THE ROLE OF OSTEOPATHS AS ALLIED HEALTH PROFESSIONALS WITHIN THE NATIONAL HEALTH SERVICE

An independent review for the Institute of Osteopathy

By
Professor Adrian Newland, CBE (Chair)
Christina Edwards, CBE
Professor Martin Roland, CBE

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“Osteopathy's educational and regulatory institutions and processes are robust and mature but not always well understood outside the profession. NHS organisations could take a number of simple steps immediately to show osteopaths that their work is recognised and their role valued, especially given the shortage of allied health professionals (AHPs).”
Panel biographies

Professor Adrian Newland, CBE (Chair)
Adrian Newland is Professor of Haematology at Barts and the London School of Medicine and Dentistry, and Honorary Consultant at Barts Health NHS Trust. He is ex-President of the British Society for Haematology, was President of the Royal College of Pathologists from 2005–2008, and President of the International Society of Hematology (ISH) from 2014 - 2016. He is currently advisor to NHS Improvement on Pathology and clinical advisor to the Transforming Cancer Support Team for London. He chaired the Professional Performance Panel for the RCPath and is a member of RCPath Consulting and in that role has reviewed many hospital pathology services in the UK and Ireland. He is a member of the World Health Organisation’s Strategic Advisory Group of Experts on In Vitro Diagnostics.

Christina Edwards, CBE
Christina Edwards has a wide experience of the NHS and the Department of Health. She qualified and worked as a nurse in acute settings, then worked as a health visitor. Previously she worked abroad, has her own business and had a varied career in administration. In 1992 she led a Department of Health scrutiny into unnecessary paperwork and bureaucracy and later served on several inquiries. In 1998 she became Regional Director of Training, Education and Nursing, including responsibility for two Deaneries in the Northern and Yorkshire Region. Christina was Vice Chairman of Sue Ryder Care for nine years, and serves as a Trustee on the Cavell Nurses Trust. Christina was a Registered Nurse member and the Deputy Chairman of the Governing Body of NHS Nene Clinical Commissioning Group from 2012 to 2017.

Professor Martin Roland, CBE
Martin Roland is Emeritus Professor of Health Services Research at the University of Cambridge. He was appointed to the Chair in General Practice in the University of Manchester in 1992. In 1994, he established, and subsequently became Director of, the National Primary Care Research and Development Centre. In 2009 he became the inaugural RAND Professor of Health Services Research at the University of Cambridge, a post which he held until 2016. Professor Roland’s main areas of research interest are developing methods of measuring quality of care and evaluating interventions to improve care in the NHS. His previous areas of research include back pain, hospital referrals, out of hours care and skill mix in primary care. Professor Roland was a practising GP for 35 years from 1979 to 2014.
Executive summary

The NHS Long Term Plan promises patients more options, better support and properly joined-up care, through the development of new service models and integrated care teams.

Musculoskeletal (MSK) problems, especially low back pain, are very common. They entail large costs in sick pay, sleep loss, depression and even opioid overprescribing and addiction. The early involvement of osteopaths and other allied health professionals should significantly improve patient care, reduce sickness absence and save money.

However, the contribution which osteopaths could make to MSK services is not well-recognised by NHS Commissioners, and osteopaths themselves have not always been assertive enough about the contribution they could make to NHS services. Our review therefore suggests actions for both the profession and the NHS and also for the Institute which commissioned our review.

In summary, we concluded:

- Osteopathy’s educational and regulatory institutions and processes are robust and mature but not always well understood outside the profession. Student osteopaths would benefit from NHS placements and the opportunity to work alongside other health professions during training.
- Low back pain and associated problems are common and put NHS services under considerable pressure. It would be highly desirable to find new care models which give patients with musculoskeletal disorders faster access to assessment, advice and treatment.
- With early assessment and intervention, osteopaths, along with other allied health professionals, have the potential to reduce the duration of symptoms for many patients, benefitting also the NHS and – as patients get back to work - the wider economy.
- Successful models of osteopathic practice and multi-disciplinary MSK practice already exist in the NHS. However, such arrangements need to be nurtured and planned for the long term, with commitment which survives NHS changes. The involvement and support of doctors is also critical for teams to function effectively.
- NHS work can be professionally satisfying for osteopaths as well as operationally useful for a stretched NHS, but osteopaths need to understand the NHS better if they are to play a bigger part in service development.
- Student osteopaths should be taught about the NHS and experience work with other health professions. Once qualified, it is in primary care that osteopaths can make the biggest contribution to patient care and NHS efficiency. The profession’s institutions should work together to explain and promote developments such as First Contact Practitioner status.
- NHS organisations could take a number of simple steps immediately to show osteopaths that their work is recognised and their role valued, especially given the shortage of allied health professionals.

