process
015	Quality Mapping Document
016	BSc (Hons) Osteopathic Medicine Approval Report
017	Information For New Course
018	Quality Handbook: M.Ost (teach out)
019	Quality Handbook: BSc (Hons) Osteopathy

RQ25 - XXX	Evidence List
020	Quality Handbook: M.Ost
021	Quality Handbook: BSc (Hons) Osteopathic Medicine - draft
022	OfS Sector Recognised Standards
023	Assessment Approval Record
024	Assessment Brief: BCNO5001
025	Assessment Brief: MOST7007
026	UoP Joint Board of Studies Agenda
027	Patient Experience Group Sub-Committee Report
028	UoP Teach Out Mapping Document for Graduate Outcomes
029	BNU Teach Out Mapping Document for Graduate Outcomes
030	iO Screenshot
031	Presentation on Physio Placement
032	Moderation Form
033	UoP Assessment Setting, Marking and Moderation Policy
034	BNU Assessment and Feedback Policy
035	Module Outcome Report
036	FCCA Email 2024
037	Student Characteristics & Outcomes Report
038	UoP Student Complaints Policy
039	BNU-ESO Student Complaints Policy
040	Email from BNU re Policy
041	AGC Agenda

RQ25 - XXX	Evidence List
042	Faculty Development Day Agenda
043	Committee Survey
044	Staff Newsletter #5
045	Committee Survey Email
046	Proposed Governance Document
047	Approved Governance Document
048	Staff Survey Committee Outcome
049	Effective Management of Committee Meetings
050	UoP Referral Board Minutes 2023-24 – Redacted
051	BNU Exit Strategy
052	Retention Scheme Email from SMT
053	Safeguarding Audit
054	Student Newsletter
055a	Safeguarding Poster Kent
055b	Safeguarding Poster London
056	UCM Survey
057	ESO-BNU Fitness to Practise Policy
058	Academic Board Minutes - Draft
059	BCNO4002 Module Handbook M.Ost
060	Professional Practice Handbook (PPH)
061	Dignity at Work Policy
062	Anti-Bullying Policy
063	Student Code of Conduct

RQ25 - XXX	Evidence List
064	Sexual Violence & Misconduct Policy
065	Whistleblowing Policy
066a	Student-Tutor Feedback London
066b	Student-Tutor Feedback Kent
067	Clinic Peer Observation of Teaching Form
068	Clinic Tutor Induction
069	Clinic Team Meeting Agenda
070	Personal Tutor Policy
071	Student Welfare Leaflet
072	Student Newsletter
073	External Examiner S Buss Report 2023-24
074	External Examiner M Hayes Report 2023-24
075a	BNU External Examiner Report 2023-24
075b	BNU External Examiner Response 2023-24
076	Safeguarding Presentation
077	Attendance Registers - Redacted
078	PEG Chair Email
079	BCNO Prevent Risk Register and Action Plan
080	BCNO Prevent Return
081a	HA Assistance Leaflet
081b	HA Assistance Poster
082	BCNO Stress Management Policy Draft

RQ25 - XXX	Evidence List
083	Faculty Experience Group Agenda
084	Student Experience Group Agenda
085	Patient Experience Group Agenda
086	Minutes of SIWAC
087	Reasonable Adjustments Policy
088	BNU Exam Board 2022-23 - Redacted
089a	Personal Tutor Report 1 Redacted
089b	Personal Tutor Report 2 Redacted
090	Personal Tutor Handbook
091	Study Skills Presentation
092-096	Anatomy Workbooks
097	Updated Study Skills Handbook
098	Pre-clinic Course Timetable 2024
099	Clinic Tutorials
100	Clinic Tutorials
101	Year 1 BCNO4002 Portfolio Notebook
102	Year 2 Portfolio and Reflective Log
103	Year 3 Portfolio and Reflective Log
104	Year 4 Portfolio and Reflective Log
105	MOST7004 Audit Example
106	UoP ADPC Form
107	UoP Approval Process

RQ25 - XXX	Evidence List
108	UoP External Advisor Nomination Form
109	UoP External Examiner Nomination Form
110	HoD Action Plan 24-25
111	Silver Sunday - Barnet Poster
112	BCNO Site Visit Form
113	VLE Audit
114	Health Questionnaire
115	Risk Assessment
116	Re-Enrolment Form
117-118	Module Handbooks
119	Student Handbook BNU
120	Student Handbook UoP Teach Out
121	Student Handbook UoP
122	BSc Communication - Weekly
123	Year 4 Workshop: BNU
124	Year 1 Workshop
125	Mini CEX Feedback Form
126	Attendance and Engagement Policy
127	Attendance Email - Redacted
128	SIWAC Agenda
129	Faculty Development Day Presentation 2023-24
130	MOST7004 Audit Form

RQ25 - XXX	Evidence List
131	OS746 Assessment Brief
132	Student Rep Training
133	Student Rep Thank You Letter
134	NSS Comparisons
135	Module Feedback Report 23-24
136	Student Perception Questionnaire Feedback Report (SPQ)
137	Action Plan 24-25
138	Joint Board of Studies Minutes 2023-24 - Redacted
139	Clinic Portfolio Focus Group
140	Clinic Portfolio Summary
141	Patient Case History Sheets
142	Clinical Integration Presentation
143	CCA Presentation
144	Example of Patient Mapping Kent
145	Example of Patient Mapping London
146	Poster for Sports Clinic
147	MCC Flyer
148	Applied Clinical Medical Template
149	Applied Clinical Medical Example
150	Learning & Development Policy
151	Learning & Development Contract
152	HR Code of Conduct
153	BCNO Organisation Chart

RQ25 - XXX	Evidence List
154	Patient Feedback Poster BCOM
155	Patient Feedback Poster ESO
156	UoP Support for Study Policy
157	BNU Support to Study Policy
158	NHS Advice Sheets
159	Student Progress Results
160	Clinic Feedback on Tutors (1)
161	Clinic Feedback on Tutors (2)
162	Clinic Feedback on Tutors (3)
163	Clinic Feedback on Tutors (4)
164	SEG Meeting - UoP
165	SEG Meeting - BNU
166	Peer Observation of Teaching (1)
167	Peer Observation of Teaching (2)
168	Peer Observation of Teaching (3)
169	Clinic Peer Observation Teaching (4)
170	BNU Annual Report 22-23
171	BNU Annual Report 23-24
172	UoP Annual Report 22-23
173	UoP Annual Report 23-24
174	HoD Action Plan example
175	Student response rate

RQ25 - XXX	Evidence List
176	Policy Register
177	Complaints Themes 23-24
178	BSc (Hons) Osteopathic Medicine - Presentation
179	BSc (Hons) Osteopathic Medicine - Financial Modelling
180	Student Protection Plan (SPP)
181	SIWAG Minutes - May 2024
182	SIWAG Minutes - October 2024
183	Email to Student re attendance
184	Student Numbers 05/01/25
185	Proposed Student Feedback 24-25 Semester 1 – Year 1
186	Proposed Student Feedback 24-25 Semester 1 – M.Ost Year 2
187	Proposed Student Feedback 24-25 Semester 1 – BSc Year 2
188a	Example of Guest Lecture – LGBTQ+ and Healthcare
188b	Example of Guest Lecture – Skills and CV Writing
188c	Example of Guest Lecture – Telehealth
188d	Example of Guest Lecture – NHS Careers
188e	Example of Guest Lecture – Osteopathic Communities
188f	Example of Guest Lecture – Pain Management
189	Career Day 2024-25
190	Example of Completed Clinic Portfolio Year 1

RQ25 - XXX	Evidence List
191	Example of Completed Clinic Portfolio Year 2
192	Example of Completed Clinic Portfolio Year 3
193	Joint Board of Studies Minutes 22-23
194	BNU Periodic Review
195	Disability Leaflet
196	Institutional Risk Register - October 2024
197	Example of timetable for BSc (Hons) Osteopathic Medicine
198	Recruitment Policy
199	New Starter Induction Checklist
200	Induction Clinic Tutors
201	Induction Health & Safety
202	Faculty Qualifications
203	FtP Response
204	Research Ethics Policy
205	Research Ethics Application Template
206	Research Ethics Committee Membership

RQ25 - XXX	List of further evidence submitted September 2025
207	Applicant Review
208	EDI Policy Draft
209	Offer Holder Invite 2025
210	M.Ost Quality Handbook
211	UoP JBS Minutes
212	Graduate Outcome Posters
213	Module Outcome and Student Characteristics Report
214	AGC Minutes_Redacted
215	Governance and Management Structure Handbook 2025-26
216	Professional Practice Handbook 2025-26
217	Harassment and Sexual Misconduct Policy (E6)
218	Code of Conduct (Staff)
219	Anti Bullying Policy Draft
220	Code of Conduct (BNU Students)
221	Safeguarding Audit 24-25
222	BCNO Prevent Risk Register
223	BCNO Prevent Risk Return
224	Code of Practice Freedom of Speech
225	Reasonable Adjustment Policy
226	Student Protection Plan
227	Teach Out Plan

RQ25 - XXX	Evidence List
228	Module Handbook BCNO 5007
229	Institutional Partner Handbook
230	Draft BCNO Handbook
231	Gap Analysis
232	Mentoring Report
233	Mentoring Handbook
234	Peer Assisted Learning Handbook
235	Support Poster
236a 236b 236c	BCOM Clinic Tutorials
237	ESO Clinic Tutorials
238a 238b 238c	Examples of CEx
239	Example of Returning Patient Summary
240	Headache Clinic
241	BCOM London Marathon
242	Formative Assessment - Checklist
243	Formative Assessment - Case
244	Applied Clinical Medicine
245	Agenda Staff Development Day