Adrian Newland  Christina Edwards  Martin Roland
Background and review method

The Institute of Osteopathy (iO) is the UK’s professional membership organisation for osteopaths. The Institute’s purpose is to support, unite, develop and promote the osteopathic profession, for the improvement of public health and patient care.

In April 2017 osteopaths were designated AHPs by NHS England (though not in Scotland, Wales or Northern Ireland). Most allied health professionals are regulated by the Health and Care Professions Council (HCPC), but osteopathy as a profession has its own statutory regulator, the General Osteopathic Council (GOsC) which requires osteopaths to undertake sufficient annual CPD to maintain their knowledge and skills.

Despite the recognition of its practitioners as allied health professionals (AHPs), osteopathy has not been in the mainstream of NHS thinking about how AHPs could be used. Indeed, it is not always noticed by NHS recruiters filling MSK posts, a point to which we will return.

An iO survey at that time showed that 71% of osteopaths would be willing to work with the NHS in some capacity and 26% would be willing to be employed by the NHS. But two years later, there has been little growth of NHS engagement with osteopaths. The NHS Long Term Plan said in 2019 that to serve a growing and ageing population and address funding and staffing pressures, the NHS would need to:

...move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.

But most of the UK’s osteopaths still work only in private practice and many MSK teams in the NHS are without osteopaths.

The Institute therefore asked us to conduct an independent review. Our remit was to look at the opportunities and possible limitations for osteopaths wanting to join with other AHPs in developing new models of care. It was not to review the effectiveness of osteopathic treatment which has been done many times and is not in question.

It is, however, worth noting that osteopathy has never been categorised as a ‘procedure of limited clinical value’ in NHS England’s guidance for clinical commissioning groups. Also, the research evidence for a large part of osteopathic practice was reviewed very recently by the National Institute for Health and Care Excellence (NICE), for 2016 guidelines on the assessment and management of low back pain and sciatica. The guidelines dismiss many interventions – acupuncture, orthotics, electrotherapies, and much pharmacology - in favour of manual therapies (section 1.2.7):

Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy.

We are not osteopaths but our starting point was that osteopathic treatment can be effective. So we then asked - why is it not more widely used in the NHS? We met or corresponded with patients, osteopaths, clinicians from other disciplines, clinical and non-clinical NHS managers, academics, and representatives of professional bodies concerned with education and clinical standards. We looked especially at examples of integrated care involving physiotherapists and doctors as well as osteopaths. Although there has been caution in the NHS’s use of osteopaths, there has also been innovation and we wanted to find tested models which others might adopt or adapt.

Many people provided us with written statements about their experiences. We have quoted extensively from these statements without identifying the sources. We are grateful to everyone who helped us understand the issues but the conclusions of this review are entirely our own.
Osteopathic practice today – an overview

Osteopaths use a range of ‘hands-on’ techniques which focus on releasing tension, improving mobility and optimising function. They are often used together with exercise, education and advice to help patients to relieve or manage pain, keep active and so far as possible maintain general health. As the iO Patient Charter puts it:

Your osteopath will provide treatment and care that reflects your needs. This includes explaining your diagnosis and the proposed treatment, as well as how to manage your condition and help prevent recurrence.

Routinely, osteopaths treat the person, not just the joint, bone or soft tissue. The approach is very much in line with Public Health England’s 2015 guidance, All our health about the need for health professionals to look at the whole person when assessing and advising patients.

UK training leads to a bachelor’s degree in osteopathy (a BSc Hons, BOst or BOstMed) or a Masters degree (MOst). Courses consist of four years of full-time study, five years part-time or a mixture of full and part-time study. The degree course includes anatomy, physiology, pathology, pharmacology, nutrition, biomechanics, diagnostic methods and at least 1,000 hours of clinical training. Nine schools currently offer osteopathy courses in the UK, and approximately 300 osteopaths qualify from them each year. The standards and guidance for osteopathic training are defined by the GOsC which has regulated osteopathy since 1997. The title ‘osteopath’ is legally protected - only registered practitioners can call themselves osteopaths.

Like any established health profession, osteopathy takes quality and standard-setting seriously. In 2012 the GOsC first published Osteopathic Practice Standards, setting out the standards of conduct and competence required of osteopaths to promote health and wellbeing and to protect patients from harm. The GOsC also encourages osteopaths to use patient-reported outcome measures (PROMS) to track treatment effectiveness by surveying patients before and after treatment. In 2018, the Institute of Osteopathy published Quality in Osteopathic Practice to bring together existing research on the patient experience, clinical effectiveness and safety. Osteopathy is generally regarded as a safe form of treatment. In rare cases, complications have been linked to therapies involving spinal manipulation but risks are minimised by giving osteopaths a good foundation education in medical sciences.

NHS Health A-Z, a patient information website, recognises that patients use osteopaths and gives this advice:

Most people who see an osteopath do so for help with conditions that affect the muscles, bones and joints, such as lower back pain, uncomplicated neck pain (as opposed to neck pain after an injury such as whiplash), shoulder pain and elbow pain (for example, tennis elbow), arthritis, problems with the pelvis, hips and legs, sports injuries, muscle and joint pain associated with driving, work or pregnancy.

In 2017 NHS England designated osteopaths as allied health professionals (AHPs) and published AHPs into action, described as a national framework and strategy focusing on the role of AHPs in transforming health, care and wellbeing. Designation as AHPs was an important step for osteopathy in England but it was not followed up on any scale and most of the UK’s 5000 osteopaths still work outside the NHS.

We asked osteopaths whether they thought their training had equipped them to work in the NHS. One, working for a community NHS trust in a band 8a management role, told us:
As osteopaths we have to prove ourselves. We need to use the language that the rest of healthcare uses and understand the NHS culture. We need to appreciate the benefits of a multi-professional teamwork approach. By default, osteopaths are trained as autonomous sole practitioners for the private market. As such, they can come across as elitist and professionally arrogant to NHS colleagues. Better exposure to the NHS, including NHS clinical placements at undergraduate level, would be immensely useful.

But just as the NHS is not presently tuned in well enough to the idea of employing osteopaths, so the desirability of the NHS playing a part in osteopathic training is poorly recognised. Osteopathy schools run their own clinics which are not usually associated with the NHS. Misunderstandings remain about the safety, training and regulation of osteopathy, with some health professionals and service managers still seeing osteopaths as ‘alternative’ or ‘complementary’ despite their designation as AHPs.

**Conclusion:** Osteopathy has educational and regulatory institutions and processes which are robust and mature but not always well understood outside the profession. Students of osteopathy would benefit from NHS placements and the opportunity to work alongside other health professions during training.

### The problem - musculoskeletal disorders

Musculoskeletal disorders are a major problem, whether measured in terms of patient symptoms, time spent on doctor consultations, NHS costs, time lost from work or social security payments. Many NHS staff suffer with back problems too – nurses especially – so finding better ways of dealing with MSK problems would be a double benefit for the NHS.

Hoy et al (2012) used a systematic review of the global prevalence of low back pain and found it to be a major problem throughout the world. In the UK the Office of National Statistics (2018) has shown musculoskeletal problems (including back pain, neck and upper limb problems) to be the second most common cause of sickness absence from work, after ‘minor illnesses’ such as coughs and colds. In 2016, 30.8 million working days were lost because of musculoskeletal conditions, accounting for 22.4% of sickness absence, with an estimated cost to the UK economy of £12.3 billion.

In a large 2018 survey, Britain's Healthiest Workplace, carried out by a private health insurer, Vitality, 44.6% of the survey’s 26,432 respondents reported suffering from lower back pain, and 14.2% (1 in 7) took sick leave and were classified as having experienced ‘severe’ pain. Sickness absence was highest for low income respondents, women of all ages and men over 50. There was a strong correlation between the incidence of back pain, the lifestyle choices that employees make and their performance at work. Physical activity, nutrition and smoking profiles were worst for the group with severe back pain though there was no association with alcohol consumption.

This puts a very large burden on primary care. Jordan et al (2010) examined consultations in four GP practices and showed 6% of patients consulting with back pain each year with one in seven consultations caused by MSK conditions. But the problem is bigger still. The Vitality survey report showed obesity, sleep problems, depression and work stress highest amongst employees with severe back pain. A 2019 Financial Times report, *Health at work*
featured the effect of ‘crippling’ musculoskeletal conditions on mental health. In England and Wales, community-dispensed opioid prescriptions rose more than 60% in the ten years to 2018, from 14 million to 23 million\(^{18}\). Opioid prescribing in Britain is not at the crisis levels seen in the USA but early assessment of musculoskeletal conditions, particularly low back pain, has the potential to reduce spending on strong painkillers and attendance at specialist pain clinics.