General Osteopathic Council

12

Council
13 May 2026
Board effectiveness review: actions and next steps

Classification	Public
Action	For decision and noting
Purpose of the paper	To share an update with Council on progress made on the recommendations from the Board Effectiveness Review.
Strategic Priority implications	Good governance underpins all that we do across the three strategic priorities.
Standards of Good Regulation implications	While there is currently no specific standard relating to Governance, actions arising from the board effectiveness review will stand the GOsC in good stead for the new standard effective from July 2026 and that we will be assessed against in 2027-28.
Communications implications	Any future changes to the terms of reference for each committee, and how those committees are either constituted or work, should be discussed by the committees in conjunction with any Council decision.
Financial, resourcing and risk implications	Delivery of the actions and next steps are being managed from internal staff resource.
Patient perspectives	The patient partners were sent the Praesta report and were able to contribute at the September 2025 development day, and subsequent Council meetings.
Diversity implications	Diversity implications are being considered in relation to the individual next steps and are not specifically included in this paper.
Welsh language implications	Welsh language implications are being considered in relation to the individual next steps and are not specifically included in this paper.
Annex(es)	A. Scheme of Delegation and Financial Delegation B. Strategic priorities and operational measures C. Clarifying the role of observers at meetings
Author	Lorna Coe, Matthew Redford

Background reading	The current Scheme of delegation is outlined in the GOsC Governance Handbook. The Private meeting of Council November 2025, Item 5, discussed the GOsC Charter, Recommendation Tracker, Scheme of Delegation, Strategic Priorities and Operational Measures, Council and Committee Planner. https://app.admincontrol.net/Viewer/Index/?token=22889405833822796 **NB: this paper will not be accessible to members of the public as it relates to the private meeting of Council.**

Recommendation(s)	1. To agree: a. The revised format for the Scheme of Delegation and Financial Delegation b. Strategic priorities and operational measures. 2. To note the role of observers at meetings.

Key messages

- Further to discussions at previous Council meetings, the Executive have progressed a number of key activities.
- Feedback was received from Council members in the latter part of last year and the Executive have taken some of this into account in the revised structure for the Scheme of Delegation and Financial Delegation.
- The Scheme of Delegation and Financial Delegation sets out the current position in terms of delegations as outlined in the Governance Handbook and in line with the Act.
- Council is not being asked, at this stage, to change any of the current delegations or delegate anything it does not already. We will come back to Council on this at future meetings.
- We have further developed the measures to underpin the Strategic Priorities. These are set out at Annex B for agreement.
- We have received feedback that it would be helpful to clarify the role of observers at meetings. Guidance is provided at Annex C.

Introduction

1. The Preasta Board Effectiveness Report made the following recommendations in relation to the Scheme of Delegation:

    a. Review the Scheme of Delegation with the goal of providing clarity on roles and responsibilities for the Council vis-à-vis the Committees.

    b. Review and reset the scheme of delegation and Committee Terms of Reference to prevent duplication.

    c. The report suggested this should include clarifying:

        I. The thresholds and limits of Committee and Executive authority

        II. What is reserved to Council and why

        III. When and how delegated decisions should be reported or escalated

        IV. And whether the current balance supports efficient, strategic governance.

Discussion

2. The Executive has continued to work on these recommendations and now presents to Council:

    - A revised Scheme of Delegation
    - A revised document that details the measurements that sit beneath the three strategic priorities
    - A reminder of the role of Observers in meetings.

3. The paper takes each in turn.

Scheme of Delegation

4. A Scheme of Delegation is a document that clarifies roles, responsibilities, and decision-making authority within an organisation, outlining who has the power to make which decisions and the limits of that power.

5. A Scheme of Delegation does not remove accountability from Council but it allows others to act on its behalf.

6. The draft Scheme of Delegation presented to Council in November 2025 introduced a new format from the current written document to a table and this change was broadly agreed. The Executive was tasked to progress looking at whether current delegations were fit for purpose and where changes could be

made to enhance the current position and make the Executive, Council and its Committee work more effectively.

7. The Executive have undertaken further work on the Scheme of Delegation to ensure that all current delegations, in line with the Osteopath Act 1993, relevant rules and Governance Handbook, were carefully and correctly incorporated into the new format. Whilst work has commenced on identifying areas where changes could be made to current delegations, the Executive are taking legal advice on this in the first instance to ensure any recommendations made to Council are done in a considered manner.

8. The version reported to Council in May 2026 does not make any changes to the current delegations within the Governance Handbook and Committee Terms of Reference and remains in line with the Osteopath Act 1993 and relevant rules.

9. The addition of the Financial Delegation in this document is to keep all delegation and decision-making limits in one document for easy reference. There are no new financial delegations suggested at this stage, rather the current limits are now presented in a table format rather than a written one.

10. The Scheme of Delegation should be used as a reference guide by Council, Committees and the Executive to check if a decision is within their delegated authority or financial limits and where to report it if not.

11. The table shows 7 levels of decision-making (there are 8 columns because Audit Committee and People Committee are the same level).

12. There are 4 roles:

    - A = Accountable for decision making either under the Osteopath's Act 1993 of via delegated powers from Council.
    - AD = Advises and makes recommendations to the Accountable person/body
    - R = Responsible for undertaking the delivery and reporting to the Accountable person/body either directly or through a committee.
    - I = Involved in the activity through the responsible person/body.

13. It is the view of the Executive that the new proposed version provides clear lines of delegations avoiding possible confusion, reducing the risk of decisions being made where authority is not in place and showing clear accountability.

14. The Executive have sought external governance views on the new format from Head of Corporate Governance at the General Medical Council and Chief of Staff at the General Optical Council as well as Praesta in light of their recommendation in the Board Effectiveness Report. Once this is received it will be shared with Council.

15. The next phase is for the Executive to take further legal advice to then provide recommendations to Council, areas where it could delegate decisions to avoid repetition and ensure more efficiencies. This will be reported at July Council.

Strategic Priorities and Operational Measures

16. The draft Strategic Priorities and Operational Measures document was discussed at the November 2025 Council meeting. Council liked the structure and approach and advised that the measures should be more specific and granular where possible. The Executive agreed with this feedback from Council.

17. The current version presented to Council at this meeting contains more robust and specific measurements to allow Council and Executive to judge what 'good' looks like.

18. It is the Executive's view that we have tightened the measurements and targets to a workable point and would propose that the agreed measures be in place for an agreed period, i.e. 12-18 months to allow a sustained period of reporting to enable judgement on efficacy.

Observer Guidelines

18. This paper is shared as a reminder to Members of the role of observers and of the guidelines to support observers and Chairs.

Executive view

19. The Executive believe that the new Scheme of Delegation provides clear lines of delegations avoiding possible confusion, reducing the risk of decisions being made where authority is not in place and showing clear accountability.

20. It is the Executive's view that this format, which is one used widely in governance, has provided the clarity of the current position and will now help us look at where efficiencies could be made with further delegations.

21. It is also of the Executive's view that the Strategic priorities and operational measures provide more specific measurements and targets which we propose we use to report to Council for a period of 12-18 months to allow a sustained period of reporting and meaningful judgement on efficacy.

Recommendation

1. To agree:

    a. The Scheme of Delegation.

    b. Strategic priorities and operational measures.

2. To note the role of observers at meetings.

General Osteopathic Council

Annex A to 12

Scheme of Delegation

The purpose of a Scheme of Delegation

A Scheme of Delegation (SoD) is the key document defining which functions have been delegated and to whom, ensuring Members, Committees and individuals are clear about who has responsibility for making which decisions in the GOsC.

Our values

We work collaboratively to be an influential and respectful regulator with an evidence-informed approach.

Collaborative: We work with our stakeholders to ensure patients and osteopaths are at the centre of our approach to regulation.

Influential: We seek to support and develop those we work with to enhance public protection.

Respectful: We seek to hear, understand and consider the views of the people with whom we engage.

Evidence-informed: We use a range of evidence to guide our work to ensure the best outcomes for patients and the public.

The Role of Council

Council is the governing body and has responsibility for ensuring that the GOsC fulfils its statutory objectives. It sets the strategic direction for the organisation and oversees the implementation of that strategy.

Governance structure and lines of accountability

Council delegate responsibility for the day to day running of the GOsC to the Chief Executive. Council will hold the Chief Executive to account for delivery of the Corporate Strategy, Business Plan, Budget risk mitigation, organisational performance, staff leadership and external perception.

The Chief Executive in turn holds other members of the Senior Management Team (SMT) to account by line managing them.

While Council cannot ever delegate its accountability, it can delegate some of the detailed scrutiny, oversight and decision-making as permitted by the Osteopath Act 1993.

The Chief Executive will report to the Council on the performance of the GOsC, and this will be supplemented by reports from the Committees and individuals with any delegated responsibilities.

The Chief Executive will be performance managed by the Chair of Council.

The Chair of Council will be performance managed by 2 Members of Council (1 Lay and 1 Osteopath).

The Role of the Chief Executive and Registrar

The Chief Executive has the delegated responsibility for the operation of the GOsC and is accountable to the Council for implementing the strategic objectives set by Council. The Chief Executive may delegate functions to other staff but will be held accountable by Council for the discharge of all functions delegated under the scheme.

General Osteopathic Council

Annex A to 12

The Role of Chair of Council

The Chair has the agreement of Council to authorise action on minor, non-contentious matters falling within its responsibilities.

The Chair has authority for urgent decisions necessitating a decision outside a Council meeting and will consult with the Chief Executive or relevant Chair of Committee in this regard, reporting to Council at the earliest opportunity and at the next meeting of Council with a record made in the minutes.

The Role of Chairs of Committees

The Chairs of Committees are responsible for reporting Committee work and decisions to Members at Council meetings.

Ad hoc Working Groups

Where any matter is to be delegated to an ad hoc working group it will be set out in terms of reference of that working group.

Terms of Reference are agreed for all Committees and ad-hoc working groups and detail any delegated powers. Routine reporting of Committees is by way of committee minutes and report at each Council meeting and in the annual report at the end of the year.

Delegation planner

The Key below outlines the 7 levels of decision-making and the actions which are permissible for the decisions shown on the subsequent pages.

Key	
Level 1:Privy Council	
Level 2: Council	
Level 3: Statutory Committee (Policy & Education Committee)	
Level 4: Committees (People, Audit)	
Level 5: Chair of Council	
Level 6: Chief Executive and Registrar	
Level 7: Member of Executive	
A	**Accountable** for decision making either under the Osteopath's Act 1993 or via delegated powers from Council.
AD	**Advises** and makes recommendations to the Accountable person/body.
R	**Responsible** for undertaking the delivery and reporting to the Accountable person/body either directly or through a committee
I	**Involved** in the activity through the responsible person/body

General Osteopathic Council

Annex A to 12

Matters	Decision	Privy Council	Council	Policy & Education Committee	Audit Committee	People Committee	Chair of Council	Chief Executive & Registrar	Member of Executive the activity is delegated to
Governance	Keep Council structure and composition under review		**A**			**AD**		**R**	**Governance Manager**
	Establish committees and regulate their procedure		**A**					**R**	**Governance Manager**
	Agree Terms of Reference for all Committees (including ad hoc working parties where applicable)		**A**					**R**	**Governance Manager**
	Ensure a high standard and inclusive non-exec appointment and re-appointment process					**A**		**R**	**HR Manager**
	Appoint Chair of Council	**A**	**I**			**AD**		**R**	**HR Manager**
	Appoint Council Members	**A**	**I**			**AD**		**R**	**HR Manager**
	Re-appointment of Council Members	**A**	**I**			**AD**	**I**	**R**	**HR Manager**
	Appointment and Re-appointment of Independent Committee Members, Council Associates, Patient Partners and any other co-opted Member.		**A**			**AD**	**I**	**R**	**HR Manager**
	Make arrangements for the performance review process for Council as a whole.		**A**			**AD**	**I**	**R**	**Governance Manager**
	Periodically review effectiveness of Committee		**A**	**R**	**R**	**R**			**Relevant Executive Lead**
	Register of all interests, business, pecuniary, loyalty for members/committee members/ Senior Management Team: establish, Publish and keep up to date.		**A**					**R**	**Governance Manager**
	Prepare annual report for Council on the work of the Committee.			**A**	**A**	**A**		**R**	**Relevant Executive Lead**
	Appoint the Registrar		**A**			**R**			**HR Manager**
	Establish and maintain the Register of osteopaths (section 2(3) of the Act and SSI 1998/1328)							**A**	**Registration Manager (Note 1)**
	Accept/decline UK applicants onto register in line with the Osteopath Act 1993 where there are no issues with the applicant's good character, as described by the GOsC Good Character Assessment Framework							**A**	**Registration Manager (Note 1)**
	Consider whether applicants for registration from outside the UK have reached the required standard of proficiency (section 3(6))							**A**	**Registration Manager (Note 1)**

General Osteopathic Council

Annex A to 12

Matters	Decision	Privy Council	Council	Policy & Education Committee	Audit Committee	People Committee	Chair of Council	Chief Executive & Registrar	Member of Executive the activity is delegated to
Registration	Suspend or remove registrants from the Register where ordered to do so by Fitness to Practise Committees.							**A**	**Registration Manager (Note 1)**
	Consider whether applicants for registration are of good character and in good health (sections 3 and SI 2000/1038).							**A**	**Registration Manager (Note 1)**
	Enter a note in the register of the details of every suspension of registration (section 7).							**A**	**Registration Manager (Note 1)**
	Refer applications for restoration to the register to the Professional Conduct Committee, and to register applicants when direction by the Committee (section 8).							**A**	**Registration Manager (Note 1)**
	Investigate allegations of fraud or error in the register and report on the investigation to Council; to suspend registration during investigation if satisfied it is necessary to protect members of the public and to remove the registration on the order of Council, subject to the right of appeal (section 10).							**A**	**General Counsel**
	Consider reports of investigations in relation to fraud or error in relation to registration		**A**					**R**	**General Counsel**
	Invite members of the IC, PCC and HCC to attend meetings of the committees (SI 2009/468).							**A**	**Director of Fitness to Practise**
	Collect entry fees, retention fees and restoration fees; to agree payment to payment by instalments; and to remove an osteopath from the register if instalments are not paid (SI 2000/1038).							**A**	**Registration Manager (Note 1)**
	Deal with continuing professional development requirements (including reductions or variations in requirements, issuing of final warnings, and removal from the register for failure to comply with the requirements) (SI 2006/3511).							**A**	**Registration Manager (Note 1)**
	Consider appeals against decision of Registrar		**A**					**R**	**Director of Fitness to Practise**
	Publish the Register		**A**					**A**	**Registration Manager (Note 1)**
	Deal with Professional indemnity insurance requirements							**A**	**Registration Manager (Note 1)**

General Osteopathic Council

Annex A to 12

Matters	Decision	Privy Council	Council	Policy & Education Committee	Audit Committee	People Committee	Chair of Council	Chief Executive & Registrar	Member of Executive the activity is delegated to
Registration	Prepare, publish and keep under review a Code of Practice. (Note 2)		**A**	**AD**					**Director of Education, Standards and Development**
	Determine the standard of proficiency before develop and regulate (Note 2)		**A**	**AD**					**Director of Education, Standards and Development**
	Develop and regulate the profession of osteopathy		**A**	**AD**				**R**	**SMT**
	Make rules as provided for under the Act in order to discharge its (Council) functions		**A**	**AD**	**AD**			**R**	**General Counsel**
	Appoint Legal Assessors, Medical Assessors and members of the statutory committees (including the approval of co-options)		**A**					**R**	**Director of Fitness to Practise**
	Consider whether certain applicants for registration [new powers applicants] are capable of the competent and safe practice of osteopathy (section 3(6A)). – **n.b. this registration category is not in use.**								
	Consider certain matters relating to Conditional Registration (section 4) – **n.b. this registration category is not in use.**								
Policy and Education	Matters relating to Education, Training, examinations or tests of competence		**A**	**AD**					**Director of Education, Standards and Development**
	Recognise qualifications in accordance with section 14(6) of the Act		**A**	**AD**					**Director of Education, Standards and Development**
	Withdraw recognition of a qualification in accordance with sections 16(10 and 18(5) of the Act.		**A**	**AD**					**Director of Education, Standards and Development**
	Appoint and manage the performance of visitors to conduct the evaluation of courses under section 12 of the Act			**A**					**Director of Education, Standards and Development**
	Exercise powers to require information from osteopathic educational institutions in connection with its statutory functions in accordance with section 18 of the Act.			**A/R**					**Director of Education, Standards and Development**

General Osteopathic Council

Annex A to 12

Matters	Decision	Privy Council	Council	Policy & Education Committee	Audit Committee	People Committee	Chair of Council	Chief Executive & Registrar	Member of Executive the activity is delegated to
Policy and Education	Pre-registration, education and training of osteopaths, including standards of practice required for registration.		**A**	**AD**					**Director of Education, Standards and Development**
	Post registration, education and training, including the requirements for ensuring osteopaths remain fit to practise.		**A**	**AD**					**Director of Education, Standards and Development**
	Standards required for initial registration and appropriate means for assessing those standards		**A**	**AD**					**Director of Education, Standards and Development**
	In relation to policy- the management, investigation and adjudication of concerns about the fitness to practise of registrants.								**Director of Education, Standards and Development**
	Matters connected to Fitness to Practise processes, including where relevant, protection of title (Section 32).		**A**	**AD**					**Director of Education, Standards and Development**
	Development of the osteopathic profession		**A**	**AD**					**Director of Education, Standards and Development**
	Measures to encourage research and research dissemination within the osteopathic profession		**A**	**AD**					**Director of Education, Standards and Development**
	Ensure policy development has been informed by effective engagement with the full range of GOsC's stakeholders			**A**					**Director of Education, Standards and Development**
	Take into account decisions of Fitness to Practise Committees, information from PSA and other relevant sources, and external legal or other requirements			**A**					**Director of Education, Standards and Development**
	Any research needs to support GOsC work		**A**	**AD**					**Director of Education, Standards and Development**
Internal Control and Risk Management	Set and regularly review the strategy, vision, objectives and values if the GOsC		**A**					**R**	**SMT**
	Prepare business plan and budgets							**A**	**SMT and Head of Resources and Assurance**
	Consider, scrutinise and approve the Business Plan and Budget at the start of each calendar year		**A**					**R**	**SMT**

General Osteopathic Council

Annex A to 12

Matters	Decision	Privy Council	Council	Policy & Education Committee	Audit Committee	People Committee	Chair of Council	Chief Executive & Registrar	Member of Executive the activity is delegated to
Internal Control and Risk Management	Monitor the implementation of the Strategy and the annual business plan.		**A**					**R**	**SMT**
	Review content and structure of the risk register at the start of each business planning cycle and keep it under review at each meeting.				**A**			**R**	**Head of Resources and Assurance**
	Review of Strategic Risks twice annually		**A**		**AD**			**R**	**SMT**
	Monitor effectiveness and proportionality of the risk management process in managing the risks.		**A**		**AD**			**R**	**Head of Resources and Assurance**
	Review the internal financial controls				**A/R**			**R**	**Head of Resources and Assurance**
	Appointment of external financial auditors to conduct the annual financial audit.		**A**		**AD**			**R**	**Head of Resources and Assurance**
	Monitor the performance and effectiveness of the external auditors				**A**			**R**	**Head of Resources and Assurance**
	Review audit planning document				**A**			**R**	**Head of Resources and Assurance**
	Scrutinise Audits Findings Report (AFR), draft Annual Report and Accounts and Governance Statement.		**A**		**AD**			**R**	**Head of Resources and Assurance**
	Approve and publish Annual Report and Accounts	**I**	**A**		**AD**			**R**	**Head of Resources and Assurance**
	Approve Financial Reserves Policy		**A**		**AD**			**R**	**Head of Resources and Assurance**
	Appoint the internal audit firm and monitor performance and effectiveness				**A**			**R**	**Head of Resources and Assurance**
	Approve and monitor internal audit strategy				**A**			**R**	**Head of Resources and Assurance**
	Consider results of internal audits and management response to issues raised				**A**			**R**	**Head of Resources and Assurance**
	Monitor the implementation of agreed recommendations.				**A**			**R**	**Head of Resources and Assurance**
	Receive reports on any incidents reportable under the serious events framework, data breaches and corporate complaints or whistleblowing, and the Executive's response to them				**A**			**R**	**Head of Resources and Assurance**
	Receive reports on the Executive's approach to organisational performance management and		**A**		**AD**			**R**	