**Conclusion:** Low back pain and associated problems are common and put NHS services under considerable pressure. It would be highly desirable to find new care models which give patients with musculoskeletal disorders faster access to assessment, advice and treatment.

**Solutions - osteopathy’s potential**

The NHS Long Term Plan of 2019 sets out how the NHS will look for new service models in which patients ‘get more options, better support, and properly joined-up care, at the right time and in the optimal care setting.’ The plan says:

> Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere. ICSs are central to the delivery of the Long Term Plan. An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care.’

It seems to us that musculoskeletal problems present an ideal set of conditions for this sort of imaginative redesign in the NHS. Physiotherapists and osteopaths both care for patients with musculoskeletal conditions. They are both (in England at least) allied health professionals who can work well independently but who can also work together as part of integrated care teams. Given the scale of the musculoskeletal problem, further collaborative working by physiotherapists and osteopaths could make a substantial contribution to delivery of the NHS plan’s objectives.

The benefits of service redesign outside the NHS are well-recognised. Good employers have shown that improved access to MSK services can more than pay for itself through reduced sickness absence. In 2011, Swansea University investigated the impact of bringing osteopathic healthcare into the workplace\(^{19}\). A clinic was set up within the university where staff were offered up to six treatment sessions following referral from the occupational health department. Sickness absence days over a four month period were compared with the same period in the previous year and showed a 25% fall, while sickness absence in other areas of the university rose 15%. The new service resulted in fewer workplace assessments and enough savings to fund the clinic sessions.

In the NHS, savings are more difficult to measure, with market testing of new service models hampered by changes in commissioning practice and lags in patient understanding of new access systems. But the Swansea evidence points strongly to the scale of saving that might be possible for the NHS.

**Conclusion:** With early assessment and intervention, osteopaths, along with other allied health professionals, have the potential to reduce the duration of symptoms for many patients, benefitting also the NHS and – as patients get back to work – the wider economy.
Current use of osteopathy in the NHS

We have summarised here some of the accounts which osteopaths gave us of their NHS work. Although osteopaths are concerned that there are few opportunities for them to work within the NHS, some have been running services and clinics successfully for many years, with models of care which might be copied. These accounts also point to some of the barriers to service development, as well as to the potential benefits.

Osteopath practice within a GP practice

An osteopath in a market town told us of his work in a GP practice for over ten years. He worked initially as a private practitioner but for the past four years has been NHS-funded via the Any Qualified Provider (AQP) initiative of 2011. He works as part of an MSK triage team receiving direct referrals from GPs, urgent care clinic nurses, and from patients needing more than physiotherapy help. He told us:

“When I put the case to the practice for joining them my impression was that the GPs were pleasantly surprised at the extent and detail of our training... Some older GPs struggle to understand or accept osteopaths, but younger GPs and consultants accept us more readily. Most GPs admit to not being best placed to manage MSK and are delighted to have osteopaths on site. We have now been approached to put together an MSK triage pathway because the Care Quality Commission has said that too many patients are being referred to orthopaedic consultants for unnecessary tests. I believe that osteopaths are well-placed to manage the middle ground between GP and consultant.”

Independent osteopathic practice

Any Qualified Practitioner arrangements have not always run smoothly, however. An osteopathic practice in a rural community applied for an AQP licence in 2012. The practice used two treatment rooms in a purpose-built clinic, with one full time osteopath and two part time associates. The practice also offered acupuncture. The clinic was open six days a week for 49 hours including extended evening and early morning opening. A licence was granted but was later not renewed despite contracted KPIs being met and impressive audit data.

We were shown audit data for 456 patients seen in 2014. A pre and post treatment audit showed statistically significant MSK improvement. 336 patients completed a satisfaction survey. 99.4% saying that they would recommend the practice to friends and family. Among 11 GPs who had made referrals at that time, ten said it was ‘very likely’ and one ‘likely’ that they would make further referrals. Ten were ‘very satisfied’ with the service and one ‘satisfied’.