General Osteopathic Council

Annex A to 12

Matters	Decision	Privy Council	Council	Policy & Education Committee	Audit Committee	People Committee	Chair of Council	Chief Executive & Registrar	Member of Executive the activity is delegated to
	corporate governance and make any recommendations.								
People	Ensure alignment of People Framework with GOsC strategy and values.					**A**		**R**	**HR Manager**
	Consider the Equality, Diversity, Inclusion and Belonging Framework as it relates to GOsC staff and non-executives.		**A**	**R**	**R**	**R**	**R**	**A/R**	**SMT**
	Monitor workforce (exec and non-exec) – planning, capability, succession and future skills.					**A**		**R**	**HR Manager**
	Consider issues of health and wellbeing as they relate to Executive and Non-Executives.		**A**			**AD**		**R**	**HR Manager**
	Make arrangements for a high standard of performance review process for non-executives					**A**		**R**	**HR Manager**
	Undertake performance review of Council, Committee Members and FtP Chairs			**A/R (Chair)**	**A/R (Chair)**	**A/R(Chair)**	**A/R (Chair)**		**Governance Manager**
	Chief Executive – appoint, review probationary period, suspend, return after suspension and dismiss		**A**			**AD**			**HR Manager**
	If applicable, performance manage Chief Executive					**AD**	**A**		**HR Manager**
	Conduct the annual appraisal and mid-year review of the performance of the Chief Executive.					**I**	**A/R**		**HR Manager**
	Consider and approve the remuneration of the Chief Executive on an annual basis					**A**			**HR Manager**
	Consider and approve recommendations of the Chief Executive in relation to pay, performance and reward of all other staff.					**A**		**R**	**HR Manager**
	Consider any issues in relation to the remuneration of non-executives and review annually.		**A**			**AD**		**R**	**HR Manager**
	Implement a reward and recognition approach that is able to attract high-quality people					**A**		**R**	**HR Manager**
	Consider skills and competencies required for Council and Committees to be effective.		**A**			**AD**		**R**	**HR Manager**

General Osteopathic Council

Note 1: Refer Governance Handbook Section 6.7 Matters delegated to the Chief Executive and Registrar

The Chief Executive has responsibility for all matters provided for specifically within the Act in their role as Registrar and additional matters as set out under Role of the Chief Executive and Registrar, in section 5.2 above.

The Registration Manager has delegated authority from the Chief Executive and Registrar to sign applicants onto the Register where there are no issues associated with the applicant's good character, as described by the GOsC Good Character Assessment Framework.

In the absence of the Chief Executive and Registrar, the Registration Manager has delegated authority to remove osteopaths from the Register in accordance with the respective legislation.

Note 2:

In practise these both are covered by the GOsC's Osteopathic Practice Standards (OPS) that set out the standards expected of osteopaths and include guidance to assist osteopaths in meeting these standards. The purpose of the standards is to ensure quality care for patients and to protect the from harm.

General Osteopathic Council

Financial Decision-Making and Delegation Table

Area/Decision	Privy Council	Council	Audit Committee	Chair of Council	Chief Executive & Registrar	Member of Executive the activity is delegated to	Limitations/ Conditions	Reference In Governance Handbook
Overall financial management					**A**	**Head of Resources & Assurance / Registration Manager (for registration fee income collection & payroll)**	CE retains accountability; delegation is operational only	7.1
Financial policies & control framework			**A**		**R**	**Head of Resources and Assurance**	Must be a robust control framework for effective management	7.1
Preparation of management accounts					**A**	**Head of Resources and Assurance**	CE and Registrar review overall position	7.1
Oversight of financial position		**I**			**A**	**Head of Resources and Assurance**	Variances from budget reviewed and reported to Council quarterly	7.1
Receipt of financial management information		**I**			**A**	**Head of Resources and Assurance**	At every Council meeting/ Heads of Department quarterly	7.1
Accounting procedures & records		**A**			**R**	**Head of Resources and Assurance**	Must comply with Charities SORP (FRS102)	7.2
Annual financial audit facilitation			**I**		**A**	**Head of Resources and Assurance**	Reports progress and issues to CE	7.2
Audit Findings Report (AFR) and Letter of Representation		**A**	**AD**		**R**	**Head of Resources and Assurance**	Audit Committee recommend any suggested actions to Council	7.2
Appointment/removal of external auditors		**A**	**AD**		**R**	**Head of Resources and Assurance**	Audit Committee must recommend	7.2
Approval of Business Plan & Budget		**A**			**R**	**Head of Resources and Assurance**	Annual approval at first meeting of calendar year	7.3
Budget transfers up to £20,000					**A**	**Head of Resources and Assurance**	Only if potential over/underspend identified by budget holder	7.3
Budget transfers over £20,000		**A**			**R**	**Head of Resources and Assurance**	Council approval required	7.3
Approval of Annual Report & Accounts	**A**	**A**	**AD**		**R**	**Head of Resources and Assurance**	Prior audit and committee processes	7.3
Reserves policy approval & review		**A**	**AD**		**R**	**Head of Resources and Assurance**	Based on charity best practice	7.4
Borrowing funds		**A**			**R**	**Head of Resources and Assurance**	Full terms must be presented in advance	7.5
Lending funds		**A**			**R**	**Head of Resources and Assurance**	Prohibited except staff season ticket loans	7.5
Income security & banking						**A/R Head of Resources and Assurance**	Income must be promptly banked – Office Manager responsible for banking cheques	7.6

General Osteopathic Council

Annex A to 12

Area/Decision	Privy Council	Council	Audit Committee	Chair of Council	Chief Executive & Registrar	Member of Executive the activity is delegated to	Limitations/ Conditions	Reference In Governance Handbook
Investment policy approval		**A**			**R**	**Head of Resources and Assurance**	Annual reporting and review investment strategy (meet investment Management team annually)	7.6
Monitoring investments		**A**			**R**	**Head of Resources and Assurance**	Reports submitted to Council	7.6
Invoice authorisation					**R**	**Department Head/Manager/Agreed individuals**	Must relate to responsibility area	7.7
Expense claim authorisation					**A**	**Head of Resources and Assurance /Line Managers**	Receipts and proper form required	7.7
Cheque signing / bank transfer authorisation					**A**	**SMT**	Person signing must not have authorised invoice	7.7
Bank payments up to £15k					**A**	**Or single member of SMT**	Signing limits apply	7.7
Bank payments £15k–£35k					**A**	**Or two members of SMT**	Signing limits apply	7.7
Bank payments £35k–£75k					**A**	**Plus single member of SMT**	Signing limits apply	7.7
Bank payments over £75k				**A**	**A/R**	**Both Chair and CE & Registrar**	Signing limits apply	7.7
Corporate credit card use					**A**	**Departmental Head**	Restricted use; reconciled statements required	7.7
Staff expense reimbursement					**A**	**Head of Resources and Assurance/ Line Managers**	Must comply with remuneration policy	7.8
Procurement under £10k					**A**	**Department Head**	One written quote required	7.9
Procurement £10k–£35k					**A/R**	**Plus Department Head**	Three written quotes required	7.9
Procurement £35k+		**A**	**AD**		**R**	**Tender Panel**	Public tender; expertise required	7.9
Waiver of procurement rules		**A**	**AD**		**R**		Exceptional circumstances only	7.9
Contract signing					**A/R**		Authorised signatory for all contracts	7.9
Fixed asset register					**A**	**Head of Resources and Assurance**	Safe custody of title deeds and contracts relating to assets owned	7.10
Building security controls					**A**	**Head of Resources and Assurance/Office Manager**	Safety of occupants required	7.11
Fraud reporting			**A**		**R**	**All staff (reporting duty)**	Immediate reporting required	7.11

General Osteopathic Council

Annex A to 12

Area/Decision	Privy Council	Council	Audit Committee	Chair of Council	Chief Executive & Registrar	Member of Executive the activity is delegated to	Limitations/ Conditions	Reference In Governance Handbook
Insurance coverage					**A**	**Head of Resources and Assurance**	Adequate insurance must be maintained	7.12
Notification of any Insurance risk		**A/R**	**A/R**		**A/R**	**Executive**	Immediate notification required to Head of Resources & Assurance	

GOsC Strategic priority areas: activities and measures

	STRENGTHENING TRUST				
GOsC business plan and business-as-usual alignment to Strategic priorities	• Support osteopaths practice in accordance with OPS. • Process registration applications – new students, renewals, international applicants. • Process fitness to practise concerns – IC, PCC, HC. • Section 32 – cease/desist letters, prosecutions, seek changes to protection of title legislation. • Implement strategic patient partner programme • Financial and Asset Framework developed. • Annual Report and Accounts submitted to Parliament. • Internal control systems operational – risk management, financial, internal audit. • Communication and Engagement Framework developed including Tone of Voice and response to DJS survey. • Consultation engagement across relevant policy areas.				
	KPI	**Measure type**	**Target**	**Frequency**	**Why it matters**
Strategic priority measurements	Registrant / Public trust in GOsC	Measured by survey	Increased trust on previous survey results by +10% compared to 2024 baseline (33% 2024)	Next survey FY2028-29	Gauges overall trust, fairness, professionalism
	Timeliness of Registration and FtP processes	Measured by operational data	Meet or exceed agreed KPIs or explain why not met	Bi-annual Registration Report and quarterly FTP reporting to Council	Delays erode trust, timeliness demonstrates fairness, competence
	Engagement in consultations	Measured by participation rates for each individual consultation	Number of responses enables diverse views. Target number and audiences to be outlined in consultation approach (specific to that consultation)	Reported to Council at beginning of consultation	Reflects how valued sector parties feel in GOsC decision-making processes
	GOsC remains a high-performing organisation	Measured by independent audits and assessments of GOsC performance	Internal audits provide assurance level not lower than 'reasonable assurance'.[1] PSA Standards of Good Regulation met.	x4 internal audits carried out each year Annually	Demonstrates fairness in GOsC processes and decision-making which supports trust and professionalism

[1] x4 levels of assurance used by TIAA: (1) Substantial Assurance (2) Reasonable Assurance (3) Limited Assurance (4) No Assurance

	CHAMPIONING INCLUSIVITY				
GOsC business plan and business-as-usual alignment to Strategic priorities	• Equality Monitoring Data collected, analysed and published. • Equity, Diversity, Inclusion and Belonging (EDIB) Framework published and actions agreed / implemented. • Promotion of our Equality Duty responsibilities. • Increase diversity of applications and inclusive recruitment processes (Executive and Non-Executive) • Encouraging diverse perspectives to enhance inclusive decision making. • Inclusive leaders who help everyone to thrive, reach their full potential and feel a true sense of belonging. • Human Resources plays a central role in championing and embedding the GOsC values, driving the approach to inclusivity and fostering a culture of belonging across all levels. • Supporting workforce recruitment and retention to maintain and increase a sustainable, diverse profession and to support osteopaths to practice in accordance with high standards. • Guidance for students / registrants around health and disability. • OPS/CPD reflective of EDIB. • Equality Impact Assessments undertaken.				
	KPI	**Measure type**	**Target**	**Frequency**	**Why it matters**
Strategic priority measurements	Diversity of registrant base, GOsC governance structure and staff	Measured by quantitative data	100% return of registrant EDI data (may include 'prefer not to say') by end January 2027 Increase 2024 response rate to EDI data monitoring survey from staff (74%) and governance (80%) baseline to a minimum 85%	Collection at initial or registration renewal Survey to be held in 2026 and at least every two years	Ensures focus on underrepresented groups and ensuring process free from bias / discrimination
	Equality Impact Assessments conducted	Measured by number conducted, assess consistency by internal audit	EIAs completed for 100% of new policies/activities and/or major revisions Internal audit to provide at least 'reasonable assurance'	Reported to Council in EDIB Annual Report, July Every 3 years: actions found met in 6 months	Shows inclusivity is embedded in policy and decision-making
	Actions from Equity, Diversity, Inclusion and Belonging Framework met	Measured by annual report to Council	Minimum of 95% of actions agreed by Council in previous report met or explained why not met	Annually. Reported through the EDIB Annual Report	Demonstrates delivery of actions committed to by GOsC
	Accessibility of processes and materials available on GOsC website	Measured as part of website development project and then by accessibility data available from website	WCAG 2.2 AA benchmark for new website Nil website accessibility corporate complaints received	Annual assessment Annual assessment	Fair access to information about GOsC areas including registration, complaints

	EMBRACING INNOVATION				
GOsC business plan and business-as-usual alignment to Strategic priorities	• Digital infrastructure investment • Alive to developments arising from AI in delivery of education, healthcare and GOsC operation. • Independent reviews – board effectiveness, skills audit, internal/external audits. • Implement more streamlined approach to data mapping, collection, insight and analysis and actions. • Efficient use of financial and people resources. • Identification of new ways of working to drive efficiency in processes which are prescriptive due to the nature of GOsC legislation. • Support osteopathic education sector as they explore different ways of delivering education. • Develop a strategy to address Corporate Social Responsibility.				
	KPI	**Measure type**	**Target**	**Frequency**	**Why it matters**
Strategic priority measurements	Piloting new initiatives to support osteopathic sector	Measured by the success/participation of the initiative being trialled	Track participation of all parties involved in initiative – c.60% of participants provide feedback Final evaluation report within 3 months of end pilot and considered by relevant committee or by Council	As arising with reports to Council and/or Committees as initiatives identified, piloted and evaluated	Demonstrates a culture of curiosity and learning
	Regulatory flexibility for emerging activity	Measured by policy reviews	Minimum of 90% of GOsC policies to be reviewed within agreed timescale (per policy) or explain why not reviewed Policies for emerging activities to be considered within 3-6 months of activity being identified	Annually (for those policies due for review) As arising	Ensures the organisation keeps pace with innovation in sector
	Staff innovation assessment	Measured by staff survey results	No baseline as not included in previous staff surveys. Next survey - late 2026 which will establish a baseline – then seek improvement in subsequent surveys	Every two years.	Measures the extent to which staff feel empowered to innovate
	Horizon scanning	Measured by engagement with external data sources (outside osteopathy) with evidence our work is informed by these sources	At least two examples per GOsC function each year of where our work has been informed by external sources Horizon scanning routinised within Council and Committee discussions. At least one example of discussion per committee meeting.	Annually Every meeting	Signals GOsC commitment to learning from those outside of the organisation and to adopting best practice

Business as usual: measures reported to Council and Committees

Area	Measurement	Reported via:
Registration	• process c.5,750 registration forms (UK and International applicants and annual renewal of registration forms) and c.5,000 reminder notices. • Support c.220 first-time applicants to join the UK Register (including applications from internationally qualified applicants and from UK qualified graduates). • undertake c.500 CPD verification and assurance audits.	• Business Plan • Bi-annual Registration report
Fitness to Practise	• receive c.200 queries from patients, members of the public, registrants and other healthcare professionals, leading to c.75 fitness to practise cases being opened, of which c.30 will be referred for investigation leading to c.12 being referred for a final determination hearing.	• Business Plan • Quarterly fitness to practise report and dashboard
Communications	• respond to c.2,000 enquiries into our osteopathic information support service for osteopaths, patients and the public; c.60 policy and ethical queries related to our standards; c.1,000 registration queries and c.650 student queries. • send out 12 monthly ebulletins to registrants achieving an open rate of c60%. • send out 4 quarterly English student ebulletins to 446 students (penultimate and final year) achieving an open rate of c40%. • send out 4 quarterly Welsh student ebulletins to 70 students living in Wales (penultimate and final year) achieving an open rate of c30%. • receive and fulfil 150 requests for personalised Registration Marks • continue to regularly receive feedback after our webinars and events that attendees have shifted their perceptions in a positive way e.g. are less fearful and have a deeper understanding about the topic	• Business Plan
Education, Standards and Development	• undertake quality assurance processes with 7 osteopathic educational providers including analysis of 7 annual reports and undertaking visits to four osteopathic educational providers. • holding 3 good practice events and continue to engage on a 1:1 basis with all osteopathic educational providers during the year. • ensure the patient voice informs the work of the GOsC through at least 100 interactions (formal and informal) with members of the patient involvement forum.	• Business Plan • Policy and Education Committee
Human Resources (external engagement activities)	• host 2 recruitment webinars attracting c.200 attendees including c.80 osteopaths and engage with c.150 interested applicants for our independent fitness to practise panel positions. • provide learning and development opportunities for our staff team and governance members.	• Business Plan • People Committee
Finance and Resources	• income and expenditure performance against budget • external financial audit reporting and management letter points	• Financial report to every Council • Internal/External audits to Audit Committee
Governance	• ensure Council and committee scrutiny and oversight of our work through servicing 15 meetings. • provide learning, development and strategy opportunities for c.50 members of the GOsC governance (decision making) structure, as well as those who advise on our statutory decision making including 12 education visitors and 8 registration assessors.	• Business Plan • People Committee
Non-departmental specific	• attend and participate in upwards of 25 osteopathic sector meetings, webinars and regional events engaging with osteopaths, students, patients and osteopathic organisations and other interested parties reaching approximately 250 students and 500 osteopaths. • internal audit reporting and management letter points	• Business Plan • Audit Committee

General Osteopathic Council

General Osteopathic Council
Council and Committee meetings: notes for observers*

Council welcomes observers to its public meetings as a demonstration of its commitment to openness, and accessibility.

Members of the governance structure may ask to observe Committees they do not sit on but should also follow these guidelines.

All observers are asked to note, and to abide by, the following principles and guidelines:

1. Anyone who wishes to attend a meeting should make a request, by email to the Governance Manager governance@osteopathy.org.uk.

2. Council meetings may be observed in person or virtually. It should be noted that numbers observing are limited for both in-person and online attendance and it may not be possible to accommodate all those who wish to attend.

3. Observers are reminded that they should not interrupt the proceedings or do anything that will disrupt Council business.

4. Observers are reminded they should await the Chair's invitation to speak but that this may not be until the end of the meeting as outlined in 7.

5. No one shall bring into a Council meeting any camera, tape recorder, or eavesdropping device, or any other device capable of capturing a permanent record, without permission.

6. If, during the meeting, it appears to the Chair that confidential business has arisen, then the Chair may need to restrict the meeting to Council or Committee members only. Those attending the meeting, both in-person and online, who are not members of Council or the Committee may be asked to leave the meeting whilst confidential matters are discussed. Observers will be invited back to continue observing proceedings as soon as it is possible to do so.

7. All observers, including Members of the governance structure who are not part of the Committee, will be allowed to raise questions, at the beginning and end of each meeting during the designated agenda item:

   i. This session will last for approximately five minutes.

   ii. Questions should be in writing and submitted in advance of the meeting.

iii. The Chair will have the discretion to determine whether the questions are replied to at the meeting or in writing, after the meeting.

iv. The Chair will ask the Chief Executive and Registrar or a member of the Senior Management Team to respond to the question(s).