The practice owner told us:

‘The paperwork submitted for the AQP licence consisted of an 18,000 word tender document referencing 13 policy documents. For a small provider like us, this was a huge amount of work requiring investment in new IT software and the creation of a management structure with a board, a Caldicott Guardian, a Senior Information Risk Owner, and so on. We were a small provider operating in a system designed for large NHS providers. We were one of the first providers to secure an AQP contract so the system was not yet designed for small private sector companies. It was very difficult for us to get the Health and Social Care Information Centre’s Information Governance Statement of Compliance which we needed in order to get access to the NHS National Network (N3) connection for Choose and Book.’
NHS changes finally brought the AQP service to an end. The practice was awarded the AQP contract by a Primary Care Trust but the Clinical Commissioning Groups which replaced the PCT seemed to view AQP as a PCT project which it did not need to continue. The practice said:

‘The CCG commissioners were not interested in and not very knowledgeable about the MSK back and neck pain service, nor indeed about osteopathy itself. We had an excellent reputation amongst many of our local GPs, which helped us to engage with them. However, the commissioners in our area were not aiding or managing the process. Having exceeded all our contract’s performance indicators, having delivered excellent outcomes for our patients, and having achieved exemplary patient and GP satisfaction levels, our AQP contract was not renewed. Indeed, none of the AQP MSK contracts were renewed in our area. Our interpretation of this (formed after a telephone conversation with commissioners) is that commissioners were looking for a cheaper way to deliver the service.’

The practice owner nevertheless believes that a well-managed AQP process would be ‘perfect’ for the NHS and should be encouraged.

**Multi-disciplinary teamworking**

A city osteopath described a multidisciplinary team made up of osteopaths, doctors, psychologists and exercise therapists, working in four clinics. Working 3½ days a week for the service as a self-employed contractor, he told us:

‘The service focuses solely on low back pain and was established in 2000 with two local GPs, one of whom also had osteopathic training. The service is known as the ‘acute back pain service’ and is run from four clinics, three of which are based in GP surgeries. Each acute clinic has an osteopath and a GP with a special interest in back problems. In a fourth (sub-acute) clinic we have cognitive behavioural therapists and exercise therapists as well. The emphasis is on the development of a multi-disciplinary collaboration. A GPwSI has a supervisory role over the whole service while four osteopaths provide triage, manipulation, lifestyle/exercise advice and overall patient management. Osteopaths also organise MRI scans. The subacute clinic is for the more chronic patients with significant psychological overlay, and for patients with specific exercise requirements because of conditions such as obesity.’

Patients are referred from all the GP practices in the city. Referrals go first to a referral management centre where a ‘GP Sifter’ looks for the most appropriate diagnostic and treatment pathway – either to the acute back pain service, a parallel physiotherapy service or to a consultant-led service. We were told:

‘Patients can be rerouted at any time so the back pain clinics are effectively a triage and treatment service. We don’t worry about defining overall responsibility for the patient. We refer patients to each other without writing letters. It’s a flexible working arrangement. I invoice the health service every month and am paid on a sessional basis. The pay is comparable to private practice and you don’t have to worry about practice costs and patient numbers. There is a target for patient numbers and waiting lists but you have the freedom to manage your time. I might see some patients for 15 minutes if that’s all they need - to discuss managing one particular facet of their problem or I could spend an hour with more complex patients.’
A joint clinic with a physiotherapist

In this practice an osteopath worked with a physiotherapist and a musculoskeletal physician. Patients were referred directly by GPs, the requirement for referral being that the patient had ‘failed’ previous primary care interventions. The musculoskeletal physician was a semi-retired local GP with a special interest – a training in musculoskeletal medicine from the British Institute of Musculoskeletal Medicine (BIMM).

The clinic’s osteopath told us:

‘We operate one day a week out of three rooms based in a surgical podiatry unit. The musculoskeletal physician is essentially the clinical lead but we work very much as a team. We sift through the paper referrals, together, working out who is the best person between us to see a patient for the initial consultation and then we refer to one another as necessary as we go along. The requirement for patients to be referred to the clinic is that they have already had other interventions in primary care that haven’t helped, such as pain relief or physiotherapy. In effect, we are very much a secondary care tier which is frustrating in some ways because it would probably be better to see the patients sooner. Our physician specialises in injections. Patients with very clear root signs or miserable radicular pain tend to be referred to him. Patients that have less root pain come to me or the physiotherapist. I see a lot of what might be described as “dysfunction”. The peripheral joint problems tend to go to the physio - they might be shoulders and knees that haven’t been helped in primary care but are deemed not to be surgical. There is some overlap. But we’ve been together for 14 years and know our strengths and weaknesses so we can identify quickly which one of us a patient should be seeing. There isn’t really any hierarchy – each opinion carries equal weight. I would describe it as a very comfortable and easy relationship – mutual respect and trust, a good understanding and a good questioning of one another.’