8. The Chair may direct any person present whose behaviour is, in their opinion, disruptive of the meeting, to leave.

***These guidelines do not apply to the observers with speaking rights on the Policy and Education Committee**

General Osteopathic Council

Council
13 May 2026
Strategic oversight of the GOsC's current and future use of Artificial Intelligence (AI)

Classification	Public
Action	For decision and noting
Purpose of the paper	To provide Council with a strategic overview of how the GOsC is currently using AI, the opportunities and risks associated with future use, and the proposed direction for embedding AI safely and responsibly across our statutory functions.
Strategic Priority implications	The paper relates to all three Strategic Priorities, particularly 'Embracing Innovation', by supporting innovation, improving regulatory effectiveness, and strengthening organisational capability.
Standards of Good Regulation implications	There is no specific PSA Standard; however, AI-enabled approaches will have implications for several PSA Standards across our whole business.
Communications implications	Clear internal and external communication will be required to ensure transparency about how AI is used, reassure stakeholders about safeguards, and support staff capability. Engagement with the profession and patients will be essential as part of our broader AI governance approach.
Financial, resourcing and risk implications	AI offers opportunities for efficiency and improved insight, but also introduces risks relating to data protection, bias, accuracy, and organisational readiness/capacity. Costs relate primarily to staff time, training, and potential procurement of AI-enabled tools.
Patient perspectives	AI has potential to strengthen patient protection through improved insight, earlier identification of risk, and more consistent decision-support. The Patient Forum will be engaged in the next phase to ensure patient voice informs how we approach our use of AI.

Diversity implications	AI systems can replicate or amplify bias if not carefully governed. Equality Impact Assessments will be applied to all significant AI use, and we will ensure appropriate testing, monitoring and human oversight.
Welsh language implications	Any AI-enabled tools used for public-facing functions must comply with the Welsh Language Scheme. This will be factored into procurement and testing.
Annex(es)	None
Author	Matthew Redford (assisted by Microsoft Co-Pilot), Lorna Coe All content has been reviewed by humans, and GOsC takes full responsibility for its accuracy and quality.
Background reading	N/A

Recommendation(s)	1. Note the progress made in the safe and responsible use of AI across the GOsC. 2. Discuss the proposed direction for expanding AI use. 3. Provide views on the governance, assurance and risk-management approach to inform the next phase of AI development. 4. Agree the Acceptable Use of Artificial Intelligence (AI),Policy for Members of the Governance Structure.

Key messages

- AI is already being used within the GOsC in controlled, low-risk ways that support productivity, insight and quality. There is potential for AI to change and enhance how we work.
- Realising these benefits requires a clear governance framework, investment in staff capability, and careful management of risks. The paper provides Council with a strategic oversight of the topic.
- An Acceptable Use of Artificial Intelligence (AI),Policy for members of the Governance Structure has been provided for approval.

Introduction

1. AI is now a mainstream tool across public services and professional regulators. The pace of development, including generative AI, presents both opportunities and risks for regulators. It is appropriate to explore AI's potential while ensuring strong governance, transparency and fairness.

2. Over the past 12 months, the GOsC has begun to use AI in targeted, low-risk areas to support internal productivity, improve insight and strengthen regulatory processes. This paper provides Council with a strategic overview.

Discussion

AI within the GOsC context

3. The GOsC has taken a cautious, controlled approach to AI adoption. Current activity includes:

   - **Internal staff guidance on AI - Acceptable Use of Artificial Intelligence (AI) Policy:** The policy outlines the acceptable use by employees of AI systems within GOsC. It aims to ensure AI is used in line with our organisational values as well as responsibly, ethically and in compliance with legal, regulatory and societal expectations.

     Principles of acceptable use - summarised:

     - Only use approved AI systems for tasks relating to your work.
     - Be open about when AI is used in your work. (GOsC has an agreed positional statement that is published on the website but should also be used where AI has been used in a piece of work ' 'All content has been reviewed by humans, and GOsC takes full responsibility for its accuracy and quality.'
     - Ensure you have been sufficiently trained to use the AI system. competently and are aware of the potential risks that it poses.
     - Always check the accuracy of AI outputs before using them in your work.
     - Report any concerns about AI system outputs to your Line Manager.

     Where AI should not be used:

     - In any manner that undermines public confidence or impartiality in our statutory functions.
     - In any Fitness to Practise detailed casework.
     - To make decisions.
     - In ways that introduces or could potentially amplify bias, discrimination, or unfair treatment.
     - To generate misleading, discriminatory, or harmful content.

- For any activity that does not support the GOsC's values, its existing policies and objectives.
- To attempt to circumvent established data protection, cybersecurity, or ethical review processes.
- To undertake any task where you do not have sufficient experience and expertise to ensure accuracy, quality, and accountability.
- To carry out any part of a grievance and/or disciplinary procedure (for example to decide a grievance outcome or appropriate disciplinary penalty).
- To carry out any task that requires you to input the organisation's confidential information and/or personal employee data (for example for financial forecasting).

  What is acceptable and what is prohibited will depend on your job and the nature of the task that you are engaged in. If you are unsure about using AI for a task that you are undertaking, you should speak to your Line Manager for further advice.

- **Internal productivity tool:** the Executive have been asked to use Microsoft 365 Copilot (M365 Copilot) as its approved AI system because, as with other large AI providers like Open AI and Google, Microsoft faces higher regulatory scrutiny and it operates within the GOsC's tenant.
- **M365 Copilot is used in** supporting drafting, summarisation and document analysis, enabling staff to focus on 'higher-value' regulatory work.
- **Process improvement**: piloting AI tools for tasks that might be considered administrative in nature, such as extracting key information from documents or providing 'first drafts' of communications, letters, papers etc.
- **Guidance for osteopaths- Artificial Intelligence**: We issued interim guidance as although human interaction, touch and a holistic approach to the patient will continue to be the key foundations of osteopathic practice, we recognised that AI is becoming increasingly integrated into healthcare settings.

  Therefore, it was essential for osteopaths who are using, or are intending to use, AI as part of their practice, to reflect on how the Osteopathic Practice Standards (OPS) are applied in this area for the benefit of osteopaths, patients and society.

- **Joint statement on use of AI in health and care professional education**: The statement, which was a GOsC-led initiative, includes a set of guiding principles for providers of health and care education to proactively consider during the design and delivery of their educational programmes.

Published together with the Health and Care Professions Council, General Chiropractic Council, General Optical Council, General Pharmaceutical Council, and Royal College of Veterinary Surgeons, the statement helps to provide education providers with clarity and an understanding of regulator views on the use of AI in health and care professional education.

- **Audit Committee appointment**: we have recently appointed Dinah Cobbinah as an independent member of the Audit Committee. Dinah has extensive experience in digital transformation and will enhance our governance scrutiny and oversight.
- **Council member engagement**: Harry Barton and David Propert have volunteered to be Council 'sponsors' for GOsC related AI activity. Members and the Executive will identify suitable training in due course.
- **Responding to PSA activity and other consultations across the healthcare sector**: the Professional Standards Authority have been considering the impact of AI on the healthcare system including 'exploring the role of AI in healthcare' and' how to guide and regulate for health and social care professionals using AI'. We have engaged with the PSA on this work. PSA AI activity.

  We have also responded to consultations across the healthcare sector including the Call for Evidence from the National Commission into the Regulation of AI in Healthcare.

4. All current uses are subject to human oversight, with no automated decision-making.

Opportunities for future use

5. AI has the potential to change how we undertake our statutory functions across several areas. **At this stage, we are not proposing to implement these opportunities.** We are simply outlining where potential exists, with the clear intention that any future use of AI within GOsC for internal functions would be considered, proportionate, approached in a careful and methodical way and subject to appropriate governance.

   - **Registration**: improving accuracy and consistency in document checking, fraud detection, and applicant support.
   - **Fitness to Practise**: supporting triage, pattern recognition, and analysis of large volumes of information.
   - **Standards and CPD**: generating insight from CPD submissions, supporting thematic analysis, and improving guidance for registrants.

- **Policy and research**: enhancing our ability to analyse sector trends, patient feedback and external data sources.
- **Corporate functions**: improving efficiency in HR, finance, communications and governance.

Risks and safeguards

6. Key risks include:

   - **Bias and fairness**: risk of replicating or amplifying bias in decision-support tools.
   - **Accuracy and reliability**: risk of incorrect outputs if models are not validated.
   - **Data protection**: there is a need to ensure compliance with UK GDPR and secure handling of sensitive information.
   - **Over-reliance**: ensuring human judgement remains central to regulatory decision-making.
   - **Reputational risk**: need for transparency and stakeholder confidence.

7. Mitigations include:

   - A formal AI governance framework
   - Clear principles for responsible use
   - Equality Impact Assessments
   - Human oversight - no decisions taken by AI
   - Staff training and capability building
   - Transparent communication with stakeholders

Further rollout of AI

8. We plan to rollout Microsoft Copilot licences (from June 2026) to allow fuller integration of the Microsoft suite so the Executive can search across all applications for relevant information and save time.

9. Microsoft Copilot uses the organisation's security, identity and access controls so the user would only be able to access what they can already.

10. A cautious approach is being taken as we would wish to avoid any unintended consequences of AI accessing data beyond desired permissions.

Acceptable Use of Artificial Intelligence (AI) for Members of the Governance Structure

11. As Members increasingly encounter AI tools in their everyday work, it is important that we provide clear guidance for acceptable use in the same way we do for the Executive. This policy is not about restricting or discouraging use but about ensuring that GOsC data, particularly sensitive or confidential information, is handled responsibly and not inadvertently shared with external AI tools.

12. The policy provides the principles of acceptable use where it is recommended, or in some cases, essential, AI is not used.

13. As with the internal policy the impetus is on the need for human interaction to check that the output from AI is accurate and does not introduce any bias, discrimination or unfair treatment.

14. If members are in any doubt they can contact the Governance Manager.

15. Any changes made to the Policy in response to significant changes in law, technology, operational risk or internal processes will be shared with Members. For example, we are aware of the EU AI Act which has some direct and indirect relevance for UK healthcare regulators, and could lead to some changes to the Policy at a future date.

Options for Council

Option		**Pros**	**Cons**
1	**Do nothing:** Continue with ad-hoc, low-risk use.	No additional cost; minimal risk.	Missed opportunities; lack of strategic coherence; potential regulatory lag.
2	**Controlled expansion (recommended):** Develop a structured programme for AI adoption with a clear governance framework, risk management and capability building.	Supports innovation; strengthens statutory functions; ensures safety and accountability.	Requires investment in staff time and training.
3	**Accelerated adoption:** Rapid expansion of AI use across functions.	Maximises potential benefits quickly.	Higher risk; requires significant resource; may outpace organisational readiness.

Questions for Council consideration

16. To aid Council in its discussions, some questions members may wish to consider include:

Strategic alignment

- How does AI strengthen public protection and improve regulatory outcomes?
- Which statutory functions stand to benefit most, and what evidence supports this?
- Are there any other areas where AI should *not* be used?

Governance and oversight

- How can Audit Committee support the Executive implement and monitor an appropriate AI Governance Framework?
- How will we ensure that human judgement remains central to all regulatory decisions?

Equality, diversity and inclusion

- How will we test for and monitor bias in AI tools?
- What safeguards will ensure that AI does not disadvantage particular groups of applicants, registrants or complainants?

Ethics

- What ethical principles should guide our use of AI, and how will we demonstrate adherence?

Organisational readiness

- What investment in training or external expertise will be required?

Osteopathic community confidence

- How will we communicate transparently with registrants, patients and the public about AI use?

Risk appetite and future-proofing

- What is the organisation's risk appetite for AI across different statutory functions?
- How will we ensure our approach remains adaptable as technologies evolve?

Executive view

17. The Executive considers that a controlled, governance-led expansion is the most appropriate route. This approach balances innovation with safety and supports our strategic priorities. It also ensures that AI enhances, rather than replaces, professional and regulatory judgement.

18. We have set out some questions for Council members to consider and reflect upon. The May 2026 meeting of Council will not be our only opportunity to consider this topic. Indeed, this paper may be seen as a launch-pad for a more in-depth and strategic discussion at our Council development day in September 2026.

Recommendations

1. Note the progress made in the safe and responsible use of AI across the GOsC.
2. Discuss the proposed direction for expanding AI use.
3. Provide views on the governance, assurance and risk-management approach for the next phase of development.
4. Agree the Acceptable Use of Artificial Intelligence (AI) Policy for members of the Governance Structure.

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Acceptable Use Policy for Artificial Intelligence (AI) for Members of the Governance Structure

Positional Statement

At GOsC we embrace innovation and the appropriate use of AI to inform our governance, oversight and strategic work. All AI-generated content must undergo human review by the relevant member(s) of the governance structure to ensure accuracy, quality, accountability and alignment with GOsC's statutory responsibilities.

Use of AI within the General Osteopathic Council (GOsC)

When you are using AI tools in your role as a member of GOsC's governance structure, this policy supports you in using them safely and in a manner that does not compromise the organisation, its statutory functions or its public reputation.

AI can be defined as software-based systems designed to perform tasks that typically require human intelligence, such as learning, reasoning and decision-making.

GOsC has committed to embracing innovation and recognises the potential benefits of AI. At the same time, we must carefully balance opportunity with risk, particularly in the context of governance, accountability and public trust.

1. Policy Objectives

The purpose of this policy is to outline the acceptable use of AI systems by members of the GOsC governance structure. It ensures AI is used responsibly, ethically and in compliance with legal, regulatory and governance expectations.

This policy aims to:

- Promote transparency, fairness and accountability in AI use
- Ensure AI is used only in accordance with this Policy
- Safeguard data privacy, public trust and institutional integrity

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• Ensure compliance with organisational values and support high standards of behaviour and conduct in governance roles.

2. Scope of AI Use

This policy applies to all members of GOsC's governance structure, including Council members, committee and panel members, and any co-opted or appointed office holders.

Internally, GOsC has approved Microsoft 365 Copilot (M365 Copilot) as its authorised AI system because of its enterprise-level security (Enterprise Data Protection), compliance and data protection controls.

Where members choose to use AI tools they are expected to do so responsibly and with due regard to the sensitivity of GOsC information. In considering whether an AI tool is appropriate, members should reflect on the following:

- How information provided to the tool is used and stored, including whether inputs may be retained, shared, or used to train AI models.
- What rights or permissions may be granted to the provider when information is entered into the tool.
- Whether the risks associated with the tool are understood, including risks relating to confidentiality, accuracy, bias, and unintended disclosure of sensitive information.
- Whether the use of the tool is consistent with GOsC's duties, values, and established information governance expectations.

3. Acceptable Use

Members using AI technologies are responsible for their actions and remain fully accountable for judgement, advice and decisions.

It is important to only ask AI to produce something that you could do anyway as then you will be confident that you can quality assure the output. The types of things you could use AI for are:

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- Brainstorming ideas
- Supporting horizon scanning or background research
- Assisting with drafting or reviewing papers

- Critically analysing work
- Adapting text for different audiences
- Proofreading

Principles of Acceptable Use

- Members should treat all non-public information as confidential.
- Members must follow organisational guidance on data protection, confidentiality and information security.
- Members should be mindful that governance decisions have legal, reputational or ethical implications.
- Be open about AI use in governance work. Declare AI use, where relevant, in papers or communications
- Ensure you have been sufficiently trained to use the AI system competently and are aware of the potential risks that it poses.
- Always check the accuracy of AI outputs before using them in your work. Involve others in the checking process if you are unsure.
- Raise concerns with the Governance Manager.

4. Where AI Should Not Be Used

- In any manner that undermines public confidence or impartiality in our statutory functions.
- In any work related to Fitness to Practise.
- To make decisions.
- In ways that introduce or could potentially amplify bias, discrimination, or unfair treatment.
- To generate misleading, discriminatory, or harmful content.
- For any activity that does not support GOsC's values, its existing policies and objectives.
- To attempt to circumvent established data protection, cybersecurity, or ethical review processes.
- To undertake any task where you do not have sufficient experience and expertise to ensure accuracy, quality, and accountability.
- For any part of grievance, disciplinary or complaints procedures.

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- To carry out any task where doing so would mean that GOsC's confidential information and/or personal data is entered into a Large Learning Model (LLM) such as Chat GPT or Claude (these examples are not exhaustive) and results in said data being in the public domain.

- Where there is uncertainty, members should seek advice from the Governance Manager before using AI.

5. Common Risks and Other Points for Consideration

Bias & Fairness	AI models may reflect or amplify societal biases, leading to unfair outcomes.
Privacy & Data Protection	Inputting personal data into AI systems can violate data protection laws. Use anonymised data and comply with GDPR or relevant laws.
Misinformation	Generative AI may produce information that sounds plausible but is factually inaccurate or misleading.
Security Vulnerabilities	AI systems may be exploited if not properly secured or monitored.
Loss of Accountability	Overreliance on AI can obscure responsibility for decisions.
Environmental impact	Use of AI systems can involve a large amount of energy consumption. Employees should be mindful of this when deciding to use any AI system in their work.

6. Governance & Oversight

Oversight of AI use rests with Council, supported by the Governance Manager and IT Manager.

Regular reviews will assess compliance, effectiveness and emerging risk.

7. Reporting & Enforcement

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Concerns about AI use or outputs should be raised with the Governance Manager.

Where misuse occurs, this will be addressed in accordance with GOsC governance frameworks, codes of conduct and relevant policies.

Whistleblowing protections apply to concerns raised in good faith.

Data Protection

Members are strictly prohibited from sharing any personal data and special categories of personal data with any AI outside of the organisation. All data must be handled in line with GOsC data protection policies.

Personal data is any information that relates to a living individual who can be identified from that information.

Special categories of personal data means information about an individual's racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, health, sex life or sexual orientation and genetic and biometric data.

Any personal data and special categories of personal data, must be handled in accordance with our data protection policy / policy on processing special categories of personal data.

Breach of policy

Members are encouraged to use AI in supporting their work. They are reminded to refer to this policy and, if in any doubt, to the Governance Manager to support data security and organisational and personal credibility. Such actions will avoid a breach.

8. Policy Changes and Review

This policy will be reviewed on a 3 monthly basis and in response to significant changes in law, technology, operational risk or internal processes.

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As these tools continue to advance and develop, we will carry on assessing and navigating the risks associated with using them to ensure that our policy remains current and effective. If there are any changes to this policy, we will notify you accordingly.

Date of Policy Review	**Changes Made**	**Version Control**	**New Review Date**
5 May 2026	New Policy	V1	5 August 2026

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Council
13 May 2026
DHSC consultation: Draft GMC Order

Classification	Public
Action	For noting
Purpose of the paper	A briefing paper for Council setting out the broad direction of the GOsC consultation response to the Draft GMC Order.
Strategic Priority implications	The Draft Order will provide the template for legislative reform for all healthcare regulators. We have not included reform within our strategic plan/priorities as our legislation will not be amended before 2030.
Standards of Good Regulation implications	We are required to meet the Standards of Good Regulation regardless of whether our legislation has been updated or not.
Communications implications	We will publish our consultation response on our website. We are also working with the Institute of Osteopathy to support them with their response to the consultation.
Financial, resourcing and risk implications	None arising from this paper.
Patient perspectives	Within our response we will ensure the patient voice is reflected.
Diversity implications	The consultation has specific questions related to equality, diversity, inclusion and belonging.
Welsh language implications	The Draft Order applies equally to Wales as it does England, Scotland and Northern Ireland
Annex(es)	None
Author	Matthew Redford
Background reading	Draft GMC Order consultation document Draft GMC Order 2026 - version for consultation.pdf

Recommendation(s)	1. To note the broad direction of the GOsC consultation response to the Draft GMC Order.

Key messages

- A consultation on the General Medical Council (GMC) Order 2026 has been issued by the Department of Health and Social Care.
- This Order will reform how the GMC regulates medical practitioners, physician associates and anaesthesia associates.
- We have set out the broad direction of how we plan to respond to the consultation. We have not set out a response to every consultation question instead drawing out the key points for Council's attention.
- We are supportive of the overall draft Order and our consultation response will be drafted in that manner.
- We continue to note that there is no timeline for when the reforms will be rolled out to all of the regulators, with only the GMC, NMC and HCPC in line for reform within the current parliament.

Introduction

1. In March 2026, the Department of Health and Social Care (DHSC) issued a consultation on the General Medical Council (GMC) Order 2026, which would reform how the GMC regulates medical practitioners, physician associates and anaesthesia associates across the UK.