As with the independent osteopathy practice already described, this clinic had felt the uncertainties of life in the NHS:

‘Over the 14 years we’ve had a few ‘near death’ experiences with the political changes to the NHS. We might be the blue-eyed boys for a while but the next minute we’re dispensable. I know the future of the clinic would be in jeopardy if our physician were to retire. I doubt if the commissioners or the local GP community would allow me or the physiotherapist to run this clinic. We would need a GP with a special interest in musculoskeletal medicine to step in. And we know there was a management attempt to close the clinic to save money. However, there was such a groundswell of support for the clinic from local GPs that the plan was dropped. One GP wrote to the local press saying that the clinic should be held up as a beacon of exemplary practice of the management of musculoskeletal conditions rather than being binned!’

We heard several accounts of skirmishes with commissioners, with a few Clinical Commissioning Groups still categorising osteopathy as a ‘procedure of limited clinical value’ in order to refuse or withdraw funding.

Secondary care models

In secondary care, there has always been more room for experimentation with different care models and we found osteopaths in a variety of clinical and management roles. We wanted to know how well osteopathy was integrated into specialist services. Almost without exception, we were told that relations with other professional groups were good and that services could be well-integrated.
In one hospital an osteopath leads a musculoskeletal team of 15. The team also includes orthopaedic physicians, a consultant rheumatologist, a consultant podiatrist, a physiotherapist, a dietician, acupuncturists, clinical psychologists and traditional Chinese therapists. The osteopath lead told us:

‘I took over from a consultant orthopaedic physician in 2012 and am responsible for the management of the clinical team in addition to providing clinical care myself. It is a part-time role – I work there two days a week. I offer osteopathy and trigger point therapy. We regularly use other services within the hospital - CBT, mindfulness training and educational classes such as chronic back pain education classes and autogenic training.’

But we were especially interested in a now decommissioned osteopathy service at a teaching hospital. When the service was running, a consultant spinal surgeon wrote:

‘Our spinal unit is a fully integrated team of surgeons, physiotherapists, specialist nurse practitioners, extended scope spinal practitioners and, since 1999, osteopaths. Our osteopaths take referrals from surgeons and other team members as well as from consultants in other units. They offer us a different approach to managing chronic and complex spinal pain and we value their input.’

The unit’s lead osteopath at the time added:

‘We’ve developed a close working relationship with our pain management consultants. We spend time in clinic with each other and we learn a lot from each other. We can also refer to the back pain team where there is a cognitive behavioural therapist and we will often collaborate with our physio. We’ve even experimented recently with joint clinics with physiotherapy where we see patients together. I would say we are becoming steadily more integrated.’

Despite this, the osteopathy service was subsequently decommissioned, as a ‘procedure of limited clinical value’

**Conclusion:** Successful models of osteopathic practice and multi-disciplinary MSK practice already exist in the NHS. However, such arrangements need to be nurtured and planned for the long term, with commitment which survives NHS changes. The involvement and support of doctors is critical for teams to function effectively.

**NHS work - benefits and challenges**

The benefits of multidisciplinary teamwork within the NHS were recognised and appreciated by all the osteopaths that we spoke to who had experience of them. They generally spoke of trust, ways of working which were flexible and informal, relationships with GPs which were improving as osteopathic services became better known.

One osteopath working in a GP practice did not feel that he was part of the same team as physiotherapists and saw a mutual perception of the professions being in opposition. But this was not often said. An osteopath working in hospital made a much more positive comment about his relationship with physiotherapists and other groups:

‘Relations are extremely good. I have an exemplary working relationship with all physiotherapists that I work with born of mutual respect. Physiotherapists and osteopath
are not so different, actually. They mustn’t be feared and we mustn’t scoff at them either. They are very, very good at their jobs and very well-educated – most physiotherapists at band 8a grade have an MSc at least and a lot have PhDs now. There is a massive overlap between all MSK disciplines – if you take a rational osteopath, a rational physio and a rational chiropractor you will find we are all talking, essentially, the same language. There might be a slight dialect but we are all dealing with similar conditions – stiffness, tight muscle, mechanical dysfunction, etc. In some cases it might be better to put your hands on and stretch a tight muscle. In others it might be better to exercise it. If we all put our minds and expertise together, it works really well. Most importantly, patients benefit.’

An osteopath working in primary care put it this way:

‘I don’t think working in the NHS has changed my practice of osteopathy but it has given me a better understanding of our profession’s role within a wider context. It has made me appreciate the scope of osteopathic practice because I have found we do have something different to offer and we approach and think quite differently. But it has also made me realise that we must recognise our limitations. I think osteopaths who work exclusively in private practice can miss a trick – they may be very well-meaning and proficient at what they do but they can exist in ivory towers. They need to recognise what else is available. We do have a different approach but you have to accept that ours is not the only way.’