2. The introduction to the consultation document sets out the purpose of the consultation:

   'The current UK model of regulation for healthcare professionals is rigid, complex and needs to be reformed to better protect the public, support our health services and help the workforce meet future challenges.

   For example, the Medical Act, which governs the regulation of doctors, dates back to 1983 but has roots in even older statutes and has only received piecemeal updates since its inception. Streamlining and updating regulators' legislation will enable them to operate more efficiently and to consistently uphold high standards and maintain public confidence in the professions the regulators oversee.

   In 2021, the former government consulted on policy proposals to reform the regulation of healthcare professionals and to introduce statutory regulation for anaesthesia associates and physician associates in the UK. This was also a joint consultation on behalf of the Secretary of State for Health and Social Care and the Scottish ministers. Responses to this consultation, Regulating healthcare professionals, protecting the public ('the 2021 regulating healthcare professionals consultation'), showed widespread support for reform of regulators' legislative frameworks to make them more efficient, modern and consistent.

   The reforms that were consulted on span 4 main areas of regulation:

   - governance and operating framework
   - education and training
   - registration
   - fitness to practise

   Draft legislation to establish a legislative framework for the regulation of anaesthesia associates and physician associates was underpinned by the policy proposals set out in the 2021 regulating healthcare professionals consultation. The subsequent consultation in 2023, Regulating anaesthesia associates and physician associates, consulted on that draft legislation. The Anaesthesia Associates and Physician Associates Order 2024 (AAPAO) came into force on 13 December 2024, apart from one provision not currently in force. The AAPAO was laid before the Westminster and Scottish Parliaments, in accordance with the requirements of the Health Act 1999.

The regulation of physician associates and anaesthesia associates in Scotland is a devolved matter because these professions were first brought into regulation after the Scotland Act 1998 became law. In Northern Ireland, the regulation of healthcare professions is a transferred matter, meaning the Northern Ireland Assembly has legislative competence, although it has historically chosen to continue with the UK-wide regulatory model. In Wales, regulation of healthcare professions is a reserved matter. GMC operates on a UK-wide basis to ensure consistent standards, patient safety and workforce mobility across all 4 nations, and as such this is a UK-wide consultation.

The AAPAO paved the way for full scale reform of the regulatory frameworks of all the healthcare professional regulators by providing a legislative template to expand upon.'

3. This paper sets out the broad direction of how we plan to respond to the consultation. We have not set out in this paper a response to every consultation question instead drawing out the key points for Council's attention.

GOsC Consultation response

Governance:

4. The draft order proposes the introduction of a unitary board model.

5. Our view is that a streamlined governance model can strengthen accountability and decision-making, but it remains essential that the professional voice is not diluted within this structure. Maintaining meaningful professional input is vital for legitimacy, confidence and trust among those regulated, ensuring that decisions are both well-informed and seen as credible across the sector.

PSA evidence gathering:

6. The draft order provides for a consequential amendment to be made to the National Health Service Reform and Health Care Professions Act 2002 to allow PSA to have a power to compel information from GMC.

7. We agree that the draft order provides the PSA with evidence-gathering powers that are broadly sufficient and proportionate, but it will be important to ensure these powers are exercised in a way that supports constructive oversight rather than creating unnecessary burden. A balanced approach - where information can be compelled when genuinely required, but routine engagement remains collaborative - will help maintain trust, transparency and an effective regulatory relationship.

Education and training:

8. The draft order sets out that the GMC can approve overseas undergraduate, foundation and postgraduate education and training programmes.

9. We agree that the GMC should be able to approve overseas undergraduate, foundation and postgraduate programmes. We believe this approach supports a consistent, high-quality approach to medical education globally and strengthens assurance around the training of doctors who may later seek UK registration. We also believe that it continues to be important that this approval function does not create any perception of preferential access to UK training pathways. Clear communication and robust safeguards will help ensure confidence in this activity.

Registration:

10. The draft order provides that medical practitioners may be able to be registered despite having a complete restriction on registration. This means they will be registered as a medical practitioner but not allowed to practise. A medical practitioner may choose to have a complete restriction on their registration, or a complete restriction could be, for example, the result of failing to complete periodic assessment.

11. We agree that doctors should be able to remain on the register with a complete restriction, as this provides a transparent and accurate record while preventing them from practising. We believe this approach supports public protection while avoiding the need to remove individuals entirely from the register.

12. The draft order also includes provisions regarding the process of entering the register. It also includes provisions which enable GMC to provide assurance that individuals on its register have the necessary education, training, knowledge, skills and experience required to practise safely in the UK.

13. Our view is that the draft order gives the GMC the powers it needs to carry out its registration functions effectively, and importantly in a way that aligns with what patients expect from a modern regulator. Patients want assurance that anyone on the register has the education, training and competence to practise safely, and the framework set out in the order provides the GMC with the tools to deliver that assurance. By enabling more responsive checks and clearer standards, the draft order supports a registration system that is transparent, trustworthy and focused on protecting patients.

Fitness to practise - mandatory removal from the register

14. The draft order requires GMC to mandatorily remove a registrant from its register, if the registrant has been convicted of a serious criminal offence, as set out in schedule 4 (known as a listed offence)[1], without GMC having to investigate or MTS having to hold a fitness to practise panel hearing to determine whether the registrant's fitness to practise is impaired.

15. We strongly agree with the listed offences in Schedule 4, as automatic removal in these circumstances is essential for protecting patients and maintaining public

[1] Listed offences include: murder, sexual offences including those against children, modern slavery including human trafficking, blackmail.

confidence in the profession. These offences are so serious that they fundamentally undermine the trust placed in a doctor, making continued registration incompatible with safe practice. This approach also avoids the cost and administrative burden of conducting investigations or hearings where the outcome is already clear.

16. Under the draft order, former registrants of GMC who have been mandatorily removed from the register following conviction for a listed offence in schedule 4 of the draft order will not be able to apply for re-entry to the register. Exceptions would apply where the conviction has been quashed or was for a lower-level listed offence (blackmail or extortion), and the custodial sentence has been quashed and replaced with a non-custodial sentence.

17. Our view is that former registrants convicted of a listed offence should not be able to apply for re-entry to the register, except in the very limited circumstances set out in the draft order. The narrow exceptions ensure fairness where convictions or sentences are overturned.

Fitness to practise – grounds for action

18. The draft order proposes that the fitness to practise of a regulated professional may be impaired if the regulated professional:

    - is unable to provide care to a sufficient standard
    - has behaved in a way which amounts to misconduct
    - is adversely affected by a physical or mental health condition

19. It is reassuring that, following several regulators, including GOsC, requesting that that adverse physical or mental health remains a separate ground for action, that the Government has listened to those concerns and decided to include adverse physical or mental health as a separate category of impairment. By way of background, in our response to the DHSC consultation on proposals for reforming professional regulation in June 2021, we highlighted several consequences that could arise should there only be only two grounds of action (misconduct and competence) as DHSC originally proposed. This included preventing the regulator dealing with future risk to the public, but we also considered that registrants who have a health condition that impacts upon their fitness to practise should not be 'labelled' with a misconduct or competence allegation if health sits at the heart of the concerns. Our experience demonstrates that registrants do find structure and support through the review mechanism and are encouraged to comply with conditions.

Interim registration measures

20. Under the draft order, a fitness to practise panel's powers will be extended so that the panel can impose interim registration measures during registration proceedings, as well as during fitness to practise proceedings. This would allow the panel to impose an interim registration measure while investigating whether a register entry is fraudulent, for example.

21. Our view is that this is a sensible approach and we are supportive of the provision.

Evidence gathering

22. Under the draft order, GMC may, for the purpose of gathering evidence in connection with registration, fitness to practise and interim registration measure proceedings, require a person to supply such information or produce such a document as GMC may specify. GMC will also be able to require a witness to attend a fitness to practise panel hearing or an appeal panel hearing.

23. Our view is that the draft order provides the GMC with evidence-gathering powers that are sufficient and proportionate. The ability to require information, documents and witness attendance is essential for robust and fair decision-making in registration and fitness to practise processes, and aligns with what patients and the public would expect from an effective regulator.

Rule-making powers

24. Under the draft order, GMC is able to make rules on specific procedures in relation to:

    - governance and operating framework
    - education and training
    - registration
    - fitness to practise
    - interim registration measures
    - revision of decisions and internal appeals

25. Our view is that the rule-making powers in the draft order are sufficient and proportionate, as they give the GMC the autonomy it needs to set clear procedures across its core functions while supporting a more efficient regulatory system. This balance allows the GMC to respond to operational needs without unnecessary rigidity, while still ensuring appropriate safeguards and accountability.

Appeals

26. Under the draft order, GMC will be permitted to administer its own internal appeals function. Applicants for registration, registrants and former registrants will be able to appeal specific registration and fitness to practise decisions to an appeal panel of GMC.

27. Our view is that the draft order provides the GMC with powers that are broadly sufficient and proportionate to administer its internal appeals function. Having a clear internal route of appeal supports fairness, efficiency and timely resolution of disputes. However, it remains important that these powers are exercised with appropriate controls to ensure transparency, independence and public confidence particularly where the GMC is both the original decision-maker and

the body administering the appeal. Ensuring strong procedural separation and clear accountability will be essential to maintaining trust in the system.

Executive view

28. We are supportive of the overall draft order and our consultation response will be drafted in that manner. We have until 23 June in order to respond to the consultation with any feedback from Council built into our final response.

29. We continue to note that there is no timeline for when the reforms will be rolled out to all of the regulators, with only the GMC, NMC and HCPC in line for reform within the current parliament. We will not have our legislation changed before 2030 and, in all likelihood, probably not before 2035 if we find ourselves behind other regulators in the queue. So, therefore, we need to continue to operate as effectively as we can within the prescriptive and costly legislation we have while making the case for a clear timeline of reform for the healthcare regulators currently outside of scope.

Recommendation

1. To note the broad direction of the GOsC consultation response to the Draft GMC Order.