Others acknowledged that working more closely with doctors had improved their clinical skills. One said:

‘...my systematic enquiry of a patient and the thoroughness of my history-taking has improved through working with medical colleagues.’

Reaching out to a wider community was also recognised as a benefit of NHS work:

‘I very much enjoy providing treatment to people who couldn’t afford osteopathy or don’t know what it is.

There was parallel recognition of the contribution osteopaths can make to the NHS. The consultant spinal surgeon already quoted said, in addition:

‘The osteopaths who have worked in our team have all been highly professional, skilled at recognising when to refer on to others in the team, and have provided high quality care to our patients. The work that the osteopathic team carry out is supported by robust clinical audit, which has demonstrated their value in reducing the numbers of patients requiring long term pain management and surgery.’

But osteopaths with experience of NHS working also gave us some insights into why there are not more osteopaths working in the NHS. We were told that osteopaths have not always been good at communicating with other health professionals, explaining what they do and ‘talking the NHS language’. One said:

‘Our profession has some responsibility in, to date, not talking to GPs or writing letters and communications in appropriate medical language, but instead favouring more ambiguous osteopathic terms.’

Another commented:

‘I think all things come back to how an osteopath is perceived by GPs and the wider health community ... I would come back to the letter writing. I think it is important to engage with the local medical community in some way because then, if they speak to a GP about
possible NHS work or knock on a commissioner’s door, there has already been some contact with them and their work and it might help open the door.’

We mentioned earlier the lack of exposure to NHS work during training. Another osteopath told us:

‘A ‘private patient’ approach to patient care can’t work in the NHS. If osteopathy is to be widely accepted within the NHS I think there needs to be some behavioural change within osteopathy as a profession… I assume that this is born from the fact that many private osteopaths work as sole practitioners, rarely integrating with other clinicians. There also needs to be an understanding of how the NHS works.’

**Conclusion:** NHS work can be professionally satisfying for osteopaths as well as operationally useful for a stretched NHS, but osteopaths need to understand the NHS better if they are to play a bigger part in service development.

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**Helping osteopaths prepare for NHS work**

It was put to us during our review that schools of osteopathy should look for ways to give their students experience of work alongside other health professions, especially AHPs. We support this. Generally, the training of health professionals is a partnership between universities and the NHS. Osteopathy training is university-validated but the only clear link with the NHS is that school clinics accept NHS referrals. We suggest:

- A round table review of the relationship between osteopathic training and the NHS, and the opportunities for placements in either direction. The review should involve the osteopathic educational institutions – the iO, GOsC and the Council of Deans of Health which represents UK university faculties for nursing, midwifery and the allied health professions.
- Undergraduate training which ensures that osteopaths are taught adequately about the structure and functions of the NHS and given training in multi-disciplinary team-working and leadership.

Practising osteopaths then need help to see multidisciplinary team working for the opportunity that it is. Unfamiliarity with NHS structures and lack of contact with other professions and networks leaves osteopaths uncertain about how to identify NHS opportunities and wary about applying for them. We suggest:

- A new iO member service programme to help osteopaths looking for ways into NHS work. It might include training in mentoring for osteopaths with experience of multi-disciplinary working, a way of introducing trained mentors to osteopaths needing advice, publication of osteopathy-focused interpretations of NHS policies, courses on tendering, advice on NHS recruitment processes, and courses to let members role-play interview situations.
Osteopaths especially need authoritative briefing about changes in the NHS. The AQP initiative, even with its cumbersome paperwork, was an opportunity in 2011 which osteopaths might have taken better advantage of. Development of First Contact Practitioners (FCPs) is another opportunity. In May 2019 NHS England and NHS Improvement set out how commissioners could enable patients with MSK conditions to self-refer to a physiotherapist working in primary care. This followed a 2018/19 evaluation of FCP working which demonstrated faster treatment for patients, improved patient satisfaction, reduced pressure on GPs, streamlined pathways and fewer unnecessary referrals. Quoting the NHSE/NHSI 2019 statement:

“Physiotherapists working as FCPs could see up to half of all patients with MSK conditions (up to 10% of all patients currently being seen by GPs).”

But the 2019 NHSE/NHSI statement also makes clear that the principles proposed for physiotherapists providing FCP services can be applied to other AHPs including osteopaths. They must first demonstrate compliance with the Health Education England (HEE) and NHS England Musculoskeletal Core Capabilities Framework but this should not be an obstacle. We asked osteopathy educators whether there was anything in the framework which would present a problem for an osteopath seeking to do FCP work. We were advised not. The framework builds on work by the Arthritis and Musculoskeletal Alliance (ARMA) and its member organisations, one of which is the Institute of Osteopathy. All that is needed now is practical advice for osteopaths on how to demonstrate compliance with the framework.

**Conclusion:** Student osteopaths should be taught about the NHS and experience work with other health professions. Once qualified, it is in primary care that osteopaths can make the biggest contribution to patient care and NHS efficiency. The profession’s institutions should work together to explain and promote developments such as First Contact Practitioner status.

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**Helping the NHS become more open to osteopathy**

Just as many osteopaths do not understand the NHS, so many of the NHS’s policy makers and managers have only limited appreciation of what osteopaths could contribute, either as individual MSK professionals or as team members. This despite a shortage of AHPs which the Nuffield Trust estimated in 2019 at 10,000.

Such ignorance is concerning, given this statement in the NHS Long Term Plan (LTP):

*AHPs can significantly support the demand profile the NHS faces and we have recently published 15 studies demonstrating how AHPs currently support patient flow across the whole system.*

LTP Workforce Implementation Groups should recognise the skills that AHPs such as osteopaths can bring to implementing the Plan and ensure that NHS England, NHS Employers, NHS Professionals, NHS Jobs, NHS Trusts and Community and Primary Care bodies all embrace the plan’s central idea on use of AHPs.
A number of practical steps could be taken immediately:

- Job descriptions and advertisements should not be too specific. Current wordings often exclude certain AHPs even though a range of AHP professionals would be suitable for the positions.

- Many job application websites in England ask for details of registration with the Health Care Professions Council (HCPC) on the first page and have no option to enter GOsC as the regulator. This is a major barrier to the recruitment of osteopaths in the NHS.

- The NHS in Scotland, Wales and Northern Ireland do not recognise osteopaths as AHPs because they are not registered with the Health Care Professions Council (HCPC). Recognition of osteopaths as AHPs should be UK-wide. Current limitations should be reviewed.

- The new GP Contract\textsuperscript{24} references physiotherapists but no other musculoskeletal practitioners. Future versions should consider adding osteopaths to the relevant sections of the GP Contract.

There should also be a re-examination of prescribing by osteopaths. Prescribing is currently approved for some nurses, pharmacists, physiotherapists and optometrists and this should be extended to include suitably trained osteopaths.

**Conclusion:** NHS organisations could take a number of simple steps immediately to show osteopaths that their work is recognised and their role valued, especially given the shortage of AHPs.
Conclusions

There is no single best way forward. Success often depends on the chemistry between individual osteopaths and doctors. To some extent, osteopaths, other AHPs and doctors have to take action themselves. Some of the solutions are educational.

It is clear that allied health professionals already contribute significantly to our health services, but they could do more with wider acceptance, involvement and extension of their roles across the healthcare system. Many physiotherapists and a few osteopaths already work in NHS primary care and in specialist MSK teams with significant success, but these professions, especially, could do much more.

The policies outlined in the NHS Long Term Plan of 2019 clearly recognise this potential contribution. But for a profession such as osteopathy to be included in these developments, some positive steps are needed beyond those required for the much longer-established AHP groups. This is not to give osteopaths preference over others. It is simply to recognise that their acceptance and inclusion is made very difficult because of their prior lack of involvement and the current structure and practices of NHS Commissioners.

Our review has listed the main problems and suggested solutions. We commend it to all interested groups and organisations for comment, consideration and action. Comments should be sent to the Institute of Osteopathy (details below) and would be welcome from patients, individual clinicians and organisations.

The Institute of Osteopathy, as the principal representative UK organisation for osteopaths, now has its own tasks to take forward, informing, developing and supporting individual osteopaths to work in or with the NHS and encouraging its regional groups to extend their local NHS contacts.

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For more information

Maurice Cheng, Chief Executive Officer
Institute of Osteopathy
email: Maurice@iOsteopathy.org

iOsteopathy.org
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THE ROLE OF OSTEOPATHS AS ALLIED HEALTH PROFESSIONALS WITHIN THE NATIONAL HEALTH SERVICE

An independent review for the Institute of Osteopathy

By
Professor Adrian Newland, CBE (Chair)
Christina Edwards, CBE
Professor Martin Roland, CBE

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